Draft: 10/26/21

Market Conduct Examination Guidelines (D) Working Group
Virtual Meeting
October 7, 2021

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1. Heard Opening Remarks

Mr. Hughes welcomed Georgia to the Working Group, represented by Ms. Nunes and Scott Sanders and Vermont, represented by Karla Nuissl.

2. Adopted its Sept. 2 Minutes

The Working Group met Sept. 2 and took the following action: 1) adopted a Title in-force standardized data request (SDR) and a Title claims SDR for inclusion in the reference documents of the *Market Regulation Handbook* (Handbook); and 2) received and discussed verbal updates from state insurance regulator volunteers who reviewed models with the potential to affect the examination standards of the Handbook. The models discussed included the *Unfair Trade Practices Act* (#880), the *Insurance Holding Company System Regulatory Act* (#440), the *Corporate Governance Annual Disclosure Model Act* (#305), the *Corporate Governance Annual Disclosure Model Regulation* (#306), the *Suitability in Annuity Transactions Model Regulation* (#275), the *Health Maintenance Organization Model Act* (#430), and the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651).

Ms. Weyhenmeyer made a motion, seconded by Mr. Pyle, to adopt the Working Group's Sept. 2 minutes (Attachment XXXXXX). The motion passed unanimously.

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Mr. Hughes said the draft chapter, which was circulated on Sept. 27, was provided by Ms. Rodriguez for the Working Group's consideration. Ms. Rodriguez said she reviewed Model #651, and she provided suggested revisions in track changes for the Working Group's review. She recommended changing all occurrences of the word "written" to "documented," as "documented" would appear to be more relevant based upon the current business environment in 2021. She mentioned that the terms "policyholder," "enrollee," etc. are used interchangeably throughout Chapter 25, and she recommended that a decision be made on which term should be used within the chapter, and perhaps the entire Handbook. She added references to Model #651 where appropriate, in the exam standards of Chapter 25, and she suggested other revisions, including, but not limited to, network adequacy exam standards 1 and 7, as well as the marketing and sales section of the chapter. Mr. Hughes said no comments had yet been received on the draft chapter, and he asked that comments on the draft be submitted by Oct. 28.

4. Discussed a New Draft Chapter 20—Conducting the Health Examination for Inclusion in the Handbook

Mr. Hughes said the draft chapter, which was circulated on Sept. 30, was provided by Ms. Paskey for the Working Group's consideration. Ms. Paskey said she reviewed Model #430, and she provided a suggested revision to the quality assessment and improvement examination standard 4, adding a new category of documents—quality of care complaints—to the documents to be reviewed section of the exam standard. She recommended the creation of an additional marketing and sales examination standard to address contract requirements, which are referenced in Section 8 of Model #430. She said she reviewed the grievances and external review examination standards in the chapter, and she noted that the definition of adverse determination in Model #430 and the *Uniform Health Carrier External Review Model Act* (#75) does not include experimental and investigational treatment, whereas the *Health Carrier Grievance Procedure Model Act* (#72) does include experimental and

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investigational treatment in the definition of adverse determination. She proposed that the definitions section of Model #430 and Model #75 be revised, for the sake of consistency, to include experimental and investigational treatment in the definition of adverse determination. Mr. Hughes said revisions to NAIC models would be beyond the scope of the Working Group; however, this issue could be brought to the attention of the appropriate working group(s) for future consideration. He asked Ms. Paskey to provide suggested language for a new marketing and sales standard regarding contract requirements. Ms. Paskey said she would be able to draft this language for the Working Group's review. Mr. Hughes said no comments had yet been received on the draft chapter, and he asked that comments on the draft be submitted by Oct. 30.

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Mr. Hughes said various state insurance regulator volunteers have been reviewing adopted models that have the potential to affect the examination standards of the Handbook. The purpose of each state insurance regulator's review was to see whether any revisions need to be made to the Handbook regarding the specific model they volunteered to review.

Ms. Shipp, who reviewed the *Real Property Lender-Placed Insurance Model Act* (#631), recommended that updates be made to Chapter 21—Conducting the Property and Casualty Examination of the Handbook regarding the model. She said Section 4—Term of Insurance Policy; Section 5—Calculation of Coverage and Payment of Premiums; Section 6—Prohibited Practices; Section 8—Evidence of Coverage; and Section 9—Filing, Approval and Withdrawal of Forms and Rates all contained provisions that should be incorporated into various sections of Chapter 21. Mr. Hughes asked Ms. Shipp to provide her suggested revisions to the chapter. Ms. Shipp said she would be submitting these for the Working Group's consideration on an upcoming call.

Mr. Kreiter reviewed Model #440, which was amended in 2020. He said he drafted and provided Mr. Hughes and Ms. Weyhenmeyer with revisions incorporating provisions from Model #440 into Operations and Management Standard 1 and Marketing and Sales Standard 1 of Chapter 20—General Examination Standards of the Handbook. Mr. Hughes said this would be exposed for Working Group consideration and discussed on an upcoming call.

Mr. Hughes said Mr. Werbeloff volunteered to review an initial draft of revisions to Chapter 23—Conducting the Life and Annuity Examination of the Handbook; the draft incorporated changes relating to the revisions adopted in February 2020 to Model #275. The draft Mr. Werbeloff reviewed was created by the former Nebraska Department of Insurance (DOI) Director, Bruce R. Ramge, in 2020 as a "first draft," and the draft had not yet been circulated, as Mr. Hughes wished to have state insurance regulator volunteers review the draft to see whether it was acceptable for presentation to the Working Group as is or if further revisions would be needed prior to exposure.

Mr. Werbeloff said the revisions proposed by Director Ramge would have removed some of the relevant content of the chapter. Mr. Werbeloff said he created a redline to: 1) incorporate the former director's suggested revisions; and 2) reincorporate the content in the chapter that should be retained. He indicated that Mr. Gendron, Steve DeAngelis (CT), and Mr. Swan were all part of the review of the redlined draft, and he asked Mr. Hughes to solicit one or more additional volunteers to review the draft before forwarding it to the Working Group for its review and consideration. Mr. Pyle volunteered to review the draft.

Ms. Amann said she is continuing to review Model #305 and Model #306. She indicated that there are six categories of review in Exhibit M, each of which have multi-part questions, and these categories appear to overlap somewhat with Market Analysis Level 1 and Level 2 review questions. She said she is continuing to review the models, specifically Exhibit M regarding potential application to market conduct examinations review criteria and how corporate governance review could be included in the procedural guidance in the Handbook. Ms. Abejar added that if market regulators are examining a foreign company, they should be able to talk to the domestic financial analyst of the state of domicile. Mr. Hughes said the Working Group will continue to discuss this issue on future open Working Group calls.

6. Discussed Other Matters

Mr. Hughes said the Market Analysis Procedures (D) Working Group adopted revisions in early 2021 to chapters of the Handbook related to market analysis—Chapters 6, 7, 8 and 9—and the chapters went before the Market Regulation and Consumer Affairs (D) Committee for consideration of adoption at the Spring National Meeting. Mr. Hughes said Petra Wallace (NAIC) is reviewing the language of the Spring National Meeting minutes to see if the chapters can be directly placed in the 2022 Handbook or if, when they were adopted by the Market Regulation and Consumer Affairs (D) Committee, the Committee indicated that the Working Group needs to vet the chapters again before being incorporated into the 2022 Handbook.

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Chapter 25—Conducting the Medicare Supplement Examination

IMPORTANT NOTE:
The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in 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.

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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~~ documented verification programs to ensure that participating health care professionals meet minimum specific professional qualifications, both initially and on an ongoing basis.

Additional introductory material is located in Chapter 20—General Examination Standards.

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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), Section 10

Review Procedures and Criteria

Ascertain that the plan of operation has been filed with the insurance commissioner.

Review the plan of operation for compliance with applicable statutes, rules and regulations.

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STANDARDS
OPERATIONS/MANAGEMENT

Standard 2
The entity reports to the insurance department on an annual basis, each resident of the state for whom the entity has more than one Medicare supplement policy or certificate in force.

Apply to: All Medicare supplement carriers

Priority: Essential

Documents to be Reviewed

_____ Reporting Medicare supplement policies form

_____ Records of issued Medicare supplement policies/certificates

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 9.2 and 22

Review Procedures and Criteria

Ascertain that the reporting Medicare supplement policies form has been filed with the insurance commissioner.

Review policy and certificate records to ascertain whether multiple sales of policies or certificates to individual enrollees have been made.

Review the reporting Medicare supplement policies form and compare with multiple sales findings during the examination to ensure that the entity has accurately reported multiple sales.

Verify plans after Jan. 1, 2020 are in compliance with Section 9.2 of Model # 651.

Verify the Benefit Chart of Medicare Supplement Plans Sold on or after Jan. 1, 2020 is correct pursuant to Model #651.

Verify the information provided by the carrier on Plan F or High Deductible F is correct pursuant to Model #651, for plans issued on or after Jan. 1, 2020.

Verify the information provided by the carrier on Plan G or High Deductible G is correct pursuant to Model #651, for plans issued on or after Jan. 1, 2020.

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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.

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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), Section 16

Review Procedures and Criteria

Review procedures, producer compensation agreements and producer manuals to ascertain whether the entity's standards for producer compensation are in compliance with applicable statutes, rules and regulations concerning replacement sales.

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B. Complaint Handling

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

C. Marketing and Sales

1. Purpose

The marketing and sales portion of the examination is designed to evaluate the representations made by the entity about its product(s). Typically, it is not based on sampling techniques, but sampling may be used as a review tool. The areas to be considered in this kind of review include all ~~written~~documented, verbal and electronic advertising and sales materials. The entity's website that informs about Medicare supplement availability and/or benefits, would be considered advertising and should be reviewed for accuracy.

2. Techniques

This area of review should include all advertising and sales material, including Internet advertising, and all producer sales training materials to determine compliance with applicable statutes, rules and regulations. Information from other jurisdictions may be reviewed, if appropriate. The examiner may contact policyholders, producers and others to verify the accuracy of the information provided or to obtain additional information. The examiner should be familiar with outlines of coverage and replacement regulations. Policyholder records are a good source for detection of multiple issues of Medicare supplement policies. Suitability should be considered in reviewing the entity's sales and marketing practices.

The entity must have procedures in place to establish and at all times maintain a system of control over the content, form and method of dissemination of its advertisements. All advertisements maintained by, or for, and authorized by the entity are the responsibility of the entity.

The same statutes, rules and regulations (such as the *Unfair Trade Practices Act* (#880)) that apply to conventional advertising also apply to Internet advertising. When the examiner is reviewing an entity's Internet advertisements, it is important to also review the safeguards implemented by the entity.

All advertisements are required to be truthful and not misleading in fact or by implication. The form and content of an advertisement of a policy shall be sufficiently clear ~~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.

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Ensure that the entity prohibits the sale of Medicare supplement policies or certificates to people enrolled in a Medicare ~~+ Choice~~ Advantage or private fee-for-service plans.

Ensure that the entity prohibits the sale of a Medicare supplement policy/certificate to an individual already covered under such a policy, unless the new policy/certificate is a replacement policy/certificate.

Ensure that producer commission schedules do not encourage replacement sales or sales of more than one Medicare supplement policy/certificate to an individual, or discourage eligible individuals with unfavorable risk characteristics.

Ensure that the entity offers to all eligible individuals all the Medicare supplement products it sells.

Determine whether individuals in the state have been eligible for ~~guaranteed issue~~ guaranteed issue because of termination of Medicare business by managed care organizations, and review company practices with respect to eligible individuals.

Determine whether individuals in the state have been eligible for guaranteed issue for other situations as described in NAIC Model References Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 12.

Review entity communications to company personnel, producers and applicants about open enrollment and guaranteed-issue rights.

3. Tests and Standards

The marketing and sales review includes, but is not limited to, the following standards addressing various aspects of the marketing and sales function. The sequence of the standards listed here does not indicate the priority of the standard.

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STANDARDS
MARKETING AND SALES

Standard 1
Entity rules concerning replacement are in compliance with applicable statutes, rules and regulations.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ Bulletins, newsletters and memos

_____ Replacement register

_____ Underwriting guidelines and files

_____ Replacement comparison forms (if external replacement)

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)

Review Procedures and Criteria

Review replacement register to see if it is cross-indexed by producer and entity to determine if the entity has been targeted for replacements by a producer (internal or external).

Ensure that the application or other form asks whether the policy or certificate is intended to replace or add to any coverage currently in force.

Ensure that the application or other form asks all the questions required by state law to be asked.

Determine if the entity permits multiple sales of Medicare supplement policies to the same person.

Using a random selection of policyholders, have the entity run a policyholder/certificateholder history to identify the number of policies or certificates sold to those individuals.

Determine if underwriting guidelines place limitations on multiple sales; i.e. limits on coverage, determination of suitability, detection of predatory sales practices, etc.

Ensure that the entity, when determining whether a sale involves replacement, furnishes to the applicant prior to policy/certificate issue, or at the time of issue in the case of a direct response sale, the required notice concerning replacement of Medicare supplement coverage, obtains the signatures required by state law, and maintains one copy of the signed notice on file.

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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~~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~~six-month preexisting condition period under their prior coverage.

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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.

DRAFT

STANDARDS
MARKETING AND SALES

Standard 3
The entity obtains receipts from applicants verifying that the outline of coverage has been received and that it is the outline of the policy for which the applicant has applied.

Apply to: All Medicare supplement carriers

Priority: Essential

Documents to be Reviewed

_____ Application files

_____ Outlines of Coverage

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 17~~C~~

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.

DRAFT

STANDARDS
MARKETING AND SALES

Standard 4
The *Guide to Health Insurance for People with Medicare* is provided to the applicant within the time frame required by law and is in compliance with applicable statutes, rules and regulations.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ Application files

_____ Underwriting files

_____ *Guide to Health Insurance for People with Medicare*

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 17~~A~~

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.

DRAFT

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~~documented, created, ~~designed~~designed, or presented.

DRAFT

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."

DRAFT

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.

DRAFT

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~~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.

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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.

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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~~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.

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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.

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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.

DRAFT

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~~endorsed, or accredited, or connected with any governmental entity.

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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.

DRAFT

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.

DRAFT

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.

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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.

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D. Producer Licensing

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

E. Policyholder Service

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

F. Underwriting and Rating

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

G. Claims

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

H. Grievance Procedures

1. Purpose

The grievance procedures portion of the examination is designed to evaluate how well the Medicare Select carrier handles grievances.

A "grievance" means dissatisfaction in writing with the administration, claims practices or provision of services concerning an issuer of a Medicare Select product or network provider.

Note that these definitions may not include all ~~written~~ documented communications that the company tracks as "complaints" under the definition of complaint.

The examiner should review the company procedures for processing grievances. Specific problem areas may necessitate an overall review of a particular segment of the company's operation.

2. Techniques

A review of grievance procedures should incorporate consumer and provider appeals, consumer direct grievances to the company and those grievances filed with the insurance department. The company should reconcile the company grievance register with a list of grievances from the insurance department. A random sample of grievances and appeals should be selected for review from the company's grievance register.

The company's ~~written~~ documented grievance procedures should be reviewed. Determine how those procedures are communicated to plan members within membership materials and upon receipt of appeals and grievances.

The examiner should review the frequency of similar grievances and be aware of any pattern of specific types of grievance. Should the type of grievance noted be cause for unusual concern, specific measures should be instituted to investigate other areas of a company's operation. This may include modifying the scope of examination to examine specific company behavior.

3. Tests and Standards

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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.

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STANDARDS
GRIEVANCE PROCEDURES

Standard 1
The entity defines as a grievance any dissatisfaction expressed in writing with the administration, claims practices or provision of services concerning an issuer of a Medicare Select product or network.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Sample documents and files, including electronic correspondence

_____ Outlines of coverage

_____ Policies and/or certificates of coverage

_____ Contracts

_____ Grievance procedures

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

Review the contracts, outlines of coverage, grievance procedures, sample grievance files and disclosures to determine if the company is correctly defining "grievance."

DRAFT

STANDARDS
GRIEVANCE PROCEDURES

Standard 2
The entity develops ~~written~~ documented grievance procedures that comply with applicable statutes, rules and regulations, and provides enrollees with a copy of its grievance procedures.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Procedures manuals

_____ Policies and/or certificates of coverage

_____ Outlines of coverage

_____ All forms used to process a grievance

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

Determine if the entity provides grievance registration information to the policyholder at the time of the issuance of a policy or certificate.

Determine if the entity has procedures to ensure that a copy of its grievance procedures is provided to any enrollee or prospective enrollee upon request.

Determine if the entity includes a copy of its grievance procedures in its policies, certificates (if applicable) and outlines of coverage.

Review the disclosure form(s) to determine if a description of the entity's grievances procedures is included.

Review the entity's grievance procedures to ensure that the procedures are aimed at mutual agreement for settlement and that, if applicable, any arbitration procedures are disclosed.

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STANDARDS
GRIEVANCE PROCEDURES

Standard 3
The entity documents, resolves and records grievances in compliance with applicable statutes, rules and regulations, and their contract language.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Entity's grievance handling policies and procedures

_____ Sample of grievance files

_____ Outlines of coverage

_____ Policies and/or certificates of coverage

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

The entity maintains a grievance register ~~consisting of written records~~ that documents all grievances received during the calendar year.

The entity reports all grievances to the insurance commissioner annually, with the information and in the format required by law.

The entity complies with its ~~written~~ documented procedures when receiving and resolving grievances.

The entity considers grievances in a timely manner and transmits grievances to appropriate decision-makers.

The entity takes corrective action promptly on valid grievances.

The entity promptly notifies concerned parties of the results of a grievance review.

DRAFT

STANDARDS
GRIEVANCE PROCEDURES

Standard 4
The company provides to any enrollee, who has filed a grievance, detailed information concerning its grievance and appeal procedures, how to use them and how to notify the insurance department, if applicable.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Procedures for processing grievances

_____ Grievance forms and other information provided to an enrollee at the time the enrollee files a grievance

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

Review the entity's procedures for processing a grievance to determine if the required disclosures are provided.

Review the entity's procedures to determine if, when required by state law, the enrollee is advised of the right to contact the insurance department.

Review the grievance procedures to ensure that a provision is made for grievance registration information to be provided at the time of issue and upon request.

As grievances are detected throughout the entire examination, ensure that they have been handled and recorded properly.

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STANDARDS
GRIEVANCE PROCEDURES

Standard 5
The company reports its grievance procedures to the insurance commissioner on an annual basis.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Procedures for processing grievances

_____ Procedures for annually reporting grievances to the insurance commissioner

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

The examiner should determine whether the entity has procedures in place for recording and reporting grievances to the insurance commissioner.

The examiner should ensure that the entity has reported on an annual basis and in the format prescribed by the insurance commissioner, the number of grievances filed in the previous year and a summary of the subject, nature and resolution of such grievances.

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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~~ documented selection standards for providers and review the plan of operation. Using the list of providers and facilities, examiners should request a sample of specific provider contracts. The review of provider contracts should include an evaluation of compliance with filing requirements and adherence to patient-protection requirements. In addition to direct contracts with providers and facilities, examiners should review the ~~written~~ documented guidelines and contractual requirements established for intermediary contracts. Availability of emergency care facilities and procedures should be evaluated. Examiners should obtain verification that accurate provider directories are provided upon enrollment, are updated and dispersed periodically, and that the company has filed its updated list of network providers with the insurance commissioner on a quarterly basis. Another area for review includes grievances related to provider access issues.

3. Tests and Standards

The network adequacy review includes, but is not limited to, the following standards related to the adequacy of the health carrier's provider network. The sequence of the standards listed here does not indicate priority of the standard.

DRAFT

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 *MK Rodriguez comment: Should ZIP code be referred to as geographic location?*

_____ Any policies or incentives that restrict access to subsets of network specialists

_____ Computer tools used to assess the network's adequacy

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Benefit Plan Network Access and Adequacy Model Act (#74), Section 5
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

Reasonable criteria include, but are not limited to:

- Ratios of providers (primary care providers and specialty providers) to enrollees;
- Geographic accessibility, as measured by the reasonable proximity of participating providers to the business or personal residence of enrollees;

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- 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~~ documented policies and procedures specifying when the company will pay for out-of-area and out-of-network services that are covered by the policy, or as are required by state law. In any case where the company is required to cover services and it has an insufficient number or type of participating providers to provide a covered benefit, the company shall ensure that the enrollee obtains the covered benefit at no greater cost than if the benefit were obtained from participating ~~providers, or~~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.

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STANDARDS
NETWORK ADEQUACY

Standard 2
The company has a plan of operation for each plan offered in the state, and files updates whenever it makes a material change to an existing plan.

Apply to: Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Plan of operation

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

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

- Covered services are available and accessible though network providers;
- Either the number of network providers in the service area is sufficient to deliver adequately all services, or that the company makes appropriate referrals for provision of such services outside its network;
- There are ~~written~~ documented agreements with network providers describing specific responsibilities;
- Emergency care is available 24 hours per day, 7 days per week;
- The provider agreements prohibit the provider from billing or otherwise seeking reimbursement from enrollees, other than for coinsurance, copayments or supplemental charges;
- A description or map of the service area;
- A description of the company's grievance procedures;
- A description of the quality assurance program, including the formal organizational structure, the criteria for selection, retention and removal of network providers and the procedures for evaluating quality of care and taking corrective action when warranted;
- A list and description of network providers, by specialty; and
- Any other information requested by the insurance commissioner.

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STANDARDS
NETWORK ADEQUACY

Standard 3
The company ensures that enrollees have access to emergency services 24 hours per day, 7 days per week within its network and provides coverage for urgently needed services and emergency services outside of the service area.

Apply to: Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Provider manuals and contracts

_____ Policy forms

_____ Plan of operation

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

Within the network, the company operates or contracts with facilities to provide enrollees with access to emergency and urgently needed services on a 24 hours per day, 7 day per week basis.

The company covers in full, emergency services or services that are immediately required for an unforeseen illness, injury or condition, when it is not reasonable to obtain services through network providers.

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STANDARDS
NETWORK ADEQUACY

Standard 4
The company files with the insurance commissioner all required contract forms and any material changes to a contract proposed for use with its participating providers and intermediaries.

Apply to: Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Provider manuals

_____ Sample of provider contracts

_____ Credentialing file

_____ Directory of providers

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10.

Review Procedures and Criteria

Determine if the provider contracts and endorsements have been filed (if required by state law).

Review provider contracts to determine if the provider is listed in the directory and to determine if credentialing is ~~up-to-date~~up to date.

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STANDARDS
NETWORK ADEQUACY

Standard 5
The company executes with each participating provider ~~written~~ documented agreements that are in compliance with applicable statutes, rules and regulations.

Apply to: Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Provider manuals, contracts and intermediary subcontracts

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10.

Review Procedures and Criteria

Every contract between a Medicare Select carrier and a participating provider or provider group contains a "hold harmless" provision specifying protection for enrollees from being billed by providers for other than coinsurance, copayments or supplemental charges.

The contract provides an extension of benefits beyond the period during which the policy was in ~~force, if~~force if the enrollee suffers continuous total disability after contract termination.

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STANDARDS
NETWORK ADEQUACY

Standard 6
The company's arrangements with participating providers comply with applicable statutes, rules and regulations.

Apply to: Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Provider manuals and contracts

_____ Credentialing and re-credentialing procedures

_____ Complaints made by providers

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Benefit Plan Network Access and Network Adequacy Model Act (#74), Section 6

Review Procedures and Criteria

When required by state law, the company complies with the following:

- The company establishes a mechanism by which the participating provider will be notified on an ongoing basis of the specific covered health services for which the provider will be responsible, including any limitations or conditions on services;
- The company develops selection standards for primary care professionals and each health care professional specialty. The standards are used in determining the selection of health care professionals by the health carrier, its intermediaries and any provider networks with which it contracts;
- The company makes its selection standards for participating providers available for review by the insurance commissioner;
- The company notifies participating providers of the providers' responsibilities with respect to the carrier's applicable administrative policies and programs, including, but not limited to, payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements and any applicable state insurance law;
- The company does not offer inducements to providers to provide less than medically necessary services to enrollees;
- The company does not prohibit a participating provider from discussing treatment options with enrollees, regardless of the health carrier's position on the treatment options, or from advocating on behalf of enrollees within the utilization review or grievance processes established by the carrier or a person contracting with the carrier;

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- 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.

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STANDARDS
NETWORK ADEQUACY

Standard 7
The company provides at enrollment a directory of providers participating in its network. It also makes available, on a timely and reasonable basis, updates to its directory and files the directory with the insurance commissioner.

Apply to: Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Provider directory and updates

_____ Provider contracts

_____ Credentialing and re-credentialing documentation

_____ Internet directory

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

Request information regarding the carrier's frequency of updates to the provider directory.

Verify that the company is providing directory updates to enrollees and to the insurance commissioner at the frequency required by state law.

Review how provider data is maintained. If the provider directory is not produced from the same system(s) that handles the administration functions, determine if the data is maintained consistently between systems.

If the provider directory is made available on the carriers' website, verify that a paper version can be requested, as an option, by the enrollee.

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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~~ documented credentialing and re-credentialing policies and procedures, the scope and timeliness of verifications, the role of health professionals in ensuring accuracy and the oversight of any delegated verification functions.

2. Techniques

Prior to reviewing records for specific providers, examiners should request all ~~written~~ documented credentialing procedures from the company. Examiners should determine the composition of the carrier's credentialing committee. Examiners should use the company's provider directory to select a sample of specific provider credential files, drawing from a variety of provider types and facilities. For each provider selected, the examiner should request:

a. The provider application;
b. Credentialing verification materials, including materials obtained through primary and secondary sources;
c. Updates to credentialing information; and
d. Copies of correspondence to providers that relates to the credentialing process.

Examiners should determine how the credentialing committee permits providers to correct information and provide additional information for reconsideration. In the event the credentialing process is subcontracted, examiners should determine whether the contracting entity is following applicable standards.

3. Tests and Standards

The provider credentialing review includes, but is not limited to, the following standards related to the adequacy of the health carrier's provider credentialing and contracting processes. The sequence of the standards listed here does not indicate priority of the standard.

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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~~ documented policies and procedures for credentialing and re-credentialing of all health care professionals with whom the company contracts and applies those standards consistently.

The company ensures that the carrier's medical director or other designated health care professional has the responsibility for, and participates in, the health care professional credentialing verification process.

The company establishes a credentialing verification committee consisting of licensed physicians and other health care professionals to review credentialing verification information and supporting documents in order to make decisions regarding credentialing verification.

The company makes all application and credentialing verification policies and procedures available for review by the applying health care professional upon written request.

The company keeps confidential all information obtained in the credentialing verification process, except as otherwise provided by state law.

The company retains all records and documents relating to a health care professional's credentialing verification process for at least the number of years required by state law.

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The company's policies and procedures for credentialing and re-credentialing of providers are in compliance with state law.

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STANDARDS
PROVIDER CREDENTIALING

Standard 2
The company verifies the credentials of a health care provider before entering into a contract with that health care provider.

Apply to: All Medicare Select plans

Priority: Essential

Documents to be Reviewed

_____ Provider credentialing files

_____ Provider contracts

_____ Provider credentialing policies and procedures

_____ Provider directory

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70), Section 5

Review Procedures and Criteria

Ensure that the company verifies that providers are properly credentialed, prior to entering into a contract with the provider and placing the provider name in the provider directory. This can be achieved by comparing the effective date of the provider's contract with the date of credentialing and the date the provider's name is entered in the provider directory.

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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.

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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).

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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.

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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.

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STANDARDS
PROVIDER CREDENTIALING

Standard 7
The company monitors the activities of the providers and provider entities with which it contracts and ensures that the requirements of state law are met.

Apply to: All Medicare Select plans

Priority: Essential

Documents to be Reviewed

_____ Provider credentialing and re-credentialing policies and procedures

_____ Intermediary contracts

_____ Periodic reports from intermediaries

_____ Reports of entity reviews and audits (if any) of credentialing activities by the company

_____ Minutes of the credentialing committee

_____ Minutes of the board of directors

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70)

Review Procedures and Criteria

The company ensures that providers and provider entities with which it contracts meet the requirements of state law applicable to such providers and provider entities.

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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~~ documented quality assessment and improvement policies and procedures, annual certifications, reporting of disciplined providers, communications with members about the program and oversight of delegated quality-related functions.

2. Techniques

In some jurisdictions, the quality assessment and improvement function may be monitored jointly by the Department of Insurance and Department of Health (or similar agency). To evaluate quality assessment and improvement activities, examiners should request information relative to the composition of the quality assessment and improvement committee. Examiners should also determine frequency of quality assessment and improvement meetings. To obtain an accurate assessment of a company's quality assessment and improvement program, it is advisable to review quality assessment and improvement committee meeting minutes for all meetings conducted during the examination period. Ascertain whether the quality assessment program reasonably encompasses all aspects of the covered health care services. Determine whether the carrier has obtained certification from a nationally recognized accreditation entity. Determine which standards will be met by virtue of the certification process. Examiners should evaluate the process by which quality assessment and improvement information and directives are communicated to network providers. Review procedures such as peer review, for including network providers in the quality assessment and improvement process. Ascertain whether outcome-based goals and objectives are being monitored and met.

3. Tests and Standards

The quality assessment and improvement review includes, but is not limited to, the following standards related to the assessment and improvement activities conducted by the health carrier. The sequence of the standards listed here does not indicate priority of the standard.

DRAFT

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.

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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~~ documented quality assessment program, periodically reviews and revises the program documents and acts to ensure ongoing appropriateness. Not less than semi-annually, the chief medical officer or clinical director reviews reports of quality assessment activities (*Quality Assessment and Improvement Model Act* (#71), Section 7).

The company has an appropriate ~~written~~documented policy to ensure the confidentiality of an enrollee's health information used in the company's quality assessment programs (*Quality Assessment and Improvement Model Act* (#71), Section 9).

The company complies with all applicable provisions of state law not expressly covered by any other of these standards.

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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).

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The company has a ~~written~~ documented quality improvement plan that includes:

- A statement of the objectives, lines of authority and accountability, evaluation tools, data collection responsibilities, performance improvement activities and annual effectiveness review of the program;
- Intent to analyze processes and outcomes of care to discern the causes of variation;
- Identification of the targeted diagnoses and treatments to be reviewed each year;
- Methods to analyze quality, including collection and analysis of information on:
    - Over- or under-utilization of services;
    - Evaluation of courses of treatment and outcome of care; and
    - Collection and analysis of information specific to an enrollee or provider gathered from multiple sources and documentation of both the satisfaction and grievances of the enrollee(s);
- A method to compare program findings with past performance and internal goals and external standards;
- Methods for:
    - Measuring the performance of participating providers;
    - Conducting peer review activities to identify practices that do not meet the company's standards;
    - Taking action to correct deficiencies;
    - Monitoring participating providers to determine whether they have implemented corrective action; and
    - Taking appropriate action when they have not;
- A plan to utilize treatment protocols and practice parameters developed with clinical input and using evaluations described above or acquired treatment protocols and providing participating providers with sufficient information about the protocols to meet the standards; and
- Evaluating access to care for covered persons according to the state's standards, and a strategy for integrating public health goals with services offered under the plan, including a description of good faith efforts to communicate with public health agencies.

The company establishes an internal system to identify practices that result in improved health care outcomes, identify problematic utilization patterns, identify those providers that may be responsible for either exemplary or problematic patterns and foster an environment of continuous quality improvement (*Quality Assessment and Improvement Model Act* (#71), Section 6A).

The company ensures that participating providers have the opportunity to participate in developing, implementing and evaluating the quality improvement system (*Quality Assessment and Improvement Model Act* (#71), Section 6D).

The company provides enrollees with the opportunity to comment on the quality improvement process (*Quality Assessment and Improvement Model Act* (#71), Section 6E).

The company uses the findings generated by the system to work on a continuing basis with participating providers and other staff to improve the health care delivered to enrollees (*Quality Assessment and Improvement Model Act* (#71), Section 6B).

The company appoints a chief medical officer or clinical director to have primary responsibility for the quality improvement activities carried out by, or on behalf of, the health carrier (*Quality Assessment and Improvement Model Act* (#71), Section 7).

The chief medical officer or clinical director approves the ~~written~~ documented quality improvement program, periodically reviews and revises the program document and acts to ensure ongoing appropriateness. Not less than semi-annually, the chief medical officer or clinical director reviews reports of quality assessment activities (*Quality Assessment and Improvement Model Act* (#71), Section 7).

The company has an appropriate ~~written~~ documented policy to ensure the confidentiality of an enrollee's health information used in the company's quality improvement programs (*Quality Assessment and Improvement Model Act* (#71), Section 9).

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The company complies with all applicable provisions of state law not expressly covered by any other of these standards.

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STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 3
The company files with the insurance commissioner a ~~written~~ documented description, in the prescribed format, of the quality assessment program, which includes a signed certification by a corporate officer of the company that the filing meets the requirements of applicable statutes, rules and regulations.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ ~~Written~~ Documented description of the quality assessment program

_____ Signed certification by a corporate officer

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Quality Assessment and Improvement Model Act (#71), Section 5D

Review Procedures and Criteria

Determine if the forms have been filed.

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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.

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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.

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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.

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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.

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L. Utilization Review

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

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Chapter 24—Conducting the Health Examination

Introduction
The examination standards in Chapter 24—Conducting the Health Examination of the *Market Regulation Handbook* provide guidance specific to all health plans that may or may not include Minimum Essential Coverage (MEC), as defined by the Affordable Care Act (ACA), whereas Chapter 24A—Conducting the Affordable Care Act (ACA) Related Examination applies only to Qualified Health Plans (QHPs); NAIC models related to the ACA are set forth separately under each examination standard in Chapter 24A. When developing an examination or review plan related to MEC or ACA compliance, it is important to consider examination standards as applicable from both Chapter 24 and Chapter 24A. In the event of duplication or conflict of examination standards between the chapters, the examination standards and review criteria located in Chapter 24A—Conducting the Affordable Care Act (ACA) Related Examination will generally take precedence for QHP and ACA-related compliance, barring applicable state or federal laws to the contrary.

The intent of Chapter 24A—Conducting the Affordable Care Act (ACA) Related Examination in the *Market Regulation Handbook* is primarily to provide guidance when reviewing insurers whose business includes major medical policies that are intended to serve as Qualified Health Plans as defined by the ACA. In its current form, Chapter 24A is not intended to fully provide guidance on which standards are applicable to MEC policies that are not designated as QHPs. Where possible, reference to the applicability of the standards to MEC policies has been included.

Regardless of which chapter is used in the *Market Regulation Handbook,* the examiner will also need to reference Chapter 20—General Examination Standards for general examination standards that apply to all insurers.

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. Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation

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When conducting an exam that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the company is meeting standards. Some standards may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.

When an examination involves a depository institution or their affiliates, the bank may also be regulated by federal agencies such as the Office of the Comptroller of the Currency (OCC), the Federal Reserve Board, the Office of Thrift Supervision (OTS) or the Federal Deposit Insurance Corporation (FDIC). Many states have executed an agreement to share complaint information with one or more of these federal agencies. If the examination results find adverse trends or a pattern of activities that may be of concern to a federal agency and there is an agreement to share information, it may be appropriate to notify the agency of the examination findings.

Examiners should note that some of the following market conduct standards may apply to all health carriers, while others may apply only to health carriers with network plans. The manner in which a state may define or distinguish a network plan from indemnity plans or other types of health benefit plans in relation to the NAIC's model definitions of those plans should be taken into account when determining the extent to which each of these market conduct standards apply to health carriers with network plans. For instance, the NAIC definition of network plans is broad; i.e., "network plan" is defined as a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier. States may have a narrower definition of "network plan" that may impact how the standards are applied. Standards that apply to disability income insurance are so noted. Review procedures and criteria relating to HIPAA and small group requirements are generally not applicable to disability income insurance.

Examiners also should note that states may require, by law or regulation, that health plans receive certification by specific private accreditation organizations in order to obtain licensing. Other states may recognize accreditation as meeting specific state requirements. To the extent an examiner may take into account accreditation for specific operational areas (such as quality assessment and improvement, credential verification, utilization review, grievance processes or utilization management), when planning the examination and setting review priorities, the examiner should become familiar with the standards applied by the accrediting entity. Individual jurisdictions may have procedures in place for communicating deviations from such standards to the applicable accrediting entity in addition to administrative procedures.

A supplemental checklist is available at the end of this chapter to verify compliance with the *Advertisements of Accident and Sickness Insurance Model Regulation* (#40).

Exempt Benefit Plans

Examiners may encounter documents in the course of a health plan examination that refer to "ERISA plans." Many health carriers perform administrative functions on behalf of self-funded employers, union trusts and other collectively bargained groups (under ERISA Section 3(40)) that are not subject to state insurance regulation.

A Multiple Employer Welfare Arrangement (MEWA) is a welfare benefit plan set up to benefit the employees of two or more employers. This can be a cost-effective way for several small employers to band together to purchase health insurance for their employees. If the group is not a collectively bargained group, a Taft-Hartley trust or a self-funded employer group, then the benefit plan should comply with state insurance regulations and the ERISA exemption does not apply.

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According to advisory opinions from the U.S. Department of Labor, there are plans operating that may claim ERISA exemptions from state regulation that do not qualify for that exemption. Examiners may need to consult others in the insurance department or other regulatory agencies to correctly determine jurisdiction. Some states have enacted the NAIC Jurisdiction to determine Jurisdiction of Providers of Health Care Benefits Model Act which also provides guidance. Examiners may reference the NAIC Health and Welfare Plans Under the Employee Retirement Income Security Act (ERISA): Guidelines for State and Federal Regulation for more information about determining whether a state law is preempted by ERISA.

HIPAA—Federal Minimum Requirements

Examiners should be aware that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes minimum requirements for health insurance coverage in certain areas and prohibits the application of any state law to the extent that it prevents the application of a HIPAA requirement. However, states that have laws in these areas that extend beyond HIPAA's minimum requirements may enforce those laws. Group and individual health insurance issues affected by HIPAA include:

- Limits on preexisting condition exclusions;
- Prohibitions on discrimination based on health status and related factors;
- Guaranteed-issue for small groups of 2 to 50;
- Guaranteed renewability for all policies, with certain exceptions;
- Expansion of COBRA entitlement;
- Portability for eligible individuals leaving group coverage, with certain exceptions;
- Minimum maternity benefits when maternity is covered by the plan;
- Minimum standards for tax-qualified long-term care (LTC) policies;
- Mental health parity; and
- Standards for association group coverage.

Many states have requirements that impose more consumer protection requirements on carriers than HIPAA, in which case the state's requirements should be enforced. (For example, a state may include a group of one in its definition of "group" or "small group.")

Federally Mandated Benefits

Examiners should also be aware of benefits mandated under federal law and if state laws or regulations meet the minimum requirements established under federal law.

Federally mandated benefits include:

- The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986;
- The Mental Health Parity Act (MHPA) of 1996;
- Newborns' and Mothers' Health Protection Act (NMHPA) of 1996;
- Women's Health and Cancer Rights Act of 1998;
- Genetic Information Nondiscrimination Act (GINA) of 2008; and
- The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

IIPRC-Approved Products

When conducting an exam that includes products approved by the Interstate Insurance Product Regulation Commission (IIPRC) on behalf of a compacting state, it is important to keep in mind that the uniform standards—and not state-specific statutes, rules and regulations—are applicable to the content and approval of the product. The IIPRC website is *www.insurancecompact.org* and the uniform standards are located on its rulemaking record. Compacting states have access through the NAIC System for Electronic Rate and Form Filing (SERFF) to product filings submitted to the IIPRC for approval and use in their respective state or jurisdiction and can 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).

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A. Operations/Management

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

B. Complaint Handling

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

C. Marketing and Sales

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.

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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.

DRAFT

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 provisions relating to any preexisting condition provision; and
- All individual health benefit plans offered by the carrier, the prices of the plans, if available to the eligible person and the availability of the plans to the individual.

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Ensure the outlines of coverage accurately represent the applicable consumer protections and minimum standards required by HIPAA, which may include:

- Limits on preexisting condition exclusions;
- Prohibitions on discrimination based on health status and related factors;
- Guaranteed-issue for small groups of 2 to 50;
- Guaranteed renewability for all policies, with certain exceptions;
- Expansion of COBRA entitlement;
- Portability for eligible individuals leaving group coverage, with certain exceptions;
- Minimum maternity benefits when maternity is covered by the plan;
- Minimum standards for tax-qualified LTC policies;
- Mental health parity requirements;
- Limits on the factors that can be used to establish and change premium rates; and
- Descriptive information about all available health benefit plans.

Ensure the regulated entity maintains complete and detailed descriptions of its rating and underwriting practices for individuals and small groups at its principal place of business.

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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 LTC and Medicare products.

Determine if underwriting guidelines place limitations on multiple sales; i.e., limits on coverage, determination of suitability, detection of predatory sales practices, etc.

Determine whether marketing materials encourage multiple issues of policies; for example, use of existing policyholder list for additional sales of similar products to those held, birth date solicitations, scare tactics, etc.

Determine if negative enrollment practices are permitted and used.

Determine if the regulated entity has a system to discourage "over-insurance" of policyholders as defined by regulated entity underwriting requirements.

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D. Producer Licensing

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

E. Policyholder Service

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.

DRAFT

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.

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STANDARDS
POLICYHOLDER SERVICE

Standard 2
Evidence of creditable coverage is provided in accordance with the requirements of HIPAA and/or applicable statutes, rules and regulations.

Apply to: All health plans

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy history file

_____ Regulated entity procedures manual

Others Reviewed

Examiners are encouraged to reference the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)

_____ _____

_____ _____

NAIC Model References

Individual Health Insurance Portability Model Act (#37), Section 7

Review Procedures and Criteria

"Creditable coverage" includes most health coverage, including prior coverage under:

- Group health plan (including a governmental or church plan);
- Health insurance coverage (either group or individual);
- Medicare;
- Medicaid;
- Military-sponsored health care program such as CHAMPUS (Civilian Health and Medical Program of the Uniformed Services);
- Program of the Indian Health Service or tribal organization;
- Qualified state health benefits risk pool;
- Federal Employees Health Benefit Program;
- Public health plan established or maintained by a state or local government;
- COBRA (Consolidated Omnibus Budget Reconciliation Act); or
- Health benefit plan provided for Peace Corps members.

Documents that may establish creditable coverage include a certificate of coverage or, in the absence of a certificate of coverage, any of the following:

- Explanations of benefits or other correspondence from a plan or issuer indicating coverage;
- Pay stubs showing a payroll deduction for health coverage;
- Health insurance identification card;

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- Certificate of coverage under a group health policy;
- Records from medical care providers indicating health coverage;
- Third-party statements verifying periods of coverage;
- Benefit termination notice from Medicare or Medicaid; or
- Other relevant documents that evidence periods of health coverage.

Determine if the health carrier issues creditable coverage certificates as required.

The carrier must issue certificates automatically and upon request. "Upon request" allows a policy or certificateholder to request a certificate within 24 months of ceasing coverage or before coverage ends. Certificates must be issued within a reasonable time and at no charge.

Certificates should automatically be issued to:

- An individual entitled to elect COBRA, at a time no later than when a notice is required to be provided for a qualifying event under COBRA;
- An individual who loses coverage under the plan and who is not entitled to elect COBRA, within a reasonable time after coverage ceases; or
- An individual who leaves COBRA, within a reasonable time after COBRA coverage terminates.

Creditable coverage certificates should include:

- An indication whether an individual has at least 18 months of creditable coverage;
- For individuals with less than 18 months of creditable coverage, an indication of the dates when coverage began and ended and the dates any waiting or affiliation period began;
- A contact phone number; and either
    - When provided upon request, each period of continuous coverage ending within the 24 months prior to the date of the request; or
    - When automatically issued, the most recent period of coverage.

The carrier should have started issuing certificates June 1, 1997, or within the following guidelines:

- By June 1, 1997, certificates should have been delivered to all persons who lost coverage or began or ended COBRA coverage between October 1, 1996 and May 31, 1997 (notices are allowed in lieu of completed certificates as long as a certificate is issued upon request); or
- Certificates after July 1, 1998 must be issued with names and individual dates of coverage for all dependents. (Use of terms "spousal" or "family" allowed until July 1, 1998.)

Duplicate certificates should be provided free of charge.

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F. Underwriting and Rating

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.

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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.

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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.

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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.

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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 may be terminated;

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- 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.

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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.

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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.

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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 (#35)

Review Procedures and Criteria

Determine appropriate handling of preexisting conditions in accordance with the requirements of HIPAA and state law. Ensure creditable coverage is properly applied. The time constraints are:

- Preexisting conditions should be limited to a "physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on the enrollment date in a plan or policy;"
- The "enrollment date" is the first day of coverage or, if earlier, the first day of the waiting period; and
- Preexisting condition exclusion periods may be applied for a maximum of 12 months or 18 months for late enrollment. The preexisting condition exclusion period should be reduced by any prior creditable coverage. Preexisting condition exclusions cannot be applied to conditions identified as a result of genetic testing, pregnancy, newborns, newly adopted children or children newly placed for adoption within 30 days.

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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.

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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.

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"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.

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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.

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STANDARDS
UNDERWRITING AND RATING

Standard 9
The regulated entity issues individual insurance coverage to eligible individuals entitled to portability under the provisions of HIPAA and in compliance with applicable statutes, rules and regulations.

Apply to: All health products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files of denied policies

_____ Regulated entity guidelines

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Individual Health Insurance Portability Model Act (#37), Sections 7 and 10

Review Procedures and Criteria

This standard is designed to ensure portability requirements from HIPAA and/or state rules are followed. States are given broad latitude to develop alternatives to federal requirements. For federal fallback option states, a regulated entity:

- May limit coverage if it offers two different policy forms. ("Policy form" does not mean separate riders or cost-sharing mechanisms; it can, however, mean out-of-pocket and deductible differences that are "significantly different.");
- May offer two largest premium volume policy forms of previous reporting year. (State reporting year or October 1 to September 30, if state reporting year is not defined.);
- Alternatively, may offer low-level or high-level coverage policy forms that meet benefits substantially similar to other health insurance coverage offered by the issuer in the state; and
- May deny coverage by a network plan if individual does not live, reside or work in the network area. States may approve denial if the insurer demonstrates inability to deliver services adequately (due to volume of current group contractholders, etc.) and it uniformly denies the individual coverage. If denial is approved by the state, the issuer may not offer coverage in the individual market for 180 days. (Financial impairment may also be demonstrated to the state to allow denial.)

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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 (#100)

Review Procedures and Criteria—Multiple Employer Groups NOT claiming exemption from state regulation

Determine if the multiple employer group satisfies appropriate state or federal law to be qualified as either an association, MEWA or other arrangement permitted by law.

Determine if regulated entity forms and rates meet state requirements for filing and approval (if any).

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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.

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G. Claims

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.

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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 (#360)
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.

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Determine if claim handling meets any applicable state laws, including:

- Usual, customary and reasonable (UCR);
- Coordination of benefits (COB), including, but not limited to, the determination of primary and secondary coverage responsibilities, the timely determination of those responsibilities and the proper handling of savings provisions;
- Deductibles and coinsurance;
- Correct payees;
- Accelerated payments; and
- Unfair trade practices and unfair discrimination acts.

Review handling of cash or advance settlements of first-party long-term disability claims to ascertain whether the claimant was provided adequate information regarding future benefits.

Ascertain whether the company has misrepresented relevant facts or policy provisions relating to coverages at issue.

Determine if claim files are handled according to policy provisions.

Determine if any required explanation of benefit statements are provided to claimants.

Determine if claim handling includes proper referral of suspicious claims.

Determine that health benefit plans that cover drugs also provide benefits for any drug prescribed to treat a covered indication, so long as the drug has been approved by the FDA for at least one indication, if the drug is recognized for the treatment of the covered indication in one or more of the standard reference compendia or peer-reviewed medical literature. Exceptions—drugs determined to be contra-indicated for treatment of the current indication and drugs used in certain research trials.

Determine appropriate handling of claims in accordance with the requirements of HIPAA. The company should have procedures, which assure that no exclusions of coverage are imposed for a preexisting condition where HIPAA preexisting condition exclusion maximums have been reached, or claims denied where an individual has periods of creditable coverage, which should be credited from prior coverage.

For disability income insurance claims:

- If the minimum benefit is payable, confirm the correct minimum benefit is being used;
- If the policy provides for a pension supplement and the claimant is entitled to it, confirm that benefit is being paid to the pension plan administrator; and
- Ascertain that investigations to determine initial liability are fair and reasonable; i.e., if medical records do not objectively support disability, despite certification of disability by the physician, are independent medical evaluations being conducted and/or are insurers obtaining clarification of medical information from the insured's physician(s)?
- Review policy provisions relating to benefits:
    - Are the policy's offset provisions correctly applied to the benefit determination?
    - Are applicable cost of living adjustment (COLA) benefits correctly applied to the benefit payment?
    - Are benefits administered in accordance with provisions relating to changes in age or maximum benefit periods?
    - Are number of days calculated consistently and according to the policy provisions?
    - Are elimination periods, such as retroactive benefits, determined correctly?
- Verify the claimant met the policy's definition of gainfully employed and disabled;
- Verify the company disclosed to the claimant, when benefits are initially paid, that overpayment of benefits, because of other income benefits not being deducted, can be recovered from the claimant;

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- 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.

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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 (#903)
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

Determine if state statutes, rules or regulations impose different and/or more restrictive requirements on carriers than federal law. If so, ensure the company is in compliance with those statutes, rules or regulations.

Unless the state has a specific exemption because of an alternative law, HIPAA requires that all group health plans, insurance companies and HMOs offering health coverage for hospital stays in connection with the birth of a child must provide health coverage for a minimum of 48 hours for a normal 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.

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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 increased two percent or more due to the application of the MHPA requirements during the first year and at least one percent of the actual cost in each subsequent year. The 1996 MHPA does not allow carriers to set annual or lifetime dollar limits on mental health benefits that are lower than any such dollar limits for medical and surgical benefits. The 2008 revisions include substance abuse parity, and the law affects items such as cost-sharing features and utilization restrictions of the substance abuse/mental health benefits when compared to the medical/surgical benefits under the policy.

Note: MHPA does not apply to policies sold in the individual market or small group marketplace.

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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.

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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.

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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.

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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.

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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.

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Verify that the health carrier's grievance register is maintained in a manner that is reasonably clear and accessible to the insurance commissioner.

Verify that the health carrier retains the grievance register compiled for a calendar year for the longer of three years or until the insurance commissioner has adopted a final report of an examination that contains a review of the grievance register for that calendar year.

Verify that the health carrier submits to the insurance commissioner, at least annually, a report in the format specified by the insurance commissioner.

Verify that the health carrier's grievance report includes, for each type of health benefit plan offered by the health carrier:

- The certificate of compliance as required by applicable state statutes, rules and regulations;
- The number of covered lives;
- The total number of grievances;
- The number of grievances for which a covered person, or, if applicable, the covered person's authorized representative, requested an additional voluntary grievance review pursuant to applicable state statutes, rules and regulations;
- The number of grievances resolved at each level, if applicable, and their resolution;
- The number of grievances appealed to the insurance commissioner that the health carrier has been informed of;
- The number of grievances referred to in alternative dispute resolution procedures or resulting in litigation; and
- A synopsis of actions being taken to correct problems identified.

The health carrier shall comply with all applicable state provisions equivalent to the *Health Carrier Grievance Procedure Model Act* and accompanying regulations not expressly covered by any other of these standards.

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STANDARDS
GRIEVANCE PROCEDURES

Standard 3
A health carrier has implemented grievance procedures, disclosed the procedures to covered persons, in compliance with applicable statutes, rules and regulations, and files with the commissioner a copy of its grievance procedures, including all forms used to process a grievance.

Apply to: All health carriers offering a health benefit plan

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Grievance procedures

_____ All forms used to process a grievance

_____ Company approval register

_____ Grievance procedure filings filed with the insurance department

_____ Certificates of compliance filed with the insurance department

_____ Sample of grievance procedure disclosures provided to covered persons (e.g., policies, certificates, membership booklets, outlines of coverage or other evidence of coverage)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Carrier Grievance Procedure Model Act (#72), Section 6

Review Procedures and Criteria

Verify that the health carrier utilizes written procedures for receiving and resolving first level review of grievances involving an adverse determination, standard review of grievances not involving an adverse determination; and voluntary review of grievances from covered persons, or, if applicable, the covered person's authorized representative, pursuant to applicable state statutes, rules and regulations.

Verify that the health carrier files with the insurance commissioner a copy of its grievance procedures required by applicable state statutes, rules and regulations regarding first level review of grievances involving an adverse determination, standard review of grievances not involving an adverse determination, and voluntary review of grievances from covered persons, or, if applicable, the covered person's authorized representative, including all forms used to process grievance requests. Verify that the health carrier also files any subsequent material modifications to the documents.

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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.

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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.

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Verify that the health carrier, within three working days of the date of receipt of a first level grievance, informs the covered person, or, if applicable, the covered person's authorized representative, of his or her right to receive from the health carrier, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the covered person's request for benefits.

With regard to the covered person's, or, if applicable, the covered person's authorized representative's, right to have reasonable access to and to receive "relevant" documents, records and other information, verify that the health carrier considers a document, record or other information "relevant" to a covered person's, or, if applicable, the covered person's authorized representative's, request for benefits when the document, record or other information:

- Was relied upon in making the benefit determination;
- Was submitted, considered or generated in the course of making the adverse determination, without regard to whether the document, record or other information was relied upon in making the benefit determination;
- Demonstrates that, in making the benefit determination, the health carrier or its designated representatives consistently applied required administrative procedures and safeguards with respect to the covered person as other similarly situated covered persons; or
- Constitutes a statement of policy or guidance with respect to the health benefit plan concerning the denied health care service or treatment for the covered person's diagnosis, without regard to whether the advice or statement was relied upon in making the benefit determination.

Verify that the health carrier calculates the time period, within which a determination is required to be made and notice provided pursuant to applicable state statutes, rules and regulations, to begin on the date the grievance requesting the review is received by the health carrier in accordance with the health carrier's procedures for filing a request, established pursuant to applicable state statutes, rules and regulations, for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

Verify that the health carrier notifies and issues a decision in writing or electronically to the covered person, or, if applicable, the covered person's authorized representative, within the time frames set forth in applicable state statutes, rules and regulations regarding the following types of grievances:

- With respect to a grievance requesting a first level review of an adverse determination involving a prospective review request, verify the health carrier notifies and issues a decision within a reasonable period of time that is appropriate, given the covered person's medical condition, but no later than thirty days after the date of the health carrier's receipt of the grievance requesting the first level review; or
- With respect to a grievance requesting a first level review of an adverse determination involving a retrospective review request, verify the health carrier notifies and issues a decision within a reasonable period of time, but no later than sixty days after the date of the health carrier's receipt of the grievance requesting the first level review.

Verify that the health carrier's decision of a first level review of a grievance involving an adverse determination is set forth in a manner calculated to be understood by the covered person, or, if applicable, the covered person's authorized representative, to include all of the following:

- The titles and qualifying credentials of the person or persons participating in the first level review process (the reviewers);
- A statement of the reviewers' understanding of the covered person's, or, if applicable, the covered person's authorized representative's, grievance;
- The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the covered person, or, if applicable, the covered person's authorized representative, to respond further to the health carrier's position;
- A reference to the evidence or documentation used as the basis for the decision; and

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- 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.

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STANDARDS
GRIEVANCE PROCEDURES

Standard 5
The health carrier has procedures for and conducts standard reviews of grievances not involving an adverse determination in compliance with applicable statutes, rules and regulations.

Apply to: All health carriers offering a health benefit plan

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Sample of grievances

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Carrier Grievance Procedure Model Act (#72), Section 8

Review Procedures and Criteria

Verify that the health carrier has established written procedures for standard review of grievances that do not involve an adverse determination.

Verify that the health carrier's procedures permit a covered person, or, if applicable, the covered person's authorized representative, to file a grievance that does not involve an adverse determination with the health carrier.

Verify that the health carrier, within three working days of receiving a grievance not involving an adverse determination, informs the covered person, or if applicable, the covered person's authorized representative, of his or her right to submit written material for the person or persons designated by the health carrier to consider when conducting the review.

Verify that the health carrier, upon receipt of the grievance that does not involve an adverse determination, designates a person or persons to conduct the standard review of the grievance.

Verify that the health carrier does not designate the same person or persons to conduct the standard review of the grievance that denied the claim or handled the matter that is the subject of the grievance.

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

Verify that the health carrier notifies in writing the covered person, or, if applicable, the covered person's authorized representative, of the decision within 20 working days after the date of receipt of the request for a standard review of a grievance.

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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.

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STANDARDS
GRIEVANCE PROCEDURES

Standard 6
The health carrier has procedures for voluntary reviews of grievances and conducts voluntary reviews of grievances in compliance with applicable statutes, rules and regulations.

Apply to: Health carriers offering a health benefit plan. The provisions in this examination standard do not apply to health indemnity plans.

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Sample of voluntary review grievances

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Carrier Grievance Procedure Model Act (#72), Section 9

Review Procedures and Criteria

Note: Although this examination standard requires a health carrier that offers managed care plans to establish an additional voluntary review process for its managed care plans, the decision to file a request for an additional voluntary review of a grievance involving an adverse determination rests solely within the discretion of the covered person, or, if applicable, the covered person's authorized representative. This examination standard addresses an optional additional level of review that the covered person, or, if applicable, the covered person's authorized representative, may voluntarily use to resolve the issue in dispute after receiving an adverse determination upon a health carrier's completion of a first level review of a grievance. The provisions of applicable state statutes, rules and regulations regarding this examination standard are not intended to be, and should not be considered to be, part of the requirements for the "full and fair review" of claim denials (known as adverse benefit determinations) under Section 503 of ERISA, as specified in the Department of Labor (DOL) final rule. As such, this section is not required to be included in any health carrier's internal claims and appeals process for purposes of complying with the DOL final rule published in the Federal Register, Nov. 21, 2000, or the interim final rules on internal claims and appeals and external review processes published in the Federal Register, July 23, 2010.

Verify that the health carrier has established an additional voluntary grievance review process for its managed care plans to give those covered persons who are dissatisfied with a first level grievance review decision involving an adverse determination, or who are dissatisfied with the standard review of grievances not involving an adverse determination, the option to request an additional voluntary review, at which the covered person, or, if applicable, the covered person's authorized representative, has the right to appear in person at the review meeting before designated representatives of the health carrier.

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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.

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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.

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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.

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STANDARDS
GRIEVANCE PROCEDURES

Standard 7
The health carrier has procedures for and conducts expedited reviews of urgent care requests of grievances involving an adverse determination in compliance with applicable statutes, rules and regulations.

Apply to: All health carriers offering a health benefit plan

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Sample of expedited appeals

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Carrier Grievance Procedure Model Act (#72), Section 10

Review Procedures and Criteria

Verify that the health carrier has established written procedures for the expedited review of urgent care requests of grievances involving an adverse determination. involving a situation where the time frame of standard grievance procedures:

- Would seriously jeopardize the life or health of a covered person or jeopardize the covered person's ability to regain maximum function; or
- In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the urgent care request.

Verify that a health carrier also provides expedited review of urgent care requests of a grievance involving an adverse determination with respect to concurrent review urgent care requests involving an admission, availability of care, continued stay or health care service for a covered person who has received emergency services, but has not been discharged from a facility.

Verify that the health carrier's procedures allow a covered person, or, if applicable, the covered person's authorized representative, to request an expedited review either orally or in writing.

Verify that the health carrier appoints an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed to review the adverse determination. Verify that a clinical peer or peers are not involved in making the initial adverse determination.

Verify that in an expedited review, the health carrier transmits all necessary information, including the health carrier's decision, between the health carrier and the covered person, or, if applicable, the covered person's authorized representative, by telephone, fax or the most expeditious method available.

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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);

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- 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.

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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.

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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;

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- 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.

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STANDARDS
NETWORK ADEQUACY

Standard 2
The health carrier files an access plan with the insurance commissioner for each network plan that the carrier offers in the state, and files updates whenever it makes a material change to an existing network plan. The carrier makes the access plans available: 1) on its business premises; 2) to regulators; and 3) to interested parties, absent proprietary information, upon request.

Apply to: Health carriers with network plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Copy of access plan filed in state and copy in use by company

_____ Member materials referencing access plans

_____ Provider manual

_____ Provider contract

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Benefit Plan Network Access and Adequacy Model Act (#74), Section 5F
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

The access plan shall describe or contain the following:

- The health carrier's network;
- The health carrier's procedures for making referrals within and outside of its network;
- The health carrier's process for monitoring and ensuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in its network plans;
- The health carrier's efforts to address the needs of covered persons with 1) limited English proficiency and illiteracy; 2) diverse cultural and ethnic backgrounds; and 3) physical and/or mental disabilities;
- The health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services;
- The health carrier's method of informing covered persons of the plan's services and features, including, but not limited to 1) the plan's grievance procedures; 2) its process for choosing and changing providers; and 3) its procedures for providing and approving emergency and specialty care;
- The health carrier's system for ensuring the coordination and continuity of care for covered persons referred to specialty physicians; for covered persons using ancillary services, including social services and other community resources; and for ensuring appropriate discharge planning;
- The health carrier's process for enabling covered persons to change primary care professionals; and

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- 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.

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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.

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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.

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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).

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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 or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering covered benefits to the carrier's covered persons;
- A health carrier shall maintain copies of all intermediary health care subcontracts at its principal place of business in the state, or ensure that it has access to all intermediary subcontracts, including the right to make copies to facilitate regulatory review, upon 20 days' prior written notice from the health carrier;
- If applicable, an intermediary shall transmit utilization documentation and claims paid documentation to the health carrier. The carrier shall monitor the timeliness and appropriateness of payments made to providers and health care services received by covered persons;
- If applicable, an intermediary shall maintain the books, records, financial information and documentation of services provided to covered persons at its principal place of business in the state and preserve them according to applicable statutory duration, in a manner that facilitates regulatory review;
- An intermediary shall allow the insurance commissioner access to the intermediary's books, records, financial information and any documentation of services provided to covered persons, as necessary to determine compliance; and

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- 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.

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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.

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The health carrier shall not prohibit a participating provider from 1) discussing treatment options with covered persons, regardless of the health carrier's position on the treatment options; or 2) advocating on behalf of covered persons within the utilization review or grievance processes established by the carrier or a person contracting with the carrier.

The health carrier shall require a provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of covered persons, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records.

The health carrier and participating provider shall provide at least 60 days' written notice to each other before terminating the contract without cause. The health carrier shall make a good faith effort to provide written notice of termination within 15 working days of receipt or issuance of a notice of termination to all covered persons who are patients seen on a regular basis by the provider whose contract is terminating, regardless of whether the termination was for cause or without cause. Where a contract termination involves a primary care professional, all covered persons who are patients of that primary care professional shall also be notified. Within 5 working days of the date that the provider either gives or receives notice of termination, the provider shall supply the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier.

The health carrier is responsible for ensuring that a participating provider furnishes covered benefits to all covered persons without regard to the covered person's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when the provider should not render services due to limitations arising from lack of training, experience, and skill or licensing restrictions.

The health carrier shall notify the participating providers of their obligations, if any, to collect applicable coinsurance, copayments or deductibles from covered persons pursuant to the evidence of coverage, or of the providers' obligations, if any, to notify covered persons of their personal financial obligations for non-covered services.

The health carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare.

The health carrier shall establish a mechanism by which participating providers may determine in a timely manner whether a person is covered by the carrier.

The health carrier shall establish procedures for resolution of administrative, payment or other disputes between providers and the health carrier.

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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.

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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.

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STANDARDS
PROVIDER CREDENTIALING

Standard 1
The health carrier establishes and maintains a program for credentialing and re-credentialing in compliance with applicable statutes, rules and regulations.

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Credentialing policies and procedures

_____ Credentialing plan

_____ Minutes of the credentialing committee

_____ Credentialing plan evaluation reports (if any)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70), Section 5A
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

The health carrier shall establish written policies and procedures for credentialing and re-credentialing verification of all health care professionals with whom the health carrier contracts and shall apply those standards consistently.

The health carrier shall ensure that the carrier's medical director or other designated health care professional shall have responsibility for, and shall participate in, the health care professional credentialing verification.

The health carrier shall establish a credentialing verification committee, consisting of licensed physicians and other health care professionals, to review credentialing verification information and supporting documents, in order to make decisions regarding credentialing verification.

The health carrier shall make all application and credentialing verification policies and procedures available for review by the applying health care professional upon written request.
The health carrier shall keep confidential all information obtained in the credentialing verification process, except as otherwise provided by law.

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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.

DRAFT

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.

DRAFT

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).

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STANDARDS
PROVIDER CREDENTIALING

Standard 4
The health carrier obtains, through either a primary or secondary credentialing verification process, the information required by applicable state provisions equivalent to the *Health Care Professional Credentialing Verification Model Act* (#70) and accompanying regulations.

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Checklist for credentialing

_____ Checklist and forms for site visits (if any)

_____ Reports made from site visits (if any)

_____ Sample of credentialing files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70), Section 6B
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

- The health care professional's license history in all states;
- The health care professional's malpractice history; and
- The health care professional's practice history.

DRAFT

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).

DRAFT

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.

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STANDARDS
PROVIDER CREDENTIALING

Standard 7
The health carrier provides a health care professional the opportunity to review and correct information submitted in support of that health care professional's credentialing verification.

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Credentialing policies and procedures

_____ Provider manual

_____ Listing of providers (active and terminated)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70), Section 7
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

The health carrier shall make available to each health care professional that is subject to the credentialing verification process the information, and the source of the information obtained by the health carrier, to satisfy the carrier's credentialing process.

The health carrier shall notify a health care professional of any information obtained during the health carrier's credentialing verification process that does not meet the health carrier's credentialing verification standards, or that varies substantially from the information provided to the health carrier by the health care professional, if the information is required to be verified by applicable state provisions equivalent to the *Health Care Professional Credentialing Verification Model Act* (#70) and accompanying regulations, unless such disclosure is prohibited by law.

The health carrier shall allow a health care professional to correct any erroneous information and request a reconsideration of the health care professional's credentialing verification application through a formal process by which the health care professional may submit supplemental or corrected information to the health carrier's credentialing verification committee.

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STANDARDS
PROVIDER CREDENTIALING

Standard 8
The health carrier monitors the activities of the entity with which it contracts to perform credentialing functions and ensures the requirements of applicable state provisions equivalent to the *Health Care Professional Credentialing Verification Model Act* (#70) and accompanying regulations are met.

Apply to: Health carriers with managed care plans that contract credentialing verification functions to intermediaries

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Credentialing policies and procedures

_____ Intermediary contracts

_____ Periodic reports from intermediaries

_____ Reports of entity reviews and audits (if any) of credentialing activities by health carrier

_____ Minutes of the health carrier's credentialing committee

_____ Minutes of the health carrier's board of directors

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70), Section 8
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

Whenever a health carrier contracts to have another entity perform credentialing functions, the health carrier shall be responsible for monitoring the activities of the entity with which it contracts and for ensuring that applicable state provisions equivalent to the *Health Care Professional Credentialing Verification Model Act* (#70) and accompanying regulations are met.

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K. Quality Assessment and Improvement

1. Purpose

The quality assessment portion of the examination is designed to ensure that companies offering managed care plans have quality assessment programs in place that enable the company to evaluate, maintain and, when required by state law, improve the quality of health care services provided to covered persons. For managed care plans that limit covered persons to a closed network, the standards also require a quality improvement program with specific goals and strategies for measuring progress toward those goals.

The areas to be considered in this kind of review include the company's written quality assessment and improvement policies and procedures, annual certifications, reporting of disciplined providers, communications with members about the program and oversight of delegated quality-related functions.

2. Techniques

In some jurisdictions, the quality assessment and improvement function may be monitored jointly by the Department of Insurance and the Department of Health (or similar agency). To evaluate quality assessment and improvement activities, examiners should request information relative to the composition of the quality assessment and improvement committee. Determine the frequency of quality assessment and improvement meetings. To obtain an accurate assessment of an insurer's quality assessment and improvement program, it is advisable to review quality assessment and improvement committee meeting minutes for all meetings conducted during the examination period. Ascertain whether the quality assessment program reasonably encompasses all aspects of the covered health care services. Determine whether the insurer has obtained certification from a nationally recognized accreditation entity. Determine which standards will be met by virtue of the certification process. Examiners should evaluate the process by which quality assessment and improvement information and directives are communicated to network providers. Review procedures, such as peer review, for including network providers in the quality assessment and improvement process. Ascertain whether outcome-based goals and objectives are being monitored and met.

3. Tests and Standards

The quality assessment and improvement review includes, but is not limited to, the following standards related to the assessment and improvement activities conducted by the health carrier. The sequence of the standards listed here does not indicate priority of the standard.

DRAFT

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.

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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.

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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.

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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;

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- 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.

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STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 4
The health carrier reports to the appropriate licensing authority any persistent pattern of problematic care provided by a provider that is sufficient to cause the health carrier to terminate or suspend contractual arrangements with the provider.

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Quality assessment and improvement policies and procedures

_____ Reports made to the licensing authority

_____ Terminated and suspended provider contract files

_____ Quality of Care complaints

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Quality Assessment and Improvement Model Act (#71), Section 5
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

Determine that policies and procedures address reporting requirements.

Ascertain whether applicable terminated and suspended contract files reflect compliance with reporting requirements. Examiners should note that some terminated and suspended contracts will involve issues that are not necessary to report.

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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.

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STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 6
The health carrier annually certifies to the insurance commissioner that its quality assessment and quality improvement program, along with the materials provided to providers and consumers, meets applicable statutes, rules and regulations.

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Certification filings

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Quality Assessment and Improvement Model Act (#71), Section 8
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

The health carrier shall make the certified materials available for review by the public upon request, subject to a reasonable fee (except for those materials subject to confidentiality requirements and materials that are proprietary to the health plan).

The health carrier shall retain all certified materials for at least 3 years from the date the material has been used or until the material has been examined as part of a market conduct examination, whichever is longer.

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STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 7
The health carrier monitors the activities of the entity with which it contracts to perform quality assessment or quality improvement functions and ensures that the requirements of applicable state provisions equivalent to the *Quality Assessment and Improvement Model Act* (#71) and accompanying regulations are met.

Apply to: All health carriers with managed care plans that contract to have another entity perform quality assessment or quality improvement activities

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Quality assessment and improvement policies and procedures

_____ Contracts with entities

_____ Reports of entity reviews and audits (if any) by health carrier

_____ Periodic reports from the entity

_____ Minutes from the health carrier's board of directors

_____ Minutes from the health carrier's quality assessment committee and quality improvement committee

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Quality Assessment and Improvement Model Act (#71), Section 10
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

The health carrier has established, implemented and enforces a policy to address effective methods of accomplishing oversight of each delegated activity.

DRAFT

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.

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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.

DRAFT

STANDARDS
UTILIZATION REVIEW

Standard 1
The health carrier establishes and maintains a utilization review program in compliance with applicable statutes, rules and regulations.

Apply to: Health carriers offering a health benefit plan providing or performing utilization review services

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations, including those related to mandated benefits and services

_____ Utilization review policies and procedures

_____ Utilization review program or plan documentation

_____ Medical criteria used to make utilization review determinations

_____ Job description of the staff position functionally responsible for day-to-day management

_____ Minutes of the health carrier's board of directors

_____ Minutes of the health carrier's utilization review committee

_____ Documentation of clinical staff credentialing maintenance and education requirements

_____ Program assessment reports

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Utilization Review and Benefit Determination Model Act (#73), Sections 5, 7 & 12

Review Procedures and Criteria

Verify that the health carrier implements procedures to ensure effective corporate oversight of its utilization review program.

Verify that a health carrier that requires a request for benefits under the covered person's health benefit plan to be subjected to utilization review, implements a written utilization review program that describes all review activities, both delegated and nondelegated for:

- The filing of benefit requests;
- The notification of utilization review and benefit determinations; and
- The review of adverse determinations in accordance with applicable state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72).

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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.

DRAFT

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.

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Verify that the health carrier has a process to ensure that utilization reviewers apply clinical review criteria in conducting utilization review consistently.

Verify that the health carrier conducts routine assessments of the effectiveness and efficiency of its utilization review program.

Verify that the health carrier's data systems are sufficient to support utilization review program activities and to generate management reports to enable the health carrier to monitor and manage health care services effectively.

If a health carrier delegates any utilization review activities to a utilization review organization, verify that the health carrier maintains adequate oversight, to include all of the following:

- A written description of the utilization review organization's activities and responsibilities, including reporting requirements;
- Evidence of formal approval of the utilization review organization program by the health carrier; and
- A process by which the health carrier evaluates the performance of the utilization review organization.

Verify that the health carrier coordinates its utilization review program activities with other medical management activity conducted by the health carrier—such as quality assurance, credentialing, provider contracting, data reporting, grievance procedures, claims adjudication, processes for assessing member satisfaction and risk management.

Verify that the health carrier provides covered persons, or, if applicable, the covered person's authorized representatives and participating providers with access to its utilization review staff via a toll-free number or collect call telephone line.

Verify that the health carrier, when conducting utilization review, collects only the information necessary, including pertinent clinical information, to make the utilization review or benefit determination.

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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 (#73), Section 13

Review Procedures and Criteria

Verify that the health carrier provides a clear and accurate summary of its utilization review and benefit determination procedures to prospective covered persons, or, if applicable, to the covered person's authorized representative.

Verify that the health carrier provides a clear and comprehensive description of its utilization review procedures, including the procedures for obtaining adverse review determinations, and a statement of rights and responsibilities of covered persons, or, if applicable, the covered person's authorized representative, with respect to those procedures, in the certificate of coverage or member handbook provided to covered persons.

Verify that the health carrier prints on its membership cards a toll-free telephone number to call for utilization review and benefit determination decisions.

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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 (#73), Section 9

Review Procedures and Criteria

Verify that the health carrier maintains written procedures, pursuant to applicable state statutes, rules and regulations, for making standard utilization review and benefit determinations on requests submitted to the health carrier by the covered person, or, if applicable, the covered person's authorized representative, for benefits and for notifying the covered person, and, if applicable, the covered person's authorized representative, of its determinations with respect to these requests within the specified time frames required pursuant to applicable state statutes, rules and regulations.

For prospective review determinations, verify that the health carrier makes the determination and notifies the covered person, or, if applicable, the covered person's authorized representative, of the determination, whether the carrier certifies the provision of the benefit or not, within a reasonable period of time appropriate to the covered person's medical condition, but in no event later than 15 days after the date the health carrier receives the request.

Whenever the determination is an adverse determination, verify that the health carrier makes the notification of the adverse determination in accordance with state statutes, rules and regulations regarding procedures for standard utilization review and benefit determination.

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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).

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For retrospective review determinations, verify that the health carrier makes the determination within a reasonable period of time, but in no event later than 30 working days after the date of receiving the benefit request.

If the retrospective review determination is an adverse determination, verify that the health carrier provides notice of the adverse determination to the covered person, or, if applicable, the covered person's authorized representative, in accordance with applicable state statutes regarding procedures for standard utilization review and benefit determination.

Verify that if the health carrier extends the time period for making a determination and notifying the covered person, or, if applicable, the covered person's authorized representative, of the determination one time for up to 15 days pursuant to applicable state statutes, rules and regulations, the health carrier has:

- Determined that the extension was necessary due to matters beyond the health carrier's control; and
- Notified the covered person, or, if applicable, the covered person's authorized representative, prior to the expiration of the initial 30 day time period, of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.

If the extension referenced above is necessary due to the failure of the covered person, or, if applicable, the covered person's authorized representative, to submit information necessary to reach a determination on the request, verify that the health carrier issues a notice of extension that:

- Specifically describes the required information necessary to complete the request; and
- Gives the covered person, or, if applicable, the covered person's authorized representative, at least 45 days from the date of receipt of the notice to provide the specified information.

Verify that the health carrier calculates the time periods, within which a prospective or retrospective determination is required to be made pursuant to applicable state statutes, rules and regulations, to begin on the date the request is received by the health carrier in accordance with the health carrier's procedures established pursuant to applicable state statutes, rules and regulations for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

If the time period for making a prospective or retrospective determination is extended due to the covered person's, or, if applicable, the covered person's authorized representative's, failure to submit the information necessary to make the determination, verify that the health carrier calculates the time period for making the determination to begin on the date on which the health carrier sends the notification of the extension to the covered person, or, if applicable, the covered person's authorized representative, until the earlier of:

- The date on which the covered person, or, if applicable, the covered person's authorized representative, responds to the request for additional information; or
- The date on which the specified information was to have been submitted.

Unless the state has a specific exemption because of an alternative law, HIPAA requires that all group health plans, insurance companies and HMOs offering health coverage for hospital stays in connection with the birth of a child must provide health coverage for a minimum of 48 hours for a normal 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.

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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 (#73), Section 9F

Review Procedures and Criteria

Verify that the health carrier issues notification of an adverse determination, in a manner calculated to be understood by the covered person, to include all of the following:

- The specific reason or reasons for the adverse determination;
- Reference to the specific plan provisions on which the determination is based;
- A description of any additional material or information necessary for the covered person, or, if applicable, the covered person's authorized representative, to perfect the benefit request, including an explanation of why the material or information is necessary to perfect the request;
- A description of the health carrier's grievance procedures established pursuant to applicable state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72), including any time limits applicable to those procedures;
- If the health carrier relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion, or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person, or, if applicable, the covered person's authorized representative, upon request;
- If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person, or, if applicable, the covered person's authorized representative, free of charge upon request;

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- 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.

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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 (#73), Section 10

Review Procedures and Criteria

Verify that the health carrier has established written procedures pursuant to applicable state statutes, rules and regulations for receiving benefit requests from covered persons, or, if applicable, their authorized representatives, and for making and notifying the covered person, or, if applicable, the covered person's authorized representative, of expedited utilization review and benefit determinations with respect to urgent care requests and concurrent review urgent care requests.

Verify that the health carrier, in the case of a failure by a covered person, or, if applicable, the covered person's authorized representative, to follow the health carrier's procedures for filing an urgent care request, notifies the covered person, or, if applicable, the covered person's authorized representative, of the failure and the proper procedures to be followed for filing the request.

Verify that the health carrier's notice regarding a covered person's, or, if applicable, the covered person's authorized representative's, failure to follow the health carrier's procedures for filing an urgent care request:

- Is provided to the covered person, or, if applicable, the covered person's authorized representative, as appropriate, as soon as possible, but not later than 24 hours after receipt of the request; and
- May be oral, unless the covered person, or, if applicable, the covered person's authorized representative, requests the notice in writing.

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Note: The provisions regarding the covered person's, or, if applicable, the covered person's authorized representative's, failure to follow the health carrier's procedures for filing an urgent care request apply only in the case of a failure that:

- Is a communication by a covered person, or, if applicable, the covered person's authorized representative, that is received by a person or organizational unit of the health carrier responsible for handling benefit matters; and
- Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment or provider for which approval is being requested.

For an urgent care request, unless the covered person, or, if applicable, the covered person's authorized representative, has failed to provide sufficient information for the health carrier to determine whether, or to what extent, the benefits requested are covered benefits or payable under the health carrier's health benefit plan, verify that the health carrier notifies the covered person, or, if applicable, the covered person's authorized representative, of the health carrier's determination with respect to the request, whether or not the determination is an adverse determination, as soon as possible, taking into account the medical condition of the covered person, but in no event later than 72 hours after the receipt of the request by the health carrier.

If the health carrier's determination is an adverse determination, verify that the health carrier provides notice of the adverse determination in accordance with applicable state statutes, rules and regulations regarding procedures for expedited utilization review and benefit determination.

If the covered person, or, if applicable, the covered person's authorized representative, has failed to provide sufficient information for the health carrier to make a determination, verify that the health carrier notifies the covered person, or, if applicable, the covered person's authorized representative, either orally or, if requested by the covered person, or, if applicable, the covered person's authorized representative, in writing of this failure and states what specific information is needed as soon as possible, but in no event later than 24 hours after receipt of the request.

Verify that the health carrier provides the covered person, or, if applicable, the covered person's authorized representative, a reasonable period of time to submit the necessary information, taking into account the circumstances, but in no event less than 48 hours after notifying the covered person, or, if applicable, the covered person's authorized representative, of the failure to submit sufficient information, pursuant to applicable state statutes, rules and regulations.

Verify that the health carrier notifies the covered person, or, if applicable, the covered person's authorized representative, of its determination with respect to the urgent care request as soon as possible, but in no event more than 48 hours after the earlier of:

- The health carrier's receipt of the requested specified information; or
- The end of the period provided for the covered person, or, if applicable, the covered person's authorized representative, to submit the requested specified information.

If the health carrier's determination is an adverse determination, verify that the health carrier provides notice of the adverse determination accordance with applicable state statutes, rules and regulations regarding procedures for expedited utilization review and benefit determination.

For concurrent review urgent care requests involving a request by the covered person, or, if applicable, the covered person's authorized representative, to extend the course of treatment beyond the initial period of time or the number of treatments, if the request is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, verify that the health carrier makes a determination with respect to the request and notifies the covered person, or, if applicable, the covered person's authorized representative, of the determination, whether it is an adverse determination or not, as soon as possible, taking into account the covered person's medical condition, but in no event more than 24 hours after the health carrier's receipt of the request.

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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.

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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 a utilization review organization or other entity perform the utilization review functions required by the *Utilization Review and Benefit Determination Model Act* (#73) or applicable state statutes, rules and regulations, the health carrier is responsible for monitoring the activities of the utilization review organization or entity with which the health carrier contracts and for ensuring that the requirements of the *Utilization Review and Benefit Determination Model Act* (#73) and applicable state statutes, rules and regulations are met.

Verify that the health carrier has policies and procedures in place that ensure the utilization review programs of designees comply with all applicable state and federal laws establishing confidentiality and reporting requirements.

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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.

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M. External Review

Use the standards set forth below.

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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 4
Health Maintenance Organization Model Act (#430)
Issues Involving External Review Procedures White Paper

Review Procedures and Criteria

The *Health Carrier External Review Model Act* (#75) shall apply to all health carriers that provide or perform utilization review, except for the following:

> "The provisions of this Act shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, as defined by [insert the reference to state law that defines long-term care insurance], vision care or any other limited supplemental benefit or to a Medicare supplement policy of insurance, as defined by the commissioner by regulation, coverage under a plan through Medicare, Medicaid or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis."

The health carrier shall notify covered persons in writing of the right to request an external review and shall:

- Include in the notice what circumstances constitute sufficient grounds for a standard, expedited or experimental/investigational review, and what procedures must be followed to request a review;
- Include an authorization form that allows the health carrier to disclose protected health information;
- Pay the cost of the independent review to the organization conducting the external review; and
- Include the telephone number and address of the insurance commissioner.

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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.

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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."

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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.

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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."

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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:

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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.

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N. Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (#40)

Applies to State?	Review Criteria	Pass	Fail	N/A
	This regulation shall apply to individual and group accident and sickness insurance (except Medicare supplement insurance or any other insurance that is covered by a separate state statute) "advertisement," as that term is defined in Section 3B, G, H and I, unless otherwise specified in this regulation. **(Section 2A)**			
	Every insurer shall establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All of the insurer's advertisements, regardless of by whom written, created, designed or presented, shall be the responsibility of the insurer whose policies are advertised. **(Section 2B)**			
	Advertising materials that are reproduced in quantity shall be identified by form numbers or other identifying means. The identification shall be sufficient to distinguish an advertisement from any other advertising materials, policies, applications or other materials used by the insurer. **(Section 2C)**			
	All information, exceptions, limitations, reductions and other restrictions required to be disclosed by this regulation shall be set out conspicuously and in close conjunction to the statements to which the information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisements so as to be confusing or misleading. This regulation permits, but is not limited to, the use of either of two methods of disclosure listed in this Section. **(Section 4)**			
	The format and content of an advertisement of an accident or sickness insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Format means the arrangement of the text and the captions. **(Section 5A)**			

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

Applies to State?	Review Criteria	Pass	Fail	N/A
	Distinctly different advertisements are required for publication in different media, such as newspapers or magazines of general circulation as compared to scholarly, technical or business journals and newspapers. Where an advertisement consists of more than one piece of material, each piece of material must, independent of all other pieces of material, conform to the disclosure requirements of this regulation. **(Section 5B)**			
	Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the commissioner from the overall impression that the advertisement may be reasonably expected to create within the segment of the public to which it is directed. **(Section 5C)**			
	Advertisements shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology, shall not be used. **(Section 5D)**			
	An insurer shall clearly identify its accident and sickness insurance policy as an insurance policy. A policy trade name shall be followed by the words "insurance policy" or similar words clearly identifying the fact that an insurance policy or health benefits product (in the case of health maintenance organizations, prepaid health plans and other direct service organizations) is being offered. **(Section 5E)**			
	An advertisement that is an invitation to contract[30] shall disclose the provisions relating to renewability, cancellability and termination and any modification of benefits, losses covered, or premiums because of age or for other reasons, in a manner that shall not minimize or render obscure the qualifying conditions. **(Section 7A)**			

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[30] An advertisement providing details about specific products and intended to promote consumer purchase of insurance. An advertisement that includes an application is generally considered an invitation to contract. Such an advertisement would be regarded as an offer to contract if it contains some language of commitment or some invitation to take action without further communication.

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

Applies to State?	Review Criteria	Pass	Fail	N/A
	Advertisements of cancelable accident and sickness insurance policies shall state that the contract is cancelable or renewable at the option of the company, as the case may be, in language substantially similar to the following: A policy that is renewable at the option of the insurance company shall be advertised in a manner similar to, "This policy is renewable at the option of the company," "The company has the right to refuse renewal of this policy," "Renewable at the option of the insurer" or "This policy can be cancelled by the company at any time." **(Section 7B)**			
	Advertisements of insurance policies that are guaranteed renewable, cancelable or renewable at the option of the company shall disclose that the insurer has the right to increase premium rates, if the policy so provides. **(Section 7C)**			
	Qualifying conditions that constitute limitations on the permanent nature of the coverage shall be disclosed in advertisements of insurance policies that are guaranteed renewable, cancelable or renewable at the option of the company. Examples of qualifying conditions are (1) age limits, (2) reservation of a right to increase premiums and (3) the establishment of aggregate limits. (1) Provisions for reduction of benefits at stated ages shall be set forth. For example, a policy may contain a provision that reduces benefits 50 percent after age 60, although it is renewable to age 65. Such a reduction shall be set forth. Also, a provision for the elimination of certain hazards at any specific ages or after the policy has been in force for a specified time shall be set forth. (2) An advertisement for a policy that provides for step-rated premium rates based upon the policy year or the insured's attained age shall disclose the rate increases and the times or ages at which the premiums increase. **(Section 7D)**			

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

Applies to State?	Review Criteria	Pass	Fail	N/A
	An insurer, directly or through its agents or brokers, shall: (1) Establish marketing procedures to assure that any comparison of policies by its agents or brokers will be fair and accurate; (2) Establish marketing procedures assuring excessive insurance is not sold or issued, except this requirement does not apply to group major medical expense coverage and disability income coverage; and (3) Establish auditable procedures for verifying compliance with this subsection. **(Section 8A)**			
	In addition to the practices prohibited in [insert reference to state law equivalent to the *Unfair Trade Practices Act* (#880)], the following acts and practices are prohibited: (1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of insurance policies or insurers for the purpose of inducing, or intending to induce, a person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert an insurance policy, or to take out a policy of insurance with another insurer; (2) High Pressure Tactics. Employing a method of marketing that has the effect of inducing the purchase of insurance, or tends to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance; and (3) Cold Lead Advertising. Making use directly or indirectly of any method of marketing that fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company. **(Section 8B)**			
	Testimonials and endorsements used in advertisements shall be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced. The insurer, in using a testimonial or endorsement, makes as its own all of the statements contained in it, and the advertisement, including the statement, is subject to all the provisions of this regulation. When a testimonial or endorsement is used more than one year after it was originally given, a confirmation must be obtained. **(Section 9A)**			

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

Applies to State?	Review Criteria	Pass	Fail	N/A
	A person shall be deemed a "spokesperson" if the person making the testimonial or endorsement: (1) Has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee or otherwise; (2) Has been formed by the insurer, is owned or controlled by the insurer, its employees or the person or persons who own or control the insurer; (3) Has any person in a policy-making position who is affiliated with the insurer in any of the above described capacities; or (4) Is in any way directly or indirectly compensated for making a testimonial or endorsement. **(Section 9B)**			
	The fact of a financial interest or the proprietary or representative capacity of a spokesperson shall be disclosed in an advertisement and shall be accomplished in the introductory portion of the testimonial or endorsement in the same form and with equal prominence. If a spokesperson is directly or indirectly compensated for making a testimonial or endorsement, the fact shall be disclosed in the advertisement by language substantially as follows: "Paid Endorsement." The requirement of this disclosure may be fulfilled by use of the phrase "Paid Endorsement" or words of similar import in a type style and size at least equal to that used for the spokesperson's name or the body of the testimonial or endorsement, whichever is larger. In the case of television or radio advertising, the required disclosure shall be accomplished in the introductory portion of the advertisement and shall be given prominence. **(Section 9C)**			
	The source of any statistics used in an advertisement shall be identified in the advertisement. **(Section 10C)**			
	When a choice of the amount of benefits is referred to, an advertisement that is an invitation to contract shall disclose that the amount of benefits provided depends upon the plan selected, and that the premium will vary with the amount of the benefits selected. **(Section 11B)**			

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

Applies to State?	Review Criteria	Pass	Fail	N/A
	When an advertisement that is an invitation to contract refers to various benefits that may be contained in two (2) or more policies, other than group master policies, the advertisement shall disclose that the benefits are provided only though a combination of policies. **(Section 11C)**			
	The name of the actual insurer shall be stated in all of its advertisements. The form number or numbers of the policy advertised shall be stated in an advertisement that is an invitation to contract. An advertisement shall not use a trade name, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device that without disclosing the name of the actual insurer, would have the capacity and tendency to mislead or deceive as to the true identity of the insurer. **(Section 14A)**			
	Advertisements used by agents, producers, brokers or solicitors of an insurer shall have prior written approval of the insurer before they may be used. **(Section 14L)**			
	An agent who makes contact with a consumer, as a result of acquiring that consumer's name from a lead-generating device, shall disclose that fact in the initial contact with the consumer. An agent or insurer may not use names produced from lead-generating devices that do not comply with the requirements of this regulation. **(Section 14M)**			
	An advertisement to join an association, trust or discretionary group that is also an invitation to contract for insurance coverage shall clearly disclose that the applicant will be purchasing both membership in the association, trust or discretionary group and insurance coverage. The insurer shall solicit insurance coverage on a separate and distinct application that requires a separate signature. The separate and distinct applications required need not be on separate documents or contained in a separate mailing. The insurance program shall be presented so as not to conceal the fact that the prospective members are purchasing insurance as well as applying for membership, if that is the case. Similarly, it is prohibited to use terms such as "enroll" or "join" to imply group or blanket insurance coverage, when that is not the fact. **(Section 15D)**			

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

Applies to State?	Review Criteria	Pass	Fail	N/A
	Advertising File. Each insurer shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of its individual policies and typical printed, published or prepared advertisements of its blanket, franchise and group policies hereafter disseminated in this or any other state, whether or not licensed in an other state, with a notation attached to each advertisement that indicates the manner and extent of distribution and the form number of any policy advertised. The file shall be subject to regular and periodical inspection by the commissioner. All of these advertisements shall be maintained in a file for a period of either 4 years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time. **(Section 18A)**			
	Certificate of Compliance. Each insurer required to file an annual statement shall file with the commissioner, with its annual statement, a certificate of compliance executed by an authorized officer of the insurer that states that, to the best of the officer's knowledge, information and belief, the advertisements that were disseminated by the insurer during the preceding statement year complied or were made to comply in all respects with the provisions of this regulation and the insurance laws of this state as implemented and interpreted by this regulation. **(Section 18B)**			
	An insurer, agent, broker, producer, solicitor or other person shall not solicit a resident of this state for the purchase of accident and sickness insurance in connection with or as the result of the use of advertisement by the person or any other persons, where the advertisement: (1) Contains any misleading representations or misrepresentations, or is otherwise untrue, deceptive or misleading with regard to the information imparted, the status, character or representative capacity of the person or the true purpose of the advertisement; or (2) Otherwise violates the provisions of this regulation. **(Section 5F)**			

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

Applies to State?	Review Criteria	Pass	Fail	N/A
	An insurer, agent, broker, producer, solicitor or other person shall not solicit residents of this state for the purchase of accident and sickness insurance through the use of a true or fictitious name that is deceptive or misleading with regard to the status, character or proprietary or representative capacity of the person or the true purpose of the advertisement. **(Section 5G)**			
	Covered Benefits. (1) The use of deceptive words, phrases or illustrations in advertisements of accident and sickness insurance is prohibited. **(Section 6A)**			
	(2) An advertisement that fails to state clearly the type of insurance coverage being offered is prohibited. **(Section 6A)**			
	(3) An advertisement shall not omit information or use words, phrases, statements, references or illustrations if the omission of information or use of words, phrases, statements, references or illustrations has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements. **(Section 6A)**			
	(4) An advertisement shall not contain or use words or phrases such as "all," "full," "complete" "comprehensive," "unlimited," "up to," "as high as," "this policy will help fill some of the gaps that Medicare and your present insurance leave out," "the policy will help to replace your income" (when used to express loss of time benefits) or similar words and phrases, in a manner that exaggerates a benefit beyond the terms of the policy. **(Section 6A)**			

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

Applies to State?	Review Criteria	Pass	Fail	N/A
	(5) An advertisement of a hospital or other similar facility confinement benefit that makes reference to the benefit being paid directly to the policyholder is prohibited unless, in making the reference, the advertisement includes a statement that the benefits may be paid directly to the hospital or other health care facility, if an assignment of benefits is made by the policyholder. An advertisement of medical and surgical expense benefits shall comply with this regulation in regard to the disclosure of assignments of benefits to providers of services. Phrases such as "you collect," "you get paid," "pays you" or other words or phrases of similar import may be used so long as the advertisement indicates that it is payable to the insured or someone designated by the insured. **(Section 6A)**			
	(6)(a) An advertisement for basic hospital expense coverage, basic medical-surgical expense coverage, basic hospital/medical-surgical expense coverage, hospital confinement indemnity coverage, accident only coverage, specified disease coverage, specified accident coverage or limited benefit health coverage or for coverage that covers only a certain type of loss is prohibited, if: (i) The advertisement refers to a total benefit maximum limit payable under the policy in any headline, lead-in or caption without also in the same headline, lead-in or caption specifying the applicable daily limits and other internal limits; (ii) The advertisement states a total benefit limit without stating the periodic benefit payment, if any, and the length of time the periodic benefit would be payable to reach the total benefit limit; or (iii) The advertisement prominently displays a total benefit limit that would not, as a general rule, be payable under an average claim. (b) This paragraph does not apply to individual major medical expense coverage, individual basic medical expense coverage or disability income insurance. **(Section 6A)**			
	(7) Advertisements that emphasize total amounts payable under hospital, medical or surgical accident and sickness insurance coverage or other benefits in a policy, such as benefits for private duty nursing, are prohibited, unless the actual amounts payable per day for the indemnity or benefits are stated. **(Section 6A)**			

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

Applies to State?	Review Criteria	Pass	Fail	N/A
	(8) Advertisements that include examples of benefits payable under a policy shall not use examples in a way that implies that the maximum payable benefit payable under the policy will be paid, when less than maximum benefits are paid in an average claim. **(Section 6A)**			
	(9) When a range of benefit levels is set forth in an advertisement, it shall be clear that the insured will receive only the benefit level written or printed in the policy selected and issued. Language that implies that the insured may select the benefit level at the time of filing claims is prohibited. **(Section 6A)**			
	(10) Language in an advertisement that implies that the amount of benefits payable under a loss-of-time policy may be increased at the time of claim or disability according to the needs of the insured is prohibited. **(Section 6A)**			
	(11) Advertisements for policies with premiums that are modest because of their limited coverage or limited amount of benefits shall not describe premiums as "low," "low cost," "budget" or use qualifying words of similar import. The use of words such as "only" and "just" in conjunction with statements of premium amounts when used to imply a bargain is prohibited. **(Section 6A)**			
	(12) Advertisements that state or imply that premiums will not be changed in the future are prohibited, unless the advertised policies expressly provide that the premiums will not be changed in the future. **(Section 6A)**			
	(13) An advertisement for a policy that does not require the premium to accompany the application shall not overemphasize that fact and shall clearly indicate under what circumstances coverage will become effective. **(Section 6A)**			
	(14) An advertisement that exaggerates the effects of statutorily-mandated benefits or required policy provisions or that implies that the provisions are unique to the advertised policy is prohibited. **(Section 6A)**			
	(15) An advertisement that implies that a common type of policy or a combination of common benefits is "new," "unique," "a bonus," "a breakthrough" or is otherwise unusual is prohibited. The addition of a novel method of premium payment to an otherwise common plan of insurance does not render it new. **(Section 6A)**			

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

Applies to State?	Review Criteria	Pass	Fail	N/A
	(16) Language in an advertisement that states or implies that each member under a family contract is covered as to the maximum benefits advertised, where that is not the fact, is prohibited. **(Section 6A)**			
	(17) An advertisement that contains statements such as "anyone can apply" or "anyone can join," other than with respect to a guaranteed-issue policy, for which administrative procedures exist to assure that the policy is issued within a reasonable period of time after the application is received by the insurer, is prohibited. **(Section 6A)**			
	(18) An advertisement that states or implies immediate coverage of a policy is prohibited, unless administrative procedures exist so that the policy is issued within 15 working days after the insurer receives the completed application. **(Section 6A)**			
	(19) An advertisement that contains statements such as "here is all you do to apply," "simply" or "merely" to refer to the act of applying for a policy that is not a guaranteed- issue policy is prohibited, unless it refers to the fact that the application is subject to acceptance or approval by the insurer. **(Section 6A)**			
	(20) An advertisement of accident and sickness insurance sold by direct response shall not state or imply that because no insurance agent will call and no commissions will be paid to agents that it is a low cost plan, or use other similar words or phrases because the cost of advertising and servicing the policies is a substantial cost in the marketing by direct response. **(Section 6A)**			
	(21) Applications, request forms for additional information and similar related materials are prohibited if they resemble paper currency, bonds, stock certificates, etc., or use any name, service mark, slogan, symbol or device in a manner that implies that the insurer or the policy advertised is connected with a government agency, such as the Social Security Administration or the Department of Health and Human Services. **(Section 6A)**			
	(22) An advertisement that implies in any manner that the prospective insured may realize a profit from obtaining hospital, medical or surgical insurance coverage is prohibited. **(Section 6A)**			

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

Applies to State?	Review Criteria	Pass	Fail	N/A
	(23) An advertisement that uses words such as "extra," "special" or "added" to describe a benefit in the policy is prohibited. No advertisement of a benefit for which payment is conditioned upon confinement in a hospital or similar facility shall use words or phrases such as "tax-free," "extra cash," "extra income," "extra pay" or substantially similar words or phrases, because these words and phrases have the capacity, tendency or effect of misleading the public into believing that the policy advertised will, in some way, enable them to make a profit from being hospitalized. **(Section 6A)**			
	(24) An advertisement of a hospital or other similar facility confinement benefit shall not advertise that the amount of the benefit is payable on a monthly or weekly basis when, in fact, the amount of the benefit payable is based upon a daily pro rata basis relating to the number of days of confinement, unless the statements of the monthly or weekly benefit amounts are in juxtaposition with equally prominent statements of the benefit payable on a daily basis. The term "juxtaposition" means side by side or immediately above or below. When the policy contains a limit on the number of days of coverage provided, the limit shall appear in the advertisement. **(Section 6A)**			
	(25) An advertisement of a policy covering only one disease or a list of specified diseases shall not imply coverage beyond the terms of the policy. Synonymous terms shall not be used to refer to any disease so as to imply broader coverage than is the fact. **(Section 6A)**			
	(26) An advertisement that is an invitation to contract for a specified disease policy that provides lesser benefit amounts for a particular subtype of disease, shall clearly disclose the subtype and its benefits. This provision shall not apply to institutional advertisements.[31] **(Section 6A)**			

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[31] An advertisement that is intended to provide general information about an insurer or company that does not include detailed product or policy specific information. Such an advertisement may, for example, be intended to promote company name recognition or to generate good will.

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

Applies to State?	Review Criteria	Pass	Fail	N/A
	(27) An advertisement of a specified disease policy providing expense benefits shall not use the term "actual" when the policy only pays up to a limited amount for expenses. Instead, the term "charges" or substantially similar language should be used that does not create the misleading impression that there is full coverage for expenses. **(Section 6A)**			
	(28) An advertisement that describes any benefits that vary by age shall disclose that fact. **(Section 6A)**			
	(29) An advertisement that uses a phrase such as "no age limit," if benefits or premiums vary by age or if age is an underwriting factor, shall disclose that fact. **(Section 6A)**			
	(30) A television, radio, mail or newspaper advertisement or lead-generating device that is designed to produce leads either by use of a coupon, a request to write or to call the company or a subsequent advertisement prior to contact shall include information disclosing that an agent may contact the applicant. **(Section 6A)**			
	(31) Advertisements, applications, requests for additional information and similar materials are prohibited if they state or imply that the recipient has been individually selected to be offered insurance or has had his or her eligibility for the insurance individually determined in advance when the advertisement is directed to all persons in a group or to all persons whose names appear on a mailing list. **(Section 6A)**			

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

Applies to State?	Review Criteria	Pass	Fail	N/A
	(32) An advertisement, including invitations to inquire[32] or invitations to contract, shall not employ devices that are designed to create undue fear or anxiety in the minds of those to whom they are directed. Examples of prohibited devices are: (a) The use of phrases such as "cancer kills somebody every two minutes" and "total number of accidents," without reference to the total population from which the statistics are drawn; (b) The exaggeration of the importance of diseases rarely or seldom found in the class of persons to whom the policy is offered; (c) The use of phrases such as "the finest kind of treatment," implying that the treatment would be unavailable without insurance; (d) The reproduction of newspaper articles, magazine articles, information from the Internet or other similar published material containing irrelevant facts and figures; (e) The use of images that unduly emphasize automobile accidents, disabled persons or persons confined in beds who are in obvious distress, persons receiving hospital or medical bills or persons being evicted from their homes due to their medical bills; (f) The use of phrases such as "financial disaster," "financial distress," "financial shock" or another phrase implying that financial ruin is likely without insurance is only permissible in an advertisement for major medical expense coverage, individual basic medical expense coverage or disability income coverage, and only if the phrase does not dominate the advertisement; (g) The use of phrases or devices that unduly excite fear of dependence upon relatives or charity; and (h) The use of phrases or devices that imply that long sicknesses or hospital stays are common among the elderly. **(Section 6A)**			

[32] An advertisement intended to promote inquiries to the insurer or its producers about a specific product or line of products. Such an advertisement would not be intended to induce an express undertaking to contract without further information, comparison or inquiry. Such advertisement may be an invitation to enter into negotiations, which may subsequently result in an offer and acceptance.

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

Applies to State?	Review Criteria	Pass	Fail	N/A
	Exceptions, Reductions and Limitations (1) An advertisement shall not contain descriptions of policy limitations, exceptions or reductions, worded in a positive manner to imply that it is a benefit, such as describing a waiting period as a "benefit builder" or stating, "even preexisting conditions are covered after two years." Words and phrases used in an advertisement to describe the policy limitations, exceptions and reductions shall fairly and accurately describe the negative features of the limitations, exceptions and reductions of the policy offered. **(Section 6B)**			
	(2) An advertisement that is an invitation to contract shall disclose those exceptions, reductions and limitations affecting the basic provisions of the policy. **(Section 6B)**			
	(3) When a policy contains a waiting, elimination, probationary or similar time period between the effective date of the policy and the effective date of coverage under the policy or at a time period between the date a loss occurs and the date benefits begin to accrue for the loss, an advertisement that is subject to the requirements of the preceding paragraph shall prominently disclose the existence of the periods. **(Section 6B)**			
	(4) An advertisement shall not use the words "only," "just," "merely," "minimum," "necessary" or similar words or phrases to describe the applicability of any exceptions, reductions, limitations or exclusions such as: "This policy is subject to the following minimum exceptions and reductions." **(Section 6B)**			
	(5) An advertisement that is an invitation to contract that fails to disclose the amount of any deductible or the percentage of any coinsurance factor is prohibited. **(Section 6B)**			
	(6) An advertisement for loss-of-time coverage that is an invitation to contract that sets forth a range of amounts of benefit levels is prohibited unless it also states that eligibility for the benefits is based upon condition of health, income or other economic conditions, or other underwriting standards of the insurer if that is the fact. **(Section 6B)**			

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

Applies to State?	Review Criteria	Pass	Fail	N/A
	(7) An advertisement that refers to "hospitalization for injury or sickness" omitting the word "covered" when the policy excludes certain sicknesses or injuries, or that refers to "whenever you are hospitalized," "when you go to the hospital" or "while you are confined in the hospital" omitting the phrase "for covered injury or sickness." if the policy excludes certain injuries or sickness, is prohibited. Continued reference to "covered injury or sickness" is not necessary where this fact has been prominently disclosed in the advertisement, and where the description of sicknesses or injuries not covered is prominently set forth. **(Section 6B)**			
	(8) An advertisement that fails to disclose that the definition of "hospital" does not include certain facilities that provide institutional care such as a nursing home, convalescent home or extended care facility, when the facilities are excluded under the definition of hospital in the policy, is prohibited. **(Section 6B)**			
	(9) The term "confining sickness" shall be explained in an advertisement containing the term. The explanation might be as follows: "Benefits are payable for total disability due to confining sickness only so long as the insured is necessarily confined indoors." Captions such as "Lifetime Sickness Benefits" or "Five-Year Sickness Benefits" are incomplete, if the benefits are subject to confinement requirements. When sickness benefits are subject to confinement requirements, captions such as "Lifetime House Confining Sickness Benefits" or "Five-Year House Confining Sickness Benefits" would be permissible. **(Section 6B)**			
	(10) An advertisement that fails to disclose any waiting or elimination periods for specific benefits is prohibited. **(Section 6B)**			
	(11) An advertisement for a policy providing benefits for specified illnesses only, such as cancer, or for specified accidents only, such as automobile accidents, or other policies providing benefits that are limited in nature, shall clearly and conspicuously in prominent type state the limited nature of the policy. The statement shall be worded in language identical to or substantially similar to the following: "This Is A Limited Policy," "This Policy Provides Limited Benefits," "This Is A Cancer Only Policy" or "This Is An Automobile Accident Only Policy." **(Section 6B)**			

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

Applies to State?	Review Criteria	Pass	Fail	N/A
	Preexisting Conditions (1) An advertisement that is an invitation to contract shall, in negative terms, disclose the extent to which any loss is not covered, if the cause of the loss is traceable to a condition existing prior to the effective date of the policy. The use of the term "preexisting condition" without an appropriate definition or description shall not be used. **(Section 6C)**			
	(2) When an accident and sickness insurance policy does not cover losses resulting from preexisting conditions, an advertisement of the policy shall not state or imply that the applicant's physical condition or medical history will not affect the issuance of the policy or payment of a claim under the policy. This regulation prohibits the use of the phrase "no medical examination required" and phrases of similar import, but does not prohibit explaining "automatic issue." If an insurer requires a medical examination for a specified policy, the advertisement, if it is an invitation to contract, shall disclose that a medical examination is required. **(Section 6C)**			
	(3) When an advertisement contains an application form to be completed by the applicant and returned by mail, the application form shall contain a question or statement that reflects the preexisting condition provisions of the policy immediately preceding the blank space for the applicant's signature. For example, the application form shall contain a question or statement substantially as follows: "Do you understand that this policy will not pay benefits during the first [insert number] [years, months] after the issue date for a disease or physical condition that you now have or have had in the past? YES" Or substantially the following statement: "I understand that the policy applied for will not pay benefits for any loss incurred during the first [insert number] [years, months] after the issue date on account of disease or physical condition that I now have or have had in the past." **(Section 6C)**			

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

Applies to State?	Review Criteria	Pass	Fail	N/A
	The disclosure requirements of this regulation shall not apply where the sole financial interest or compensation of a spokesperson, for all testimonials or endorsements made on behalf of the insurer, consists of the payment of union scale wages required by union rules, and if the payment is actually the scale for TV or radio performances. **(Section 9D)**			
	An advertisement shall not state or imply that an insurer or an accident and sickness insurance policy has been approved or endorsed by any individual, group of individuals, society, association or other organizations, unless that is the fact, and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial has been formed by the insurer or is owned or controlled by the insurer or the person or persons who own or control the insurer, the fact shall be disclosed in the advertisement. If the insurer or an officer of the insurer formed or controls the association, or holds any policy-making position in the association, that fact must be disclosed. **(Section 9E)**			
	When a testimonial refers to benefits received under an accident and sickness insurance policy, the specific claim data, including claim number, date of loss and other pertinent information shall be retained by the insurer for inspection for a period of 4 years or until the filing of the next regular report of examination of the insurer, whichever is the longer period of time. The use of testimonials that do not correctly reflect the present practices of the insurer or that are not applicable to the policy or benefit being advertised is not permissible. **(Section 9F)**			

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

Applies to State?	Review Criteria	Pass	Fail	N/A
	An advertisement relating to the dollar amounts of claims paid, the number of people insured, or similar statistical information relating to an insurer or policy shall not use irrelevant facts, and shall not be used, unless it accurately reflects all of the current and relevant facts. The advertisement shall not imply that the statistics are derived from the policy advertised, unless that is the fact, and when applicable to other policies or plans shall specifically so state. (1) An advertisement shall specifically identify the accident and sickness insurance policy to which statistics relate and where statistics are given that are applicable to a different policy, it shall be stated clearly that the data do not relate to the policy being advertised. (2) An advertisement using statistics that describe an insurer, such as assets, corporate structure, financial standing, age, product lines or relative position in the insurance business, may be irrelevant and, if used at all, shall be used with extreme caution because of the potential for misleading the public. As a specific example, an advertisement for accident and sickness insurance that refers to the amount of life insurance which the company has in force or the amounts paid out in life insurance benefits is not permissible, unless the advertisement clearly indicates the amount paid out for each line of insurance. **(Section 10A)**			
	An advertisement shall not represent or imply that claim settlements by the insurer are "liberal," "generous" or use words of similar import, or that claim settlements are or will be beyond the actual terms of the contract. An unusual amount paid for a unique claim for the policy advertised is misleading and shall not be used. **(Section 10B)**			
	An advertisement that uses the word "plan" without prominently identifying it as an accident and sickness insurance policy is prohibited. **(Section 11A)**			

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

Applies to State?	Review Criteria	Pass	Fail	N/A
	An advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits or comparisons of non-comparable policies of other insurers, shall not disparage competitors, their policies, services or business methods and shall not disparage or unfairly minimize competing methods of marketing insurance. An advertisement shall not contain statements such as "no red tape" or "here is all you do to receive benefits." **(Section 12A)**			
	Advertisements that state or imply that competing insurance coverages customarily contain certain exceptions, reductions or limitations not contained in the advertised policies are prohibited, unless the exceptions, reductions or limitations are contained in a substantial majority of the competing coverages. **(Section 12B)**			
	Advertisements that state or imply that an insurer's premiums are lower or that its loss ratios are higher because its organizational structure differs from that of competing insurers are prohibited. **(Section 12C)**			
	An advertisement that is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits. **(Section 13A)**			
	An advertisement shall not create the impression directly or indirectly that the insurer, its financial condition or status, or the payment of its claims, or the merits, desirability, or advisability of its policy forms or kinds or plans of insurance are approved, endorsed or accredited by any division or agency of this state or the federal government. Terms such as "official" or words of similar import, used to describe any policy or application form are prohibited because of the potential for deceiving or misleading the public. **(Section 13B)**			
	An advertisement shall not imply that approval, endorsement or accreditation of policy forms or advertising has been granted by any division or agency of the state or federal government. Approval of either policy forms or advertising shall not be used by an insurer to imply or state that a governmental agency has endorsed or recommended the insurer, its policies, advertising or its financial condition. **(Section 13C)**			

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

Applies to State?	Review Criteria	Pass	Fail	N/A
	An advertisement shall not use any combination of words, symbols, or physical materials that by their content, phraseology, shape, color or other characteristics are so similar to combination of words, symbols or physical materials used by agencies of the federal government or of this state, or otherwise appear to be of such a nature that it tends to confuse or mislead prospective insureds into believing that the solicitation is in some manner connected with an agency of the municipal, state or federal government. **(Section 14B)**			
	Advertisements, envelopes or stationery that employ words, letters, initials, symbols or other devices that are similar to those used in governmental agencies or by other insurers are not permitted, if they may lead the public to believe: (1) That the advertised coverages are somehow provided by or are endorsed by the governmental agencies or the other insurers; (2) That the advertiser is the same, connected with or is endorsed by the governmental agencies or the other insurers. **(Section 14C)**			
	An advertisement shall not use the name of a state or political subdivision of a state in a policy name or description. **(Section 14D)**			
	An advertisement in the form of envelopes or stationery of any kind may not use any name, service mark, slogan, symbol or any device in a manner that implies that the insurer or the policy advertised, or that any agent who may call upon the consumer in response to the advertisement, is connected with a governmental agency, such as the Social Security Administration. **(Section 14E)**			
	An advertisement may not incorporate the word "Medicare" in the title of the plan or policy being advertised unless, wherever it appears, the word is qualified by language differentiating it from Medicare. The advertisement, however, shall not use the phrase "[…] Medicare Department of the […] Insurance Company" or language of similar import. **(Section 14F)**			
	An advertisement may not imply that the reader may lose a right or privilege or benefit under federal, state or local law if he or she fails to respond to the advertisement. **(Section 14G)**			

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

Applies to State?	Review Criteria	Pass	Fail	N/A
	The use of letters, initials or symbols of the corporate name or trademark that would have the tendency or capacity to mislead or deceive the public as to the true identity of the insurer is prohibited, unless the true, correct and complete name of the insurer is in close conjunction and in the same size type as the letters, initials or symbols of the corporate name or trademark. **(Section 14H)**			
	The use of the name of an agency or "[ ] Underwriters" or "[ ] Plan" in type, size and location, so as to have the capacity and tendency to mislead or deceive as to the true identity of the insurer, is prohibited. **(Section 14I)**			
	The use of an address so as to mislead or deceive as to the true identity of the insurer, its location or licensing status is prohibited. **(Section 14J)**			
	An insurer shall not use, in the trade name of its insurance policy, any terminology or words so similar to the name of a governmental agency or governmental program as to have the tendency to confuse, deceive or mislead the prospective purchaser. **(Section 14K)**			
	An advertisement of a particular policy shall not state or imply that prospective insureds become group or quasi-group members covered under a group policy and as members, enjoy special rates or underwriting privileges, unless that is the fact. **(Section 15A)**			
	This regulation prohibits the solicitations of a particular class, such as governmental employees, by use of advertisements which state or imply that their occupational status entitles them to reduced rates on a group or other basis when, in fact, the policy being advertised is sold only on an individual basis at regular rates. **(Section 15B)**			
	Advertisements that indicate that a particular coverage or policy is exclusively for "preferred risks" or a particular segment of the population or that a particular segment of the population is an acceptable risk, when the distinctions are not maintained in the issuance of policies, are prohibited. **(Section 15C)**			

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

Applies to State?	Review Criteria	Pass	Fail	N/A
	An advertisement to join an association, trust or discretionary group that is also an invitation to contract for insurance coverage shall clearly disclose that the applicant will be purchasing both membership in the association, trust or discretionary group and insurance coverage. The insurer shall solicit insurance coverage on a separate and distinct application that requires a separate signature. The separate and distinct applications required need not be on separate documents or contained in a separate mailing. The insurance program shall be presented so as not to conceal the fact that the prospective members are purchasing insurance as well as applying for membership, if that is the case. Similarly, it is prohibited to use terms such as "enroll" or "join" to imply group or blanket insurance coverage, when that is not the fact. **(Section 15D)**			
	Advertisements for group or franchise group plans that provide a common benefit or a common combination of benefits shall not imply that the insurance coverage is tailored or designed specifically for that group, unless that is the fact. **(Section 15E)**			
	(1) An advertisement of an individual policy shall not directly or by implication represent that a contract or combination of contracts is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless that is the fact. An advertisement shall not contain phrases describing an enrollment period as "special," "limited" or similar words or phrases when the insurer uses the enrollment periods as the usual method of marketing accident and sickness insurance. **(Section 16A)**			

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

Applies to State?	Review Criteria	Pass	Fail	N/A
	(2) An enrollment period during which a particular insurance product may be purchased on an individual basis shall not be offered within this state, unless there has been a lapse of not less than [insert number] months between the close of the immediately preceding enrollment period for the same product and the opening of the new enrollment period. The advertisement shall indicate the date by which the applicant must mail the application, which shall be not less than 10 days and not more than 40 days from the date that the enrollment period is advertised for the first time. This regulation applies to all advertising media, i.e., mail, newspapers, the Internet, radio, television, magazines and periodicals, by any one insurer. It is inapplicable to solicitations of employees or members of a particular group or association that otherwise would be eligible under specific provisions of the insurance code for group, blanket or franchise insurance. The phrase "any one insurer" includes all the affiliated companies of a group of insurance companies under common management or control. **(Section 16A)**			
	(3) This regulation prohibits any statement or implication to the effect that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy, unless that is the fact. **(Section 16A)**			
	The phrase "a particular insurance product" in Paragraph (2) of this subsection means an insurance policy that provides substantially different benefits than those contained in any other policy. Different terms of renewability; an increase or decrease in the dollar amounts of benefits; an increase or decrease in any elimination period or waiting period from those available during an enrollment period for another policy shall not be sufficient to constitute the product being offered as a different product eligible for concurrent or overlapping enrollment periods. **(Section 16A)**			

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

Applies to State?	Review Criteria	Pass	Fail	N/A
	B. An advertisement shall not offer a policy that utilizes a reduced initial premium rate in a manner that overemphasizes the availability and the amount of the initial reduced premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, the advertisement shall not display the amount of the reduced initial premium either more frequently or more prominently than the renewal premium, and both the initial reduced premium and the renewal premium must be stated in juxtaposition in each portion of the advertisement where the initial reduced premium appears. **(Section 16B)**			
	C. Special awards, such as a "safe driver's award," shall not be used in connection with advertisements of accident and sickness insurance. **(Section 16C)**			
	An advertisement shall not contain statements that are untrue in fact, or by implication misleading, with respect to the assets, corporate structure, financial standing, age or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system, unless it clearly indicates the purpose of the recommendation and the limitations of the scope and extent of the recommendations. **(Section 17)**			

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Chapter 21—Conducting the Property and Casualty Examination

IMPORTANT NOTE:
The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in Chapter 1—Introduction.

This chapter provides a suggested format for conducting property/casualty insurance regulated entity examinations. Procedures for conducting life and health insurance regulated entity examinations and other types of specialized examinations—such as managed care organizations, third-party administrators and surplus lines brokers—may be found in separate chapters.

The examination of property/casualty insurance operations may involve any review of one or a combination of the following business areas:

A. Operations/Management
B. Complaint Handling
C. Marketing and Sales
D. Producer Licensing
E. Policyholder Service
F. Underwriting and Rating
G. Claims

When conducting an examination that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the regulated entity is meeting standards. Some standards may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.

When an examination involves a depository institution or their affiliates, the bank may also be regulated by federal agencies such as the Office of the Comptroller of the Currency (OCC), the Federal Reserve Board, the Office of Thrift Supervision (OTS) or the Federal Deposit Insurance Corporation (FDIC). Many states have executed an agreement to share complaint information with one or more of these federal agencies. If the examination results find adverse trends or a pattern of activities that may be of concern to a federal agency and there is an agreement to share information, it may be appropriate to notify the agency of the examination findings.

A. Operations/Management

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

B. Complaint Handling

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

C. Marketing and Sales

Use the standards for this business area that are listed in Chapter 20—General Examination Standards and the standards set forth below.

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STANDARDS
MARKETING AND SALES

Standard 1
The regulated entity's mass marketing of property/casualty insurance is in compliance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ New business policy forms and certificate of insurance

_____ Advertising materials

_____ Disclosure materials

_____ Marketing complaints

_____ Underwriting guidelines

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Mass Marketing of Property and Liability Insurance Model Regulation (#710)
Group Personal Lines Property and Casualty Insurance Model Act (#760)
Real Property Lender Placed Model Act (#631), Sections 5, 8 and 9

Review Procedures and Criteria

Review documentation in new business policy files to determine a legitimate basis for the group. If not evident from the file, request additional documentation from the regulated entity to verify that the group is not fictitious.

Review underwriting guidelines, new business policy files, advertising materials, disclosure materials and complaints to verify:

- Compulsory participation not required for employment or group membership;
- Tie-in sales are not a condition of purchase; and
- Disclosures are provided, as required.

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D. Producer Licensing

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

E. Policyholder Service

Use the standards for this business area that are listed in Chapter 20—General Examination Standards and the standards set forth below.

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STANDARDS
POLICYHOLDER SERVICE

Standard 1
Claims history and loss information is provided to the insured in a timely manner.

Apply To: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Claim files

_____ Regulated entity's procedures manuals

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Unfair Trade Practices Act (#880), Section 4(O)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Review sample claim files to determine if the regulated entity is providing loss information for the three previous years to the first named insured within 30 days of receipt of the written request, including:

- On all claims, the date and description of occurrence and the total amount of payment; and
- For any occurrence not included above, the date and description of occurrence.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

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F. Underwriting and Rating

1. Statistical Coding

In addition to the general standards, the examiner should review the regulated entity's statistical coding procedures. Coding on individual policies should be current and accurate. The examiner should determine to what statistical agencies the regulated entity reports its rating/underwriting data.

The examiner should confirm that the regulated entity is using the most current codes, classes, territories, town protection classes, ZIP codes, etc.

Errors should be noted with regard to overcharges or undercharges.

Additional introductory material is located in Chapter 20—General Examination Standards of this handbook.

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STANDARDS
UNDERWRITING AND RATING

Standard 1
Credits, debits and deviations are consistently applied on a non-discriminatory basis.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files and supporting documentation

_____ Insurance department approval of deviations (if applicable)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Property and Casualty Model Rating Guideline (File and Use Version) (#1775)
Property and Casualty Model Rating Guideline (Prior Approval Version) (#1780)
Property and Casualty Commercial Rate and Policy Form Model Law (Condensed) (#777)
Unfair Trade Practices Act (#880)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Credits and deviations should be filed, where required.

Determine if credits and deviations are applied consistently.

Determine if the reasons for use of credits and deviations are documented.

Verify proper handling of consent-to-rate or excess rate forms.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

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STANDARDS
UNDERWRITING AND RATING

Standard 2
Schedule rating or individual risk premium modification plans, where permitted, are based on objective criteria with usage supported by appropriate documentation.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files, including the Individual Risk Premium Modification (IRPM) worksheet

_____ Schedule rating worksheet where IRPM worksheet is used

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Property and Casualty Model Rating Guideline (File and Use Version) (#1775)
Property and Casualty Model Rating Guideline (Prior Approval Version) (#1780)
Property and Casualty Commercial Rate and Policy Form Model Law (Condensed) (#777)
Unfair Trade Practices Act (#880)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Verify that the application of the plan complies with limitations imposed by the state.

Verify that changes in the amounts of credit or debit are supported by documentation or an explanation that is consistent with the change. Also verify that the basis for use is appropriate (i.e., based on objective criteria, not on perceived competitive pressures).

Determine if the regulated entity is adjusting individual premiums to target premium levels for competitive reasons. Typically, the test for this is to review the documentation in the underwriting files.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

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STANDARDS
UNDERWRITING AND RATING

Standard 3
Verification of use of the filed expense multipliers; the regulated entity should be using a combination of loss costs and expense multipliers filed with the insurance department.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ National Council on Compensation Insurance (NCCI) pure premium tables

_____ Regulated entity's filed multipliers that modify the NCCI's (or similar advisory organization) filed loss costs

_____ Rate charts by classification codes (charts maintained at the regulated entity level)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Property and Casualty Model Rating Guideline (File and Use Version) (#1775)
Property and Casualty Model Rating Guideline (Prior Approval Version) (#1780)
Property and Casualty Commercial Rate and Policy Form Model Law (Condensed) (#777)

Review Procedures and Criteria

Obtain from the regulated entity the filed expense multipliers which were applicable at the inception of the policy. (This filing should be stamped either "Approved" or "Filed" by the insurance department.)

Obtain the regulated entity's table of rates for each classification code. Check the sample's premium audit data (showing the actual rate charged to an employer for individual classification codes) against the table of rates, which includes the NCCI's (or similar advisory organization) loss costs and the filed expense multiplier, to verify accuracy.

The regulated entity's documents should be reviewed. Any additional areas or lack of information should be discussed with the regulated entity's management.

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STANDARDS
UNDERWRITING AND RATING

Standard 4
Verification of premium audit accuracy and the proper application of rating factors.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Insurance department approved and/or filed rating plans, including risk modification plans

_____ Copies of cost containment certificates and loss improvement criteria to determine cost containment discount

_____ Final rate manual tables by classification codes applicable to the period under examination (tables maintained at the regulated entity level)

_____ Workers' Compensation Experience Modification Rating Sheets pertaining to the policy sample (experience modifiers as published by the NCCI and similar advisory organizations)

_____ Documentation showing regulated entity's separate rates for mortgage servicer obtained lender-placed insurance versus voluntary insurance on real estate owned property

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Property and Casualty Model Rating Guideline (File and Use Version) (#1775)
Property and Casualty Model Rating Guideline (Prior Approval Version) (#1780)
Property and Casualty Commercial Rate and Policy Form Model Law (Condensed) (#777)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)
Real Property Lender Placed Model Act (#631), Section 9

Review Procedures and Criteria

The purpose of this review is to determine that the final premium charged to the employer is being applied correctly, fairly and consistently.

The sample's premium audits should contain specific information on each policy. The sample's information should be compared to the NCCI unit statistical report and to the company's rating plan, to verify accuracy in the application and reporting of the following factors when applicable:

- Premiums by classification code;
- Payroll exposure;

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- Schedule rating;
- Cost containment discount;
- Premium discounting;
- Designated medical provider discount;
- Expense loading;
- Application of the correct experience modifier;
- Small employer discount;
- Discount for rehiring previously disabled employees; and
- Any other rating elements.

The company documents should be reviewed. Any additional areas or lack of information should be discussed with company management.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

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STANDARDS
UNDERWRITING AND RATING

Standard 5
Verification of experience modification factors.

Apply to: All workers' compensation examinations

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Premium audit reports from the policy sample

_____ Experience rating rules published by the NCCI (and similar advisory organizations)

_____ Workers' compensation experience modification rating sheets pertaining to the policy sample (experience modifiers pertaining to the policy sample as published by the NCCI and similar advisory organizations)

_____ Unit statistical reports pertaining to the policy sample and used to report the regulated entity's information (data) to the NCCI and similar advisory organizations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Property and Casualty Model Rating Guideline (File and Use Version) (#1775)
Property and Casualty Model Rating Guideline (Prior Approval Version) (#1780)
Property and Casualty Commercial Rate and Policy Form Model Law (Condensed) (#777)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

The experience modifier issued by the NCCI (and similar advisory organizations) should reflect the information reported to the NCCI (or similar advisory organization) using the unit statistical reports. Experience modifiers should be reconciled to what is reported on the unit statistical reports and what is shown on the workers' compensation experience modification rating sheets.

Net loss reporting should be properly applied to both large and small deductible policies.

The regulated entity's documents should be reviewed. Any additional areas or lack of information should be discussed with the regulated entity's management.

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STANDARDS
UNDERWRITING AND RATING

Standard 6
Verification of loss reporting.

Apply to: All workers' compensation examinations

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ NCCI (and similar advisory organizations') rules governing the reporting of losses on unit statistical reports

_____ Loss data pertaining to the policy sample and maintained by the regulated entity

_____ Unit statistical reports pertaining to the policy sample and used to report regulated entity information to the NCCI (and similar advisory organizations)

_____ Applicable reports filed with the commissioner (e.g., required reporting for insurers with at least $100,000 in direct written premium for lender-placed insurance, required rate filing for insurers with an annual loss ratio of less than 35% in any lender-placed program for two consecutive years)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Property and Casualty Model Rating Guideline (File and Use Version) (#1775)
Property and Casualty Model Rating Guideline (Prior Approval Version) (#1780)
Property and Casualty Commercial Rate and Policy Form Model Law (Condensed) (#777)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)
Real Property Lender Placed Model Act (#631), Section 9

Review Procedures and Criteria

Losses under each policy should be clearly and accurately maintained at the regulated entity, so that paid amounts, reserves, ~~and~~ deductibles and any excess amounts paid to the mortgagor can be easily reviewed. The sample data should be compared to the unit statistical reports to verify accuracy of reporting of the following items:

- Paid losses;
- Paid loss adjustment expenses;
- Net of deductible reporting on the unit statistical reports;
- Adjustments to reserves and revised unit statistical reports; and
- Any other adjustments, such as subrogation.

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The regulated entity's documents should be reviewed. Any additional areas or lack of information should be discussed with the regulated entity's management.

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STANDARDS
UNDERWRITING AND RATING

Standard 7
Verification of the regulated entity's data provided in response to the NCCI call on deductibles.

Apply to: All workers' compensation examinations

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ The NCCI (or similar advisory organization) data call and resulting report made by the insurance regulated entity to the NCCI (or similar advisory organization)

_____ Loss data pertaining to sample policies written on a deductible basis and maintained by the regulated entity

_____ Unit statistical reports pertaining to sample policies written on a deductible basis and used to report regulated entity information to the NCCI (and similar advisory organizations)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Property and Casualty Model Rating Guideline (File and Use Version) (#1775)
Property and Casualty Model Rating Guideline (Prior Approval Version) (#1780)
Property and Casualty Commercial Rate and Policy Form Model Law (Condensed) (#777)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Note that a new sample (the "deductible sample") should be taken for this standard, sampling only policies with deductibles (both large and small deductibles).

During an examination, it should be verified that losses are reported on the unit statistical reports to the NCCI (or similar advisory organizations) net of deductibles. The Independent Deductible Data Call that the NCCI requests should be reported gross, including the deductibles. This must be verified with the policy sample, unit statistical reports and loss data maintained by the regulated entity.

The regulated entity's documents should be reviewed. Any additional areas or lack of information should be discussed with the regulated entity's management.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

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STANDARDS
UNDERWRITING AND RATING

Standard 8
Underwriting, rating and classification are based on adequate information developed at or near inception of the coverage rather than before the effective date of the insurance, near the expiration of a claim, or following a claim.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Application

_____ Underwriting files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Unfair Trade Practices Act (#880)
Real Property Lender Placed Model Act (#631), Section 4

Review Procedures and Criteria

Decisions should be based on information that reasonably should have been developed at the inception of the policy or during initial underwriting and not, through audit or other means, before the policy went into effect or after the policy has expired.

Determine if the initial underwriting of a policy is based on the information obtained after a claim is submitted.

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STANDARDS
UNDERWRITING AND RATING

Standard 9
Audits, when required, are conducted accurately and timely.

Apply to: All auditable personal policies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files

_____ Premium audits pertaining to the policy sample

_____ Payroll records associated with the premium audits and with the policy sample

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Verify that all auditable commercial policies have a structured system for conducting payroll or other audits used to verify final premium.

Verify what is all auditable commercial policies' procedure for waiving audits. Verify that the basis is reasonable.

Determine what is all auditable commercial policies' time frame for completion of audits. Companies typically have a time frame for the completion of an audit following expiration.

Verify if all auditable commercial policies' auditors or independent auditors conduct audits.

Perform an independent verification to ensure that return premiums are received by insureds in a timely manner.

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STANDARDS
UNDERWRITING AND RATING

Standard 10
The regulated entity's underwriting practices are not unfairly discriminatory. The regulated entity adheres to applicable statutes, rules and regulations and the regulated entity's guidelines in the selection of risks.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ New business application

_____ All underwriting information obtained

_____ Regulated entity's underwriting guidelines

_____ Underwriting bulletins

_____ Declination procedures

_____ Agency agreements and correspondence with producers

_____ Interoffice memoranda and regulated entity minutes

_____ Policy declaration page

_____ Underwriter's file or notes on a system log

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Insurance Fraud Prevention Model Act (#680)
Model Regulation on Unfair Discrimination in Life and Health Insurance on the Basis of Physical or Mental Impairment (#887)
Model Regulation on Unfair Discrimination on Basis of Blindness or Partial Blindness (#888)
Unfair Trade Practices Act (#880)
Credit Reports and Insurance Underwriting White Paper

Review Procedures and Criteria

Review relevant underwriting information to ensure that no unfair discrimination is occurring, according to the state's definition of unfair discrimination.

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Determine if the regulated entity is following its underwriting guidelines, and that the guidelines conform to state laws and are not unfairly discriminatory.

Determine, if required, that the regulated entity's underwriting guidelines have been filed with the insurance department.

Review interoffice memoranda for evidence of anti-competitive behavior.

Underwriting guidelines may vary by geographic areas in the jurisdiction and, therefore, such guidelines should be reviewed for each regional office being examined.

Some indication of industry underwriting practices may be obtained by survey of residual markets (e.g., FAIR Plan and JUA), surplus lines markets and consent-to-rate filings.

Inconsistent handling of rating or underwriting practices, even if not intentional, can result in unfair discrimination, including requests for supplemental information.

Examine new business applications for the required fraud warning statement.

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STANDARDS
UNDERWRITING AND RATING

Standard 11
All forms and endorsements forming a part of the contract are listed on the declaration page and should be filed with the insurance department (if applicable).

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ New business application

_____ Policy declaration page

_____ Insurance department approval for forms and endorsements

_____ Regulated entity's files or register of approved forms

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Unfair Trade Practices Act (#880)
Insurance Fraud Prevention Model Act (#680)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Determine if the forms and endorsements have been filed.

Determine if the regulated entity lists all forms and endorsements that form part of the contract on the declaration page.

Examine new business applications for the required fraud warning statement.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

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STANDARDS
UNDERWRITING AND RATING

Standard 12
Regulated entity verifies that the VIN number submitted with the application is valid and that the correct symbol is utilized.

Apply to: All automobile lines

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files

_____ Regulated entity's rating system

_____ Regulated entity's symbol or Insurance Services Office (ISO) symbol manual

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Unfair Trade Practices Act (#880)
Insurance Fraud Prevention Model Act (#680)

Review Procedures and Criteria

Determine how the regulated entity checks the validity of the vehicle identification number (VIN) on the application. The regulated entity may use an automated program to verify the accuracy of the VIN.

Verify if the regulated entity is a member of or reports to any fraud detection bureau or organization. Some state statutes require reporting of suspected fraud.

Determine how a regulated entity handles updated symbols.

Determine if the correct symbol has been used.

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STANDARDS
UNDERWRITING AND RATING

Standard 13
The regulated entity does not engage in collusive or anti-competitive underwriting practices.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files

_____ Books and records containing compensation, contingent commissions, profit sharing and other payments dependent on profitability or loss ratios

_____ Third party agreements for outsourced services

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Unfair Trade Practices Act (#880)
Real Property Lender Placed Model Act (#631), Section 6

Review Procedures and Criteria

Any practice suggesting anti-competitive behavior may involve legal considerations that should be referred to insurance department legal counsel. This would include engaging in collusive underwriting practices that may inhibit competition; e.g., entering into an agreement with other companies to divide the auto market within the jurisdiction by territory.

The examiner should be aware of unlawful pricing and other prohibited anti-competitive acts or practices.

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STANDARDS
UNDERWRITING AND RATING

Standard 14
The regulated entity's underwriting practices are not unfairly discriminatory. The regulated entity adheres to applicable statutes, rules and regulations in its application of mass marketing plans.

Apply to: All property and casualty companies with mass marketing plans

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ New business policy files

_____ Underwriting guidelines

_____ Canceled and nonrenewed policies

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Mass Marketing of Property and Liability Insurance Model Regulation (#710)
Credit Reports and Insurance Underwriting White Paper

Review Procedures and Criteria

Review documentation in new business policy files and underwriting guidelines to determine that the regulated entity does not apply underwriting standards to a mass marketing program that are more restrictive than those applied to an individually underwritten program.

Review underwriting guidelines, canceled and nonrenewed policy files to verify that failure of the employer or group to remit premium is not regarded as "nonpayment of premium" for the insured, unless the insured is sent appropriate notice and has failed to make timely payment.

Review underwriting guidelines and policy forms to verify that the employee or group member is given the right to continue coverage for 60 days after leaving employment or the group.

Review canceled and nonrenewed policies to verify that the notice of right to employee or member is given at cancellation or nonrenewal; allowing the employer or group to provide additional explanation why the individual should not be canceled.

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STANDARDS
UNDERWRITING AND RATING

Standard 15
All group personal lines property and casualty policies and programs meet minimum requirements.

Apply to: Group personal lines property and casualty insurance

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Master policy

_____ Program rules

_____ Certificates

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Group Personal Lines Property and Casualty Insurance Model Act (#760)

Review Procedures and Criteria

Check for state jurisdictional requirements regarding group policies.

Verify that conversion options are included in notices of individual terminations.

Determine that conversion policies issued on an individual basis effective upon termination or ineligibility date have coverage and limits at least equal to the minimum coverage and limits required by statute.

Determine that program rules do not contain any provision making participation in the group program a condition of employment or membership in a group, nor subject employees or members to any penalty for non-participation.

Determine that group coverage is not contingent upon the purchase of any other insurance, product or service.

Confirm that any experience refund or dividend is applied for the sole benefit of the insured employee or member to the extent that any experience refund or dividend exceeds the policy or certificateholder's contribution to the premium for the period covered.

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STANDARDS
UNDERWRITING AND RATING

Standard 16
Cancellation/nonrenewal notices comply with policy provisions and state laws, including the amount of advance notice provided to the insured and other parties to the contract.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy contract

_____ Notice of cancellation/nonrenewal

_____ Insurance department's approval of forms

_____ Underwriter's file or notes on a system log

_____ Insured's request (if applicable)

_____ Regulated entity's cancellation/nonrenewal guidelines

_____ Certificate of mailing

_____ Producer records/notices issued

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Determine if the notice of cancellation/nonrenewal was valid according to policy provisions and state law.

Does the notice of cancellation include the specific reason for cancellation where required?

Are adverse underwriting decision notices provided where required?

Review cancellation notice and billing notices, grace period descriptions, reinstatement offers, lapse notices, etc., to ensure the form, if necessary, has been approved by the insurance department.

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Review the notice and the certificate of mailing to ensure that adequate notice of cancellation/nonrenewal was provided to the insured and any mortgagees or lien holders.

Does the regulated entity lull insureds into a false sense of security through use of misleading billing notices, grace period descriptions, reinstatement offers, lapse notices, etc.?

If cancellation was at the insured's request, ensure that there is proper documentation.

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STANDARDS
UNDERWRITING AND RATING

Standard 17
All policies are correctly coded.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files

_____ Regulated entity's rating system

_____ Regulated entity's coding manual

_____ Rating organization's coding manual

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Require Reporting of Statistical Data by Property and Casualty Insurance Companies (#751)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Determine that the regulated entity confirms that the coding as reported by the producer is correct and current.

Determine that the regulated entity promptly updates all coding manuals and programs.

Determine that the regulated entity correctly codes all policies according to current codes.

Determine that the regulated entity reviews data errors and subsequent changes are made.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

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STANDARDS
UNDERWRITING AND RATING

Standard 18
Application or enrollment forms are properly, accurately and fully completed, including any required signatures, and file documentation adequately supports decisions made.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Application

_____ Underwriting files

_____ Electronic documentation

_____ Policy

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Application should be complete and signed, where required (includes electronic signatures).

Determine that the underwriting file contains necessary information to tell the regulated entity what exposure it has.

Determine when and under what conditions the regulated entity requires a physical inspection, a motor vehicle report (MVR), an inspection report, a credit report or other underwriting information to confirm exposure or premium basis.

Verify that when a policy is issued on a basis other than applied for, that notice of an adverse underwriting decision is provided in accordance with applicable state statutes and regulations.

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G. Claims

In addition to the general examination techniques, the examiner should define the scope of the property/casualty claims examination in terms of the lines of business and type of claims covered. Lines of business should be defined as specifically as possible; e.g., physical damage coverage rather than automobile coverage. Types of claims covered should differentiate between first-party and third-party claims or total losses and partial losses.

Claim procedure manuals, adjuster training manuals and claim bulletins should be reviewed. Regulated entity procedures for total loss settlement, salvage disposition and subrogation efforts should be determined. If the jurisdiction licenses company or independent adjusters, licensing records should be cross checked with claim adjustment records to ensure that assigned adjusters are properly licensed.

a. Total loss survey

Record identifying data, such as claim/policy number, date of loss and claimant's name. Review files for accuracy and adequacy of documentation. Review files for method of vehicle evaluation and compare with specific state requirements. Review reductions in value for appropriateness and accuracy. Review file for state-specific additions to value, such as sales tax or title fees.

Review file for correct disposition of salvage and compliance with specific state requirements for disposition of title and registration.

b. Subrogation survey

From the regulated entity's records, select a representative sample of the subrogated files with complete or partial recoveries. Record identifying data such as claim/policy number, date of loss and claimant name. Review files to determine if the subrogated amount included the insured's deductible. It should also be determined if the deductible was recovered and whether it was returned to the insured.

If a partial recovery was made, was a pro rata amount returned? Specific state requirements should be reviewed to determine the regulated entity's compliance. Determine if the insured's recovery was reduced by collection charges. Determine if the specific state law permits the reductions. Determine if recovery was reduced by written or oral agreements with other companies. Determine if such agreement is in compliance with specific state laws.

c. Loss statistical reporting

Determine to which statistical agencies the regulated entity reports its loss data. Review claim drafts to determine if loss data is correctly coded as to the proper line of business. Review drafts to determine if claim expenses are separated from claim payments. If the review indicates significant errors in coding, the data should be included in the report.

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STANDARDS
CLAIMS

Standard 1
Regulated entity uses the reservation of rights and excess of loss letters, when appropriate.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity's claim procedure manuals

_____ Claim training manuals

_____ Claim files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Review the regulated entity's procedures manual to determine if guidelines exist for the use of the reservation of rights letter and notice of excess of loss.

Claims where the regulated entity has reason to question coverage should have a reservation of rights letter sent to the insured.

Claims where it is apparent that the amount of loss will exceed policy limits should have an excess of loss letter send to the insured.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

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STANDARDS
CLAIMS

Standard 2
Deductible reimbursement to insureds upon subrogation recovery is made in a timely and accurate manner.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Subrogation register

_____ Subrogation files

_____ Review the regulated entity's subrogation and recovery procedures

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Determine if the regulated entity refunds deductibles from subrogation proceeds.

Determine if, upon complete recovery, the insured's deductible is promptly refunded.

Determine if refunds are made periodically on no less than a pro rata basis for long-term subrogation cases. Requirements may vary among states.

Determine if recovery payments are made to employees under workers' compensation, when applicable.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

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STANDARDS
CLAIMS

Standard 3
Loss statistical coding is complete and accurate.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Claim files

_____ Regulated entity's claims coding manual

_____ Regulated entity's coding system

_____ Rating organization's coding manual

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Require Reporting of Statistical Data by Property and Casualty Insurance Companies (#751)
Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Determine that the regulated entity codes the correct loss data onto the draft copies or system.

Determine that the regulated entity promptly updates all coding manual and programs.

Determine that the regulated entity accurately codes the loss amounts. Determine that the regulated entity separates loss amounts from loss expense amounts.

Determine that the regulated entity reviews data errors and subsequent changes are made.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

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Chapter 20—General Examination Standards

The examination of the insurance operations of a regulated entity may involve reviewing one or more of the following business areas:

A. Operations/Management
B. Complaint Handling
C. Marketing and Sales
D. Producer Licensing
E. Policyholder Service
F. Underwriting and Rating
G. Claims

When conducting an examination that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the regulated entity is meeting standards. Some standards may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.

When an examination involves a depository institution or their affiliates, the bank may also be regulated by federal agencies, such as the Office of the Comptroller of the Currency, the Federal Reserve Board, the Office of Thrift Supervision or the Federal Deposit Insurance Corporation. In addition, banks may also be regulated at the state level. Many states have executed an agreement to share complaint information with one or more of these federal or state agencies. If the examination results find adverse trends or a pattern of activities that may be of concern to a federal or state agency and there is an agreement to share information, it may be appropriate to notify the agency of the examination findings.

This chapter contains examination standards that are relevant to nearly all types of examinations. Chapters 21 through 32 contain standards that are specific to various product lines and specialized entities.

A. Operations/Management

1. Purpose

The Operations/Management portion of the examination is designed to provide a view of what the regulated entity is and how it operates. It is not based on sampling techniques; it is more concerned with structure. This review is not intended to duplicate a financial examination review, but is important in providing the market conduct examiner with an understanding of the examinee. Many troubled companies have become so because management has not been structured to recognize and address the problems that can arise in the insurance industry. The areas to be considered in this kind of review include:

a. History;
b. Profile;
c. Subcontractor oversight;
d. Internal audits;
e. Antifraud initiatives;
f. Certificates of authority;
g. Disaster recovery plan;
h. Computer systems;
i. Minutes from all meetings attended by the board of directors; and
j. Privacy.

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2. Techniques

Typically, the items to be reviewed here can be prepared by the regulated entity and provided at the pre-examination conference. Supplemental information, including history and profile may be available in the insurance department files. Other items suggest an active review of regulated entity files relating to managing general agent (MGA) or subcontractor oversight, internal audits, procedure manuals, record management, computer systems controls and antifraud plans. The latter category of items should have substantial supporting documentation.

The absence of subcontractor oversight, internal audit functions, written procedures or an antifraud plan should be specifically noted when preparing the examination report.

a. History

The examiner should prepare for the examination report a very brief history of the regulated entity, including its formation; its type; its structure, including the parent corporation and other members of the group; and any major changes that are relevant to the current examination.

b. Profile

The profile includes an overview of the regulated entity's operations, including management structure, type of carrier, states where the regulated entity is licensed and the entity's major line(s) of business. A total change in the management team may generate the need to review the regulated entity on an abbreviated time cycle.

The examiner should review Market Action Tracking System (MATS) findings from prior examinations, Regulatory Information Retrieval System (RIRS) results, complaint index reports and reports from other NAIC applications and databases to determine if other regulators have expressed concerns that may require additional attention during the examination. RIRS and MATS information should not be included in the examination report.

The total written premiums for the major lines of business should be compared to the total writing in a given state to determine the market share. The loss, expense and combined ratios can be obtained from the expense exhibit attached to the annual statement or the NAIC Financial Analyst Workbench (FAW) system and may be calculated for the specific jurisdiction. Review IRIS ratios, which can be an indicator of market conduct problems. The surplus ratio should also be examined and noted for the period under review. Substantial shifts in the geographical area of operation and kinds of business written and volume should be noted, questioned and described.

c. Subcontractor Oversight

The jurisdiction's statutes on MGAs and other subcontractors are sources of tests for this oversight. The aim is to ensure that a regulated entity using subcontractors engages in a realistic level of oversight. Contracts should be reviewed to ensure compliance with the MGA statutes governing contract content and oversight features. The focus is on the oversight impacting records and actions considered in a market conduct examination such as, but not limited to, trade practices, claims practices, policy selection and issuance, rating, complaint handling, etc. Examiners should pay particular attention to a subcontractor's dealings with policyholders and claimants.

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d. Internal Audits

A regulated entity that has no internal audit function lacks the ready means to detect structural problems until after problems have occurred. Any questionable findings about the internal audit function should be referred to the Examiner-in-Charge.

e. Antifraud Plans

The regulated entity should have antifraud plans which are reasonably calculated to detect, prosecute and prevent fraudulent insurance acts. Written procedural manuals or guides and antifraud plans should provide sufficient detail to enable employees to perform their functions in accordance with the goals and direction of management. In addition, insurers may be required by law to establish antifraud plans, and examiners should be aware of any state-specific legal requirements pertaining to antifraud measures.

The guidelines set forth in the *Antifraud Plan Guideline* (#1690), adopted by the NAIC in March 2011, are intended to provide a road map for state fraud bureaus, insurers' Special Investigative Units (SIU)s or contracted SIU vendors for preparation of an antifraud plan.

Flexibility should be allowed for each insurer to develop a plan that meets its individual needs and still meet state compliance standards. The *Antifraud Plan Guideline* does not preempt other state laws or preempt or amend any guidance previously published by the NAIC Antifraud (D) Task Force or in the *Fraud Prevention Model Act* (#680).

f. Certificates of Authority

The examiner should determine if the regulated entity's operations conform with the regulated entity's certificates of authority.

g. Disaster Recovery Plan

It is essential that the regulated entity has a formalized disaster recovery plan that will detail procedures for continuing operations in the event of any type of disaster. The examiners should determine if the regulated entity maintains separate backups of all records and facilities to continue operations.

h. Computer Systems

The examiners should determine the types of controls, safeguards and procedures for protecting the integrity of the computer information. The focus in this case is on those records subject to a market conduct examination that are maintained in electronic format, such as, but not limited to, underwriting files, claim files, rate and form filings, complaint files, statistical data used to support rates, etc.

The regulated entity should identify the location(s) of all websites maintained by or for and authorized by the regulated entity and all approved producer sites.

In addition, an Internet search using the regulated entity's name should be conducted using a search engine such as Yahoo, Google or a metasearch (aggregator) search engine such as WebCrawler. If any additional sites are located that the regulated entity did not identify, it should be specifically noted when preparing the examination report. The examiner should be mindful that some searches may produce a large volume of "hits." In such a situation, the examiner should employ sampling techniques to determine the regulated entity's general practices on the Internet.

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i. Minutes from All Meetings Attended by the Board of Directors

A review of the minutes of meetings with the board of directors should be conducted to ensure the board has proper oversight of the company's operations and activities. Note: When a credit company is the subject of an examination, examiners should be aware that there may be statutes, rules, and regulations with specific requirements regarding the organization and structure of credit organizations.

j. Privacy

The NAIC has adopted several sets of privacy requirements, and examiners will need to determine which requirement(s) the state imposes to conduct an examination. The first is the *NAIC Insurance Information and Privacy Protection Model Act* (#670) (hereinafter, the 1982 Model Act). The second NAIC approach was the *Health Information Privacy Model Act* (#55), which, according to NAIC records, as of April 2015 had not been adopted by any state, although a few states have related laws.

The NAIC then adopted a model titled *Privacy of Consumer Financial and Health Information Regulation* (#672) (hereinafter, the 2000 Model Privacy Regulation) to assist states with promulgation of regulations to comply with certain requirements of Title V of the federal Gramm-Leach-Bliley Act (GLBA) (PL 102-106), enacted by Congress in 1999. And, in 2002, the *Standards for Safeguarding Customer Information Model Regulation* (#673) (hereinafter, the 2002 Model Information Security Regulation) was adopted to assist states in establishing standards for development and implementation of safeguards by insurers to protect customer information, also required by Title V of GLBA.

In some cases, a state may have one or more of these measures, or a combination thereof, in force. NAIC records indicate that as of April 2015, 39 states plus the District of Columbia and Puerto Rico have enacted regulations/laws based on the 2000 Model Privacy Regulation.

1982 Model Act (#670)
The 1982 Model Act is focused primarily on the insurance application process, underwriting, policy issuance and related transactions. It requires various disclosures to applicants regarding the insurer's practices (e.g., that an investigative consumer report may be obtained and that information may be disclosed to insurance support organizations which, in turn, may retain and later re-disclose the information to others) and the applicant's rights (e.g., that the applicant has a right to obtain a copy of any investigative consumer report and that the applicant has the rights of access to and correction of information about him/her).

Notices providing these disclosures may be required at application and whenever there is a "change of status"—e.g., at renewal or reinstatement—if new or additional information is to be collected from a source other than the applicant. There is no requirement for annual notices. If an insurer intends to disclose information for the marketing of a product or service, the customer must be given an opportunity to opt out. Operations/Management Examination Standards #10 and #11 in this chapter are applicable only for those states that have enacted the 1982 Model Act or substantially similar privacy requirements.

2000 Model Privacy Regulation (#672)
The 2000 Model Privacy Regulation was adopted to implement certain privacy provisions of the Gramm-Leach-Bliley Act. Title V of GLBA addressed the confidentiality of information about customers of "financial institutions," a term that includes insurance companies, banks and depository institutions, broker-dealers, investment companies, registered investment advisors and a variety of other kinds of businesses. Title V, as further implemented by the 2000 Model Privacy Regulation, requires that financial institutions establish and implement a privacy policy and

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provide notices to customers describing such policies and the customer's rights to opt out of disclosures other than those allowed by the exceptions in Sections 14 through 16 (Section 17B of the 2000 Model Privacy Regulation sets forth exceptions for the customer authorization requirement for certain health information disclosures). The adoption of regulations and guidelines was delegated to the functional regulators of the various financial institutions.

The federal functional regulators (including, among others, the Securities and Exchange Commission, the Office of the Comptroller of Currency and the Federal Trade Commission) and the NAIC have taken substantially similar positions in their regulations regarding the disclosure of customer personal information and notices. The federal regulations are nearly identical to each other, with very minor differences to reflect the different financial products and services involved and related business practices. The 2000 Model Privacy Regulation is very similar to the federal regulations with respect to the treatment of financial information, with appropriate changes for insurance products and services, as well as established business practices and relationships.

The notices required by the 2000 Model Privacy Regulation include initial, revised and annual privacy notices, which must reflect the privacy policy, including financial information disclosure practices, of the insurance regulated entity or other licensee. It should be noted that privacy policies differ from insurer to insurer, from insurer to other licensee, etc. There is no set format required for privacy notices, although they must be "clear and conspicuous" as that term is defined in the regulation. The regulation does, however, list the topics that the privacy notice must address. Since a privacy notice reflects a specific insurer's or other licensee's own particular financial information privacy practices, notices will legitimately differ.

The 2000 Model Privacy Regulation differs from the federal agency regulations in that the model includes protections for certain health information. In general, a licensee must get an individual's approval (opt-in) prior to disclosing nonpublic personal health information, unless the disclosure falls under an exception listed in Subsection 17B or the licensee is in compliance with the health privacy regulation promulgated by the U.S. Department of Health and Human Services (HHS) pursuant to the federal Health Information Portability and Accountability Act (HIPAA). Even if the licensee is not subject to HIPAA, the 2000 Model Privacy Regulation allows the option of complying with the HHS standards as an alternative to the NAIC standards.

Operations/Management Examination Standards #12, #13, #14, #15 and #16 in this chapter are applicable for examination of compliance with the 2000 Model Privacy Regulation regarding the disclosure of customer information.

2002 Model Information Security Regulation (#673)

The 2002 Model Information Security Regulation was adopted to establish standards regarding safeguarding of customer information, also required by Title V of GLBA. It should be noted that the 2002 Model Information Security Regulation requires that a licensee establish an information security program "appropriate to the size and complexity of the licensee," as well as appropriate to the "nature and scope of (the licensee's) activities." The regulation provides illustrative examples of various factors that a licensee may consider when developing its information security program. Operations/Management Examination Standard #17 in this chapter is applicable for examination of compliance with the 2002 Model Information Security Regulation for security standards.

Insurance Data Security Model Law (#668)

Operations/Management Examination Standard #17 in this chapter is also applicable for examination of compliance with the *Insurance Data Security Model Law* (#668). Note: When reviewing a regulated entity's information security program for compliance with applicable state statutes, rules or regulations relating to Model #668, in the absence of a "Cybersecurity Event," as defined in applicable state statutes, rules or regulations, please refer to the Insurance Data

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Security Pre-Breach Checklist found in the Reference Documents of the *Market Regulation Handbook*. Regulators may access Reference Documents on StateNet at the link Market Regulation Handbook, Handbook Updates and Reference Documents. Non-regulators may access Reference Documents via their login credentials on NAIC Account Manager at *https://www.naic.org/account_manager.htm*.

When reviewing a regulated entity's information security program and response to a "Cybersecurity Event" for compliance with applicable state statutes, rules or regulations relating to the *Insurance Data Security Model Law* (Model #668), after a Cybersecurity Event has occurred, as defined in applicable state statutes, rules or regulations, please refer to the Insurance Data Security Post-Breach Checklist provided as Addendum A to Operations/Management Examination Standard 17 in this chapter.

3. Tests and Standards

The operations and management review includes, but is not limited to, the following standards addressing various aspects of a regulated entity's operations. The sequence of the standards listed here does not indicate priority of the standard.

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STANDARDS
OPERATIONS/MANAGEMENT

Standard 1
The regulated entity has an up-to-date, valid internal or external audit program.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Audit plan and regulated entities' procedural manuals

_____ Audit reports and results

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Consumer Credit Insurance Model Regulation (#370), Section 12
Model Regulation to Require Reporting of Statistical Data by Property and Casualty Insurance Companies (#751), Section 11
Best Practices Organizations White Paper
Insurance Holding Company System Regulatory Model Act (#440)

Review Procedures and Criteria

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

Determine how management is using the reports.

Determine if the regulated entity responds to internal audit recommendations to correct, modify and implement procedures.

Determine if accuracy of internal statistical data and information systems is periodically tested by the regulated entity's audit program.

Determine if the regulated entity conducts periodic reviews of creditors with respect to their credit insurance business with such creditors.

Determine if the regulated entity has adopted edit and audit procedures to screen and check data submitted by the regulated entity's statistical agent.

Determine if the NAIC Liquidity Stress Test Framework needs to be utilized for a specified data year.

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Determine if there is a holding company system in place. And if so, whether there should be a group capital calculation request from the U.S. Federal Reserve or whether a lead state commissioner should require a group capital calculation for US operations of any non-U.S. based insurance holding company system.

Determine if the confidentiality of any group capital contribution or group capital ratio is maintained and if the confidentiality of the liquid stress test results and supporting disclosure are maintained which includes any Federal Reserve Board filings and information.

Note: The examiner should be mindful of the proprietary nature of internal audit reports. Administrative action should not be recommended by the examiner based on results of internal audit findings for which the regulated entity has taken appropriate corrective action.

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STANDARDS
OPERATIONS/MANAGEMENT

Standard 2
The regulated entity has appropriate controls, safeguards and procedures for protecting the integrity of computer information.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Electronic records control, recovery/backup plan and regulated entity's procedural manuals; whether the records are electronic

_____ Negotiated contracts

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Insurance Information and Privacy Protection Model Act (#670)
Health Information Privacy Model Act (#55)
Standards for Safeguarding Consumer Information Model Regulation (#673)

Review Procedures and Criteria

Review regulated entity records, central recovery and backup procedures. The plan and procedures should be valid and up-to-date.

Review computer security procedures.

If the regulated entity permits changes to be made to policies either electronically or verbally, check what security procedures the regulated entity has established to permit these changes. These may include who has authority to make those changes, and what verification is done by the regulated entity with the insured after changes are made.

Ensure there is adequate security of applicant/insured data during the electronic transference of information. Identify any areas where the applicant's/insured's privacy is not properly protected.

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STANDARDS
OPERATIONS/MANAGEMENT

Standard 3
The regulated entity has antifraud initiatives in place that are reasonably calculated to detect, prosecute and prevent fraudulent insurance acts.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity antifraud plan and procedural manuals

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Insurance Fraud Prevention Model Act (#680)
Antifraud Plan Guideline (#1690)
Stranger-Originated Annuity Transactions (STOA) NAIC Sample Bulletin

Review Procedures and Criteria

Review the regulated entity's antifraud initiatives in conjunction with applicable statutory requirements. Antifraud initiatives may include fraud investigators, who may be insurer employees or independent contractors, and an antifraud plan.

Verify that the insurer, if required by applicable state statutes, rules and regulations, submits its antifraud plan to the insurance commissioner:

- Within ninety days of receiving a certificate of authority;
- Every five years thereafter; and
- Within thirty days of a material change made to the antifraud plan.

Determine if the plan is adequate, up-to-date and in compliance with statutes, rules and regulations.

Review the regulated entity's implementation (staffing, support, etc.) of its plan and, if necessary, discuss with management.

Note: An SIU antifraud plan may cover several insurer entities within a regulated entity, if one SIU has the fraud investigation mission for all entities.

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Verify that the insurer's antifraud plan includes the following five sections:

1. General Requirements
    - An acknowledgment that the SIU has established criteria that will be used for the investigation of acts of suspected insurance fraud relating to the different types of insurance offered by that insurer;
    - An acknowledgement that the insurer or SIU shall record the date that suspected fraudulent activity is detected, and shall record the date that reports of such suspected insurance fraud were sent directly to the insurance department or other applicable state regulatory agency within a specific time frame;
    - A provision stating whether the SIU is an internal unit or an external or third-party unit;
    - If the SIU is an internal unit, provide a description of whether the unit is part of the insurer's claims or underwriting departments, or whether it is separate from such departments;
    - A written description or chart outlining the organizational arrangement of the insurer's antifraud positions responsible for the investigation and reporting of possible fraudulent insurance acts:
        - If the SIU is an internal unit, the insurer shall provide general contact information for the company's SIU;
        - If the SIU is an external unit, the insurer shall provide (1) the name of the company or companies used; (2) contact information for the company; and (3) a company organizational chart. The insurer shall specify the person or position at the insurer responsible for maintaining contact with the external SIU company; and
        - If an external SIU is employed for purposes of surveillance, the insurer shall include a description of the policies and procedures implemented;
    - A provision where the insurer provides the appropriate NAIC individual and group code numbers;
    - A statement as to whether the insurer has implemented a fraud awareness or outreach program. If the insurer has an awareness or outreach program, a brief description of the program shall be included; and
    - If the SIU is a third-party unit, a description of the insurer's policies and procedures for ensuring that the third-party unit fulfills its contractual obligations to the insurer and a copy of the contract with the third-party vendor.

    Note: States that do not mandate fraud reporting should revise or remove inapplicable requirements from this section.

2. Prevention, Detection and Investigation of Fraud
    - A description of the insurer's corporate policies for preventing fraudulent insurance acts by its policyholders;
    - A description of the insurer's established fraud detection procedures (i.e. technology and other detection procedures);
    - A description of the internal referral criteria used in reporting suspicious claims of insurance fraud for investigation by the SIU;
    - A description of the SIU investigation program (i.e. by business line, external form claims adjustment, vendor management Statement of Positions (SOPs); and
    - A description of the insurer's policies and procedures for referring suspicious or fraudulent activity from its claims or underwriting departments to the SIU.

3. Reporting of Fraud
    - A description of the insurer's reporting procedures for the mandatory reporting of possible fraudulent insurance acts to the insurance commissioner or applicable state regulatory agency pursuant to applicable state statutes, rules and regulations;

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- A description of the insurer's criteria or threshold for reporting fraud to the insurance commissioner; and
- A description of the insurer's means of submission of suspected fraud reports to the insurance commissioner (e.g., the NAIC Online Fraud Reporting System (OFRS), National Insurance Crime Bureau (NICB), National Health Care Anti-Fraud Association (NHCAA), electronic state system or other).

Note: States that do not mandate fraud reporting should revise or remove inapplicable requirements from this section.

Note: The examiner should be aware of any applicable state statutes, rules and regulations regarding state antifraud mandatory reporting methods.

4. Education and Training
    - If applicable, a description of the insurer's plan for antifraud education and training initiatives of any personnel involved in antifraud related efforts. This description shall include:
        - The internal positions the insurer offers regular education and training, such as underwriters, adjusters, claims representatives, appointed agents, attorneys, etc.;
        - If the training will be internal and/or external;
        - Number of hours expected per year; and
        - If training includes ethics, false claims or other legal-related issues.

5. Internal Fraud Detection and Prevention
    - A description of insurer's internal fraud detection policy for employees, consultants or others, such as underwriters, claims representatives, appointed agents, etc.; and
    - A description of the insurer's internal fraud reporting system.

Determine if the regulated entity has procedures in place to prevent persons convicted of a felony involving dishonesty or breach of trust from participating in the business of insurance.

Determine if the regulated entity has procedures in place to provide information regarding fraudulent insurance acts to the insurance commissioner and in a manner prescribed by the insurance commissioner.

Examiners may wish to remind insurers that sell annuities of the existence of the *Stranger-Originated Annuity Transactions (STOA) NAIC Sample Bulletin* because sales of stranger-originated annuities may be an indicator of potentially fraudulent transactions.

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STANDARDS
OPERATIONS/MANAGEMENT

Standard 4
The regulated entity has a valid disaster recovery plan.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Description of the regulated entity's disaster recovery plan, procedural manuals and controls

_____ Description of protective devices for various hazards and procedures/controls for protection from those hazards

_____ Negotiated contracts

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Market Conduct Record Retention and Production Model Regulation (#910)

Review Procedures and Criteria

Determine that the regulated entity's database(s) are protected from various hazards, including environmental hazards.

Review the regulated entity's documents. Any additional areas or lack of information should be discussed with the regulated entity's management. The disaster recovery plan should be valid, specific and operational, with procedures for implementation and should also be current. Failure of the regulated entity to adequately plan for the future means the standard was not met.

Failure of the regulated entity to adequately (on an ongoing basis) provide for off-site backup, failure of the regulated entity to provide adequate controls and, in the case of a catastrophe, failure to provide for recovery, means the standard was not met.

Operations/Management Examination Standard #2 in this chapter also addresses disaster recovery issues.

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STANDARDS
OPERATIONS/MANAGEMENT

Standard 5
Contracts between the regulated entity and entities assuming a business function or acting on behalf of the regulated entity, such as, but not limited to, managing general agents (MGAs), general agents (GAs), third-party administrators (TPAs) and management agreements, must comply with applicable licensing requirements, statutes, rules and regulations.

Apply to All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Contracts

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Service Contracts Model Act (#685)
Managing General Agents Act (#225)
Registration and Regulation of Third-Party Administrators, An NAIC Guideline (#1090)
Third Party Administrator Statute (#90)

Review Procedures and Criteria

Review the contract to determine compliance with state statutes and rules.

The contract should specify the responsibilities of the subcontractor regarding recordkeeping and responsibilities of the regulated entity for conducting audits.

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STANDARDS
OPERATIONS/MANAGEMENT

Standard 6
The regulated entity is adequately monitoring the activities of any entity that contractually assumes a business function or is acting on behalf of the regulated entity.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Contracts

_____ Audit reports

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Managing General Agents Act (#225), Section 5
Registration and Regulation of Third-Party Administrators, An NAIC Guideline (#1090)
Third Party Administrator Statute (#90), Section 6
Consumer Credit Insurance Model Regulation (#370), Section 12
Variable Life Insurance Model Regulation (#270)

Review Procedures and Criteria

Entities can include an MGA, GA or TPA. Suppliers of consulting, investment, administrative, sales, marketing, custodial or other services with respect to variable life insurance operations are also considered entities (*Variable Life Insurance Model Regulation* (#270), Section 3E).

Review entity contracts to determine compliance with statutes, rules and regulations. The contract should specify the responsibilities of the MGA, GA and TPA concerning recordkeeping and responsibilities of the regulated entity for conducting audits.

Review audit reports to determine whether the regulated entity is adequately monitoring the activities of the contracted entity.

Review activities of entities to ensure compliance with applicable statutes and rules.

For credit insurance, each insurer is responsible for conducting a thorough periodic review of creditors with respect to their credit insurance business. The review should ensure compliance with statutes, rules and regulations. Written records of the reviews must be maintained by the insurer.

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STANDARDS
OPERATIONS/MANAGEMENT

Standard 7
Records are adequate, accessible, consistent and orderly and comply with state record retention requirements.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ All records, files and documents

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation for Complaint Records to be Maintained Pursuant to the NAIC Unfair Trade Practices Act (#884)
Market Conduct Record Retention and Production Model Regulation (#910)
Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Model Law on Examinations (#390), Section 4
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
The Use of Social Media in Insurance White Paper

Review Procedures and Criteria

Evaluate the orderly organization, legibility and structure of files.

Review state record retention requirements to determine regulated entity compliance.

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STANDARDS
OPERATIONS/MANAGEMENT

Standard 8
The regulated entity is licensed for the lines of business that are being written.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Certificate of authority or other similar documents

_____ Access NAIC financial system

_____ Regulated entity system

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Service Contracts Model Act (#685)
Nonadmitted Insurance Model Act (#870)
Unauthorized Transaction of Insurance Criminal Model Act (#890)

Review Procedures and Criteria

Review certificates of authority; compare writings with authorized lines.

Review financial annual statement submitted to the NAIC; compare writings with authorized states.

Obtain explanation of any discrepancies.

Access regulated entity system to verify that writings are in line with written premium reported in the financial annual statement.

Automation Tip:
The Financial Applications section of NAIC iSite+ contains the annual statement financial information for insurance companies that report to the NAIC. The most useful for market conduct examiners would be the annual statement Pick-a-Page. The State Page Exhibit displays the direct written premiums in any particular state for any particular year.

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STANDARDS
OPERATIONS/MANAGEMENT

Standard 9
The regulated entity cooperates on a timely basis with examiners performing the examinations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations, especially insurance examination law

_____ All records, files and documents

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Law on Examinations (#390)

Review Procedures and Criteria

Monitor regulated entity's cooperation during the course of the examination; this may be noted in the examination report.

Automation Tip:
Requests for information or "crits" can be monitored using either a database or spreadsheet. The information that should be captured includes: area of review, type of request, contact person, date given, date due and date received. Databases and spreadsheets contain functions that will calculate the number of days between two dates. The information can be easily sorted and reviewed to see what is still outstanding and if the regulated entity is responding in a timely fashion.

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STANDARDS
OPERATIONS/MANAGEMENT

Standard 10
The regulated entity has procedures for the collection, use and disclosure of information gathered in connection with insurance transactions so as to minimize any improper intrusion into the privacy of applicants and policyholders.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Written procedures of regulated entity for maintaining personal information and privileged information of applicants and policyholders

_____ The "Notice of Information Practices" required to be provided to applicants and policyholders

_____ Disclosure authorization forms

_____ Written procedures for the correction, amendment or deletion of recorded personal information

Others Reviewed

____ _____

____ _____

NAIC Model References

NAIC Insurance Information and Privacy Protection Model Act (#670)
Health Information Privacy Model Act (#55)
Unfair Discrimination Against Subjects of Abuse in Property and Casualty Insurance Model Act (#898)
Unfair Discrimination Against Subjects of Abuse in Life Insurance Model Act (#896)
Unfair Discrimination Against Subjects of Abuse in Health Benefit Plans Model Act (#895)
The Use of Social Media in Insurance White Paper

Review Procedures and Criteria

Determine if the regulated entity appropriately provides a "notice of information practices" that contains the required information.

Determine if the content of disclosure authorization forms meet content standards.

Determine if the regulated entity properly handles the use of investigative consumer reports.

Determine if the regulated entity's procedures appropriately limit access to personal information.

Determine if the regulated entity provides specific and accurate reasons for adverse underwriting decisions.

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STANDARDS
OPERATIONS/MANAGEMENT

Standard 11
The regulated entity has developed and implemented written policies, standards and procedures for the management of insurance information.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity procedure manual

_____ Regulated entity training manual

_____ Internal regulated entity claim audit procedures

_____ Regulated entity bulletins regarding insurance information

_____ Contractual arrangements between the carrier and a person other than the covered person

Others Reviewed

____ _____

____ _____

NAIC Model References

Health Information Privacy Model Act (#55), Section 5
NAIC Insurance Information and Privacy Protection Model Act (#670), Sections 4-9

Review Procedures and Criteria

Review regulated entity procedures, training manuals and claim bulletins to determine if regulated entity standards exist and whether standards comply with state law.

Review contractual arrangements between the regulated entity and other persons to determine if the contracts address privacy procedures and standards for the person with whom the regulated entity is contracting.

Review the regulated entity's methods for handling, disclosing, storing and disposing of insurance information. The examiners should determine whether there are procedures in place to ensure proper authorization is obtained prior to disclosure of insurance information.

Review the regulated entity's training manual to determine whether the regulated entity's employees are properly trained on the handling of insurance information.

Verify that the regulated entity provides a "Notice of Information Practices" to all applicants or policyholders or has procedures in place for the producer to deliver the notice. The examiner should determine whether the notice contains all provisions required by applicable state law.

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Verify that the regulated entity specifies those questions designed to obtain information solely for marketing or research purposes.

Verify that the regulated entity has implemented reasonable procedures to address investigative consumer reports and personal interviews.

Verify that the regulated entity has established procedures to address access to, correction, amendment or deletion of recorded personal information.

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STANDARDS
OPERATIONS/MANAGEMENT

Standard 12
The regulated entity has policies and procedures to protect the privacy of nonpublic personal information relating to its customers, former customers and consumers that are not customers.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity privacy policies and procedures

_____ Other regulated entity manuals/instruction books

_____ Communication provided by the regulated entity to employees and producers subject to the regulated entity's privacy policies

_____ Prior to conducting an examination, the examiner should review the state's definition of "customer" and "consumer" to determine appropriate usage of the terms. The examiner should also review the various exceptions and exclusions contained in the state's privacy act/regulation.

Others Reviewed

____ _____

____ _____

NAIC Model References

Privacy of Consumer Financial and Health Information Model Regulation (#672)

Review Procedures and Criteria

Review the regulated entity's policies, practices and procedures regarding protection and disclosure of nonpublic personal information of customers, former customers and consumers who are not customers, to verify that they comply with applicable state laws regarding privacy.

Review employee procedures regarding the treatment of nonpublic personal information to verify that they comply with the regulated entity's privacy policies, practices and procedures and with applicable state laws regarding privacy.

As applicable, verify that the regulated entity/licensee has provided a copy of its privacy notice to its producers.

Determine that the regulated entity does not unfairly discriminate against customers and consumers who are not customers who (1) have opted out from the disclosure of nonpublic personal financial information to nonaffiliated third parties; and (2) have not authorized disclosure of nonpublic personal health information, if applicable.

Review all privacy-related consumer complaints and inquiries.

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STANDARDS
OPERATIONS/MANAGEMENT

Standard 13
The regulated entity provides privacy notices to its customers and, if applicable, to its consumers who are not customers regarding treatment of nonpublic personal financial information.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity privacy policies and procedures

_____ Sample notices to customers: initial, annual, revised and simplified, if applicable

_____ Sample notices to consumers that are not customers, if applicable: initial (standard and short-form) notices and revised notice

_____ Prior to conducting an examination, the examiner should review the state's definition of "customer" and "consumer" to determine appropriate usage of the terms. The examiner should also review the various exceptions and exclusions contained in the state's privacy act/regulation.

Others Reviewed

____ _____

____ _____

NAIC Model References

Privacy of Consumer Financial and Health Information Model Regulation (#672)

Review Procedures and Criteria

Review the content of the regulated entity's initial, annual and revised notices.

Verify that these notices are clear and conspicuous and accurately reflect privacy policies and practices.

Notices should include the following:

- Identification of the regulated entity, if applicable;
- The categories of nonpublic personal financial information that the regulated entity collects;
- The categories of nonpublic personal financial information that the regulated entity discloses, if applicable;
- The categories of affiliates and nonaffiliated third parties to whom the regulated entity discloses nonpublic personal financial information, other than disclosures permitted under Sections 15 and 16 of Model #672, if applicable;
- The categories of nonpublic personal financial information about the regulated entity's former customers that the regulated entity discloses and the categories of affiliates and nonaffiliated third parties to whom the regulated entity discloses nonpublic personal financial information about the regulated entity's former customers, other than disclosures permitted under Sections 15 and 16 of Model #672, if applicable;

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- If a regulated entity discloses nonpublic personal financial information to a nonaffiliated third party under Section 14 of Model #672, a separate description of the categories of information the regulated entity discloses and the categories of third parties with whom the regulated entity has contracted;
- An explanation of the consumer's right to opt out of the disclosure of nonpublic personal financial information to nonaffiliated third parties, including the methods by which the consumer may exercise that right, if applicable;
- Any disclosures that the regulated entity may make under Section 603(d)(2)(A)(iii) of the federal Fair Credit Reporting Act (15 USC Section 1681a(d)(2)(A)(iii) (i.e., notices regarding the ability to opt out of disclosures of information among affiliates, other than transaction and experience information);
- The regulated entity's policies and practices with respect to protecting the confidentiality and security of nonpublic personal information; and
- If a regulated entity only discloses nonpublic personal financial information as authorized under Sections 15 and 16 of Model #672, a statement that indicates the regulated entity makes disclosures to other affiliated or nonaffiliated third parties, as applicable, as permitted by law.

Review the content of the regulated entity's simplified notice, if applicable, which shall include:

- Identification of the regulated entity and affiliates or subsidiaries, if applicable;
- The categories of nonpublic personal financial information that the regulated entity collects;
- The regulated entity's policies and practices with respect to protecting the confidentiality and security of nonpublic personal information; and
- That the regulated entity only discloses nonpublic personal financial information to affiliates and nonaffiliated third parties, as applicable, as authorized under Sections 15 and 16 of Model #672.

Review the content of the regulated entity's short-form notice for consumers who are not customers, if applicable, which shall state that the regulated entity's privacy notice is available upon request and provide a reasonable means by which the consumer may obtain a full notice.

Verify that the regulated entity's process for delivery of notices includes:

- Initial notice, if applicable, to consumers who are not customers;
- Initial notice to all customers, as required;
- Annual notice to all customers, as required;
- Revised notice to customers and consumers who are not customers entitled to notice, if applicable;
- Where applicable, simplified notices to customers, if the regulated entity only discloses nonpublic personal financial information about customers and former customers to affiliates and nonaffiliated third parties as authorized under Sections 15 and 16 of Model #672 (or the applicable sections under state law regarding privacy); and
- Short-form notices to consumers who are not customers, in lieu of initial notices, if applicable.

Verify that a notice is delivered to the regulated entity's customers at or prior to the time the regulated entity establishes a customer relationship (initial notice), and at least once in any period of 12 consecutive months or once in each calendar year thereafter (annual notice) during the continuation of the customer relationship, if appropriate. If initial notice was provided to customers after the customer relationship was established, verify that the notice was delivered within a reasonable time after the customer relationship was established and (1) establishing the customer relationship was not at the customer's election; or (2) providing notice at or prior to the establishment of the relationship would have substantially delayed the customer's transaction and the customer agreed to receive the notice at a later time.

Verify that if the regulated entity discloses any consumer's nonpublic personal financial information to any nonaffiliated third party, other than as authorized under Section 15 or 16 of Model #672 (or the applicable sections under state laws regarding privacy), the regulated entity delivers a notice before disclosing the information.

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Verify that individuals deemed consumers under applicable law are provided with an initial notice where applicable (such as where a licensee discloses a claimant's nonpublic personal financial information outside Sections 14 through 16 of Model #672 or its equivalent under state laws regarding privacy).

Verify that a notice was delivered to the regulated entity's customers and, if applicable, to consumers who are not customers in a manner that can reasonably be expected to provide actual notice.

Verify that a notice was provided to the regulated entity's customers and, if applicable, to consumers who are not customers, in writing, or, if the licensee provides and if the consumer has agreed, electronically.

Verify that the regulated entity has provided customers with clear and conspicuous initial, annual and revised notices in a manner that allows the customer to retain the notices or obtain them later in writing or, if the customer has agreed, electronically.

If the regulated entity is an excess lines insurer and does not disclose nonpublic personal financial information to nonaffiliated third parties, except as authorized under Sections 15 and 16 of Model #672, verify that the notice set forth in Section 4Q(3)(ii) of Model #672 has been delivered to all customers at the time the regulated entity established ongoing relationships with the customers. If the regulated entity makes disclosures other than as authorized under Sections 15 and 16 of Model #672, the regulated entity is required to comply with applicable initial, annual and revised notice requirements and the opt-out requirements.

Review the regulated entity's notice content and notice delivery procedures to verify that the regulated entity complies with applicable statutes, rules and regulations regarding privacy.

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STANDARDS
OPERATIONS/MANAGEMENT

Standard 14
If the regulated entity discloses information subject to an opt-out right, the regulated entity has policies and procedures in place so that nonpublic personal financial information will not be disclosed when a consumer who is not a customer has opted out, and the regulated entity provides opt-out notices to its customers and other affected consumers.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity privacy policies and procedures

_____ Sample notices to customers: initial, annual and, if applicable, revised

_____ Sample notices to consumers who are not customers, if applicable

_____ Sample opt-out notice, if applicable

_____ Regulated entity records of consumers and other customers who have opted out, if applicable

_____ Communication of customers' and consumers who are not customers' opt-out elections to producers of record

_____ Prior to conducting an examination, the examiner should review the state's definition of "customer" and "consumer" to determine appropriate usage of the terms. The examiner should also review the various exceptions and exclusions contained in the state's privacy act/regulation.

Others Reviewed

____ _____

____ _____

NAIC Model References

Privacy of Consumer Financial and Health Information Model Regulation (#672)

Review Procedures and Criteria

Determine whether the regulated entity discloses nonpublic personal information relating to customers or consumers who are not customers beyond the scope permitted under Sections 14, 15 and 16 of Model #672.

- Verify that consumers who may be affected by such disclosures have been offered the opportunity to opt out before the disclosures are made. Continue with Steps 1 through 5 below.
- If not, verify that any communications the regulated entity makes regarding opt-out rights are accurate and are in compliance with applicable law.
    1. If applicable, verify that the regulated entity has policies and procedures in place so that customers and other affected consumers may opt out of the disclosure of their nonpublic personal

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financial information to nonaffiliated third parties, except to the extent such disclosure is permitted under Sections 14, 15 and 16 of Model #672.

2. If applicable, review the regulated entity's policies and procedures to verify that the regulated entity has the capability to keep nonpublic personal financial information from being unlawfully disclosed to nonaffiliated third parties when a consumer has opted out.

3. If applicable, verify that the regulated entity does not disclose, directly or through any affiliate, unless authorized or permitted by applicable federal and/or state law or regulations, nonpublic personal financial information about a consumer or to a nonaffiliated third party except when:
    - The regulated entity has provided a notice to the consumer;
    - The regulated entity has provided an opt-out notice to the consumer;
    - The regulated entity has given the consumer a reasonable opportunity to opt out of the disclosure before the regulated entity discloses the consumer's nonpublic personal financial information to a nonaffiliated third party; and
    - The consumer does not opt out.

4. As applicable, determine that the regulated entity's initial, annual, revised and short-form notices accurately explain the consumer's right to opt-out, including the methods by which the consumer may exercise that right at any time, in accordance with applicable law and the regulated entity's policies and procedures.

5. If applicable, review the content of the regulated entity's opt-out notice to determine if it is clear and conspicuous and includes, either on the form or on the initial privacy notice:
    - A statement that the regulated entity discloses or reserves the right to disclose nonpublic personal financial information about its consumer to a nonaffiliated third party;
    - A statement that the consumer has the right to opt out of that disclosure; and
    - A reasonable means by which the consumer may exercise the opt-out right.

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STANDARDS
OPERATIONS/MANAGEMENT

Standard 15
The regulated entity's collection, use and disclosure of nonpublic personal financial information are in compliance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity privacy policies and procedures

_____ Joint marketing agreements, if any

_____ Sample service agreements, if any, with nonaffiliated third parties involved in the regulated entity's marketing activities

_____ Prior to conducting an examination, the examiner should review the state's definition of "customer" and "consumer" to determine appropriate usage of the terms. The examiner should also review the various exceptions and exclusions contained in the state's privacy act/regulation.

Others Reviewed

____ _____

____ _____

NAIC Model References

Privacy of Consumer Financial and Health Information Model Regulation (#672)

Review Procedures and Criteria

If the regulated entity discloses nonpublic personal financial information of its customers or consumers who are not customers to nonaffiliated third parties for joint marketing purposes, verify that all such disclosures are in compliance with Model #672:

- Verify that the regulated entity has provided initial notices to its customers and other affected consumers that include the required information regarding the regulated entity's joint marketing and servicing activities; and
- Review joint marketing agreements, where applicable, to verify that they prohibit the nonaffiliated third party from disclosing or using the nonpublic personal financial information received from the regulated entity other than to carry out the purposes for which the regulated entity disclosed the information, including use under an exception in Sections 15 or 16 of Model #672.

Verify that the regulated entity does not disclose nonpublic personal financial information that it receives from a nonaffiliated financial institution, except in compliance with Model #672.

Review sample service agreements under which a third party markets a licensee's own products and services, if any, to verify inclusion of non-disclosure requirements.

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Verify that the regulated entity prohibits disclosure of policy numbers or similar forms of access numbers or access codes for a consumer's policy or transaction account to any nonaffiliated third party, except as permitted by applicable law or regulation regarding privacy.

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STANDARDS
OPERATIONS/MANAGEMENT

Standard 16
In states promulgating the health information provisions of the *Privacy of Consumer Financial and Health Information Model Regulation* (#672), or providing equivalent protection through other substantially similar laws under the jurisdiction of the insurance department, the regulated entity has policies and procedures in place so that nonpublic personal health information will not be disclosed, except as permitted by law, unless a customer or a consumer who is not a customer has authorized the disclosure.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity privacy policies and procedures

_____ Sample authorizations used by the regulated entity to permit disclosure of nonpublic personal health information, if applicable

_____ Regulated entity records of customer and other consumer authorizations

_____ Prior to conducting an examination, the examiner should review the state's definition of "customer" and "consumer" to determine appropriate usage of the terms. The examiner should also review the various exceptions and exclusions contained in the state's privacy act/regulation.

Others Reviewed

____ _____

____ _____

NAIC Model References

Privacy of Consumer Financial and Health Information Model Regulation (#672)

Review Procedures and Criteria

If applicable, verify that the regulated entity has policies and procedures in place to secure authorizations from its customers and consumers who are not customers before disclosing their nonpublic personal health information to nonaffiliated third parties, except to the extent such disclosure is permitted under Subsection 17B of Model #672.

If applicable, verify that the regulated entity has obtained valid authorizations from customers and consumers who are not customers before disclosing their nonpublic personal health information, except to the extent such disclosures are permitted under Subsection 17B of Model #672. A valid authorization shall include:

- The identity of the consumer who is the subject of the nonpublic personal health information;
- A general description of the types of nonpublic personal health information to be disclosed;
- A general description of the parties to whom the licensee discloses nonpublic personal health information;
- A general description of the purpose of the disclosure of the nonpublic personal health information;
- A general explanation of how the nonpublic personal health information will be used;

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- The signature of the consumer who is the subject of the nonpublic personal health information or the individual who is legally empowered to grant disclosure authority and the date signed;
- A notice of the length of time for which the authorization is valid; and
- A notice that the consumer may revoke the authorization at any time, and an explanation of the procedure for making a revocation.

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STANDARDS
OPERATIONS/MANAGEMENT

Standard 17
Each licensee shall implement a comprehensive written information security program for the protection of nonpublic customer information.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity written materials describing its information security program

_____ Regulated entity policies, procedures and other materials it uses to implement its information security program

_____ Prior to conducting an examination, the examiner should review the state's definition of "customer" and "consumer" to determine appropriate usage of the terms. The examiner should also review the various exceptions and exclusions contained in the state's privacy act/regulation.

Others Reviewed

____ _____

____ _____

NAIC Model References

Standards for Safeguarding Customer Information Model Regulation (#673)
Insurance Data Security Model Law (#668)

Review Procedures and Criteria

Note: When reviewing a regulated entity's information security program for compliance with applicable state statutes, rules or regulations relating to the *Insurance Data Security Model Law* (Model #668), in the absence of a Cybersecurity Event, as defined in applicable state statutes, rules or regulations, please refer to the Insurance Data Security Pre-Breach Checklist found in the Reference Documents of the *Market Regulation Handbook*. Regulators may access Reference Documents on StateNet at the link Market Regulation Handbook, Handbook Updates and Reference Documents. Non-regulators may access Reference Documents via NAIC Account Manager at *https://www.naic.org/account_manager.htm*.

Note: When reviewing a regulated entity's information security program and response to a Cybersecurity Event for compliance with applicable state statutes, rules or regulations relating to the *Insurance Data Security Model Law* (Model #668), after a Cybersecurity Event has occurred, as defined in applicable state statutes, rules or regulations, please refer to the Insurance Data Security Post-Breach Checklist provided as Addendum A to Operations/Management Examination Standard 17 in Chapter 20—General Examination Standards.

Review the regulated entity's written information security program to determine whether the security program includes administrative, technical and physical safeguards.

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Determine whether, when developing safeguards, the regulated entity took into consideration the:

- Size and complexity of the regulated entity; and
- Nature and scope of regulated entity's activities.

In making the assessment above, consider factors such as: (1) the products and services offered by the regulated entity; (2) the methods of distribution for the products and services; (3) the types of information maintained by the regulated entity; (4) the size of the regulated entity (which may include the number of employees and the volume of business, etc.); (5) the marketing arrangements; and (6) the extent to which, or methods by which, the regulated entity communicates electronically with customers, producers and other third parties.

Evaluate whether the regulated entity's information security program is designed to:

- Ensure the security and confidentiality of customer information;
- Protect against any anticipated threats or hazards to the security or integrity of the information; and
- Protect against unauthorized access to or use of the information that could result in substantial harm or inconvenience to any customer.

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ADDENDUM A TO OPERATIONS/MANAGEMENT STANDARD 17
CHAPTER 20—GENERAL EXAMINATION STANDARDS
MARKET REGULATION HANDBOOK
INSURANCE DATA SECURITY POST-BREACH CHECKLIST

Supplemental Incident Response Plan Investigation (Post-Breach) and Notification Cybersecurity Event Checklist for Operations/Management Standard #17
Model #668, Sections 5 and 6

Company Name	
Period of Examination	
Examination Field Date	
Prepared By	
Date	

GUIDANCE
Insurance Data Security Model Law (#668)

The guidance that follows should only be used in states that have enacted the *Insurance Data Security Model Law* (#668) or legislation, which is substantially similar to Model #668. Moreover, in performing work during an exam in relation to Model #668, it is important that the examiners first obtain an understanding and leverage the work performed by other units in the department, including but not limited to, financial examination-related work.

OVERVIEW
The purpose and intent of Model #668 is to establish standards for data security and standards for the investigation of and notification to the Commissioner or Director of Insurance of a Cybersecurity Event affecting Licensees.

REVIEW GUIDELINES AND INSTRUCTIONS

When reviewing a Licensee's Information Security Program (ISP) for compliance with Model #668 for the prevention of a Cybersecurity Event, as defined in Model #668, please refer to the pre-breach examination checklist in the Reference Documents of the *Market Regulation Handbook* . Regulators can access the pre-breach examination checklist on the Market Regulation Handbook Reference Documents web page on StateNet. Non-regulators may access the pre-breach examination checklist at *https://www.naic.org/account_manager.htm*.

When reviewing a Licensee's ISP and response to a Cybersecurity Event for compliance with Model #668 subsequent to a suspected and/or known Cybersecurity Event, as defined in Model #668, please refer to both the pre-breach examination checklist and the post-breach examination checklist.

When considering whether to underake such a review, refer to Section 9 of Model #668, which provides certain exceptions to compliance for licensees with fewer than 10 employees; licensees subject to the Health Insurance Portability and Accountability Act (HIPAA) (Pub.L, 104–191, 110 Stat. 1936, enacted Aug. 21, 1996); and certain employees, agents, representatives, or designees of licensees who are in themselves licensees.

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ADDENDUM A TO OPERATIONS/MANAGEMENT STANDARD 17
CHAPTER 20—GENERAL EXAMINATION STANDARDS
MARKET REGULATION HANDBOOK
INSURANCE DATA SECURITY POST-BREACH CHECKLIST, CONT'D

Supplemental Incident Response Plan Investigation (Post-Breach) and Notification Cybersecurity Event Checklist for Operations/Management Standard #17
Model #668, Sections 5 and 6

Company Name	
Period of Examination	
Examination Field Date	
Prepared By	
Date	

POST-EVENT INVESTIGATION BY LICENSEE (Section 5)

REVIEW CRITERIA	**NOTES *(YES, NO, NOT APPLICABLE, OTHER)***
1. Did the Licensee conduct a prompt investigation of the Cybersecurity Event? (Section 5A)	
2. Did the Licensee appropriately determine the nature and scope of the Cybersecurity Event? (Section 5B)	

NOTICE TO COMMISSIONER/DIRECTOR OF INSURANCE (Section 6)

REVIEW CRITERIA	**NOTES *(YES, NO, NOT APPLICABLE, OTHER)***
3. Did the Licensee provide timely notice (no later than 72 hours) to the Commissioner or Director of Insurance following the Cybersecurity Event? (Section 6A)	
4. Did the notification to the Commissioner or Director of Insurance include the following information, to the extent reasonably available? (Section 6B)	
4a. The date of the Cybersecurity Event, or the date upon which it was discovered?	
4b. A description of how the Nonpublic Information was exposed, lost, stolen or breached, including the specific roles and responsibilities of Third-Party Service Providers, if any?	
4c. How the Cybersecurity Event was discovered?	
4d. Whether any lost, stolen or breached Nonpublic Information has been recovered, and if so, how this was done?	
4e. The identity of the source of the Cybersecurity Event?	
4f. Whether the Licensee has filed a police report or has notified any regulatory, government or law enforcement agencies? *(If YES, did the Licensee provide the date(s) of such notification(s)?)*	
4g. A description of the specific types of Nonpublic Information acquired without authorization?	
4h. The period during which the Information System was compromised by the Cybersecurity Event?	
4i. A best estimate of the number of total Consumers in this state and globally affected by the Cybersecurity Event?	
4j. The results of any internal review of automated controls and internal procedures and whether or not such controls and procedures were followed?	

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ADDENDUM A TO OPERATIONS/MANAGEMENT STANDARD 17
CHAPTER 20—GENERAL EXAMINATION STANDARDS
MARKET REGULATION HANDBOOK
INSURANCE DATA SECURITY POST-BREACH CHECKLIST, CONT'D

Supplemental Incident Response Plan Investigation (Post-Breach) and Notification Cybersecurity Event Checklist for Operations/Management Standard #17
Model #668, Sections 5 and 6

Company Name	
Period of Examination	
Examination Field Date	
Prepared By	
Date	

NOTICE TO COMMISSIONER/DIRECTOR OF INSURANCE (Section 6) (CONT'D)

REVIEW CRITERIA	**NOTES *(YES, NO, NOT APPLICABLE, OTHER)***
4k. A description of efforts being undertaken to remediate the circumstances which permitted the Cybersecurity Event to occur?	
4l. A copy of the Licensee's privacy policy and a statement outlining the steps the Licensee will take to investigate the Cybersecurity Event and to notify affected Consumers?	
4m. The name of a contact person familiar with the Cybersecurity Event and authorized to act for the Licensee?	
5. Did the Licensee provide timely updates to the initial notification and Questions 4a–4m above? (Section 6B)	

OTHER NOTIFICATIONS (Section 6)

REVIEW CRITERIA	**NOTES *(YES, NO, NOT APPLICABLE, OTHER)***
6. Did the Licensee provide timely and sufficient notice of the Cybersecurity Event to Consumers? (*If YES, did the Licensee provide a copy of the notification to the Commissioner(s)/Directors of all affected states?)* (Section 6C)	
7. Did the reinsurer Licensee provide timely and sufficient notice of the Cybersecurity Event to ceding insurers? (Section 6E)	
8. Did the Licensee provide timely and sufficient notice of the Cybersecurity Event to independent insurance producers and/or producers of record of affected Consumers? (Section 6F)	

THIRD-PARTY SERVICE PROVIDERS

REVIEW CRITERIA	***NOTES (YES, NO, NOT APPLICABLE, OTHER)***
9. Did the Cybersecurity Event occur at a Third-Party Service Provider? *(If YES, did the Licensee fulfill its obligations to ensure compliance with this law, either directly or by the Third-Party Service Provider?)* (Sections 5C and 6D)	

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ADDENDUM A TO OPERATIONS/MANAGEMENT STANDARD 17
CHAPTER 20—GENERAL EXAMINATION STANDARDS
MARKET REGULATION HANDBOOK
INSURANCE DATA SECURITY POST-BREACH CHECKLIST, CONT'D

Supplemental Incident Response Plan Investigation (Post-Breach) and Notification Cybersecurity Event Checklist for Operations/Management Standard #17
Model #668, Sections 5 and 6

Company Name	
Period of Examination	
Examination Field Date	
Prepared By	
Date	

POST-EVENT ANALYSIS

REVIEW CRITERIA	***NOTES (YES, NO, NOT APPLICABLE, OTHER)***
10. What changes, if any, are being considered to the Licensee's ISP as a result of the Cybersecurity Event and the Licensee's response?	

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STANDARDS
OPERATIONS/MANAGEMENT

Standard 18
All data required to be reported to departments of insurance is complete and accurate.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Claim files

_____ Underwriting files

_____ Regulated entity's medical professional liability closed claim reports (if applicable)

_____ Regulated entity's Market Conduct Annual Statement (MCAS) submissions

_____ Regulated entity's responses to state-specific data requests

Others Reviewed

Statutory or regulatory authority for state-specific data requests

____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Medical Professional Liability Closed Claim Reporting Model Law (#77)
Market Conduct Surveillance Model Law (#693)

Review Procedures and Criteria

Interview the regulated entity's personnel who prepare loss statistical reports, medical professional liability loss reports, MCAS data and state-specific data requests; analyze regulated entity's internal communications between various departments which report same.

Determine that the regulated entity reviews data errors and subsequent changes are made.

Determine if the regulated entity's medical professional liability closed claims reports are accurate and reported within the required time frame.

Request that the regulated entity reconcile closed claims reports, state-specific data requests and MCAS data with the State Page of the annual statement to include payments, case reserves, and defense cost containment expenses, and explain differences.

Request that the regulated entity reconcile closed claims reports to data provided on the standardized data request.

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B. Complaint Handling

1. Purpose

The NAIC definition of a complaint is "any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the state's insurance laws. An oral communication, which is subsequently converted to a written form, would meet the definition of a complaint for this purpose." The examiner should review the regulated entity's procedures for processing consumer or other related complaints. Specific problem areas may necessitate an overall review of a particular segment of the regulated entity's operation.

If a regulated entity is using social media, the examiner should review the regulated entity's policies and procedures with regard to regulated entity handling of complaints received via social media, in which the regulated entity is active.

2. Techniques

A review of complaint handling should incorporate both consumer direct complaints to the regulated entity and those complaints filed with the insurance department. The examiner should reconcile the regulated entity's complaint register with a list of complaints from the insurance department. A random sample of complaints should be selected for review from the regulated entity's complaint register. If such a register is not maintained, alternative methods of isolating complaints may be implemented.

The examiner should review the frequency of similar complaints and be aware of any pattern of specific type of complaints. The examiner should take into consideration the increase of complaints that typically follows a catastrophe. Should the type of complaints generated be cause for unusual concern, specific measures should be instituted to investigate other areas of the regulated entity's operations. This may include modifying the scope of examination to examine specific regulated entity behavior.

The examiner should review the NAIC Complaints Database System (CDS) to determine the regulated entity's complaint index, along with any adverse trends in complaint volume. The examiner may wish to review complaint trends and the complaint index for the preceding three years.

The examiner should review the final disposition of the complaints and determine if the regulated entity has taken adequate steps to finalize the complaint. The examiner should determine if the actions taken are in compliance with statutes, rules and regulations.

In states that have established a statutory or regulatory standard of promptness, a study should be conducted to determine how promptly the regulated entity responds to complaints, the adequacy of the responses and what, if any, actions were taken to resolve the problems.

If the examination involves a depository institution or their affiliates, it may also be regulated by a federal agency, such as the Office of the Comptroller of the Currency, the Federal Reserve Board, the Office of Thrift Supervision or the Federal Deposit Insurance Corporation. In addition, banks may also be regulated at the state level. If the state has signed an agreement to share complaint information with these agencies, any adverse trends or pattern of concern to the examiners may be identified and relayed to the agency.

3. Tests and Standards

The complaint handling review includes, but is not limited to, the following standards addressing various aspects of a regulated entity's operations. The sequence of the standards listed here does not indicate priority of the standard.

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STANDARDS
COMPLAINT HANDLING

Standard 1
All complaints are recorded in the required format on the regulated entity's complaint register.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity complaint register

_____ Insurance department's complaint records

_____ Direct consumer complaints

_____ Complaints received electronically (i.e., via Internet or email)

Others Reviewed

____ _____

____ _____

NAIC Model References

Model Regulation for Complaint Records to be Maintained Pursuant to the NAIC Unfair Trade Practices Act (#884)
Consumer Complaints White Paper
Unfair Trade Practices Act (#880), Section 4K

Review Procedures and Criteria

All of the above should be reviewed to make sure the regulated entity is:

- Recording all complaints (both consumer direct and insurance department); and
- Recording required information in the regulated entity complaint register.

Determine if the regulated entity complaint register meets minimum standards as required by law. At a minimum, the complaint register should include:

- Line of business;
- Function (underwriting, marketing and sales, claims, policyholder services or miscellaneous); and
- Reason for complaint (underwriting, application, cancellation, recission, nonrenewal).

Automation Tip:
Most companies maintain this information in some sort of PC-based spreadsheet format, such as Lotus or Excel. Request that this spreadsheet be copied in its usual format for comparison with insurance department records. Do not specify which data to be supplied, but instead go with exactly what the regulated entity tracks. A review can be made to see if they contain the information that should be collected from each complaint. Then, a sample can be pulled to review individual complaints to see if the regulated entity's procedures are being followed.

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Obtain complaint data file from the insurance department (in whatever format available; e.g., ASCII text file, Microsoft Access, etc.). Convert the data file to a format compatible to the spreadsheet/database from the regulated entity. Compare the complainant name, claim number, policy number, etc., in both files to determine if all of the insurance department complaints were correctly logged by the regulated entity.

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STANDARDS
COMPLAINT HANDLING

Standard 2
The regulated entity has adequate complaint handling procedures in place and communicates such procedures to policyholders.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Complaint handling procedure manuals

_____ Policy files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Consumer Complaints White Paper

Review Procedures and Criteria

Review the regulated entity's manuals to verify that complaint procedures exist.

Determine whether there are sufficient procedures in place to require satisfactory handling of complaints received, as well as internal procedures for analysis in areas developing complaints.

Determine whether there is a method for distribution of and obtaining and recording responses to complaints. This method should be sufficient to allow response within the time frame required by state law.

The regulated entity should provide a telephone number and address for consumer inquiries.

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STANDARDS
COMPLAINT HANDLING

Standard 3
The regulated entity takes adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules and regulations and contract language.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ Regulated entity complaint register

_____ Complaint letter or email and regulated entity complaint response

_____ Supporting documentation (claim files, underwriting files, etc.)

_____ Regulated entity correspondence

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Consumer Complaints White Paper

Review Procedures and Criteria

Review complaints documentation to determine if the regulated entity response fully addresses the issues raised. If the regulated entity did not properly address/resolve the complaint, the examiner should ask the regulated entity what corrective action it intends to take.

Criteria for reviewing complaint responses:

- The response is timely;
- The response is complete and responds to all issues raised;
- The response includes adequate documentation to support the respondent's position;
- The respondent's actions are appropriate from a business practice standpoint;
- The respondent's actions comply with all applicable statutes, rules and policy or contract provisions; and
- The appropriate remedies for the consumer are identified.

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STANDARDS
COMPLAINT HANDLING

Standard 4
The time frame within which the regulated entity responds to complaints is in accordance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Complaint letter or email

_____ Regulated entity response and supporting documentation

_____ Regulated entity complaint register

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Consumer Complaints White Paper

Review Procedures and Criteria

Review complaints to ensure regulated entity is maintaining adequate documentation.

Determine if the regulated entity's response is timely. The examiner should refer to state laws for the required time frame.

Automation Tip:
Most companies maintain this information in some sort of PC-based spreadsheet format, such as Lotus or Excel. Request that this spreadsheet be copied in its usual format for comparison with insurance department records. Using either an Excel spreadsheet or a Microsoft Access database, calculate the number of days between the date the complaint was received and the date a final resolution was sent to the complainant. Use the features of either application to identify those complaints where the number of days to resolve the complaint exceeds the statutory standard.

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C. Marketing and Sales

1. Purpose

The Marketing and Sales portion of the examination is designed to evaluate the representations made by the regulated entity about its product(s) or services. It is not typically based on sampling techniques. The areas to be considered in this kind of review include all media (radio, television, videotape, electronic medium, social media, etc.), written and verbal advertising and sales materials.

2. Techniques

This area of review should include all advertising and sales material and all producer sales training materials to determine compliance with statutes, rules and regulations. Information from other jurisdictions may be reviewed, if appropriate. The examiner may contact policyholders, producers and others to verify the accuracy of information provided or to obtain additional information.

As with all of its advertising, regardless of the medium, every regulated entity is required to have procedures in place to establish and, at all times, maintain a system of control over the content, form and method of dissemination of all of its advertisements. All of these advertisements maintained by or for the regulated entity and authorized by the regulated entity are the responsibility of the regulated entity.

The exact same regulations and statutes (such as the *Unfair Trade Practices Act* (#880)) that apply to conventional advertising also apply to Internet advertising. Bearing that in mind, when the examiner is reviewing a regulated entity's Internet advertisements, it is important to also review the safeguards implemented by the regulated entity.

All advertisements are required to be truthful and not misleading in fact or by implication. The form and content of an advertisement of a policy shall be sufficiently clear so as to avoid deception. The advertisement shall not have the capacity or tendency to mislead or deceive. Whether an advertisement has the capacity or tendency to mislead or deceive shall be determined upon reviewing the overall impression that the advertisement reasonably may be expected to create upon a person of average education or intelligence within the segment of the public to which the advertisement is directed.

3. Tests and Standards

The marketing and sales review includes, but is not limited to, the following standards addressing various aspects of the marketing and sales function. The sequence of the standards listed here does not indicate priority of the standard.

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STANDARDS
MARKETING AND SALES

Standard 1
All advertising and sales materials are in compliance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ All regulated entity advertising and sales materials, including radio and audiovisual items such as television commercials, telemarketing scripts, pictorial materials, social media or other electronic medium

_____ Policy forms as they coincide with advertising and sales materials

_____ Producer's own advertising and sales materials

_____ Regulated entity policies and procedures

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Trade Practices Act (#880)
Advertisements of Life Insurance and Annuities Model Regulation (#570), Section 3B
Risk-Based Capital (RBC) for Insurers Model Act (#312), Section 8B
Life Insurance Disclosure Model Regulation (#580), Section 8C
Life and Health Insurance Guaranty Association Model Act (#520), Section 19A
Long-Term Care Insurance Model Act (#640)
Life Insurance Illustrations Model Regulation (#582)
Small Employer and Individual Health Insurance Availability Model Act (#35)
Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Model Act (#171), Section 7(H)(1)(a)(I)
Advertisements of Accident and Sickness Insurance Model Regulation (#40)
Individual Health Insurance Portability Model Act (#37), Section 5
Title Insurers Model Act (#628)
Title Insurance Agent Model Act (#230)
Home Service Disclosure Model Act (#920)
Marketing Insurance Over the Internet White Paper
Group Health Insurance Standards Model Act (#100)
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)
The Use of Social Media in Insurance White Paper
Insurance Holding Company System Regulatory Model Act (#440)

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IIPRC Uniform Standard References

IIPRC Standards for Individual Long-Term Care Advertising Materials (applicable to individual long-term care (LTC) products and associated advertising materials submitted and/or approved by the IIPRC)

Review Procedures and Criteria

Review advertising materials in conjunction with the appropriate policy form. If statistics are included, proper citation should be included in the documentation.

Materials should not:

- Misrepresent the dividends or share of the surplus to be received on any policy;
- Make a false or misleading statement as to the dividends or share of the surplus previously paid on the policy;
- Misrepresent any policy as being shares of stock;
- Misrepresent policy benefits forms or conditions by failing to disclose limitations, exclusions or reductions or use terms or expressions that are misleading or ambiguous;
- Make unfair or incomplete comparisons with other policies;
- Make false, deceptive or misleading statements or representations with respect to any person, regulated entity or organization in the conduct of insurance business; and
- Offer unlawful rebates or inducements.

Materials should:

- Disclose the name and address of insurer;
- Comply with applicable statutes, rules and regulations; and
- Cite the source of statistics used by the regulated entity.

Determine if the regulated entity approves producer sales materials and advertising. Determine if advertisements or lead-generating calls falsely project the image that they were sent by a government agency.

Review the regulated entity's and producer's websites with the following questions in mind:

- Does the website disclose who is selling/advertising/servicing for the website?
- Does the website disclose what is being sold or advertised?
- If required by statutes, rules or regulations, does the website reveal the physical location of the regulated entity/entities?
- Does the website reveal the jurisdictions where the advertised product is (or is not) approved, or use some other mechanism (including, but not limited to, identifying persons by geographic location) to accomplish an appropriate result?

For the review of Internet advertisements:

- Run an inquiry with the regulated entity's name;
- Review the regulated entity's home page;
- Identify all lines of business referenced on the regulated entity's home page;
- Research the ability to request more information about a particular product and verify the information provided is accurate; and
- Review the regulated entity's procedures related to producers advertising on the Internet and ensure the regulated entity requires prior approval of the producer pages, if the regulated entity name is used.

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For the review of social media:

- Perform a search of social media sites with the regulated entity's name;
- Identify social media sites in which the regulated entity is active;
- Review identified social media sites and verify any product information provided by the regulated entity is accurate;
- Review the regulated entity's policies and procedures to identify the personnel involved in monitoring the regulated entity's marketing and sales-related social media activity;
- Review the regulated entity's policies and procedures for tracking marketing and sales-related social media requiring regulated entity review; and
- If the regulated entity requires preapproval of producer advertising on the Internet, review the regulated entity's preapproval procedures to determine whether the regulated entity identifies marketing and sales-related social media as also requiring regulated entity preapproval.

For the review of group capital calculation, resulting group capital ratio and liquidity stress test:

- Review the making, publishing, disseminating, circulating or placing before the public, or causing directly or indirectly to be made, published, disseminated, circulated or placed before the public in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station or any electronic means of communication available to the public, or in any other way as an advertisement, announcement or statement containing a representation or statement with regard to the group capital calculation, group capital ratio, the liquidity stress test results, or supporting disclosures for the liquidity stress test of any insurer or any insurer group, or of any component derived in the calculation by any insurer, broker, or other person engaged in any manner in the insurance business because it would be misleading and is therefore prohibited; and
- Review if any materially false statement with respect to the group capital calculation, resulting group capital ratio, an inappropriate comparison of any amount to an insurer's or insurance group's group capital calculation or resulting group capital ratio, liquidity stress test result, supporting disclosures for the liquidity stress test, or an inappropriate comparison of any amount to an insurer's or insurance group's liquidity stress test result or supporting disclosures is published in any written publication and if the insurer is able to demonstrate to the commissioner with substantial proof the falsity of such statement or the inappropriateness, as the case may be, then the insurer may publish announcements in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

Automation Tip:
Enter a summary of all marketing materials of whatever description in an Excel spreadsheet. Capture the regulated entity's name of the material; the form number, if any; the edition date, if any; source, if applicable; and media, such as Internet or direct mail. Include fields to note exceptions, such as unsupported statistics or possible misleading statements. Insert each possible violation/exception in a separate field.

Statistics and statements are likely to be repeated in more than one "piece" of marketing material. It is also possible that one piece of marketing material will contain more than one violation/exception.

The spreadsheet will make it easier to track any repeated statements and to identify any marketing material containing apparent multiple violations/exceptions.

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STANDARDS
MARKETING AND SALES

Standard 2
Regulated entity internal producer training materials are in compliance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity's producer training manuals, videos and sales scripts

Others Reviewed

____ _____

____ _____

NAIC Model References

Producer Licensing Model Act (#218)
Life Insurance Disclosure Model Regulation (#580), Section 5A(2)
Advertisements of Life Insurance and Annuities Model Regulation (#570)
Small Employer and Individual Health Insurance Availability Model Act (#35)
Individual Health Insurance Portability Model Act (#37), Sections 11D and 11E
Title Insurers Model Act (#628)
Title Insurance Agent Model Act (#230)
Advertisements of Accident and Sickness Insurance Model Regulation (#40)
Group Health Insurance Standards Model Act (#100)
Long-Term Care Insurance Model Act (#640)
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the Medicare Supplement Insurance Minimum Standards Model Act (#651)

Review Procedures and Criteria

Review all producers' training materials for compliance with state statutes, rules and regulations.

Review materials for references to employing unfair discrimination tactics or avoiding statutory compliance.

Determine whether producers' prepared materials are permitted and, if so, under what conditions and controls.

The examiners should be aware of the results of the review of common consumer complaints against the regulated entity, as that could point toward problems in this area.

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Automation Tip:
Enter a summary of all training materials of whatever description in an Excel spreadsheet. Capture the regulated entity's name of the material; the form number, if any; the edition date, if any; source, if applicable; and media, such as video, sales script, etc. Include fields to note exceptions, such as incomplete disclosure or possible misleading statements. Insert each possible violation/exception in a separate field.

Statistics and statements are likely to be repeated in more than one "piece" of training material. It is also possible that one piece of training material will contain more than one violation/exception.

The spreadsheet will make it easier to track any repeated statements and to identify any training material containing apparent multiple violations/exceptions.

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STANDARDS
MARKETING AND SALES

Standard 3
Regulated entity communications to producers are in compliance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Bulletins, newsletters and memos

_____ Organizational chart of marketing division

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Trade Practices Act (#880)
Small Employer and Individual Health Insurance Availability Model Act (#35)
Title Insurers Model Act (#628)
Title Insurance Agent Model Act (#230)
Group Health Insurance Standards Model Act (#100)
Long-Term Care Insurance Model Act (#640)
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the Medicare Supplement Insurance Minimum Standards Model Act (#651)

Review Procedures and Criteria

Review written and electronic communication between the regulated entity and producers in accordance with applicable statutes, rules and regulations.

Determine if communication includes references to new rates, rules and regulations.

Determine if communication conforms to Marketing and Sales Examination Standard #1 in this chapter when referencing advertising and sales.

Determine if the regulated entity uses email to communicate with producers. The examiner should ask to review saved, stored or archived email that was broadcast to the sales force.

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Automation Tip:
Enter a summary of all producer communications of whatever description in an Excel spreadsheet. Capture the regulated entity's title or subject line for the communication, the date of the communication, source of the communication, etc. Include fields to note exceptions, such as misleading statements or instructions to producers that are in conflict with statutes or regulations. Insert each possible violation/exception in a separate field.

Statistics and statements are likely to be repeated in more than one regulated entity communication. It is also possible that a single regulated entity communication will contain more than one violation/exception.

The Excel spreadsheet will make it easier to track any repeated statements and to identify any regulated entity communications containing apparent multiple violations/exceptions.

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D. Producer Licensing

1. Purpose

The producer licensing portion of the examination is designed to test a regulated entity's compliance with state producer licensing laws and rules. The focus of the standard relating to producer accounts current is to aid in the detection of fraud or misuse of funds held by the producer in a fiduciary capacity.

2. Techniques

The examiner should review and compare information obtained from insurance departments and regulated entity records pertaining to licenses held by individuals or entities soliciting business on behalf of the regulated entity. Information related to producer licensing may be obtained from the NAIC State Producer Licensing Database (SPLD). In addition to aggregate listings of licensed/appointed/terminated producers, compliance with producer licensing statutes should be verified during the review of individual policy files, which take place during other portions of the examination (see Section F Underwriting and Rating in this chapter).

The examiner should compare information obtained from insurance departments and regulated entity records pertaining to the licenses held by individuals or entities soliciting business on behalf of the regulated entity. Insurance department records may be obtained through the NAIC SPLD, if the state is actively submitting information to the database. The SPLD contains information about a producer's license and any appointments they have with a regulated entity.

3. Tests and Standards

The producer licensing review includes, but is not limited to, the following standards related to producer licensing. The sequence of the standards listed here does not indicate priority of the standard.

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STANDARDS
PRODUCER LICENSING

Standard 1
Regulated entity records of licensed and appointed (if applicable) producers and in jurisdictions where applicable, licensed company or contracted independent adjusters agree with insurance department records.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Insurance department listing of producers and, if applicable, adjusters or the SPLD (State Producer Licensing Database)

_____ Regulated entity listing of currently licensed and/or appointed producers and, if applicable, adjusters

_____ Regulated entity listing of commissions

Others Reviewed

____ _____

____ _____

NAIC Model References

Mass Marketing of Property and Liability Insurance Model Regulation (#710)
Producer Licensing Model Act (#218)
Title Insurance Agent Model Act (#230)
Independent Adjuster Licensing Guideline (#1224)

Review Procedures and Criteria

Reconcile above regulated entity lists with corresponding insurance department lists to determine any discrepancies. If the state is actively participating in the State Producer Licensing Database (SPLD), the examiner should validate the producer's or adjuster's licensure status through the SPLD in lieu of obtaining a hardcopy of the producer's or adjuster's license.

Determine that any producer writing business in connection with a mass marketing plan is appropriately licensed.

Refer discrepancies to appropriate divisions within the insurance department.

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Automation Tip:
Obtain from the regulated entity a list of all producers licensed and appointed at any time during the examination period, and, where applicable, all company or contracted independent adjusters licensed at any time during the examination period. Include the producer's or adjuster's National Producer Number (NPN) or, if unavailable, Social Security number, Federal Employer Identification number, name, address, licensed date, appointed date, type of license, and internal regulated entity or employee number for the producer. Obtain from the insurance department's licensing division a similar list. Obtain from the regulated entity a list of all producers who received commission during the examination period. Include the producer's National Producer Number (NPN) or, if unavailable, Social Security number, Federal Employer Identification number, name, address, licensed date, appointed date, type of license, date first commission received and internal regulated entity or employee number for the producer. Obtain from the regulated entity a list of all new business written during the examination period. Include the date the policy was issued and the producer's internal regulated entity or employee number.

- Compare the regulated entity's producer and adjuster licensing list to the insurance department's licensed producers list by comparing National Producer Numbers (NPN) or, if unavailable, Social Security numbers, Federal Employer Identification numbers, extracting any producers on the regulated entity's list who are not on the insurance department's list;
- Compare the regulated entity's commissions list to the insurance department's licensed producers list by comparing National Producer Numbers (NPN) or, if unavailable, Social Security numbers, Federal Employer Identification numbers, extracting any producers on the regulated entity's list who are not on the insurance department's list. Also compare commission first earned dates to the insurance department's license/appointment dates to see if commissions were earned prior to license/appointment date; and
- Compare the regulated entity's new business written list to the insurance department's licensed producers list by comparing National Producer Numbers (NPN) or, if unavailable, Social Security numbers, Federal Employer Identification numbers or internal regulated entity/employee numbers), extracting any producers on the regulated entity's list who are not on the insurance department's list. Also compare policy issued date to the insurance department's license/appointment dates to see if policies were written prior to license/appointment date. This may need to be cross-referenced with the regulated entity's licensed producer list to correlate the producer's National Producer Number (NPN) and the internal regulated entity/employee number.

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STANDARDS
PRODUCER LICENSING

Standard 2
The producers are properly licensed and appointed and have appropriate continuing education (if required by state law) in the jurisdiction where the application was taken.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ New business application

_____ Insurance department listing of licensed and/or appointed producers or the State Producer Licensing Database (SPLD)

_____ Copy of producer's license or electronic verification of producer's license via the State Producer Licensing Database (SPLD)

_____ Regulated entity listing of all currently licensed and/or appointed producers

_____ Notice of appointment

_____ Regulated entity procedures for appointing a producer

_____ Regulated entity list of commissions paid by line of business

Others Reviewed

____ _____

____ _____

NAIC Model References

Producer Licensing Model Act (#218)
Title Insurance Agent Model Act (#230)
Unfair Trade Practices Act (#880)
Long-Term Care Insurance Model Act (#640)

Review Procedures and Criteria

Review the regulated entity's procedures for the appointment of producers.

Review the producer's license and the appointment records. Determine if the appointment was effective within 15 days of the producer writing business on behalf of the regulated entity.

Review the producer's authority for the types of business he/she is eligible to solicit. Determine if the producer is acting within the scope of that authority.

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Determine that the producer has met continuing education requirements and, if appropriate, has met the producer training requirements for selling long-term care insurance (LTCI).

Identify the producer of each selected policy and determine proper licensure and appointment (if required).

Automation Tip:
Obtain from the regulated entity a list of all producers licensed and appointed at anytime during the examination period. Include the producer's National Producer Number (NPN) or, if unavailable, Social Security number or Federal Employer Identification number, name, address, licensed date, appointed date, type of license and internal regulated entity or employee number for the producer. Obtain from the insurance department's licensing division a list of all producers licensed and appointed at any time during the examination period. Include the producer's National Producer Number (NPN) or, if unavailable, Social Security number or Federal Employer Identification number, name, address, licensed date, appointed date, applicable jurisdictions and type of license. Obtain from the regulated entity a list of all applications taken during the examination period. Include the date the application was taken, the producer's internal regulated entity or employee number and the jurisdiction where the application was taken. Compare these files using National Producer Numbers (NPN) or, if unavailable, Social Security numbers or Federal Employer Identification numbers and internal regulated entity/employee number for the producer and jurisdictions. Extract any producers who took applications from jurisdictions where they were not licensed/appointed.

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STANDARDS
PRODUCER LICENSING

Standard 3
Termination of producers complies with applicable standards, rules and regulations regarding notification to the producer and notification to the state, if applicable.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity/agency contracts

_____ Regulated entity listing of producer terminations for examination review period

_____ Regulated entity listing of commissions

_____ Insurance department listing of terminations

_____ Copies of individual termination notifications sent to terminated producers

_____ Copies of individual termination notifications sent to insurance department

Others Reviewed

____ _____

____ _____

NAIC Model References

Producer Licensing Model Act (#218)
Title Insurance Agent Model Act (#230)

Review Procedures and Criteria

Reconcile the regulated entity's listing of producer terminations with the listing of commissions paid to determine if payouts are being made properly to terminated producers.

Review individual termination notices from the regulated entity to producers to determine compliance with termination notification periods and allowance for renewal commissions.

Refer any discovery of terminated producers still submitting new business to appropriate divisions within the insurance department.

Review the regulated entity's contract with producers to determine how commissions are paid to producers who have been terminated (e.g., vesting provisions).

Compare the regulated entity's listing of producer terminations with the National Insurance Producer Registry (NIPR) to ensure accuracy in reporting.

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STANDARDS
PRODUCER LICENSING

Standard 4
The regulated entity's policy of producer appointments and terminations does not result in unfair discrimination against policyholders.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Listing of appointments and terminations for examination review period

_____ Listing of producer appointments by line of business (if applicable) by producer's business ZIP code

_____ Listing of terminations by line of business (if applicable) by producer's business ZIP code

_____ Regulated entity market plan or synopsis

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Compare the number of appointments/terminations for the current review period with previous review period and, if difference is significant, determine the reason(s).

Review the regulated entity's marketing plan.

Review ZIP code listings to determine the placement of producers and if there is evidence of under-served or over-served geographical areas.

Automation Tip:
Obtain from the regulated entity a list of all producers licensed and appointed at any time during the examination period. Include the producer's National Producer Number (NPN) or, if unavailable, Social Security number, Federal Employer Identification number, name, address, county, ZIP code, licensed date, appointed date, termination date, type of license and internal regulated entity or employee number for the producer. Extract a list of all producers that were licensed/appointed and/or terminated during the examination period. Run a count on the number of producers that are licensed/appointed by ZIP code or county and a count on the number of producers terminated by ZIP code or county. Also run a count on the original file by ZIP code or county. A comparison of the counts may show ZIP codes or counties that are under-served or over-served.

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STANDARDS
PRODUCER LICENSING

Standard 5
Records of terminated producers adequately document reasons for terminations.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity listings of terminated producers for examination review period

_____ Regulated entity individual files of terminated producers

_____ Insurance department's list of acceptable reasons for terminations

Others Reviewed

____ _____

____ _____

NAIC Model References

Producer Licensing Model Act (#218)
Title Insurance Agent Model Act (#230)

Review Procedures and Criteria

Determine reasons for producer terminations.

Review all or sample of individual terminated producer files.

Review above documents for inadequately or inaccurately documented termination reasons. If necessary, refer to the appropriate division within the insurance department.

Compare the regulated entity's listing of producer terminations with NIPR to ensure accuracy in reporting.

Determine if the insurance department is notified of termination for cause (if applicable).

Automation Tip:
Obtain from the regulated entity a list of all producers terminated at any time during the examination period. Include the producer's National Producer Number (NPN) or, if unavailable, Social Security number, Federal Employer Identification number, name, address, termination date and reason for termination. Review the regulated entity's files for these producers to determine if the terminations were adequately documented.

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STANDARDS
PRODUCER LICENSING

Standard 6
Producer account balances are in accordance with the producer's contract with the insurer.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Listing of producer accounts current exceeding contract limits

_____ Producer and/or agency contracts

Others Reviewed

____ _____

____ _____

NAIC Model References

Producer Licensing Model Act (#218)
Title Insurance Agent Model Act (#230)
Unfair Trade Practices Act (#880)
Insurance Fraud Prevention Model Act (#680)

Review Procedures and Criteria

Review listing of producer accounts current.

Discuss excessive balances with the regulated entity.

Accounts current exceeding contract limits may indicate producer mishandling of funds.

Refer to appropriate division within the insurance department.

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E. Policyholder Service

1. Purpose

The policyholder service portion of the examination is designed to test a regulated entity's compliance with statutes regarding notice/billing, delays/no response, and premium refund and coverage questions.

2. Techniques

While larger companies may have a full staff to handle policyholder service, smaller companies may well do policyholder service as a function of the claims or underwriting department.

Policyholder service departments vary from regulated entity to regulated entity. Some companies do only what is required of them by state statute (i.e., notification of the toll-free number or policyholder complaint telephone number). In contrast, some actually contact policyholders that have had occasion to deal directly with the regulated entity, such as presenting a claim or requesting a policy change.

It is important that the examiner check with the examination coordinator to determine where the policyholder service function lies and then apply the following tests to determine the effectiveness of the unit.

3. Tests and Standards

The policyholder service review includes, but is not limited to, the following standards related to the adequacy and level of policyholder service provided by the regulated entity. The sequence of the standards listed here does not indicate priority of the standard.

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STANDARDS
POLICYHOLDER SERVICE

Standard 1
Premium notices and billing notices are sent out with an adequate amount of advance notice.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ Underwriting files

_____ Underwriting procedure manuals

Others Reviewed

____ _____

____ _____

NAIC Model References

Improper Termination Practices Model Act (#915)
Property Insurance Declination, Termination and Disclosure Model Act (#720)
Automobile Insurance Declination, Termination and Disclosure Model Act (#725)
Universal Life Insurance Model Regulation (#585), Section 7F

Review Procedures and Criteria

Check renewal business to determine if the regulated entity's procedures for handling renewals are in accordance with state guidelines.

Check underwriting files to determine if premium notices for endorsements were sent timely, and not at audit or policy expiration.

Check mailroom for billings sent out by the regulated entity to ensure timeliness.

Automation Tip:
Obtain from the regulated entity a data file of all cancellations due to nonpayment. Include in the file the policy number, the date the notice was generated/mailed and the effective date of the cancellation. Using either a spreadsheet or database (if the file is quite large, use ACL), calculate the number of days between the date the regulated entity represents the notice was generated/mailed and the effective date of the cancellation. Using ACL or some other sampling software, select a sample of cancellation and premium notices that appear to conform to state requirements. Request documentation that the notice was mailed on the date reported by the regulated entity. Also extract a report of all notices, which apparently fail to comply with state requirements and submit to the regulated entity for explanations.

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STANDARDS
POLICYHOLDER SERVICE

Standard 2
Policy issuance and insured-requested cancellations are timely.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting manuals

_____ Insured's request for cancellation

_____ Cancellation notices

_____ Procedure manuals

_____ Underwriting files

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Determine if insured-requested cancellations are handled in a timely manner without excessive paperwork requirements for the insured.

Perform a time study on policy issuance to determine that policies and endorsements are issued in a timely manner.

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STANDARDS
POLICYHOLDER SERVICE

Standard 3
All correspondence directed to the regulated entity is answered in a timely and responsive manner by the appropriate department.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity correspondence files

_____ Electronic correspondence

_____ Policy/Underwriting files

Others Reviewed

____ _____

____ _____

NAIC Model References

NAIC Insurance Information and Privacy Protection Model Act (#670)
Unfair Claims Settlement Practices Act (#990)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Title Insurers Model Act (#628)
Title Insurance Agent Model Act (#230)

Review Procedures and Criteria

Review correspondence to ensure that the response was made by the appropriate department.

Ensure the original question or problem was properly addressed in a timely manner.

Determine if the regulated entity responds to inquiries from the applicant regarding the specific reason(s) for adverse underwriting decisions.

Review correspondence contained in the policy files from the regulated entity to determine appropriateness and timeliness of handling.

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STANDARDS
POLICYHOLDER SERVICE

Standard 4
Whenever the regulated entity transfers the obligation of its contracts to another regulated entity pursuant to an assumption reinsurance agreement, the regulated entity has gained prior approval of the insurance department, and the regulated entity has sent the required notices to affected policyholders.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Assumption reinsurance agreements

_____ Order of insurance commissioner approving assumption reinsurance agreement

_____ Notice of transfer sent to policyholders, producers and brokers

_____ Response card sent to policyholders

_____ Written regulated entity procedures for handling inquiries regarding the assumption transaction and for processing the policyholders' response cards

Others Reviewed

____ _____

____ _____

NAIC Model References

Assumption Reinsurance Model Act (#803)

Review Procedures and Criteria

According to the model act, "assumption reinsurance agreement" means any contract which both:

- Transfers insurance obligations and/or risks of existing or in force contracts of insurance from a transferring insurer to an assuming insurer; and
- Is intended to affect a novation of the transferred contract of insurance with the result that the assuming insurer becomes directly liable to the policyholders of the transferring insurer.

Determine if any assumption reinsurance agreements exist.

Obtain a list of policyholders covered by any assumption reinsurance agreements in order to determine sample.

Determine if the class of policyholder or type of product was covered by the assumption reinsurance agreement.

Determine if affected policyholders received the notice of transfer and the response card and that each includes appropriate language.

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Determine whether the regulated entity appropriately handled a policyholder's right to reject the transfer.

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STANDARDS
POLICYHOLDER SERVICE

Standard 5
Policy transactions are processed accurately and completely.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ Regulated entity correspondence files

_____ Policy underwriting files involving nonforfeiture, surrenders, benefit changes, existing policy changes and other post-issue transactions

Others Reviewed

____ _____

____ _____

NAIC Model References

Modified Guaranteed Annuity Model Regulation (#255), Section 6B(1)(b)
Consumer Credit Insurance Model Act (#360)

Review Procedures and Criteria

Ensure proper documentation is maintained for the following:

- Cash surrenders;
- Policy loans;
- Bank draft acceptance and clearance; and
- Beneficiary changes.

Ensure that policyholder requests are processed as soon as reasonably possible.

Ensure that matured endowments are processed when due. Determine if the regulated entity takes appropriate steps to notify policyholders of guaranteed options to purchase additional insurance.

Premium refunds for modified guaranteed life products. Special requirements may exist, under policy provisions or state law, for calculation of refunds involving "10-day right to return" periods for life products, which include a separate account.

For credit insurance, if a debt is refinanced prior to the scheduled maturity date, the in force insurance must be terminated before any new insurance is issued.

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STANDARDS
POLICYHOLDER SERVICE

Standard 6
Reasonable attempts to locate missing policyholders or beneficiaries are made.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Schedule F of the annual statement

_____ Policies scheduled for matured endowments

_____ Underwriting files

_____ Unpaid payees of returned benefit checks

Others Reviewed

____ _____

____ _____

NAIC Model References

Review Procedures and Criteria

Determine if the regulated entity has made reasonable attempts to locate beneficiaries, policyholders and recipients of unclaimed properties.

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STANDARDS
POLICYHOLDER SERVICE

Standard 7
Unearned premiums are correctly calculated and returned to the appropriate party in a timely manner and in accordance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ Policy contract

_____ Notice of cancellation/nonrenewal

_____ Refund check or complete documentation of refund, if canceled check information is maintained on the computer system

Others Reviewed

____ _____

____ _____

NAIC Model References

Consumer Credit Insurance Model Regulation (#370)
Universal Life Insurance Model Regulation (#585)

Review Procedures and Criteria

Calculate the unearned premium (short rate, pro rata or sum of digits method) in accordance with policy provisions or state law.

Verify that refunds provided to producers are properly distributed.

Verify that unearned premiums were returned to the insured in a timely manner.

Verify that the regulated entity adheres to applicable "free look" periods.

For credit insurance:

- If the creditor has opened a line of credit for a debtor and is charging for the line of credit rather than the amount of debt (i.e., credit cards), at the debtor's death the insured amount due is the amount of established credit against premium was last charged;
- If a debtor prepays the debt in full, any credit insurance shall be terminated and an appropriate refund of premium shall be paid or credited to the debtor; and
- In the event of termination, no charge may be made for the first 15 days of a month and a full month may be charged for over 16 days.

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F. Underwriting and Rating

1. Purpose

These standards, in general, apply to insurance companies, although some or all of these standards may be applicable to other regulated entities to the extent that they address functions that have been delegated to them by insurance companies.

The underwriting portion of the examination is designed to provide a view of how the regulated entity treats the public and whether that treatment is in compliance with applicable statutes, rules and regulations. It is typically determined by testing a random sampling of files and applying various tests to the sampled files. It is concerned with compliance issues. The areas to be considered in this kind of review include:

a. Rating practices;
b. Underwriting practices;
c. Use of correct and properly filed and approved forms and endorsements;
d. Termination practices;
e. Unfair discrimination;
f. Use of proper disclosures, buyers' guides and delivery receipts;
g. Reinsurance; and
h. Statistical coding.

2. Techniques

During an examination, it is necessary for examiners to review a number of information sources, including:

- Rating manuals and rate cards;
- Rate classifications;
- Symbol manuals or tables;
- Rating systems filed with regulators;
- Payment plans;
- Minimum premiums;
- Policy fees;
- Discounts;
- Dividend rating plans;
- Regulated entity automated rating systems;
- Rating materials provided to producers;
- Reinsurer policies/treaties;
- Reinsurer guidelines and manuals;
- Documentation of required disclosures and delivery receipts;
- Premium statements and billing statements;
- Premium refund documentation;
- Replacement and conservation materials;
- Underwriting manuals, guidelines and classification manuals;
- Medical underwriting manuals;
- Issued and renewed policy and certificate files;
- Canceled and nonrenewed policy and certificate files;
- Declined applications and notices;
- Individual and group lapsed policy files and notices;
- Individual and group nonforfeiture files and notices;

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- Rescission files;
- Underwriting guidelines;
- Sample of premium audit files;
- Applicable policy forms and endorsements and summaries;
- Producer licensing information;
- Group trust and association arrangements where applicable;
- Producer compensation agreements where applicable;
- Statistical reporting requirements; and
- Underwriting files content and structure.

For purposes of this chapter, "underwriting file" means the file or files containing the new business application; renewal application; rate calculation sheets; billings; audits, including binders; engineering reports; inspection reports; risk or hazard investigative or evaluation reports; motor vehicle reports (MVRs); credit reports; all underwriting information obtained or developed; policy declaration page; endorsements; premium finance agreements with regulated entities activities; cancellation or reinstatement notices; correspondence; and any other documentation supporting selection, classification, rating or termination of the risk.

In selecting samples for testing, personal lines should generally not be combined with commercial lines. These two areas are generally not homogeneous, and conclusions or inferences to be made from the results of sampling may not be valid if combined. The examiner should be familiar with any statutory or regulatory distinctions made between personal lines and commercial lines as respects the various tests to be developed. Then examiners also should be familiar with the process for gathering and processing underwriting information, and the quality controls for the issuance of policies, endorsements and premium statement/billings. The list of files from which a sample is to be drawn may be generated through a computer run or in some cases through a policy register covering the period of time selected in the notice or call of examination.

Determine the regulated entity's policy population (policy count) by line of business. Review a random selection of business for application of a particular test or apply specific tests to a census population using automated tools. (In the event specific files are chosen for a target review, the examiner must be certain the examination results are clearly identified as being from the target selection.) The examiner should maintain a list of the various tests to be applied to each file in the sample. This will aid in consistency by ensuring that each test is considered for each file in the sample.

If exceptions are noted, the examiner must determine if the exception is caused by such practices as use of faulty automated rating systems, or development of improperly or vaguely worded manuals or guidelines. When exceptions are noted, it is advisable to determine the scope and extent of the problem. The examiner responses should maximize objectivity; the examiner should avoid replacing examiner judgment for regulated entity judgment.

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a. Rating Practices

It is necessary to determine if the regulated entity is in compliance with rating systems that have been filed with, and, in some cases, approved by the various state insurance departments. Where rates are not required to be filed with an applicable regulatory agency, it is prudent to determine if rates are being applied consistently and in accordance with the regulated entity's own rating methods. In general, rates should not be unfairly discriminatory. Wide-scale application of incorrect rates by a regulated entity may raise financial solvency questions or be indicative of inadequate management oversight. Deviation from established rating plans may also indicate a regulated entity is engaged in unfair competitive practices. Inconsistent application of rates, individual risk premium modifications, modification factors and deviations can result in unfair discrimination.

The procedure for determining adherence to rates filed or used by a regulated entity varies between personal lines and commercial lines. There can also be considerable variation by kind of insurance. The examiner should become familiar with the regulated entity's policy form numbers or other identification procedures, inasmuch as references may be made to such numbers or procedures in lieu of having the particular form attached. If policies are issued by an automated system, the examiner should manually rate policies based on a selection of various classes and various territories to verify that the computer has been programmed correctly. Once this has been established, the examiner should check only the input data for other policies against the information included in the inspection report or from information obtained from other sources in order to determine that they have been rated correctly. If rating exceptions are noted, the examiner must determine if the exception is caused by such practices as use of faulty automated rating systems, or development of improperly or vaguely worded rating manuals. When exceptions are noted, it is advisable to determine the scope and extent of the problem.

When possible, the examination team should make use of audit software to verify correct application of specific rating components. This allows for a more thorough review and can save time during the examination process. All new automated audit applications that are developed should be submitted to the NAIC File Repository, in order to assist in building a comprehensive set of audit programs.

Rating practices of renewal policies, as well as newly issued policies, should be reviewed. By reviewing renewal policies, the examiner can verify whether the regulated entity is updating rating components, such as vehicle-identification number (VIN) symbol changes or property protection class changes. The examiner can look for cases where initial year premium rates were set at artificially low levels for competitive reasons.

The complexity of rating systems varies greatly from line to line. Some lines require little in the way of documentation focused on the appropriate use of the rating system. Some systems are so complex that appropriate determination is difficult if a worksheet is not maintained. This is generally more true of commercial lines than it is for personal lines. The examiner should ensure that the underwriting files contain sufficient information to support the rates that have been applied to a policy. Inherent in the more complex systems is the concern for unfair discrimination.

Examiners may wish to review situations involving multiple related companies under common underwriting management for issues involving unfair discrimination between similarly situated policyholders.

Restraint of trade issues also may be involved if there are indications of two or more unrelated companies attempting to conspire to monopolize an insurance market.

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b. Underwriting Practices

The examiner should review relevant underwriting information; e.g., the regulated entity's underwriting guidelines, underwriting bulletins, declination procedures, agency agreements and correspondence with producers. Interoffice memoranda and regulated entity minutes, which may furnish evidence of anti-competitive behavior, may also be requested. In addition to reviewing the content of the above information for indications of unfairly discriminatory practices, the examination team also will use the above information to determine regulated entity compliance with its own manuals and guidelines. The examiner should confirm that the regulated entity's underwriters and producers consistently apply the regulated entity's guidelines for all business selected or rejected. The examination team should verify that the regulated entity has correctly classified insured individuals.

File documentation should also be sufficient to support underwriting decisions made. Underwriting decisions that are adequately documented generally afford management of the regulated entity the opportunity to know what business it has selected through its underwriters and producers. The examiner should verify that properly licensed and appointed (where applicable) producers have been used in the production of business.

Underwriting guidelines may vary by geographic areas in the jurisdiction and, therefore, such guidelines should be reviewed for each regional office being examined.

Any practice suggesting anti-competitive behavior may involve legal considerations that should be referred to insurance department counsel. Ultimately, the information so obtained may be useful in drafting legislation or regulations.

In some lines of business, a survey of nonstandard (e.g., surplus lines markets and consent-to-rate filings) and residual markets (e.g., FAIR—Fair Access to Insurance Requirements Plan, JUA—Joint Underwriting Association and high-risk health pools) may provide some insight into general industry underwriting practices.

c. Use of Correct and Properly Filed Forms and Endorsements

The examination team should verify that all policy forms and endorsements used have been filed with the appropriate regulatory authority, if applicable. Additionally, the examination team should verify the consistent and correct use of policy forms and endorsements. The examiner should also be mindful of possible outdated forms or endorsements. If coverages and riders requested by the applicant are not issued, proper notification should be provided to the applicant. In some cases, supplemental applications are appropriate.

If the forms have been approved by the Interstate Insurance Product Regulation Commission (IIPRC), the examiner should verify that the compacting state was included in the IIPRC-approved product filing and the form being marketed has a prefix of "ICCxx" (where "xx" represents the appropriate year the form was submitted for filing). If IIPRC-approved forms are being used or mixed and matched with forms approved by the compacting state, the examiner may wish to verify the forms approved by the compacting state were identified on the statement of intent schedule, which is required to be submitted, updated and maintained by the insurer in the product filing submitted to the IIPRC. Compacting states have access through the NAIC System for Electronic Rate and Form Filing (SERFF) to product filings submitted to the IIPRC for approval and use in their respective state or jurisdiction and can use the export tool in SERFF to extract relevant information.

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d. Termination Practices

The examiner should review the regulated entity's declination, cancellation and nonrenewal of policy practices to determine compliance with applicable statutes, rules and regulations and to determine conformance with regulated entity rules, guidelines and policy provisions.

The review of cancellation and nonrenewal practices in a particular line of insurance should involve a request for the underwriting file for each policy selected from the random sample of canceled policies. For nonrenewals, the examiner should select the sample from the expiration list. Cancellations of specific lines of business have unique requirements. The sampling should be completed separately for each product line in order to get a fair sampling for each line of business to be reviewed. The examiner should review material submitted to determine that the cancellations comply with statutory provisions and policy provisions.

Cancellation processing for nonpayment of premium should include a formal notice to the insured. Some companies use the last billing notice as the cancellation notice. If this is the case, that billing notice must clearly state the effective date of termination of coverage, the insured's rights to an explanation, as provided by statutes where required, and a concise statement of the reason for termination of coverage. Make sure that the loss payee is receiving a copy of the same notice, or separate notice from the regulated entity, to advise that coverage is being terminated. Refer to the specific statute and rule that applies.

The accuracy of return premiums on canceled policies and, in particular, pro rata vs. short rate return of premiums should be verified. When coverage other than homeowners is canceled at the request of the insured, short rate methodology should be used. Cancellations initiated by the regulated entity and all homeowner cancellations should be pro rata.

The examination team should review reinstatement offers and determine what the regulated entity practice is for offering reinstatement. Additionally, the examination team should be mindful of billing practices that may encourage policy lapses.

e. Declination Practices

The examiner should review the regulated entity's declination of policy practices to determine compliance with applicable statutes, rules and regulations and to determine conformance with regulated entity rules and guidelines. "Declination" includes only refusal of an insurer to issue a policy upon receipt of a written nonbinding application or written request for coverage from a producer or an applicant, or the refusal of a producer or broker to transmit to an insurer a written nonbinding application or written request for coverage.

Insurers should maintain declination files and producers should maintain files on declinations made on behalf of the regulated entity. The applicant must be provided with a written, specific reason for the declination.

The review of declination practices in a particular line of insurance should involve a request for the underwriting file for each policy selected from the random sample of declinations. The sampling should be completed separately for each product line in order to get a fair sampling for each line of business to be reviewed. The examiner should review material submitted to determine that the declinations are in compliance with the applicable rules and regulations and in conformance with the rules and guidelines for the specific line of business.

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f. Reinsurance

Most state statutes include a feature that for many lines of business the regulated entity is not permitted to place more than 10 percent of its surplus to policyholders at risk on any one placement of insurance. While this is primarily a solvency issue, it is one that market conduct examiners are in an ideal position to test in view of the sampling of underwriting files utilized for other tests.

Adherence to the requirement is easy to test but requires familiarity with the structure and content of the reinsurance treaties covering the business written by the regulated entity. This item is particularly important for companies that hold minimal policyholder surplus accounts (i.e., surplus of less than $10 million). It may also reflect on the care the regulated entity's management places on its selection of business, and represent a danger to the financial health of the regulated entity. Errors in this area should result in alerts to the insurance department's financial examiners. Any tests of this type must be coordinated with the state's financial examiners.

3. Tests and Standards

The underwriting and rating review includes, but is not limited to, the following standards addressing various aspects of the regulated entity's underwriting activities. The sequence of the standards listed here does not indicate priority of the standard.

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STANDARDS
UNDERWRITING AND RATING

Standard 1
The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the regulated entity's rating plan.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ New business application

_____ All underwriting information obtained

_____ Rating manuals

_____ Policy declaration page

_____ Underwriter's file or notes on a system log

Others Reviewed

____ _____

____ _____

NAIC Model References

Property and Casualty Model Rating Law Guideline (File and Use Version) (#1775)
Property and Casualty Model Rating Law Guideline (Prior Approval Version) (#1780)
Property and Casualty Commercial Rate and Policy Form Model Law (Condensed) (#777)
Small Employer and Individual Health Insurance Availability Model Act (#35)
Stop Loss Insurance Model Act (#92)
Individual Health Insurance Portability Model Act (#37), Sections 5A–H, 5J, 5K, 7 and 9
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Verify all rating factors, including class, territory, symbol assignment, surcharges, deductible factors and increased limit factors.

If no source document application exists, review what procedures the regulated entity has in place to determine the accuracy of the information that was given to issue the policy.

Calculate the policy premium to verify it is in accordance with filed rates.

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Verify that the proper rules are being used.

Verify that the filed implementation date is used uniformly, including at different branches.

Confirm that rates in use were filed and approved prior to use, where required.

Confirm that rates in use have been submitted as required, if system is other than prior approval.

Verify the basis of premium is correct.

Verify that the protection classes and other rating factors are correct.

Verify that the rating rules are properly utilized. The examiner should be alert for incorrect interpretation of rating rules.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

Automation Tip:
Obtain from the regulated entity a data file that contains new business written during the examination period. The file should contain policy number, policy form, address, territory code or any other rating factor that is standardized by the regulated entity. Obtain from the regulated entity a data file that contains these standardized rating factors. For example, if the regulated entity underwrites by county, then obtain a data file that contains the county codes and a new business file that contains the policyholder's county. Compare the two files to see if the appropriate rating code is being applied. Since variations can happen, ask for explanations only in areas where the error rate is unacceptable.

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STANDARDS
UNDERWRITING AND RATING

Standard 2
All mandated disclosures are documented and in accordance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ Underwriting or policy files

_____ Lapsed policies

_____ Rating/Quote information provided electronically

Others Reviewed

____ _____

____ _____

NAIC Model References

Cancer Insurance Shopper's Guide
Model Regulation to Implement the Small Employer Insurance Portability Model Act (#119)
Small Employer and Individual Health Insurance Availability Model Act (#35)
Accident and Sickness Insurance Minimum Standards Model Act (#170), Section 5
Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171), Sections 8A(10) and 8A(11)
Consumer Credit Insurance Model Act (#360)
Individual Health Insurance Portability Model Act (#37), Section 11
Unfair Trade Practices Act (#880)
Long-Term Care Insurance Model Act (#640)
Long-Term Care Insurance Model Regulation (#641)
Life Insurance Disclosure Model Regulation (#580), Section 5A(1)
Life Insurance Illustrations Model Regulation (#582)
Consumer Credit Insurance Model Regulation (#370)
Charitable Gift Annuities Model Act (#240)
Charitable Gift Annuities Exemption Model Act (#241)
Bulletin pertaining to Voluntary Expedited Filing Procedures for Insurance Applications Developed to allow Depository Institutions to meet their Disclosure Obligations under Section 305 of the Gramm-Leach-Bliley Act
Group Life Insurance Definition and Group Life Insurance Standard Provisions Model Act (#565)
Military Sales Practices Model Regulation (#568)
Group Health Insurance Standards Model Act (#100)
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)

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Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Verify that written notice of Medicare supplement replacements are provided to applicants and existing insurers and that appropriate buyer's guides are used.

Verify that appropriate notices regarding credit-related coverages are documented.

Verify that notices regarding the existence of health insurance pools are provided, where applicable.

Review other notices and disclosures required by various jurisdictions.

Determine if state law requires that telephone help numbers be provided, including state insurance department telephone numbers and addresses.

Determine if changes in coverage are disclosed in a timely manner.

Determine if the regulated entity underwriting guidelines comply with applicable statutes, rules and regulations.

Determine if mandated optional coverages are disclosed and documented.

Verify that quotations are made accurately and in a timely manner.

Verify that delivery receipts are obtained where necessary.

Verify that changes in rates are disclosed in a timely manner and in accordance with applicable statutes, rules, regulations and policy provisions.

Determine if the regulated entity is in compliance with rules related to fair marketing.

Verify that the *Shopper's Guide to Cancer Insurance* complies with required disclosures and policy limitations.

Ensure disclosures to consumers represent the applicable consumer protections required by state law, including:

- Limits on preexisting condition exclusions;
- Prohibitions on discrimination based on health status and related factors;
- Guaranteed renewals for all policies, with certain exceptions;
- Limits on the factors that can be used to establish and change premium rates; and
- Descriptive information about all available health benefit plans.

Ensure the regulated entity maintains complete and detailed descriptions of its rating and underwriting practices for individuals and small groups at its principal place of business.

Where required, individual accident and sickness insurance policies shall include with delivery or application an outline of coverage, in a prescribed format. Outlines of coverage delivered in connection with individual hospital confinement indemnity, specified disease or limited benefit health insurance coverages to persons eligible for Medicare by reason of age shall contain language that indicates "This policy IS NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the regulated entity."

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Insurers shall give any person applying for specified disease insurance a buyer's guide approved by the insurance commissioner. Direct response insurers shall provide the buyer's guide upon request, but not later than the time the policy is delivered.

Credit disability income products

Ensure the debtor is provided a disclosure with the following information prior to the election to purchase insurance:

- That the purchase of consumer credit insurance is optional and not a condition of obtaining credit approval;
- If more than one kind of consumer credit insurance is being made available to the debtor, whether the debtor can purchase each kind separately or the multiple coverages only as a package;
- The conditions of eligibility;
- That, if the consumer has other insurance that covers the risk, he or she may not want or need credit insurance;
- That within the first 30 days after receiving the individual policy or group certificate, the debtor may cancel the coverage and have all premiums paid by the debtor refunded or credited. Thereafter, the debtor may cancel the policy at any time during the term of the loan and receive a refund of any of the unearned premium. However, only in those instances where insurance is a requirement for the extension of credit, the debtor may be required to offer evidence of alternative insurance acceptable to the creditor at the time of cancellation;
- A brief description of the coverage, including a description of the amount, the term, any exceptions, limitations and exclusions, the insured event, any waiting or elimination period, any deductible, any applicable waiver of premium provision, to whom the benefits would be paid and the premium rate for each coverage or for all coverages in a package; and
- That, if the premium or insurance charge is financed, it will be subject to finance charges at the rate applicable to the credit transaction.

LTC products

Verify that written notice of LTC replacements is provided to applicants and existing insurers, suitability worksheets are completed and submitted and that appropriate buyer's guides and contract or policy summaries are used.

Ensure the entity maintains, at its home office or principal office, a complete file containing one specimen copy of each disclosure document authorized and used by the entity (i.e., buyer's guide, contract, outline of coverage, statement of policy information for applicant, etc.). The file should contain one copy of each authorized form for a period of 3 years following the date of its last authorized use. Many jurisdictions have repealed the requirement for policy summaries if the product is declared to be marketed with an illustration that meets the requirements of statutes, rules and regulations.

Workers' compensation products

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

IIPRC-approved products

If the forms and advertisements have been approved by the Interstate Insurance Product Regulation Commission (IIPRC), please note that the notices and disclosures required to be included within the approved forms and advertisements are governed by the IIPRC uniform standards and not state law. State law that requires notices and disclosures during the sale, underwriting and claims processes are still applicable to products and advertisements approved by the IIPRC, provided such state law requirements do not pertain to or affect the content or approval of the IIPRC-approved products and advertisements.

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STANDARDS
UNDERWRITING AND RATING

Standard 3
The regulated entity does not permit illegal rebating, commission-cutting or inducements.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Complaint files/logs

_____ Underwriting files

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Trade Practices Act (#880)
Producer Licensing Model Act (#218)
Interest-Indexed Annuity Contracts Model Regulation (#235)
Consumer Credit Insurance Model Regulation (#370)
Individual Health Insurance Portability Model Act (#37), Section 11
Title Insurers Model Act (#628)
Title Insurance Agent Model Act (#230)
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)

Review Procedures and Criteria

Check commission schedule for inappropriate variances.

Determine that producer commissions adhere to the commission schedule and, if not, verify that the file documentation reflects reasons for the variance.

Check billings and invoices for varying commission percentages.

Check regulated entity advertising for indications of illegal commission-cutting or inducements.

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STANDARDS
UNDERWRITING AND RATING

Standard 4
The regulated entity's underwriting practices are not unfairly discriminatory. The regulated entity adheres to applicable statutes, rules and regulations and regulated entity guidelines in the selection of risks.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ New business and renewal applications

_____ All underwriting information obtained

_____ Regulated entity underwriting guidelines

_____ Underwriting bulletins

_____ Declination procedures

_____ Agency agreements and correspondence with producers

_____ Interoffice memoranda and regulated entity minutes

_____ Policy declaration page

_____ Underwriter's file or notes on a system log

Others Reviewed

____ _____

____ _____

NAIC Model References

Insurance Fraud Prevention Model Act (#680)
Model Regulation on Unfair Discrimination in Life and Health Insurance on the Basis of Physical or Mental Impairment (#887)
Model Regulation on Unfair Discrimination on Basis of Blindness or Partial Blindness (#888)
Unfair Trade Practices Act (#880)
Title Insurers Model Act (#628)
Title Insurance Agent Model Act (#230)
Military Sales Practices Model Regulation (#568)
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)
Small Employer and Individual Health Insurance Availability Model Act (#35)
Group Health Insurance Standards Model Act (#100)
Stranger-Originated Annuity Transactions (STOA) NAIC Sample Bulletin

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Review Procedures and Criteria

Review relevant underwriting information to ensure that no unfair discrimination is occurring according to the state's definition of unfair discrimination.

Determine if the regulated entity is following its underwriting guidelines, and that the guidelines conform to state laws and are not unfairly discriminatory.

Determine, if required, that the regulated entity's underwriting guidelines have been filed with the insurance department.

Review interoffice memoranda for evidence of anti-competitive behavior.

Underwriting guidelines may vary by geographic areas in the jurisdiction and, therefore, such guidelines should be reviewed for each regional office being examined.

Ensure that the regulated entity does not discriminate against individuals by using any of an individual's past lawful travel or future lawful travel plans to refuse life insurance, refuse to continue existing life insurance, or limit the amount, extent or kind of life insurance available to an individual.

Ensure that the regulated entity's procedures are in compliance with the Genetic Information Nondiscrimination Act (GINA).

Some indication of industry underwriting practices may be obtained by a survey of residual markets (FAIR Plan and JUA), surplus lines markets and consent-to-rate filings.

Inconsistent handling of rating or underwriting practices, even if not intentioned, can result in unfair discrimination, including requests for supplemental information.

Examine new business and renewal applications for the required fraud warning statement.

Review whether the insurer has established a system of STOA-related oversight (underwriting criteria). If not, discuss the existence of the STOA bulletin with the insurer. The examiner should be mindful that the provisions within the bulletin may not be legally required by their applicable jurisdiction.

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STANDARDS
UNDERWRITING AND RATING

Standard 5
All forms, including policies, contracts, riders, amendments, endorsement forms and certificates are filed with the insurance department, if applicable.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ New business application

_____ Policy or contract determination page

_____ Regulated entity's approval register

_____ Insurance department's approval for all forms, including policies, contracts, riders, amendments, endorsements and certificates (Note: All forms submitted to the IIPRC for approval in the applicable compacting state can be verified through the NAIC System for Electronic Rate and Form Filing (SERFF) or by contacting the designated IIPRC representative(s) within the compacting state)

Others Reviewed

____ _____

____ _____

NAIC Model References

Health Policy Rate and Form Model [Act] [Regulation] (#165)
Individual Health Insurance Portability Model Act (#37), Sections 7 and 9
Insurance Fraud Prevention Model Act (#680)
Unfair Trade Practices Act (#880)
Group Health Insurance Standards Model Act (#100)
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Determine if the forms and endorsements have been filed. Where required, determine that either prior approval has been obtained or that applicable waiting periods following the filing have been met.

Determine if the regulated entity lists, on the summary page, all forms that constitute a part of the contract.

Examine new business applications for the required fraud warning statement.

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When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

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STANDARDS
UNDERWRITING AND RATING

Standard 6
Policies, contracts, riders, amendments and endorsements are issued or renewed accurately, timely and completely.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ Underwriting files

_____ Application

_____ Underwriting procedure manuals

_____ Underwriting and binding guidelines

Others Reviewed

____ _____

____ _____

NAIC Model References

Anti-Arson Application Model Bill (#715)
Improper Termination Practices Model Act (#915)
Property Insurance Declination, Termination and Disclosure Model Act (#720)
Automobile Insurance Declination, Termination and Disclosure Model Act (#725)
Consumer Credit Insurance Model Regulation (#370)
Consumer Credit Insurance Model Act (#360)
Health Policy Rate and Form Model [Act] [Regulation] (#165)
Uniform Individual Accident and Sickness Policy Provision Law (#180), Sections 2A(7), 2B(5) and 5C
Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act (#171), Sections 6G and 8A(2)
Administrative Procedure Relative to Renewability and Cancellation Provisions in the Approval of Accident and Health Policies Drafted In Accordance with the Uniform Individual Accident and Sickness Provision Law, Section 8
Individual Health Insurance Portability Model Act (#37), Sections 6, 7, 8 and 11
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)
Small Employer and Individual Health Insurance Availability Model Act (#35)
Group Health Insurance Standards Model Act (#100)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

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Review Procedures and Criteria

Determine if policies and endorsements are issued in appropriate time frames.

Verify how much time elapses between completion of the application and issuance of coverage.

Note that this standard may need flexibility or special application when dealing with assigned risk plans, joint insurance arrangements, anti-arson applications, FAIR (Fair Access to Insurance Requirements) plans or other involuntary business.

Review new issues prior to mailing to ensure correct procedures, forms, disclosures, etc., are used.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

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STANDARDS
UNDERWRITING AND RATING

Standard 7
Rejections and declinations are not unfairly discriminatory.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy contract

_____ Notice of declination

_____ Regulated entity guidelines for cancellation/nonrenewal/declination

_____ Producer records/issued policies and declinations

Others Reviewed

_____ The Genetic Information Nondiscrimination Act (GINA)

____ _____

NAIC Model References

NAIC Insurance Information and Privacy Protection Model Act (#670), Sections 10-12
Small Employer and Individual Health Insurance Availability Model Act (#35)
Group Health Insurance Standards Model Act (#100)
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)
Unfair Trade Practices Act (#880)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Determine if the regulated entity provides valid reasons for rejection/declination when required.

Determine if the regulated entity responds to inquiries from the applicant regarding the specific reason(s) for adverse underwriting decisions. Was the adverse underwriting decision based on previous adverse underwriting decisions?

Determine if the regulated entity uses valid reasons for rejection/declination and documents these reasons.

Review the regulated entity's procedures for rejection/declination to determine if the regulated entity is following its own guidelines.

Determine if the regulated entity monitors agency rejection/declination for appropriate practices.

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Review for any unfairly discriminatory practices.

Verify appropriate refund has been made to the applicant.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

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STANDARDS
UNDERWRITING AND RATING

Standard 8
Cancellation/nonrenewal, discontinuance and declination notices comply with policy and contract provisions, state laws and the regulated entity's guidelines.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ Policy contract

_____ Notice of cancellation/nonrenewal

_____ Agent's/MGA's/Underwriter's file or notes on a system log

_____ Producer records/notices issued

_____ Insured's request (if applicable)

_____ Regulated entity cancellation/nonrenewal guidelines

Others Reviewed

____ _____

____ _____

NAIC Model References

Property Insurance Declination, Termination and Disclosure Model Act (#720)
Automobile Insurance Declination, Termination and Disclosure Model Act (#725)
Improper Termination Practices Model Act (#915), Section 8A
Unfair Trade Practices Act (#880)
Group Coverage Discontinuance and Replacement Model Regulation (#110)
Individual Health Insurance Portability Model Act (#37), Section 11
Long-Term Care Insurance Model Act (#640)
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)
Small Employer and Individual Health Insurance Availability Model Act (#35)
Group Health Insurance Standards Model Act (#100)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

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Review Procedures and Criteria

Determine if the reason for cancellation/nonrenewal or declination was valid according to policy provisions and state law.

Review the regulated entity's procedures for cancellation/nonrenewal and declinations to determine if the regulated entity is following its own guidelines.

Review regulated entity-initiated cancellations and consider a separate sample for insured-initiated cancellation.

Determine if the regulated entity monitors agency cancellation, declination and nonrenewals for appropriate practices.

Review for any unfairly discriminatory practices.

Review declinations, including declinations made by producers on behalf of the regulated entity. Declinations shall, as required, include the specific reasons for the declination.

Review notice of cancellation/nonrenewal to determine that it was mailed or delivered by the insurer to the first named insured's last known address.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

Automation Tip:
Obtain from the regulated entity a data file of all cancellations/nonrenewals and declinations during the examination period. Include in the file the policy number, the date the notice was generated/mailed and the effective date of the cancellation/nonrenewal or declination. Using either a spreadsheet or database (if the file is quite large, use ACL), calculate the number of days between the date the regulated entity represents the notice was generated/mailed and the effective date of the cancellation/nonrenewal or declination. Using ACL or some other sampling software, select a sample of cancellation and premium notices that appear to conform to state requirements. Request documentation that the notice was mailed on the date reported by the regulated entity. Also extract a report of all notices which apparently fail to comply with state requirements and submit to the regulated entity for explanations.

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STANDARDS
UNDERWRITING AND RATING

Standard 9
Rescissions are not made for non-material misrepresentation.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ List of rescinded policies

_____ Underwriting files and supporting documentation, including claim files

Others Reviewed

_____ Case law for state impacted

____ _____

____ _____

NAIC Model References

Improper Termination Practices Model Act (#915)
Unfair Trade Practices Act (#880)
Long-Term Care Insurance Model Act (#640)
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)
Group Health Insurance Standards Model Act (#100)

Review Procedures and Criteria

Determine if rescinded policies indicate a trend toward post-claim underwriting practices.

Determine if decisions to rescind policies are made in accordance with applicable statutes, rules and regulations.

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G. Claims

1. Purpose

These standards, in general, apply to insurance companies, although some or all of these standards may be applicable to other regulated entities to the extent that they address functions that have been delegated to them by insurance companies. The claims portion of the examination is designed to provide a view of how the regulated entity treats claimants and whether that treatment is in compliance with applicable statutes, rules and regulations. It is determined by testing a random sampling of files and applying various tests to open and closed claims.

For purposes of this chapter, "claim file" means the file or files containing the notice of claim, claim forms, proof of loss, medical records, health facility pre-admission certification or utilization review documentation, settlement demands, accident reports, police reports, adjusters' logs, claim investigation documentation, inspection reports, supporting bills (including electronic payment records, estimates and valuation worksheets), correspondence to and from insureds and claimants or their representatives, complaint correspondence, copies of claim checks and/or check numbers and amounts, releases, all applicable notices and correspondence used for determining and concluding claim payments or denials, subrogation and salvage documentation, and any other documentation necessary to support claim-handling activity.

The review is concerned with the regulated entity's claims practices by line of business for compliance with statutes, rules and regulations and policy provisions. The areas to be considered in this kind of review include:

a. Time studies to measure acknowledgment, investigation and settlement times;
b. General handling study;
c. Total loss valuation survey;
d. Closed without payment survey;
e. Subrogation survey;
f. Litigation survey;
g. Unfair claims practices survey;
h. Claims form review;
i. Loss statistical reporting survey;
j. Time study on canceled checks; and
k. Review of other procedures, as deemed necessary.

2. Techniques

Each area of claims review involves selecting a sample of claims (open, closed without payment, closed, denied). However, it is not necessary to use different samples to review timeliness of payment, conformity to policy language or adequacy of proof.

A general approach to examination would be to:

- Define the scope of the examination in terms of the lines of business and type of claims covered. Lines of business should be defined as specifically as possible; e.g., physical damage coverage rather than automobile coverage.
- Become familiar with the regulated entity's claim handling procedures for the line of business identified. Review corresponding policy forms for coverage, exclusions and nonstandard provisions. Review the methods for processing claims from notification to conclusion. Review with the claim manager or other appropriate personnel the maintenance of claim records and draft and settlement authority.

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- Select a representative sample of files to be reviewed. Chapter 17—Sampling of this handbook should be reviewed. If field sizes are relatively small and the regulated entity's records appear complete, representative samples or a census should be selected. In the case of large field sizes and incomplete or complicated records, the use of audit software should be considered. Care should be taken that no adverse selection occurs.
    a. Time studies to measure acknowledgment, investigation and settlement times

        Record the date of loss/claim, the date reported to the producer or regulated entity, the date sufficient information was available to determine the regulated entity's liability and the date the regulated entity accepted or rejected the claim. Record identifying data, such as the claim/policy number and the claimant's name.

        Determine for each claim the number of days the regulated entity took to accomplish each category. Compare days required by regulated entity to appropriate state standards and document those claims that exceed standards for inclusion in the report. Delays beyond the control of the regulated entity should be excluded; e.g., a delay caused by an uncooperative insured. Establish a mean and median time to acknowledge, investigate and accept/deny claims, if necessary, to determine a business practice.

        Caution: If a file has a violation of a standard with multiple tests, and the standard is the item measured, the file can only fail one time. If the individual test is the item measured, the file can fail each test. If failure of a standard or of a test ensures failure of another standard or test under another standard, then no substitution of the file need occur. The relationship, however, should be explained.

    b. General handling study

        Record identifying data such as claim/policy number, date of loss and claimant name. Files should be reviewed for adequate and accurate documentation. Correct application of deductibles, coinsurance and limits of coverage should be established. Mathematical accuracy should be determined. Reductions based on depreciation, obsolescence, etc., should be reviewed for fairness and accuracy.

        Checks or drafts should be reviewed for correct payees. Files should be reviewed for specific state requirements. Compliance with the regulated entity's own standards should be established.

    c. Closed without payment review

        This includes denied, rejected, incomplete and claims not paid for any other reason, including deductibles/waiting periods not met. Conduct tests similar to "General handling study" above. Record identifying data such as claim/policy number, date of loss and claimant name. Review specific state requirements for content and method of denial notification to the claimant. Note general handling by the regulated entity to determine validity of its action in the final disposition of these types of claims.

    d. Litigation survey

        Determine the extent of suits against the regulated entity. Separate first- and third-party actions. If a review is deemed appropriate, select a representative sample or census.

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Record identifying data such as claim/policy number, date of loss and claimant name. Files should be reviewed to determine the basis for suit and the regulated entity's position for denial or settlement offer. Closed litigated files should be reviewed to determine accuracy, regulated entity position and if punitive or bad faith judgments were rendered. Recognition of attorney-client privileged documents or work products should occur during the file review. A principal focus is compliance with unfair claims practices statutes and regulations.

e. Unfair claims practices review

Record identifying data such as claim/policy number, date of loss and claimant name. Review selected files for violations of specific state unfair claims practices, such as misrepresentation of policy provisions or concealment of coverage.

Calculate error ratios for the sample and field sizes. This is especially important in this study, since most unfair claims practices statutes make reference to "business practices."

f. Claim forms

Request copies of all claim forms in use for the lines of business being examined. Forms should be reviewed for content and appropriate usage. Inappropriate forms should be documented and included in the report. Claim forms also may be reviewed as they are encountered in the file reviews.

g. Review of canceled drafts/checks

This review should be considered if solvency is an issue, if the examiner determines delays in issuing a payment, or if consumer complaints indicated delays that are not supported by other time studies.

From the regulated entity's records, select a representative sample of the type of claims being reviewed. The selection should include drafts/checks reflecting a substantial payment amount on any one claim. Compare the date the regulated entity indicated the draft/check was forwarded to the claimant with the date the draft/check was presented for payment. If the review indicates significant and numerous delays in presenting drafts/checks for payment, additional investigation to determine the causes should be done.

Canceled checks should be reviewed to verify that the amount paid and the claim amount approved are the same, that payees are the same and that the information recorded in the computer system matches what is on the check (payee, amount, date of check, etc.).

h. Review of other procedures

Other review, as deemed necessary, should follow the same format for objectivity and sampling techniques as those already described. These reviews may be instituted by consumer complaints regarding specific claims practices and should be tailored to resolve specific issues.

3. Tests and Standards

The claims review includes, but is not limited to, the following standards addressing various aspects of the regulated entity's claim handling practices. The sequence of the standards listed here does not indicate priority of the standard.

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STANDARDS
CLAIMS

Standard 1
The initial contact by the regulated entity with the claimant is within the required time frame.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity claims procedure manuals

_____ Claims training manuals

_____ Internal regulated entity claims audit reports

_____ Claim files

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Title Insurers Model Act (#628)
Title Insurance Agent Model Act (#230)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Review the regulated entity's procedures, training manuals and bulletins to determine if regulated entity standards exist. Determine whether the regulated entity's standards comply with applicable statutes, rules and regulations.

Determine if initial contact procedures are in place and in compliance with the mandated time frame. Perform a time study of acknowledgment times.

Determine if initial contact with claimants meets required contract standards.

Determine if subsequent responses and claim handling delay notices comply with applicable statutes, rules and regulations.

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When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

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STANDARDS
CLAIMS

Standard 2
Timely investigations are conducted.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity claims procedure manuals

_____ Claims training manual

_____ Internal regulated entity claims audit reports

_____ Claim bulletins

_____ Antifraud procedures

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Consumer Credit Insurance Model Act (#360)
Title Insurers Model Act (#628)
Title Insurance Agent Model Act (#230)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Review the regulated entity's procedures, training manuals and claim bulletins to determine if regulated entity standards exist and whether standards comply with state statutes.

Determine if investigations are initiated and concluded in compliance with state statutes.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

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STANDARDS
CLAIMS

Standard 3
Claims are resolved in a timely manner.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity claims procedure manuals

_____ Claims training manuals

_____ Internal regulated entity claims audit reports

_____ Review of canceled claim checks

_____ Claim files

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Consumer Credit Insurance Model Act (#360)
Title Insurers Model Act (#628)
Title Insurance Agent Model Act (#230)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Review the regulated entity's procedures, training manuals and claim bulletins to determine if regulated entity standards exist and whether standards comply with state statutes.

Determine if claim resolutions—i.e., liability, determinations, coverage questions and claims payment—are made in accordance with state requirements. Perform time studies to measure the settlement time of claims.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

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Automation Tip:
Obtain from the regulated entity a listing of claims closed with payment or claims closed without payment by claim feature. Include in the file the claim number(s), date the claim was reported to the regulated entity, the first payment date (if applicable), and the date the claim feature was closed. Using ACL, a database or spreadsheet, calculate the number of days from the date the claim feature was closed to the date the claim was reported. Group the number of days in any appropriate time periods, for example, 1 to 15 days, 16 to 30 days, etc., and perform a count on each time period. Investigate any patterns of untimeliness.

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STANDARDS
CLAIMS

Standard 4
The regulated entity responds to claims correspondence in a timely manner.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity claims procedure manuals

_____ Claims training manuals

_____ Claim files

_____ Electronic claims correspondence

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Consumer Credit Insurance Model Act (#360)
Title Insurers Model Act (#628)
Title Insurance Agent Model Act (#230)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Review the regulated entity's procedures, training manuals and claim bulletins to determine if regulated entity standards exist and whether standards comply with state statutes.

Determine if correspondence related to claims is responded to in accordance with state requirements.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

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STANDARDS
CLAIMS

Standard 5
Claim files are adequately documented.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity claims procedure manuals

_____ Electronic records of claims activities

_____ Claims training manuals

_____ Internal regulated entity claims audit reports

_____ Claim bulletins

_____ Claim files

_____ Claim forms

Others Reviewed

____ _____

____ _____

NAIC Model References

Insurance Fraud Prevention Model Act (#680)
Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Title Insurers Model Act (#628)
Title Insurance Agent Model Act (#230)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Review the regulated entity's procedures, training manuals and claim bulletins to determine if regulated entity standards exist and whether standards comply with state statutes.

Determine if quality of the claim documentation meets state requirements.

Determine if claim files retention/destruction program meets state requirements.

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Determine if claim files documentation is sufficient to support or justify the ultimate claim determination.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

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STANDARDS
CLAIMS

Standard 6
Claims are properly handled in accordance with policy provisions and applicable statutes (including HIPAA), rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity claims procedure manuals

_____ Claims training manuals

_____ Internal regulated entity claims audit reports

_____ Claim bulletins

_____ Regulated entity claim forms manual

_____ Regulated entity subrogation and salvage logs

_____ Claim files

_____ Regulated entity depreciation schedules

_____ Auto—total loss evaluation procedures

Others Reviewed

____ _____

____ _____

NAIC Model References

Insurance Fraud Prevention Model Act (#680)
Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Retained Asset Accounts Sample Bulletin (#573)
Consumer Credit Insurance Model Regulation (#360)
Long-Term Care Insurance Model Act (#640)
Coordination of Benefits Model Regulation (#120)
Off-Label Drug Use Model Act (#148), Section 4
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

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Review Procedures and Criteria

Review regulated entity procedures, training manuals and claim bulletins to determine if regulated entity standards exist and whether standards comply with state statutes.

Determine if the regulated entity's procedures provide for the detection and reporting of fraudulent or potentially fraudulent insurance acts to the commissioner.

Determine if claim handling meets state-specific statutes and regulations as applied to total loss evaluations, sales tax payment, disposition of salvage, correct payees, improper release of claims, proper payment of non-disputed claims and proper referral of suspicious claims.

Determine if coverage was checked for proper application of deductible or appropriate exclusionary language.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

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STANDARDS
CLAIMS

Standard 7
Regulated entity claim forms are appropriate for the type of product.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Claim forms for product being examined

_____ Electronic claims notification screens

_____ Claim files

Others Reviewed

____ _____

____ _____

NAIC Model References

Insurance Fraud Prevention Model Act (#680)
Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Standardized Health Claim Form Model Regulation (#30)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Determine if claim form(s) include appropriate content and are used appropriately. Use of inappropriate forms should be documented and included in the examination report.

Review claim forms as they are encountered in the file reviews.

Examine all claim forms for the required fraud warning statement.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

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STANDARDS
CLAIMS

Standard 8
Claim files are reserved in accordance with the regulated entity's established procedures.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity claims procedure manuals

_____ Claims training manuals

_____ Internal claims audit reports

_____ Individual claim file

_____ Average reserve data

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Review the regulated entity's claims procedure manuals for established reserving practices.

Determine if individual reserves are evaluated and posted.

Determine if reserve adjustments are made.

Determine if reserves are excessive/inadequate.

Determine if reserves are reduced, if a redundancy is apparent.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

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STANDARDS
CLAIMS

Standard 9
Denied and closed without payment claims are handled in accordance with policy provisions and state law.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity claims procedure manuals

_____ Claims training manuals

_____ Internal regulated entity claims audit reports

_____ Claim bulletins

_____ Claim files

Others Reviewed

____ _____

____ _____

NAIC Model References

Insurance Fraud Prevention Model Act (#680)
Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Determine if denied and closed without payment claims are based on policy provisions and applicable state statutes and regulations.

Determine if notices of claim denials reference specific policy provisions or exclusions.

Determine if the regulated entity provides claimants with a reasonable basis for the denial, when required by statutes, rules or regulations.

Where required, determine if claimants are provided with instructions for having rebuttals to denials reviewed by the insurance department or by the regulated entity.

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Determine if the regulated entity refers suspicious claims to a regulatory authority/law enforcement agency, when appropriate.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

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STANDARDS
CLAIMS

Standard 10
Canceled benefit checks and drafts reflect appropriate claim handling practices.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Cashed benefit checks and drafts

_____ Regulated entity claims procedure manuals

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)

Review Procedures and Criteria

Perform a time study on canceled claim checks or drafts to ascertain whether claim proceeds are being promptly mailed or delivered.

Determine if canceled checks include the correct payee and are for the correct amount.

Ascertain whether payment checks indicate the payment is "final" when such is not the case.

Ascertain whether checks or drafts purport to release the insurer from total liability when such is not the case.

Review endorsements to see if they are consistent with the payee name listed on the check.

If drafts are used, ascertain whether there is prompt clearance by the insurer.

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STANDARDS
CLAIMS

Standard 11
Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than is due under the policy.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Closed litigated claim files

_____ Regulated entity claims procedure manuals

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)

Review Procedures and Criteria

Review a sample or entire population of closed litigated claim files, if feasible. Determine if litigated files indicate problematic claim handling practices. If warranted, notify the insurance department's financial examination division.

Note: The examiner should review applicable state statutes to determine which particular claims should adhere to this standard. For example, bodily injury claims may not readily fit this standard.

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Market Conduct Examination Guidelines (D) Working Group 2021 Charges

(Posted on the Working Group's web page at https://content.naic.org/cmte_d_market_conduct_exam_guidelines.htm)

The Market Conduct Examination Guidelines (D) Working Group will:

1. Develop market conduct examination standards, as necessary, for inclusion in the Market Regulation Handbook.
2. Monitor the adoption and revision of NAIC models and develop market conduct examination standards to correspond with adopted NAIC models.
3. Develop updated standardized data requests, as necessary, for inclusion in the *Market Regulation Handbook*.
4. Develop uniform market conduct procedural guidance (e.g., a library, depository or warehouse with market conduct examination templates, such as an exam call letter, exam exit agenda, etc.) for inclusion in, or for use in conjunction with, the *Market Regulation Handbook*.
5. Coordinate with the Innovation and Technology (EX) Task Force to develop market conduct examiner guidance for the oversight of regulated entities' use of insurance and non-insurance consumer data and models using algorithms and artificial intelligence (AI).
6. Discuss the effectiveness of a group's supervision of market conduct risks and develop examination procedural guidance, as necessary.
7. Discuss the role of market conduct examiners in reviewing insurers' corporate governance as outlined in the *Corporate Governance Annual Disclosure Model Act* (#305) and the *Corporate Governance Annual Disclosure Model Regulation* (#306).

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