_____ (*Chapter/Section/Title TBD*)—Conducting the Mental Health Parity and Addiction Equity Act (MHPAEA) Related Examination

Introduction

The intent of _____ (*Chapter/Section/Title TBD*)—Conducting the Mental Health Parity and Addiction Equity Act (MHPAEA) Related Examination in the *Market Regulation Handbook* is primarily to provide guidance when reviewing insurers whose business includes major medical policies offering mental health and/or substance use disorder coverage.

The examination standards in *Market Regulation Handbook* Chapter 20—Conducting the Health Examination provide guidance specific to all health ~~carriers~~insurers, but large group coverage may or may not include ~~offering~~ mental health and/or substance use disorder coverage. _____ (*Chapter/Section/Title TBD*) strictly applies to examinations to determine compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) ~~of 2008~~ found at 42 U.S.C. 300gg-26 and its implementing regulations found at 45 CFR 146.136 and 45 CFR 147.160, and is to be used for plans that offer mental health and/or substance use disorder benefits.

Generally, MHPAEA ~~examinations focus on barriers to covered benefits ("treatment limitations"), including~~regulations require that any financial ~~barriers such as~~ requirement (FR) (e.g., copayments, ~~and medical management barriers such as preauthorization requirements. An insurer violates MHPAEA if it imposes higher treatment limitations~~deductibles, coinsurance, or out-of-pocket maximums) or quantitative treatment limitation (QTL) (e.g., day or visit limits) imposed on mental health ~~or~~and substance use disorder (MH/SUD) benefits~~, compared to~~ not be more restrictive than the ~~treatment limitations for~~predominant financial requirement or treatment limitation of that type that applies to substantially all medical and surgical benefits~~. MHPAEA applies to group health plans, and~~ , on a classification-by ~~incorporation of mental health and~~ classification basis, as discussed below. With regard to any nonquantitative treatment limitation (NQTL) (e.g., preauthorization requirements, fail-first requirements), MHPAEA regulations prohibit imposing an NQTL with respect to MH/SUD benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical (M/S) benefits in the same classification.

MHPAEA applies to major medical group and individual health insurance. Mental health and substance use disorder treatment as an essential health benefit under the Patient Protection and Affordable Care Act, ~~MHPAEA applies to qualified health plans in the~~ so examination of individual and small group ACA-compliant plans will include parity analysis. In the large group market~~.~~, an insurer's plan is not required to cover mental health and/or substance use disorder services. If the insurer's large group plan does cover mental health and/or substance use disorder services, parity requirements apply. MHPAEA does not apply to excepted benefit plans, nor to short-term limited duration insurance. Some states may have mental health parity requirements that are stricter than federal requirements.

Federal law relies on state insurance regulators as the first-line enforcers of health reform provisions in the individual, small group, and large group insurance markets.

Examination Standards

Each examination standard includes a citation to MHPAEA ~~and~~or its implementing regulations, but additional ~~standards~~information can be found in federal guidance documents and state law or state interpretation of federal law. Please note that the federal government periodically updates its guidance documents related to MHPAEA. Examiners should refer to the U.S. Departments of Labor, Health and Human Services, and the Treasury for any updates or new MHPAEA guidance. MHPAEA allows states to enact statutes or regulations that are stricter than federal requirements. Examiners should ~~also~~ contact their state's legal division for assistance and interpretation of ~~such~~federal guidance, as well as any additional state requirements. Where there is a reasonable interpretation of MHPAEA, that reasonable interpretation should be given due consideration.

Collaboration Methodology

The development of state market conduct compliance tools for MHPAEA will result in enhanced state collaboration, to provide more consistent interpretation and review of parity standards.

LIST OF QUESTIONS

Question 1.
Is this insurance coverage exempt from MHPAEA~~?~~ (45 CFR 146.136(f))? If so, please indicate the reason (e.g., retiree-only plan, excepted benefits (45 CFR § 146.145(b)), short term, limited duration insurance[1], small employer ~~exception,~~exemption (45 CFR § 146.136(f)), increased cost ~~exception).~~exemption (45 CFR § 146.136(g)).

Question 2.
If not exempt, does the insurance coverage provide MH~~/~~ and/or SUD benefits in addition to providing M/S benefits?

Unless the insurance coverage is exempt or does not provide MH/SUD benefits (note that MH/SUD is one of the ~~EHB for QHPs~~EHBs for non-grandfathered coverage in the individual and small group markets), continue to the following sections to examine compliance with requirements under MHPAEA.

Question 3.
Does the insurance coverage provide MH/SUD benefits in every classification in which M/S benefits are provided?

Under the MHPAEA regulations, the six classifications of benefits are:

1) *inpatient, in-network;*
2) *inpatient, out-of-network;*
3) *outpatient, in-network;*
4) *outpatient, out-of-network;*
5) *emergency care; and*
6) *prescription drugs.*

See 45 CFR 146.136(c)(2)(ii).

Because parity analysis for this standard is at the classification level, data must be collected for each classification. An example data collection tool is provided, which collects information needed to answer this question.

Question 4.
If the plan includes multiple tiers in its prescription drug formulary, are the tier classifications based on reasonable factors (such as cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up) determined in accordance with the rules for NQTLs~~,~~ at 45 CFR 146.136(c)(4)(i), and without regard to whether the drug is generally prescribed for MH/SUD or M/S benefits? Explain the plan's tiering factors for prescription drugs.

See 45 CFR 146.136(c)(3)(iii)(A).

Question 5.
If the plan includes multiple network tiers of in-network providers, is the tiering based on reasonable factors (such as quality, performance, and market standards) determined in accordance with the rules for NQTLs at 45 CFR 146.136(c)(4)(i), and without regard to whether a provider provides services with respect to MH/SUD benefits or M/S benefits? Explain the plan's tiering factors for network tiers.

See 45 CFR 146.136(c)(3)(iii)(B).

Question 6.
Does the plan comply with the parity requirements for aggregate lifetime and annual dollar limits, including the prohibition on lifetime dollar limits or annual dollar limits for MH/SUD benefits that are lower than the lifetime or annual dollar limits imposed on M/S benefits? List the services subject to lifetime or annual limits, separated into MH/SUD and M/S benefits.

[1] Under the Public Health Services Act (as added by HIPAA), short term limited duration insurance is excluded from the definition of individual health insurance coverage (45 C.F.R. § 144.103).

See 45 CFR 146.136(b). This prohibition applies only to dollar limits on what the plan would pay, and not to dollar limits on what an individual may be charged. If a plan or issuer does not include an aggregate lifetime or annual dollar limit on any M/S benefits, or it includes one that applies to less than one-third of all M/S benefits, it may not impose an aggregate lifetime or annual dollar limit on MH/SUD benefits. 45 CFR 146.136(b)(2). ~~Also note that for QHPs,~~Also note that the parity requirements regarding lifetime and annual dollar limits only apply to the provision of MH/SUD benefits that are not EHBs because lifetime limits and annual dollar limits are prohibited for EHBs, including MH/SUD services.

Question 7.

Does the plan impose any financial requirements (e.g., deductibles, copayments, coinsurance, and out-of-pocket maximums) or quantitative treatment limitations (e.g., annual, episode, and lifetime day and visit limits) on MH/SUD benefits in any classification that ~~are~~is more restrictive than the predominant financial requirement or quantitative treatment limitation of that type that applies to substantially all M/S benefits in the same classification? Demonstrate compliance with this standard by completing the attached data collection tool.

See 45 CFR 146.136(c)(2). Because parity analysis is at the classification level and analysis is based on the dollar amount for expected benefits paid, data must be collected per classification. An example data collection tool is provided, which collects information needed to answer this question.

Financial Requirements (FRs) include deductibles, copayments, coinsurance, and out-of-pocket maximums. 45 CFR 146.136(c)(1)(ii). Quantitative Treatment Limitations (QTLs) include annual, episode, and lifetime day and visit limits, ~~for example~~such as number of treatments, visits, or days of coverage. 45 CFR 146.136(c)(1)(ii).

~~*Classification is important because it prevents insurers from selecting a more favorable comparison point on the M/S side in order to justify imposing a higher treatment limitation on the MH/SUD side. For example, if a higher copayment applies for physical therapy, but a lower copayment applies for the rest of outpatient in-network M/S treatment, the insurer cannot use only the physical therapy benefits to justify imposing that higher copayment for all MH/SUD outpatient in-network treatment.*~~

~~*If*~~
If a plan includes a FR (copayment or coinsurance) or QTL (session or day limit) for MH/SUD benefits ~~raises concern for the examiner~~, the first step is to identify the comparison point by looking at M/S benefits for that classification. Determine whether the FR or QTL applies to at least two-thirds ("substantially all") of the M/S benefits ~~for~~in that classification. ~~"Applies" means~~For purposes of determining whether a type of FR or QTL applies to at least two-third of all M/S benefits in a classification, the FR or QTL is considered to apply regardless of the magnitude or level of that type of FR or QTL. For example, a copayment, coinsurance, session or day limit ~~applies~~is considered to apply to the benefits~~,~~ regardless of the dollar amount, coinsurance percentage, or number of sessions or days~~. Benefits are judged~~ for that type of FR or QTL. The portion of M/S benefits subject to the FR or QTL is based on the dollar amount of expected payments for M/S benefits in a year. ~~If~~If the type of FR or QTL applies to less than two-thirds of the M/S benefits in a classification ~~have the same FR or QTL~~, then ~~the~~that type of FR or QTL cannot be ~~imposed on those~~applied to MH/SUD benefits in ~~the same~~that classification. If the type of FR or QTL applies to two-thirds or more of the ~~payments in a year are for~~ M/S benefits in ~~a~~the classification ~~are limited by a FR or QTL,~~, as determined under 45 CFR 146.136(c)(3)(i)(A), the examiner will go ~~on~~ to the next step to look at the level of the FR or QTL, for example the specific copayment dollar amount, coinsurance percentage, or limitation on number of sessions or days.

If the type of FR or QTL is imposed on at least two-thirds of the M/S benefits in a classification, then the "level" (e.g., copayment dollar amount, coinsurance percentage, or limitation on number of days or sessions) is analyzed ~~for parity in a second step.~~to determine the "predominant" level. In this second step, the examiner will look at the M/S benefits to which the FR or QTL applies and find the "predominant" level of the limitation—this means the specific ~~limitation~~ dollar amount, coinsurance percentage, or limitation on number of sessions or days that applies to more than 50% of the M/S benefits in that classification~~.~~ subject to the FR or QTL. The FR or QTL imposed on MH/SUD benefits cannot be more restrictive than the predominant level.

If less than 50% of the M/S benefits that are subject to the FR or QTL in a classification are subject to ~~the~~a certain "level" of FR or QTL~~, then that~~ levels of the FR or ~~QTL at that "level" cannot~~QTL can be ~~imposed on MH/SUD~~combined to reach50% of the M/S benefits in the ~~same~~ classification~~.~~, with the least restrictive level within the combination being the level that can be applied to MH/SUD benefits in the classification.

Question 8.
Does the plan apply any cumulative financial requirement or cumulative QTL for MH/SUD benefits in a classification that accumulates separately from any cumulative financial requirement or QTL established for M/S benefits in the same classification? Demonstrate compliance with this standard by completing the attached data collection tool.

See 45 CFR 146.136(c)(3)(v). For example, a plan may not impose an annual $250 deductible on M/S benefits in a classification and a separate $250 deductible on MH/SUD benefits in the same classification. Cumulative financial requirements are financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maximums (but do not include aggregate lifetime or annual dollar limits because those two terms are excluded from the meaning of financial requirements). 45 CFR 146.136(a).

Cumulative financial requirements and treatment limitations are also subject to the predominant and substantially all tests in Question 7.

Question 9.
Does the plan impose Non-Quantitative Treatment Limitations (NQTLs) on MH/SUD benefits in any classification ~~that are comparable to, and applied no more stringently than, those used in applying the limitation to M/S benefits within the same classification?~~? If so, do the NQTLs comply with parity requirements? Please provide or make available copies of documents that contain the required disclosures, with the disclosures flagged in those documents, then demonstrate compliance with this standard by completing the attached data collection tool.

~~**Please provide or make available copies of the following procedures. For any procedure that does not apply to all plan benefits, provide a cover sheet that describes the benefits to which the procedure applies, separated into MH/SUD and M/S benefits. If parity questions arise, you may be asked to provide the expected plan payments attributable to benefits for a particular NQTL.**~~

Examples of NQTLs (not exclusive):

a) **Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;**

b) **Prior authorization and ongoing authorization requirements;**

c) **Concurrent review standards;**

d) **Formulary design for prescription drugs;**

e) **For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;**

f) **Standards for provider admission to participate in a network, including reimbursement rates;**

g) **Plan or ~~issuer~~insurer's methods for determining usual, customary and reasonable charges;**

~~g)~~

h) **Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as "fail-first" policies or "step therapy" protocols);**

~~i) Exclusions of specific treatments for certain conditions;~~

~~j)~~i) **Restrictions on applicable provider billing codes;**

~~k)~~j) **Standards for providing access to out-of-network providers;**

~~l)~~k) **Exclusions based on failure to complete a course of treatment;** ~~**and**~~

~~m)~~l) **Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan** ~~**or coverage.**~~**; and**

m) **Any other non-numerical limitation on MH/SUD benefits.**

Note that not every NQTL needs an evidentiary standard. There is flexibility under MHPAEA for plans to use NQTLs. The focus is on finding out what processes and standards the plan actually uses.

See 45 CFR 146.136(c)(4~~)(i~~) and pages 14-20 of the Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA) for analysis advice. available at https://www.dol.gov/sites/default/files/ebsa/about-ebsa/out-activities/resource-center/publications/compliance-guide-appendix-a-mhpaea.pdf.

Question 10.

Does the insurer comply with MHPAEA disclosure requirements including (1) criteria for medical necessity determinations for MH/SUD benefits, ~~**reasonable access to and copies (free of charge) of all documents, records, and other information relevant to**~~**and (2) the** ~~**claim**~~**reasons for** ~~**benefits, including documents with information about the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to M/S benefits and MH/SUD benefits under the plan**~~**any denial?**

See 45 CFR 146.136(d)(~~3).~~1) and (2).

Note that the state's grievance procedure and external review statutes may contain additional disclosure requirements.

DATA COLLECTION TOOL FOR MENTAL HEALTH PARITY ANALYSIS

Most parity analysis examines benefits by comparing MH/SUD to M/S within a classification. 45 CFR 146.136(c)(2)(i). The exception is aggregate lifetime or annual dollar limits~~,~~ (to the extent the plan is not prohibited from imposing such limits under Federal or State law), which are examined for the plan as a whole. 45 CFR 146.136(b). The following is intended to simplify data collection for parity analysis at the classification level. Examiners may find it helpful to identify a person with MHPAEA experience, from the state's legal or health policy division, to interpret results after data is received from the insurer.

GUIDANCE FOR PLACING BENEFITS INTO CLASSIFICATIONS:

~~CLASSIFICATION OF BENEFITS:~~

MH/SUD and M/S benefits must be mapped to one of six classifications of benefits: (1) inpatient in-network, (2) inpatient out-of-network, (3) outpatient in-network, (4) outpatient out-of-network, (5) prescription drugs, and (6) emergency care. 45 CFR 146.136(c)(2)(ii).

- The "inpatient" classification typically refers to services or items provided to a beneficiary when a physician has written an order for admission to a facility, while the "outpatient" classification refers to services or items provided in a setting that does not require a physician's order for admission and does not meet the definition of emergency care.

- "Office visits" are a permissible sub-classification separate from other outpatient services~~, as well as for plans that use multiple tiers of in-network providers~~.

- The term "emergency care" typically refers to services or items delivered in an emergency department setting or to stabilize an emergency or crisis, other than in an inpatient setting.

- Some benefits, for example lab and radiology, may fit into multiple classifications depending on whether they are provided during an inpatient stay, on an outpatient basis, or in the emergency department. ~~For benefits that fit into multiple classifications, the insurer should divide them into classifications, including the dollars that will be paid for those services as divided.~~

- Insurers should use the same decision-making standards to classify all benefits, so that the same standard applies to M/S and MH/SUD ~~classifications.~~benefits. For example, if a plan classifies care in skilled nursing facilities and rehabilitation hospitals for M/S benefits as inpatient benefits, it must classify covered care in residential treatment facilities for MH/SUD benefits as inpatient benefits.

FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT LIMITATIONS:

Types of Financial Requirements (FRs) include deductibles, copayments, coinsurance, and out-of-pocket maximums. 45 CFR 146.136(c)(1)(ii). Types of Quantitative Treatment Limitations (QTLs) include annual, episode, and lifetime day and visit limits, for example number of treatments, visits, or days of coverage. 45 CFR 146.136(c)(1)(ii). A two-part ~~cost~~ analysis ~~test~~ applies to financial requirements (FRs) and quantitative treatment limitations (QTLs). ~~The~~ In general ~~parity rule is,~~ MHPAEA regulations require that ~~no~~any FR or QTL ~~may apply to~~imposed on MH/SUD benefits ~~in a classification if the FR or QTL is~~not be more restrictive than the predominant level of financial requirement or treatment limitation of that type that applies to substantially all medical/surgical benefits in a classification.

If the plan applies a cumulative FR or QTL (a FR or QTL that determine whether or to what extent benefits are provided based on accumulated amounts), the FR or QTL must not accumulate separately from any established for M/S benefits in ~~the same~~a classification.

	Inpatient In-Network (if network tiers, may separate into tiers in accordance with 45 CFR 146.136(c)(3)(iii)(B)).	Inpatient Out-of-Network	Outpatient In-Network (Issuer can choose to have subclassifications for Outpatient Office Visits, and Other Outpatient Services) (if network tiers, may separate into tiers in accordance with 45 CFR 146.136(c)(3)(iii)(B))		Outpatient Out-of-Network (Issuer can choose to have subclassifications for Outpatient Office Visits, and Other Outpatient Services)		Emergency Care	Prescription Drugs
Does the plan provide MH/SUD benefits?								
Does the plan provide M/S benefits?								
Total dollar amount of all plan payments for MH/SUD benefits expected to be paid for the relevant plan year								
Total dollar amount of all plan payments for M/S benefits expected to be paid for the relevant plan year								
List each financial requirement that applies to the classification for MH/SUD benefits, and attribute expected plan payments to each applicable financial requirement								
For each type of financial requirement that applies to MH/SUD benefits, list the expected percentage of M/S benefits in each classification that are subject to that same type of financial requirement.								
For each level of each type of financial requirement								

that applies to at least 2/3rds of all M/S/ benefits in the classification, , list the expected percentage of M/S benefits subject to that financial requirement, that are subject to that level.							
Does the plan impose a separate cumulative financial requirement or QTL for MH/SUD benefits that accumulates separately from any cumulative financial requirement or QTL for M/S benefits?							

	Inpatient In-Network (if network tiers, may separate into tiers in accordance with 45 CFR 146.136(c)(3)(iii)(B)).	Inpatient Out-of-Network	Outpatient In-Network (Issuer can choose to have subclassifications for Outpatient Office Visits, and Other Outpatient Services) (if network tiers, may separate into tiers in accordance with 45 CFR 146.136(c)(3)(iii)(B))		Outpatient Out-of-Network (Issuer can choose to have subclassifications for Outpatient Office Visits, and Other Outpatient Services)		Emergency Care	Prescription Drugs
List each QTL that applies to the classification for MH/SUD benefits.								
For each type of QTL that applies to MH/SUD benefits, list the expected percentage of M/S benefits in each classification that are subject to that same type of QTL.								
For each level of each type of QTL that applies to at least 2/3rds of all M/Sbenefits in the classification, , list the expected percentage of M/S benefits subject to that QTL, that are subject								

to that level.								

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NON-QUANTITATIVE TREATMENT LIMITATIONS:

Non-Quantitative Treatment Limitations include but are not limited to medical management~~,~~ techniques such as step therapy~~,~~ and pre-authorization requirements. Coverage cannot impose a NQTL with respect to MH/SUD benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors ~~included~~used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to M/S benefits in the classification. Note that not every NQTL needs an evidentiary standard. There is flexibility under MHPAEA for plans to use NQTLs. The focus is on finding out what processes and standards the plan actually uses.

All plan standards that are not FRs or QTLs and that limit the scope or duration of benefits for services are subject to the NQTL parity requirements. This includes restrictions such as geographic limits, facility-type limits, and network adequacy.

~~Because medical management standards do not fit into a chart the way copays or deductibles would, NQTLs are not included for initial data collection in the chart below. Instead, the insurer is asked to provide a copy of the procedures for listed types of NQTLs, with a description of the benefits to which the procedure applies, with the benefits separated into MH/SUD and M/S. If a parity concern arises from the insurer's description of benefits to which a particular NQTL procedure applies, dollar amounts for benefits in each classification can be requested using blanks in the chart below.~~

	~~Inpatient In-Network~~	~~Inpatient Out-of-Network~~	~~Outpatient In-Network Office Visit (if network tiers, acceptable to separate into tiers)~~	~~Outpatient In-Network, All Benefits Other than Office Visit~~	~~Outpatient Out-of-Network Office Visit~~	~~Outpatient Out-of-Network, All Benefits Other than Office Visit~~	~~Emergency Care~~	~~Prescription Drugs~~
~~Does the plan provide MH/SUD benefits?~~								
~~Does the plan provide M/S benefits?~~								
~~Total dollar amount of all plan payments for MH/SUD benefits expected to be paid for the relevant plan year~~								
~~Total dollar amount of all plan payments for M/S benefits expected to be paid for the relevant plan year~~								
~~List each financial requirement that applies to the classification for MH/SUD benefits, and attribute expected plan payments to each applicable financial requirement~~								

~~List each financial requirement that applies to the classification for M/S benefits, and attribute expected plan payments to each applicable financial requirement~~								

The following data collection chart is modeled after a tool used in federal MHPAEA examinations. Insurers who have completed "Table 5" for NQTLs may substitute those documents for completion of this chart.

[insert Table 5]

~~Does the plan impose a separate cumulative financial requirement or QTL for MH/SUD benefits that accumulates separately from any cumulative financial requirement or QTL for M/S benefits?~~								

	~~Inpatient In-Network~~	~~Inpatient Out-of-Network~~	~~Outpatient In-Network Office Visit (if network tiers, acceptable to separate into tiers)~~	~~Outpatient In-Network, All Benefits Other than Office Visit~~	~~Outpatient Out-of-Network Office Visit~~	~~Outpatient Out-of-Network, All Benefits Other than Office Visit~~	~~Emergency Care~~	~~Prescription Drugs~~
~~List each QTL that applies to the classification for MH/SUD benefits, and attribute expected plan payments to each applicable QTL~~								
~~List each QTL that applies to the classification for M/S benefits, and attribute expected plan payments to each applicable QTL~~								
~~*[Add specific NQTL if a concern arises]*~~								

From: Theresa Morfe -MDInsurance- <theresa.morfe@maryland.gov>
Sent: Wednesday, October 31, 2018 12:47 PM
To: Wallace, Petra <PWallace@naic.org>
Subject: Re: NAIC Notice: Save the Date Market Conduct Examination Standards (D) Working Group November 6 1:30 p.m. Central/2:30 p.m. Eastern Call

Hi Petra,

Question 9: We are not sure what is being requested with the statement, "Please provide or make available copies of documents that contain the required disclosures[.]" What is meant by "the required disclosures"?

The second to last paragraph in Question 9 that starts, "Note that not every NQTL needs an evidentiary standard..." should be removed unless this statement came from comments by DOL/HHS/DOT.

Data Collection Tool

- Remove second row of the FR table, "Total dollar amount of all plan payments for MH/SUD benefits expected to be paid for the relevant plan year." This is not a part of the MHPAEA analysis, so it seems unnecessary to collect this information.
- Similarly, remove from the fourth row of the table, regarding MH/SUD, "and attribute expected plan payments to each applicable financial requirement." This is not a part of the MHPAEA analysis. Only M/S expected plan payments are analyzed.
- Change the fifth row to: "For each type of financial requirement that applies to MH/SUD benefits, list the expected percentage of *plan payments for* M/S benefits in each classification that are subject to that same type of financial requirement." (Italicized language added). It is important to remember that the analysis is focused on expected plan payments for M/S.
- Change the sixth row to: "For each level of each type of financial requirement that applies to at least 2/3 of all M/S benefits in the classification, list the expected percentage *of plan payments for* M/S benefits subject to that financial requirement that are subject to that level."
- For the QTL Table- Change the second row to: "For each type of financial requirement that applies to MH/SUD benefits, list the expected percentage of *plan payments for* M/S benefits in each classification that are subject to that same type of QTL." (Italicized language added).
- Change the third row to: "For each level of each type of QTL that applies to at least 2/3 of all M/S benefits in the classification, list the expected percentage *of plan payments for* M/S benefits subject to that financial requirement that are subject to that level."
- Under the NQTL Section: Remove the last three sentences of the first paragraph, starting with "Note that not every NQTL needs an evidentiary standard..." unless this comment was provided by DOL/HHS/DOT.
- Table 5 was not inserted and the other referenced "data collection chart" also was not included. It appears all NQTL charts were deleted.

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ABHW
Advancing Health Care Policy
for Mental Health and Addiction

October 31, 2018

Via Electronic Mail (Petra Wallace - pwallace@naic.org)
Director Bruce R. Ramge
Nebraska Department of Insurance
941 O Street, Suite 400
Lincoln, NE 68508

Re: Mental Health Parity Guidance

Dear Director Ramge,

I am writing to you today in your capacity as Chair of the Market Conduct Exam Standards (D) Working Group of the National Association of Insurance Commissioners (NAIC) to comment on the October 18th, 2018 draft Mental Health Parity Guidance on behalf of the Association for Behavioral Health and Wellness (ABHW). You may recall that we submitted comments previously and participated in the August 29th conference call.

As a reminder, ABHW is the leading association working to advance federal policy on mental health and addiction services. Founded in 1994, ABHW is dedicated to shifting the paradigm in treatment and policies for mental health and addiction to ensure access to quality care, improve overall health outcomes, and advance solutions for public health challenges. Our members include top national and regional health plans that care for more than 175 million people in both the public and private sectors.

We are writing today to comment on the Data Collection Tool for Mental

Association for Behavioral Health and Wellness
1325 G Street NW · Suite 500 · Washington DC, 20005 · 202.449.7660 · ABHW.ORG

Health Parity Analysis. First, we'd like to thank you for some of the changes that have been made since the first version of the document. Second, we have a few technical corrections to the document and some clarifying language suggestions.

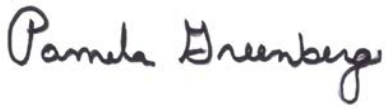
In terms of our technical corrections, on page 2 in the far left column of the chart where it states "List each financial requirement that applies to the classification for MH/SUD benefits, and attribute expected plan payments to each applicable financial requirement" the reference to MH/SUD should be M/S. The same is true for the box that states "For each type of financial requirement that applies to MH/SUD benefits, list the expected percentage of M/S benefits in each classification that are subject to that same type of financial requirement" the reference to MH/SUD should be M/S.

On page 4 in the non-quantitative treatment limitations section, first paragraph, where it states "Note that not every NQTL needs an evidentiary standard." We suggest adding the underlined clarifying language so the sentence reads - Note that not every NQTL, or NQTL factor, needs an evidentiary standard.

On page 5 the table is crossed out and there is a note to insert table 5 but no table is inserted. We believe the reference to table 5 is a reference to the table used by the Center for Medicare and Medicaid Services (CMS) to conduct mental health parity compliance exams. We suggest replacing the chart that is crossed out in the document with the CMS compliance chart (attached).

Thank you once again for the opportunity to comment on the Workgroup's draft guidance. If you would like to discuss our letter I can be reached at greeenberg@abhw.org or (202) 449-7660.

Sincerely,



Pamela Greenberg, MPP
President and CEO

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Plan Name:
Benefit Plan Design Effective Date: *Benefit Plan Design Identifier:*

Federal Mental Health Parity and Addiction Equity Filing

Table 5: Non-Quantitative Treatment Limitations

Submit a separate form for each benefit plan design.

A. Plan Name:		B. Date:
C. Contact Name:	D. Telephone Number:	E. Email:
F. Line of Business (HMO, EPO, POS, PPO):		
G. Contract Type (large group, small group, individual):		
H. Benefit Plan Effective Date:		I. Benefit Plan Design(s) Identifier(s):[1]

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described *and list this documentation on Table 6*.
A. Definition of Medical Necessity What is the definition of medical necessity?			

[1] Use the same benefit plan design identifier(s) as for Tables 1-4.

Plan Name:
Benefit Plan Design Effective Date: *Benefit Plan Design Identifier:*

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described *and list this documentation on Table 6*.
B. Prior-authorization Review Process Include all services for which prior-authorization is required. Describe any step-therapy or "fail first" requirements and requirements for submission of treatment request forms or treatment plans. Inpatient, In-Network:			
Outpatient, In-Network: Office Visits:			
Outpatient, In-Network: Other Outpatient Items and Services:			
Inpatient, Out-of-Network:			

Plan Name:
Benefit Plan Design Effective Date: *Benefit Plan Design Identifier:*

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described *and list this documentation on Table 6*.
Outpatient, Out-of-Network: Office Visits:			
Outpatient, Out-of-Network: Other Items and Services:			
C. Concurrent Review Process, including frequency and penalties for all services. Describe any step-therapy or "fail first" requirements and requirements for submission of treatment request forms or treatment plans. Inpatient, In-Network:			
Outpatient, In-Network: Office Visits:			
Outpatient, In-Network: Other Outpatient Items and Services:			

Plan Name:
Benefit Plan Design Effective Date: *Benefit Plan Design Identifier:*

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described *and list this documentation on Table 6*.
Inpatient, Out-of-Network:			
Outpatient, Out-of-Network: Office Visits:			
Outpatient, Out-of-Network: Other Items and Services:			
D. Retrospective Review Process, including timeline and penalties. Inpatient, In-Network:			
Outpatient, In-Network: Office Visits:			
Outpatient, In-Network: Other Outpatient Items and Services:			

Plan Name:
Benefit Plan Design Effective Date: *Benefit Plan Design Identifier:*

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described *and list this documentation on Table 6*.
Inpatient, Out-of-Network:			
Outpatient, Out-of-Network: Office Visits:			
Outpatient, Out-of-Network: Other Items and Services:			
E. Emergency Services			
F. Pharmacy Services Include all services for which prior-authorization is required, any step-therapy or "fail first" requirements, any other NQTLs. Tier 1:			

Plan Name:
Benefit Plan Design Effective Date: *Benefit Plan Design Identifier:*

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described *and list this documentation on Table 6*.
Tier 2:			
Tier 3:			
Tier 4:			
G. Prescription Drug Formulary Design How are formulary decisions made for the diagnosis and medical necessary treatment of medical, mental health and substance use disorder conditions?			
Describe the pertinent pharmacy management processes, including, but not limited to, cost-control measures, therapeutic substitution, and step therapy.			

Plan Name:
Benefit Plan Design Effective Date: *Benefit Plan Design Identifier:*

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described *and list this documentation on Table 6*.
What disciplines, such as primary care physicians (internists and pediatricians) and specialty physicians (including psychiatrists) and pharmacologists, are involved in the development of the formulary for medications to treat medical, mental health and substance use disorder conditions.			
H. Case Management What case management services are available?			
What case management services are required?			
What are the eligibility criteria for case management services?			

Plan Name:
Benefit Plan Design Effective Date: *Benefit Plan Design Identifier:*

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described *and list this documentation on Table 6*.
I. Process for Assessment of New Technologies Definition of experimental/investigational:			
Qualifications of individuals evaluating new technologies:			
Evidence consulted in evaluating new technologies:			

Plan Name:
Benefit Plan Design Effective Date: *Benefit Plan Design Identifier:*

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described *and list this documentation on Table 6*.
J. Standards for provider credentialing and contracting			
Is the provider network open or closed?			
What are the credentialing standards for physicians?			
What are the credentialing standards for licensed non-physician providers? Specify type of provider and standards; e.g., nurse practitioners, physician assistants, psychologists, clinical social workers.			
What are the credentialing/contracting standards for unlicensed personnel; e.g., home health aides, qualified autism service professionals and paraprofessionals?			
K. Exclusions for Failure to Complete a			

Plan Name:
Benefit Plan Design Effective Date: *Benefit Plan Design Identifier:*

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described *and list this documentation on Table 6*.
Course of Treatment Does the Plan exclude benefits for failure to complete treatment?			
L. Restrictions that limit duration or scope of benefits for services Does the Plan restrict the geographic location in which services can be received; e.g., service area, within California, within the United States?			
Does the Plan restrict the type(s) of facilities in which enrollees can receive services?			

Plan Name:
Benefit Plan Design Effective Date: *Benefit Plan Design Identifier:*

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described *and list this documentation on Table 6*.
M. Does the Plan restrict the types of provider specialties that can provide certain M/S and/or MH/SUD benefits?			

FROM THE NAIC CONSUMER REPRESENTATIVES

To: Market Conduct Examination Standards (D) Working Group
Chair Ramge
Vice Chair Mealer
Petra Wallace

Date: November 26, 2018

Re: Market Regulation Data Collection Tool: Mental Health Parity

The undersigned NAIC consumer representatives write to comment on the proposed data collection tool related to the enforcement of mental health parity protections under the Mental Health Parity and Addiction Equity Act (MHPAEA). We applaud the Working Group's efforts to promote compliance with MHPAEA standards during market conduct exams. This effort is particularly important given that some insurers have continued to engage in discriminatory practices, and states and the federal government have struggled with enforcement efforts. These comments identify additional recommendations from the consumer representatives on ways to better clarify the proposed standards.

Defining Conditions

There is not any question, item, or other line of inquiry regarding how the insurer has defined mental health conditions and substance use disorders. 45 CFR 146.136(a) specifies that "any condition defined by the plan or coverage as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD, or State guidelines)." An identical specification exists for substance use disorders. It is critically important to know if an insurer is defining certain conditions as not being a mental health condition or substance use disorder and if that is consistent with generally recognized independent standards of current medical practice.

This is especially true pertaining to autism spectrum disorders. Autism spectrum disorder is contained within the DSM 5 and listed in the mental and behavioral disorders section of the ICD. However, it is not uncommon for insurers to define autism spectrum disorder as a medical/surgical condition and not a mental health condition. Defining autism spectrum disorder as "not a mental health condition" flies in the face of what is specified in the section of the final rules referenced above.

There should be a question or item that asks the insurer to justify that its definitions of mental health conditions, substance use disorders, and medical conditions are consistent with independent standards of current medical practice and which standards were relied upon. The data collection tool should also ask for a list of all conditions defined as medical conditions, all conditions defined as mental health conditions, and all conditions defined as substance use disorders.

The tool could include this proposed question: "Are all conditions that are defined as being or as not being a mental health condition, a substance use disorder, or a medical condition defined in a manner that is consistent with generally recognized independent standards of current medical practice?" The data collection tool could contain a table that is structured as such:

Type of Condition	Medical Conditions	Mental Health Conditions	Substance Use Disorders
List of all covered conditions or disorders			

Questions 4 and 5

Question 4 pertains to prescription drug formulary tiering and correctly notes that the "reasonable factors" must be in accordance with the NQTL rules. However, the prompt after the question that solicits an explanation of the tiering factors may not yield a sufficient response. The prompt should reflect the requirements of the NQTL rules. Namely, it should ask about comparability and stringency, as the NQTL rules stipulate. Here is a proposed change to the prompt:

"If the plan includes multiple tiers in its prescription drug formulary, are the tier classifications based on reasonable factors (such as cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up) determined in accordance with the rules for NQTLs, at 45 CFR 146.136(c)(4)(i), and without regard to whether the drug is generally prescribed for MH/SUD or M/S benefits? Explain how the plan's tiering factors for MH/SUD prescription drugs are comparable to and are applied no more stringently than the tiering factors for M/S prescription drugs."

A similar change is proposed for Question 5:

"If the plan includes multiple network tiers of in-network providers, is the tiering based on reasonable factors (such as quality, performance, and market standards) determined in accordance with the rules for NQTLs at 45 CFR 146.136(c)(4)(i), and without regard to whether a provider provides services with respect to MH/SUD benefits or M/S benefits? Explain how the plan's tiering factors for MH/SUD network tiers are comparable to and are applied no more stringently than the tiering factors for M/S network tiers."

Financial Requirements and Quantitative Treatment Limitations

The data collection tool has a very useful table for financial requirements (FRs) and quantitative treatment limitations (QTLs). However, the prompt in the third row on page 2 that pertains to total dollar amount of plan payments for MH/SUD benefits is unnecessary and could potentially confuse both regulators and insurers. All the testing on FRs to determine if the "substantially all" and "predominant" tests are satisfied is performed on M/S benefits. There is no calculation or testing that should or could be done for MH/SUD spending. The testing is performed on M/S benefits within the classification to determine if an FR may apply to MH/SUD benefits within the classification ("substantially all" test), and then to determine the most restrictive level of FR that may be applied to MH/SUD benefits within the classification ("predominant" test). There is never any need to determine the total amount spent on MH/SUD benefits in a classification or any calculation of percentages of MH/SUD spending or levels in the classification. The testing is exclusive to M/S benefits.

Additionally, using the same rationale, the prompt in the fifth row on page 2 is unnecessary and could potentially confuse both regulators and insurers. There is no need to perform any calculations on

MH/SUD benefits for the purposes of the "substantially all" test. The testing is exclusive to M/S benefits within the classification.

The prompts for QTLs do not duplicate these unnecessary prompts and therefore are correct.

Nonquantitative Treatment Limitations

There are several issues with the nonquantitative treatment limitation (NQTL) prompt and the data collection tool that should be addressed. First, here is a proposed edit to Question 9:

"Does the plan impose Non-Quantitative Treatment Limitations (NQTLs) on MH/SUD benefits in any classification? If so, ~~do the NQTLs comply with parity requirements? Please provide or make available copies of documents that contain the required disclosures, with the disclosures flagged in those documents,~~ then demonstrate compliance with this standard by completing the attached data collection tool."

It is not clear why there would be disclosures in addition to completing a data collection tool. Asking for the completion of the data collection tool is sufficient and will help streamline the process and not solicit unnecessary or duplicative information.

As for "table 5" for NQTLs in the data collection tool, although it is not attached, we assume that it is "table 5," originally created by California's Department of Managed Health Care (DMHC). We find this approach to be troublesome for several reasons.

The table contains four columns. The first column lists the type of NQTL by classification of benefits (ie, prior authorization for inpatient, in-network benefits, etc.) The second column asks that insurers summarize the NQTL for medical/surgical benefits. The third column asks that insurers summarize the NQTL for MH/SUD benefits. The fourth column ask insurers to "Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described and list this documentation on Table 6."

While this approach was markedly better than any other regulatory approach pursued prior to September of 2014 when DMHC created the table, it has several problematic aspects. One, the emphasis is on description and not comparison. To properly determine if there is compliance or not, there must be a comparison of the processes, strategies, evidentiary standards, or other factors to determine if they are in fact comparable to and applied no more stringently, both as written and in operation. While it is possible that the wording above could yield a comparative analysis, it does not demand one. Asking insurers to merely "describe" the processes, strategies, evidentiary standards and factors is insufficient. This lack of specificity and stipulation that comparative analyses be provided could lead to imprecise and vague attestations of compliance.

A more appropriate approach would be to create a table that aligns with the stepwise process contained on pages 13 through 17 of the Department of Labor's Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act. These steps create a much more orderly process for determining compliance. By breaking apart the required analyses into sequential components, this format should allow for more precision in compliance reporting. Additionally, step 4 explicitly requires a demonstration of

comparability and equivalent stringency, both as written and in operation. This is a logical way to unbundle the dense language of 45 CFR 146.136(c)(4)(i).

A last point on NQTLs is in relation to this passage that is just after Question 9, and just before Question 10:

"Note that not every NQTL needs an evidentiary standard. There is flexibility under MHPAEA for plans to use NQTLs. The focus is on finding out what processes and standards the plan actually uses."

We recommend that this language be removed because it is making a definitive declaration about a term in 45 CFR 146.136(c)(4)(i) that is not stated anywhere in the final rule or its preamble, the interim final rule or its preamble, or any sub-regulatory guidance that has been issued by the federal agencies. While the concept that not every NQTL has an evidentiary standard may be open for debate in some sort of dialogue probing the abstract, a chapter devoted to performing a MHPAEA examination should adhere to the concrete terms and stipulations of the statute, its regulations, and associated sub-regulatory guidance. The conclusion that not every NQTL has an evidentiary standard is absent from the plain language of MHPAEA, its implementing regulations, and associated guidance documents and therefore should be absent from this proposed chapter.

Thank you in advance for your consideration, and we look forward to continuing to work closely with the Working Group on these new standards. If you have any questions, please contact Andrew Sperling (asperling@nami.org) or Katie Keith (katie@out2enroll.org).

Sincerely,

Ashley Blackburn	Debra Judy	Matthew Smith
Dave Chandrasekaran	Katie Keith	Andrew Sperling
Laura Colbert	Sarah Lueck	Lorri Unumb
Deborah Darcy	Jim Roberts	Silvia Yee
Anna Howard	Carl Schmid	

MARKET REGULATION HANDBOOK
INSURANCE DATA SECURITY PRE-BREACH AND POST-BREACH CHECKLISTS

Company Name	
Period of Examination	
Examination Field Date	
Prepared By	
Date	

GUIDANCE

NAIC Insurance Data Security Model Law (#668)

Note: The guidance that follows should only be used in states that have enacted the *NAIC Insurance Data Security Model Law (#668)*. Moreover, in performing work during an exam in relation to the Model Law, it is important 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 the Insurance Data Security Model Law 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 for compliance with the Insurance Data Security Model Law (NAIC Model #668) for the prevention of a Cybersecurity Event as defined in the model law, please refer to the examination checklist attached as Exhibit A hereto.

When reviewing a Licensee's Information Security Program and response to a Cybersecurity Event for compliance with the Insurance Data Security Model Law subsequent to a suspected and/or known Cybersecurity Event as defined in the model law, please refer to both examination checklists attached as Exhibits A and Exhibit B hereto.

When considering whether to underake such a review, refer to Section 9 of NAIC Model #668, which provides certain exceptions to compliance for Licensees with fewer than ten employees; Licensees subject to the Health Insurance Portability and Accountability Act (Pub.L, 104-191, 110 Stat. 1936, enacted August 21, 1996); and certain employees, agents, representatives, or designees of Licensees who are in themselves Licensees.

Exhibit A: Supplemental Incident Response Plan Readiness (Pre-Breach) Checklist for Operations/Management Standard #17 Insurance Data Security Model Law #668, Section 4

INFORMATION SECURITY PROGRAM (Sections 4A and 4B)

REVIEW CRITERIA	**NOTES *(YES, NO, NOT APPLICABLE, OTHER)***
1. Does the Licensee have a written Information Security Program (ISP)?	
2. Does the ISP clearly state the person(s) at the Licensee responsible for the program?	
3. Has the ISP been reviewed and approved by the Licensee's executive management?	
4. Has the ISP been reviewed and approved by the Licensee's Board of Directors? (Section 4E)	
5. Has the ISP been reviewed and approved by the Licensee's IT steering committee?	
6. How often is the ISP reviewed and updated? (Section 4G)	
7. Are any functions of the ISP outsourced to third parties? (*If YES, identify any such providers, review their roles and responsibilities, and the Licensee's oversight of the third parties*.)	
8. Does the ISP contain appropriate administrative, technical and physical safeguards for the protection of Nonpublic Information and the Licensee's Information Systems?	
9. Does the Licensee stay informed regarding emerging threats and vulnerabilities? (Section 4D(4))	
10. Does the Licensee regularly communicate with its employees regarding security issues?	
11. Does the Licensee ensure that employees' hardware is updated on a timely basis to ensure necessary security software updates and patches have been downloaded and installed?	
12. Does the Licensee provide cybersecurity awareness training to its personnel? (Section 4D(5))	
13. How soon after onboarding a new employee does the Licensee provide cybersecurity awareness training? At what intervals is the training renewed?	
14. Does the Licensee utilize reasonable security measures when sharing information? (Section 4D(4))	

Exhibit A: Supplemental Incident Response Plan Readiness (Pre-Breach) Checklist for Operations/Management Standard #17 Insurance Data Security Model Law #668, Section 4

RISK ASSESSMENT (Section 4C)

REVIEW CRITERIA	**NOTES *(YES, NO, NOT APPLICABLE, OTHER)***
15. Has the Licensee conducted a Risk Assessment to identify foreseeable internal and external threats to its information security?	
16. When was the last Risk Assessment conducted or updated?	
17. Has the Licensee designed its ISP to address issues identified in its Risk Assessment?	
18. Are Cybersecurity Risks included in the Licensee's Enterprise Risk Management process? (Section 4D(3))	

COMPONENTS OF INFORMATION SECURITY PROGRAM (Section 4D)

REVIEW CRITERIA	**NOTES *(YES, NO, NOT APPLICABLE, OTHER)***
19. Has the Licensee determined that the following security measures are appropriate, and has the Licensee implemented them as part of its ISP? *(If NO for any item, interview the appropriate responsible personnel to discuss the reason(s) such measures were not implemented.)*	
19a. Access controls to limit access to Information Systems to Authorized Individuals?	
19b. Physical controls on access to Nonpublic Information to limit access to Authorized Individuals?	
19c. Protection of Nonpublic Information by encryption or other appropriate means while being transmitted externally or stored on portable computing devices or media?	
19d. Secure development practices for in-house applications and procedures for testing the security of externally developed applications?	
19e. Controls for individuals accessing Nonpublic Information such as Multi-Factor Authentication?	
19f. Regular testing and monitoring of systems to detect actual and attempted attacks or intrusions into Information Systems?	
19g. Audit trails in the ISP to detect and respond to Cybersecurity Events and permit reconstruction of material financial transactions?	
19h. Measures to prevent Nonpublic Information from physical damage, loss or destruction?	
19i. Secure disposal procedures for Nonpublic Information?	

Exhibit A: Supplemental Incident Response Plan Readiness (Pre-Breach) Checklist for Operations/Management Standard #17 Insurance Data Security Model Law #668, Section 4

THIRD-PARTY SERVICE PROVIDERS (Section 4F)

REVIEW CRITERIA	**NOTES *(YES, NO, NOT APPLICABLE, OTHER)***
20. Does the Licensee have Third-Party Service Providers with which it shares Nonpublic Information?	
21. Does the Licensee include information security standards as part of its contracts with such providers?	
22. Does the Licensee conduct inspections or reviews of its providers' information security practices?	

INCIDENT RESPONSE PLAN (Section 4H)

REVIEW CRITERIA	**NOTES *(YES, NO, NOT APPLICABLE, OTHER)***
23. Does the ISP contain a written incident response plan and/or detailed process for responding to a Cybersecurity Event?	
24. Does the incident response plan provide clear guidance on when to initiate a Cybersecurity Event investigation?	
25. Does the incident response plan contain a list of clear and well-defined objectives?	
26. Does the incident response plan provide clear roles, responsibilities and levels of decision-making authority?	
27. Does the incident response plan require written assessment of the nature and scope of a Cybersecurity Event?	
28. Does the incident response plan require determination of whether any Nonpublic Information was exposed during a Cybersecurity Event and to what extent?	
29. Does the incident response plan provide clear steps to be taken to restore the security of any information systems compromised in a Cybersecurity Event?	
30. Does the incident response plan sufficiently address steps to take when a Cybersecurity Event occurs at a Third-Party Service Provider where data provided by the Licensee is potentially at risk?	
31. Does the incident response plan provide detailed instructions for external and internal communications, as well as information sharing with regulatory authorities?	
32. Does the incident response plan define various levels of remediation based on the severity of identified weaknesses?	

Exhibit A: Supplemental Incident Response Plan Readiness (Pre-Breach) Checklist for Operations/Management Standard #17 Insurance Data Security Model Law #668, Section 4

DOCUMENTATION AND REPORTING

REVIEW CRITERIA	**NOTES *(YES, NO, NOT APPLICABLE, OTHER)***
33. Does the ISP describe documentation and reporting procedures for Cybersecurity Events and related incident response activities? (Section 4H)	
34. Does the ISP require a post-event evaluation following a Cybersecurity Event? (Section 4H)	
35. Does the ISP require retention of all records related to Cybersecurity Events for a minimum of five years? (Section 5D)	
36. Has the Licensee prepared and submitted annual certifications to its domiciliary state Commissioner/Director of Insurance? (Section 4I)	

PRIOR EXAMINATION FINDINGS

REVIEW CRITERIA	**NOTES *(YES, NO, NOT APPLICABLE, OTHER)***
37. Has the Licensee addressed and implemented corrective actions to any material findings from any prior examinations?	

Exhibit B: Supplemental Incident Response Plan Investigation (Post-Breach) and Notification Cybersecurity Event Checklist for Operations/Management Standard #17 Insurance Data Security Model Law #668, Section 5 and 6

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?	
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)	

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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POLICY IN FORCE STANDARDIZED DATA REQUEST
Property & Casualty Line of Business
Private Passenger Auto

Contents: This file should be downloaded from company system(s) and contain one record for each vehicle insured under a private passenger auto policy issued in [applicable state] which was in force at any time during the examination period.

For any fields where there are multiple entries, please repeat field as necessary.

Uses: Data will be used to determine if the company follows appropriate procedures with respect to the issuance and/or termination of private passenger automobile policies in [applicable state] within the scope of the examination:

- Cross-reference with the company's MCAS data to validate MCAS reporting and review the exam data for completeness;
- Cross-reference with the claims data file to validate the completeness of the in force file; and
- Cross-reference to state(s) licensing information to ensure proper producer licensure.

Field Name	Start	Length	Type	Decimals	Description
CoCode	1	5	A		NAIC company code
PolPre	6	3	A		Policy prefix (**Blank if NONE**)
PolNo	9	20	A		Policy number
PolSuf	29	3	A		Policy suffix (**Blank if NONE**)
PolStTyp	32	3	A		Policy status type for the record (i.e., new or renewal) **Please provide a list to explain any codes used**
PolTyp	35	25	A		Type of policy, if any (i.e., standard, preferred, nonstandard) **Please provide a list to explain any codes used**
PolForm	60	10	A		Policy form number as filed with the insurance department
PrCode	70	9	A		Company internal producer, CSR, or business entity producer identification code **Please provide a list to explain any codes used**
NPN	79	6	A		National producer number
InsFirst	85	15	A		First name of the first named insured
InsMid	100	15	A		Middle name of the first named insured
InsLast	115	20	A		Last name of the first named insured
InsAddr	135	25	A		Insured street address (mailing)
InsCity	160	20	A		Insured city (mailing)
InsSt	180	2	A		Insured state (mailing)
InsZip	182	9	A		Insured ZIP code (mailing)
GarAddr	191	25	A		Vehicle garaging address
GarCity	216	20	A		Vehicle garaging city
GarSt	236	2	A		Vehicle garaging state

GarZip	238	9	A		Vehicle garaging ZIP code
PUndDrSx	247	1	A		Primary underwritten driver's sex
PUndDrMs	248	1	A		Primary underwritten driver's marital status
PUndDrEd	249	25	A		Primary underwritten driver's education level **Please provide a list to explain any codes used**
PUndDrOc	274	50	A		Primary underwritten driver's occupation **Please provide a list to explain any codes used**
VehUBI	324	1	A		Does usage based insurance apply to vehicle (Y/N)
PolPrem	325	11	N	2	Total policy premium amount (Sum of all premium for all vehicles, which includes premium, fees, etc.)
UWTier	336	25	A		Underwriting tier (policy or vehicle), if tier rating is utilized **Please provide a list to explain any codes used**
VehYr	361	4	A		Vehicle year
VehMake	365	15	A		Vehicle make **Please provide a list to explain any codes used**
VehModel	380	20	A		Vehicle model **Please provide a list to explain any codes used**
VIN	400	17	A		Vehicle identification number
VehSym	417	5	A		Vehicle symbol **Please provide a list to explain any codes used**
VehPrem	422	11	N	2	Total vehicle premium amount (Sum of all premium for the vehicle, involving all premium, fees, etc.)
BIBas	433	11	N	2	Bodily injury liability term base premium for this limit
BICls	444	6	A		Bodily injury liability driver class factor **Please provide a list to explain any codes used**
BIDev	450	6	A		Bodily injury liability deviation factors (i.e., discounts, credits, etc.) **Please provide a list to explain any codes used**
BILmtPP	456	3	N		Bodily injury limit per person (in thousands)
BILmtPA	459	3	N		Bodily injury limit per accident (in thousands)
BITrm	462	6	A		Bodily injury liability term factor
PDBas	468	11	N	2	Property damage liability term base premium
PDCls	479	6	A		Property damage liability driver class factor **Please provide a list to explain any codes used**
PDDev	485	6	A		Property damage liability deviation factors (i.e., discounts, credits, etc.) **Please provide a list to explain any codes used**
PDLmt	491	3	N		Property damage liability limit per accident (in thousands)
PDTrm	494	6	A		Property damage liability term factor
LiaCsl	500	3	N		Single liability limit (in thousands)
CLBas	503	11	N	2	Collision term base premium
CLCls	514	6	N		Collision driver class factor
CLDed	520	11	N	2	Collision deductible
CLDev	531	6	A		Collision deviation factors (i.e., discounts, credits, etc.) **Please provide a list to explain any codes used**
CLDedFct	537	6	A		Collision deductible factor
CLTrm	543	6	A		Collision term factor
CMBas	549	11	N	2	Comprehensive term base premium for this model year and symbol vehicle

CMCls	560	6	A		Comprehensive class factor
CMDed	566	11	A	2	Comprehensive deductible
CMDev	577	6	A		Comprehensive deviation factor (i.e., discounts, credits, etc.) **Please provide a list to explain any codes used**
CMFact	583	6	A		Comprehensive deductible factor
CMTrm	589	6	A		Comprehensive term factor
MPBas	595	11	N	2	Medical payments term base premium for this limit
MPCls	606	6	A		Medical payments class factor
MPDev	612	6	A		Medical payments deviation factors (i.e., discounts, credits, etc.) **Please provide a list to explain any codes used**
MPLmt	618	11	N	2	Medical payments limit
MPTrm	629	6	A		Medical payments term factor
ERSTrm	635	11	N	2	Emergency road service term base premium
ERSOpt	646	11	N	2	Emergency road service optional benefit **If codes are used, provide a list of codes along with their meanings**
RentTrm	657	11	N	2	Rental reimbursement term base premium
RentDay	668	11	N	2	Rental reimbursement daily limit
RentAgg	679	11	N	2	Rental reimbursement aggregate
UMPDBas	690	11	N	2	Uninsured motorist property damage term base premium
UMPDDev	701	6	A		Uninsured motorist property damage deviation factors **If codes are used, provide a list of codes along with their meanings**
UMPDLmt	707	3	N		Uninsured motorist property damage limit (in thousands)
UMPDDed	710	11	N	2	Uninsured motorist property damage deductible
UMPDFact	721	6	A		Uninsured motorist property damage deductible factor
UMBIBas	727	11	N	2	Uninsured motorist bodily injury term base premium
UMBIDev	738	6	A		Uninsured motorist bodily injury deviation factors **If codes are used, provide a list of codes along with their meanings**
UMBIPP	744	11	N	2	Uninsured motorist bodily injury limit per person (in thousands)
UMBIPA	755	3	N		Uninsured motorist bodily injury limit per accident (in thousands)
UMCsl	758	3	N		Uninsured motorist combined single limit (in thousands)
UIMBas	761	11	N	2	Underinsured motorist term base premium
UIMDev	772	6	A		Underinsured motorist deviation factors **If codes are used, provide a list of codes along with their meanings**
UIMPP	778	3	N		Underinsured motorist limit per person (in thousands)
UIMPA	781	3	N		Underinsured motorist limit per accident (in thousands)
UIMTrm	784	6	A		Underinsured motorist term factor
RateTerr	790	5	A		Code specifying rating territory **Provide a list of codes along with their meanings**

MVRDt	795	10	D		Date of most recent motor vehicle record (MVR) [MM/DD/YYYY]
DrDOB	805	10	D		Driver date of birth [MM/DD/YYYY]
VehSur	815	11	N	2	Vehicle surcharge amount (2 decimal places. Do not use commas or dollar signs.) **If codes are used, provide a list of codes along with their meanings**
VehDis	826	5	A		Vehicle discounts **If codes are used, provide a list of codes along with their meanings**
DrSur	831	11	N	2	Driver surcharge amount (2 decimal places. Do not use commas or dollar signs.) **If codes are used, provide a list of codes along with their meanings**
DriDis	842	5	A		Driver discounts **If codes are used, provide a list of codes along with their meanings**
AppRecDt	847	10	D		Date application received [MM/DD/YYYY]
AppProDt	857	10	D		Date application processed [MM/DD/YYYY]
InceptDt	867	10	D		Inception date of the policy [MM/DD/YYYY]
EffDt	877	10	D		Policy effective date [MM/DD/YYYY]
ExpDt	887	10	D		Policy expiration date (MM/DD/YYYY)
PdDt	897	10	D		Date policy was paid to before cancellation [MM/DD/YYYY]
CanReqDt	907	10	D		Date cancellation requested, if applicable [MM/DD/YYYY]
CanTerRs	917	64	A		Reason for cancellation/termination of coverage (i.e., lapse, insured request, company cancellation) **If codes are used, provide a list of codes along with their meanings**
CanTer	981	1	A		Who cancelled the coverage **C=Consumer and I=Insurer**
CanTerDt	982	10	D		Date policy cancelled/terminated [MM/DD/YYYY]
CanTerNt	992	10	D		Date the cancellation/termination notice was mailed [MM/DD/YYYY]
PremRef	1002	11	N	2	Amount of premium refunded to the insured
RfndDt	1013	10	D		Date premium refund mailed [MM/DD/YYYY]
RefMthd	1023	25	A		Refund method (i.e., 90%, pro rata, etc.) **If codes are used, provide a list of codes along with their meanings**
SurAmt	1048	11	N	2	Surcharge amount (2 decimal places. Do not use commas or dollar signs.)
TrafVio	1059	3	A		Number of rated traffic violations
MVAccd	1062	3	A		Number of rated vehicle accidents
EndRec	1065	1	A		End of record marker. Please place an asterisk in this field to indicate the end of the record. This must be in the same character position for every record in this table.

CLAIMS STANDARDIZED DATA REQUEST
Property & Casualty Line of Business
Private Passenger Auto

Contents: This file should be downloaded from company system(s) and contain one record for each claim transaction (i.e. paid/denied/pending/closed w/o payment) that the company processed within the scope of the examination. Include all claims open during the examination period. Do not include expense payments to vendors.

Uses: Data will be used to determine if the company follows appropriate procedures with respect to the handling of Property & Casualty claims within the scope of the examination.

- Cross-reference to annual statement claims data (amount) to ensure completeness of exam data submitted;
- Cross-reference with the company's MCAS data to validate MCAS reporting and review the exam data for completeness; and
- Cross-reference to state (s) licensing information to ensure proper adjuster licensure.

Field Name	Start	Length	Type	Decimals	Description
CoCode	1	5	A		NAIC company code
PolPre	6	3	A		Policy prefix (**Blank if NONE**)
PolNo	9	20	A		Policy number
PolSuf	29	3	A		Policy suffix (**Blank if NONE**)
ClmNo	32	15	A		Claim number
ClmPre	47	3	A		Claim number prefix (**Blank if NONE**)
ClmSuf	50	3	A		Claim number suffix (**Blank if NONE**)
Cov	53	5	A		Coverage under which claim was submitted
CovStat	58	10	A		Coverage status (e.g. paid, denied, pending, etc.) **Please provide a list to explain any codes used**
CATCode	68	6	A		Catastrophe (CAT) loss code, if applicable (**Blank if NONE**)
InsFirst	74	15	A		First name of insured
InsMid	89	15	A		Middle name of insured
InsLast	104	20	A		Last name of insured
InsAddr	124	100	A		Insured street address (mailing)
InsCity	224	20	A		Insured city (mailing)
InsSt	244	2	A		Insured resident state (mailing)
InsZip	246	5	A		Insured ZIP code (mailing)
CmtFirst	251	15	A		First name of claimant
CmtMid	266	15	A		Middle name of claimant
CmtLast	281	20	A		Last name of claimant (Entity filing proof of loss, e.g. business, etc.)

Field Name	Start	Length	Type	Decimals	Description
CmtAddr	301	100	A		Claimant street address
CmtCity	401	20	A		Claimant city
CmtSt	421	2	A		Claimant state
CmtZip	423	5	A		Claimant ZIP code
ClmStat	428	10	A		Claim status P = Paid, D = Denied, N = Pending, H = Partial Payment, C = Closed Without Payment, R = Rescinded
AdjCode	438	9	A		Internal adjuster identification code **Please provide a list to explain any codes used**
NPN	447	6	A		National (adjuster) number
LossDt	453	10	D		Date loss occurred [MM/DD/YYYY]
RcvdDt	463	10	D		First notice of loss [MM/DD/YYYY]
ClmAckDt	473	10	D		Date company or its producer acknowledged the claim [MM/DD/YYYY]
DtClmFrm	483	10	D		Date claim forms sent to claimant [MM/DD/YYYY]
NtcInvDt	493	10	D		Date of written notice to insured/claimant regarding incomplete investigation [MM/DD/YYYY]
PdClmAmt	503	11	N	2	Total amount of claim paid
ClmPay	514	50	A		Claim payee
ClmPdDt	564	10	D		Claim paid date [MM/DD/YYYY]
IntPdAmt	574	11	N	2	Amount of interest paid, if applicable
IntPdDt	585	10	D		Date interest paid [MM/DD/YYYY]
ClmDnyDt	595	10	D		Date claim was denied [MM/DD/YYYY]
ClmDenRsn	605	100	A		Reason for claim denial **Please provide a list to explain any codes used**
Subro	705	1	A		Indicate whether claim was subrogated (Y/N)
SubRecdDt	706	10	D		Date company received subrogation refund [MM/DD/YYYY]
SubAmt	716	11	N	2	Subrogation received amount
AmtSubRm	727	11	N	2	Amount of subrogation reimbursed to insured
SubRefDt	738	10	D		Date subrogation refunded to insured [MM/DD/YYYY]
TotalLoss	748	1	A		Indicate whether claim was a "Total Loss" (Y/N)
FrstLiab	749	5	N	2	Percentage of first party comparative negligence (e.g. 30%= 0.30), if applicable
ThrdLiab	754	5	N	2	Percentage of third party comparative negligence (e.g. 30%= 0.30), if applicable (repeat if necessary)
VehYr	759	4	A		Vehicle year
VehMake	763	20	A		Vehicle make **Please provide a list to explain any codes used**
VehModel	783	20	A		Vehicle model **Please provide a list to explain any codes used**
VIN	803	17	A		Vehicle identification number
NumOcc	820	2	A		Number of occupants in vehicle at time of accident

Field Name	Start	Length	Type	Decimals	Description
NetRpr	822	1	A		Repair handled through network repair shop (Y/N)
EndRec	823	1	A		End of record marker. Please place an asterisk in this field to indicate the end of the record. This must be in the same character position for every record in this table.

DECLINATION STANDARDIZED DATA REQUEST
Property & Casualty Personal Line of Business

Contents: This file should be downloaded from company or agency system(s) and contain one record for each policy application declined in [applicable state] at any time during the examination period.

Uses: Data will be used to determine if the company/agency follows appropriate procedures with respect to the declination of policy applications in [applicable state] at any time during the examination period:

- Cross-reference to producer data file to test for producers with declination rates that are significantly higher than or lower than the average;
- Test for unfair discrimination in declinations; and
- Test for compliance with declination notice requirements.

Field Name	Start	Length	Type	Decimals	Description
CoCode	1	5	A		NAIC company code
AppNo	6	10	A		Application number or quote number
PRCode	16	9	A		Company internal producer, CSR, or business entity producer identification code **Please provide a list to explain any codes used**
NPN	25	6	A		National producer number
LOB	31	3	A		Line of business according to annual financial statement **Please provide a list to explain LOB codes**
AppFirst	34	15	A		First name of applicant
AppMid	49	15	A		Middle name of applicant
AppLast	64	20	A		Last name of applicant
AppAddr	84	25	A		Applicant address
AppCity	109	20	A		Applicant city
AppState	129	2	A		Applicant state
AppZip	131	9	A		Applicant ZIP code
AppRecDt	140	10	D		Date application received [MM/DD/YYYY]
DeclDt	150	10	D		Date of declination [MM/DD/YYYY]
DeclRsn	160	20	A		Reason for declining application **If codes are used, provide a list of codes along with their meanings**
EndRec	180	1	A		End of record marker. Please place an asterisk in this field to indicate the end of the record. This must be in the same character position for every record in this table.