

Date: 9/29/16

Market Conduct Examination Standards (D) Working Group  
Conference Call  
September 14, 2016

The Market Conduct Examination Standards (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Sept. 14, 2016. The following Working Group members participated: Bruce R. Ramage, Chair, and Cindy Williamson (NE); Jim Mealer, Vice Chair, and Robert Reichart (MO); Bruce Glaser and Damion Hughes (CO); Kurt Swan (CT); Teresa Winer (GA); Mark Crandell (IA); Russ Hamblen (KY); Richard Bradley and John Turchi (MA); Sherri Mortensen-Brown (MN); Tracy Biehn (NC); Win Pugsley (NH); Peggy Willard-Ross (NV); Robert McLaughlin (NY); Rodney Beetch (OH); Shelly Ondiak and Joel Sander (OK); Constance Arnold (PA); Laura Klanian (VA); Christina Rouleau (VT); John Haworth and Jeanette Plitt (WA); Lori Carlson, Susan Ezalarab, John Kitslaar, Cari Lee, Darcy Paskey and Marcia Zimmer (WI); and Mark Hooker (WV).

1. Adopted the Report of the Standardized Data Request (D) Subgroup

Mr. Hamblen said the Standardized Data Request (D) Subgroup met via conference call Aug. 31 and July 13 in regulator-to-regulator session pursuant to paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance, including, but not limited to, annual and quarterly statement blanks and instructions, the *Accounting Practices and Procedures Manual* and similar materials) of the NAIC Policy Statement on Open Meetings. Mr. Hamblen said that during the calls, the Subgroup reviewed the Producer, Marketing and Sales, Commission and Complaint standardized data requests. Mr. Hamblen said that the Subgroup finalized the four standardized data requests for submission to the Working Group for exposure, review and comment. Mr. Hamblen said that the Subgroup is scheduled to meet in September to review and discuss updates to the life declinations and life replacements standardized data requests.

Mr. Hamblen made a motion, seconded by Mr. McLaughlin, to adopt the report of the Standardized Data Request (D) Subgroup (Attachment XXXX). The motion passed unanimously.

2. Reviewed and Discussed Draft New Producer, Marketing and Sales, Commission and Complaint Standardized Data Requests, Sept. 1 Drafts for Inclusion in the *Market Regulation Handbook* Reference Documents

Director Ramage said that the original standardized data request, titled the Producer, Commission and Complaint standardized data request, was broken out into its four subparts—the producer, marketing and sales, commission, and complaint standardized data requests. Updates that were made to the four standardized data requests were very extensive. Therefore, redlines are not shown in the document. Mr. Hamblen, chair of the Standardized Data Request (D) Subgroup, said that the Subgroup reviewed the standardized data requests, edited the “contents” and “uses” sections of each standardized data request, and assessed the use and validity of each field—choosing to revise, add or remove data elements as needed.

Mr. Hooker asked that the commission standardized data request be revised to include the data element “payee.” Director Ramage said that the comments due date on the standardized data requests is Oct. 17. Director Ramage asked the Working Group to review the four standardized data requests simultaneously, and requested that the Working Group adopt the standardized data requests this year so that they may proceed to the Market Regulation and Consumer Affairs (D) Committee meeting by the Fall National Meeting. Director Ramage stated that when the standardized data requests are subsequently adopted by the Executive (EX) Committee and Plenary, they will be included in the reference documents section of the *Market Regulation Handbook*.

3. Heard a Presentation on Process Review Methodology

Director Ramage said he had recently received a proposal from Don Koch (NorthStar Exams, LLC) for a *Market Regulation Handbook* chapter outlining process review methodology, and he asked Mr. Koch to provide a brief presentation to the Working Group regarding the subject.

Mr. Koch said that while conventional market conduct examination methodology is to look for and find violations of state statutes, rules and regulations, errors, and unfair treatment of consumers that have already occurred in the business practices of regulated entities (i.e., a retrospective approach), process review methodology involves a review of a regulated entity’s internal controls to identify causation of error (i.e., a prospective approach). Examiners using process review methodology: 1) review the regulated entity’s processes, procedures and controls that are in place; 2) interview upper management and the documentation and communication of processes/procedures to employees; and 3) review the regulated entity’s ongoing

auditing for compliance with its documented procedures. This type of review identifies areas where the risks of noncompliance (potential violations of state statutes, rules and regulations) are likely to occur. Using the process review methodology approach, an examiner's review of regulated entity internal controls and management can help identify where inadequate or perhaps no processes and controls are found, thereby increasing the potential, or risk, for regulated entity violation of applicable state statutes, rules and regulations.

Mr. Koch said that the chapter is drafted to look similar to other chapters of the *Market Regulation Handbook*; it is organized with an introductory section, followed by enabling statutes and review considerations, application and uses of process review methodology, requests for information, tests common to the structure of all processes, and tests specific to a particular process and evaluation of processes. Mr. Koch said although the chapter is a work in progress (not all sections are completed) the draft nevertheless provides the Working Group with a basic understanding of process review methodology.

Mr. Crandell said that the process review methodology approach would allow for risk-based review of a regulated entity's processes instead of conventional examination methodology, which is based on a transactional review of noncompliance and consumer harm that has already occurred. Mr. McLaughlin said that the risk-focused review of regulated entity processes could be helpful to pinpoint lack of regulated entity oversight.

Mr. Hooker said that the examination standards, review process and criteria in the *Market Regulation Handbook* are based upon enforcement and, by extension, violation of existing state statutes, rules and regulations. Mr. Hooker said that state statutes, rules and regulations typically do not address regulated entity processes. Mr. Hooker and Mr. Mealer asked how an examiner's determination that a violation that is likely to occur can be written up in a final examination report as a violation, associated with a relevant citation to relevant state statute, rules and regulations.

Director Ramege asked Petra Wallace (NAIC) to distribute the draft proposal for review at the Working Group's next scheduled conference call.

#### 4. Reviewed and Discussed Draft Health Reform Market Conduct Examination Standards – Network Adequacy, April 26 Draft for Inclusion in the *Market Regulation Handbook*

Director Ramege said that since the last Working Group conference call, numerous comments have been received regarding the April 26 draft of the health reform-related network adequacy examination standards. Director Ramege said that comments had been received from New York, Washington, the NAIC consumer representatives, America's Health Insurance Plans (AHIP) and Blue Cross and Blue Shield Association (BCBSA).

Mr. McLaughlin said that the New York comments added review criteria pertaining to sample testing of regulated entity provider directories, in relation to health care providers. David Korsh (BCBSA) presented the comments from the NAIC consumer representatives, AHIP and the BCBSA. Mr. Korsh said that the network adequacy exam standards revisions proposed by the consumer representatives, AHIP and the BCBSA were the product of several collaborative conference call sessions between the groups. Mr. Korsh said that the purpose of the revisions to the exam standards is to remove some of the language in the exam standards relative to drafting notes, while still aligning the exam standards with the *Health Benefit Plan Network Access and Adequacy Model Act* (#74) for those states that have adopted or have yet to adopt the model. Claire McAndrew (Families USA) said that the proposed revisions allow for flexibility, taking into account state statutes, rules and regulations, while recognizing federal oversight with regard to the issue of network adequacy provisions related to health reform.

Mr. Hooker said there are a number of redundancies in the draft exam standards with regard to examiner review of network access plans; a review of these plans is found in Standard 1, Standard 2 and Standard 3. Mr. Hooker asked whether each standard is a stand-alone standard. If each standard is not a stand-alone standard, Mr. Hooker suggested that the exam standards be revised to reduce the number of times that an examiner would need to review network access plans.

At Director Ramege's request, the Working Group determined that the Aug. 15 draft revisions of the NAIC consumer representatives, AHIP and the BCBSA will be used going forward as the basis for revised network adequacy exam standards, and to include New York's Sept. 9 comments and Washington's Sept. 14 comments. Director Ramege asked that Ms. Wallace incorporate all revisions into a revised draft document for discussion at the Working Group's next scheduled conference call. Director Ramege requested that the Working Group adopt the network adequacy exam standards this year so that they may proceed to the Market Regulation and Consumer Affairs (D) Committee meeting at the Fall National Meeting.

#### 5. Discussed Referral from the Cybersecurity (EX) Task Force

Director Ramege said that since the Working Group's last meeting on July 7, the Working Group received a referral from the Cybersecurity (EX) Task Force. Commissioner Adam Hamm (ND), Task Force chair, has requested that the Working Group review and consider updating the *Market Regulation Handbook* to add market conduct examination-related guidance addressing cybersecurity, particularly in Chapter 16, which discusses general examination standards. Recognizing the need for a uniform approach, the Cybersecurity (EX) Task Force suggests that the Working Group use the updates regarding cybersecurity in the *Financial Condition Examiners Handbook* as a basis for updates to the *Market Regulation Handbook*.

Director Ramege said that prior to making redlined draft exposure documents, the Working Group should begin this project by creating a draft outline so that the Working Group may strategize the scope of the cybersecurity-related revisions to the *Market Regulation Handbook*. In addition, Director Ramege and NAIC staff will be communicating with the chair of the IT Examination (E) Working Group—the Working Group that updates the *Financial Condition Examiners Handbook*—so that the Working Group may align its revisions with the IT Examination (E) Working Group's updates, yet not duplicate its efforts.

6. Discussed Proposed *Market Regulation Handbook* Revisions Received from the Market Information Systems Research and Development (D) Working Group

Director Ramege said that since the Working Group's last meeting on July 7, it received a referral from the Market Information Systems Research and Development (D) Working Group. The Working Group recently reviewed the *Market Regulation Handbook* and identified specific areas within the handbook for potential revision. System-related and non-technical changes were suggested. A document outlining the changes will be distributed for review and discussion at the next scheduled Working Group conference call.

7. Discussed Other Matters

Director Ramege said that a new chapter has been drafted for the Working Group's review and discussion for inclusion in the *Market Regulation Handbook*. The chapter will provide guidance for state insurance regulators regarding closing continuum actions. Mr. Mealer asked for volunteers to provide a final review of the chapter, prior to circulation to the Working Group. Ms. Plitt volunteered to review the chapter and provide Mr. Mealer with feedback. Mr. Mealer asked that any other regulators wishing to review the chapter contact Ms. Wallace.

Director Ramege said NAIC staff will provide advance email notice of the next scheduled conference call.

Having no further business, the Market Conduct Examination Standards (D) Working Group adjourned.

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*Conference Calls*

**STANDARDIZED DATA REQUEST (D) SUBGROUP  
September 21, 2016 / October 12, 2016**

**Summary Report**

The Standardized Data Request (D) Subgroup met Oct. 12 and Sept. 21, 2016. The meetings were held in regulator-to-regulator session pursuant to paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings. During these meetings, the Subgroup:

1. Discussed updates to the life replacements standardized data request (SDR).
2. Discussed and began making updates to Chapter 13-Standardized Data Requests of the *Market Regulation Handbook*, to correspond with changes made by the Subgroup to the SDRs.
3. Agreed to meet in November via conference call to conclude its review of the life replacements SDR and begin its initial review of the life declinations, life claims and life in force SDRs.

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**PROVISION TITLE:** Network Adequacy Standards

**CITATION:** PHSA §2702 (c) & 45 CFR §156.230

**EFFECTIVE DATE:** Plan years and, in the individual market, policy years beginning on or after Jan. 1, 2014

**PROVISION:** The NAIC established network adequacy standards as set forth in revised Model law Health Benefit Plan Network Access and Adequacy Model Act (#74) for the creation and maintenance of networks by health carriers and to assure the adequacy, accessibility, transparency and quality of health care services offered under a network plan. In addition, provisions of the federal Patient Protection and Affordable Care Act (Affordable Care Act or ACA) established a requirement that a health carrier offering qualified health insurance coverage plans in the individual or group markets in a state must meet minimum criteria for the adequacy of provider networks delivering covered services to covered persons.

**BACKGROUND:** In November 2015, the NAIC adopted a substantially revised network adequacy model, the Health Benefit Plan Network Access and Adequacy Model Act (#74). The NAIC established standards for the creation and maintenance of networks by health carriers and assures the adequacy, accessibility, transparency and quality of health care services offered under a network plan. Based upon the Affordable Care Act, federal regulatory agencies, including the Regulations and associated FAQs, issued by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury) have issued regulations and associated regulatory guidance, including frequently asked questions (FAQs) that set forth minimum criteria for network adequacy that health carriers' network plans must meet in order to be certified as Qualified Health Plans (QHP's) and stand-alone dental plans (SADPs).

~~The purpose of the network adequacy provisions of the federal Affordable Care Act is to assure the adequacy, accessibility, transparency and quality of health care services provided to covered individuals in individual and group market health insurance network plans. Pursuant to 45 C.F.R. §156.230(a)(2), a health carrier which issues a QHP or SADP that uses a provider network must "maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to assure that all services will be accessible to enrollees without unreasonable delay." All health carriers applying for QHP certification need to attest that they meet this standard as part of the certification/recertification process.~~

Note: This provision applies State regulators need to determine whether these examination standards are to apply to all health carriers in the individual market and to group plans. This provision applies to, including non-grandfathered group health plans, or to only a subset of health insurance markets and policies, in accordance with state statute and regulations.

**FAQs:** See the HHS website for federal guidance.

**NOTES:** Examiners should obtain specific direction from the insurance commissioner ordering the examination as to whether there are provisions for which examiners are to apply federal statutes and regulations in addition to, or in place of, state statutes and regulations when applying these examination standards. Examiners should familiarize themselves with specific state and federal statutes and regulations as they pertain to network adequacy. States have considerable flexibility in determining how they want to address network adequacy issues, and the federal regulatory agencies have traditionally deferred to that inherent state authority. States may therefore require examiners to refer to specific state and federal law and regulations instead of the language found in NAIC Model #74-the *Health Benefit Plan Network Access and Adequacy Model Act (#74)*.

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## STANDARDS NETWORK ADEQUACY

**Standard 12 (*Editor Note: Standard 2 in the April 26, 2016 draft is now Standard 1*)**

**A health carrier offering individual and group market health insurance network plans shall develop and file an access plan with the insurance commissioner in accordance with requirements regarding content and filing of network access plans set forth in applicable state statutes, rules and regulations.**

**Apply to:** Those individual and group health products and related provider networks as set forth in the state's statutes and regulations. For state examinations, in the absence of state statutes and regulations addressing Affordable Care Act provisions, to all Qualified Health Plan products that use a provider network~~All individual and group health products (non-grandfathered products) for policy years and plan years beginning on or after Jan. 1, 2014~~

~~This standard does not apply to grandfathered health plans in accordance with §147.140~~

~~This standard does not apply to transitional plans~~

**Priority:** Essential

### Documents to be Reviewed

State [and federal] statutes and regulations and exchange requirements, addressing filing and approval of network adequacy or access plans

Approved network access plan(s)

Health carrier policies and procedures related to the implementation of access plans

~~Health carrier policies and procedures related to content of access plans~~

~~Health carrier policies and procedures related to filing of access plans and material changes to access plans~~

Policies and/or incentives that restrict, or unduly burden an enrollee's access to network providers, including provider specialists

~~Copy of access plan filed in the applicable state and copy of access plan in use by health carrier~~

~~Health carrier communication and educational materials related to access plans provided to applicants, enrollees, policyholders, certificate—holders and beneficiaries, including communications with producers~~

~~Health carrier employees' and appointed agent Ttraining materials~~

State exchange filing requirements

~~\_\_\_\_\_ Producer records~~

~~\_\_\_\_\_ Applicable state statutes, rules and regulations~~

~~Others Reviewed~~

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## NAIC References

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

## Other References

~~\_\_\_\_\_ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials~~  
~~Federal regulations, including FAQs and other regulatory guidance~~

## Review Procedures and Criteria

~~Verify that the health carrier has established and implemented written policies and procedures regarding the health carrier's filing of access plans at the time it files a newly offered provider network, with the insurance commissioner of the applicable state, for individual and group market health insurance health benefit network plans, in accordance with final regulations established by HHS, the DOL and the Treasury.~~

~~Verify that a health carrier has filed a network access plan in a compliant manner and form and obtained all necessary approvals from the appropriate state regulators prior to or at the same time it files a newly offered network.~~

~~Verify that the health carriers' network(s) comply(ies) with approved access plan(s). This verification can be performed by directly confirming active provider participation, "secret shopping," reviewing regulatory or health carrier customer service inquiries and/or complaints, surveying policyholders and enrollees, or by other tools generally employed or otherwise utilized by examiners to verify a health carrier's compliance with filings.~~

~~Verify that the health carrier makes access plans, absent [proprietary, competitive or trade secret] information, available online, at its business premises, and to any person upon request.~~

~~Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.~~

~~Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek legal advice and assistance from the state insurance department.~~

~~Verify that a health carrier files with the insurance commissioner of the applicable state for review (or for approval) prior to or at the time it files a newly offered network, in a manner and form defined by rule of the insurance commissioner, an access plan meeting the requirements of applicable state statutes, rules and regulations regarding network adequacy.~~

~~Note: Examiners need to be aware that requirements for access plans will vary by state. A state may require that a health carrier file access plans with the insurance commissioner of the applicable state for approval before use, or a state may require a health carrier to file access plans with the insurance commissioner for review, but permit the health carrier to use the access plan while it is subject to review. In addition, a health carrier may request an insurance commissioner to deem sections of an access plan as [proprietary, competitive or trade secret] information that shall not be made public. Verify that the health carrier makes access plans, absent [proprietary, competitive or trade secret] information, available online, at its business premises, and to any person upon request. Information is considered [proprietary or competitive or a trade secret] if revealing the information would cause the health carrier's competitors to obtain valuable business information. Applicable state statutes, rules and regulations should be reviewed to determine which term "proprietary," "competitive" or "trade secret" is being used in the applicable state.~~

~~Verify that when a health carrier prepares an access plan prior to offering a new network plan, the health carrier notifies the insurance commissioner of the applicable state of any material change to any existing network plan within fifteen (15) business days after the change occurs. Verify that the notice to the insurance commissioner provided by the health carrier includes a reasonable timeframe within which the health carrier will submit to the insurance commissioner, for approval or file with the insurance commissioner, as appropriate, an update to an existing access plan.~~

~~Note: Examiners need to be aware that the definition of "material change" will vary by state. For example, a "material change" may be a certain percentage change, as determined by a state, in the health carrier's network of providers or type of providers available in the network to provide health care services or specialty health care services to covered persons or it may be any change that renders the health carrier's network noncompliant with one or more network adequacy standards.~~

~~Verify that the health carrier's access plan describes or contains at least the following:~~

- ~~• The health carrier's network, including how the use of telemedicine or telehealth or other technology may be used to meet network access standards, if applicable;~~
- ~~• The health carrier's procedures for making and authorizing referrals within and outside its network, if applicable;~~
- ~~• The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in network plans;~~
- ~~• The factors used by the health carrier to build its provider network, including a description of the network and the criteria used to select [and/or tier] providers;~~
- ~~• The health carrier's efforts to address the needs of covered persons, including, but not limited to children and adults, including those with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, physical or mental disabilities, and serious, chronic or complex medical conditions. This includes the carrier's efforts, when appropriate, to include various types of essential community providers (ECPs) in its network;~~
- ~~• The health carrier's 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 covered services and features, including but not limited to:~~
  - ~~The plan's grievance and appeals procedures;~~
  - ~~Its process for choosing and changing providers;~~
  - ~~Its process for updating its provider directories for each of its network plans;~~
  - ~~A statement of health care services offered, including those services offered through the preventive care benefit, if applicable; and~~
  - ~~Its procedures for covering and approving emergency, urgent and specialty care, if applicable (Note: Examiners need to be aware that a state may have an existing definition of "urgent" care in applicable state statutes, laws and regulations.)~~
- ~~The health carrier's system for ensuring the coordination and continuity of care in situations where the health carrier, or its intermediary due to insolvency or other cessation of operations, and when a participating provider is being removed or leaving the network with or without cause:~~
  - ~~For covered persons referred to specialty physicians; and~~
  - ~~For covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;~~
- ~~The health carrier's process for enabling covered persons to change primary care professionals, if applicable;~~
- ~~The health carrier's 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 transitioned to other providers in a timely manner;~~
- ~~The health carrier's process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, hospitalist care and pathology/laboratory services at the health carrier's participating hospitals. (Note: Examiners need to be aware that if a limited-scope dental and/or vision uses hospitals and/or other type of facility in its provider network, then the limited-scope dental and/or vision plan shall comply with applicable state statutes, rules and regulations regarding network adequacy pertaining to hospitals and/or other type of facility); and~~
- ~~Any other information required by the insurance commissioner of the applicable state to determine compliance with applicable state statutes, rules and regulations regarding network adequacy.~~

~~Note: Examiners need to be aware that for dental network plans, some states may not require the preparation and submission of a so-called "access plan" for purposes of determining the sufficiency of a dental provider network. These states may require other documentation to be included in the form filings to accomplish this purpose in order to review and determine the sufficiency of a dental and/or vision provider network. Examiners, however, need to be aware that dental carriers seeking certification to offer limited-scope dental plans on a health insurance exchange or exchange use the term "access plan."~~

#### General Review Procedures and Criteria

~~Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about network access plans.~~

~~Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, the DOL and the Treasury provisions and final regulations pertaining to network access plans.~~

~~Review health carrier training materials to verify that information provided therein is complete and accurate with regard to network access plans.~~

~~Review producer records and health carrier communication with producers to verify that information provided by producers to applicants/proposed insureds is complete and accurate with regard to network access plans.~~

~~Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.~~

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## STANDARDS NETWORK ADEQUACY

**Standard ~~21~~ (*Editor Note: Standard 1 in the April 26, 2016 draft is now Standard 2*)**

A health carrier offering individual and group market health insurance network plans shall maintain a network that is sufficient in number and types of providers, including those that serve predominantly low-income, medically underserved individuals, to assure that all covered services to covered persons will be accessible, without unreasonable travel or delay and that emergency services are accessible 24 hours per day, 7 days per week.

**Apply to:** ~~All Those~~ individual and group health products (~~non-grandfathered products~~) for policy years and plan years beginning on or after Jan. 1, 2014 and related provider networks as set forth in the state's statutes and regulations. For state examinations being conducted in the absence of state statutes and regulations addressing Affordable Care Act provisions, to all Qualified Health Products that use a provider network

~~This standard does not apply to grandfathered health plans in accordance with §147.140~~

~~This standard does not apply to transitional plans~~

**Priority:** Essential

### Documents to be Reviewed

~~\_\_\_\_\_ State [and federal] statutes and regulations addressing network adequacy and plan design~~

~~\_\_\_\_\_ Approved health carrier network access plan~~

\_\_\_\_\_ Health carrier policies and procedures related to implementing and maintaining network adequacy and ~~plan design~~access plans

~~\_\_\_\_\_ Health carrier correspondence with state regulators addressing issues related to maintaining network adequacy~~

~~\_\_\_\_\_ Health carrier policies and procedures related to filings for material changes to access plans~~

\_\_\_\_\_ Provider selection [tiering] criteria and supporting documentation regarding selection [tiering] criteria for maintaining network adequacy and access plans

\_\_\_\_\_ Documents related to ~~physician~~ recruitment and selection of providers, including following approval of network access plan

\_\_\_\_\_ Provider directory/listings

~~\_\_\_\_\_ Health carrier policy/plan design 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

~~\_\_\_\_\_ Electronic tools used to assess the health carrier's network adequacy (e.g. GeoAccess®)~~

~~\_\_\_\_\_ Complaint register/logs/files regarding inadequate networks and out of network service denials~~

\_\_\_\_\_ Health carrier complaint records concerning network adequacy, ~~and~~ plan design and out of network service denials (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

\_\_\_\_\_ Health carrier marketing and sales policies and ~~procedures' references~~ procedures that reference to network adequacy and plan design

\_\_\_\_\_ Health carrier ~~communication-marketing~~ and educational materials related to network adequacy and plan design ~~provided to applicants, enrollees, policyholders, certificate holders and created for insureds, beneficiaries, and prospective purchasers~~ including communications with producers

\_\_\_\_\_ Health carrier employee Ttraining materials related to network adequacy maintenance activities

~~\_\_\_\_\_ Producer records~~

~~\_\_\_\_\_ Applicable state statutes, rules and regulations~~

**Others Reviewed**

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### NAIC References

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

### Other References

~~\_\_\_\_\_ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials~~ Federal regulations, including FAQs and other regulatory guidance

### Review Procedures and Criteria

Verify the health carrier has maintained its provider network(s) in accordance with terms of the approved network access plan(s) and state [and federal] statutes and regulations, as applicable.

Verify the health carrier has implemented the administrative functions necessary to meet the size and performance requirements of its provider network(s), including any reasonable criteria in accordance with its approved access plan and state [and federal] statutes and regulations, as applicable.

Verify that the health carrier has established and implemented written policies and procedures regarding network adequacy and plan design/filings of individual and group market health insurance health benefit network/amended access plans, in accordance with final regulations established by HHS, the DOL and the Treasury when necessitated by materials in its provider networks.

Verify as required by the approved access plan, and by state [and federal] statutes and regulations, that the health carrier's established network(s) address(es) at least the following:

- The use of telemedicine or telehealth or other technology to meet network access standards, if applicable; procedures for making and authorizing referrals within and outside its network, if applicable; factors used by the health carrier to build its provider network, including a description of the network and the criteria used to select [and/or tier] providers;
- The health carrier's efforts to address the needs of covered persons, including, but not limited to children and adults, including those with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, physical or mental disabilities, and serious, chronic or complex medical conditions. This includes the carrier's efforts, when appropriate, to include various types of essential community providers (ECPs) in its network;
- The health carrier's system for ensuring the coordination and continuity of care in situations where the health carrier, or its intermediary, due to insolvency or other cessation of operations, and when a participating provider is being removed or leaving the network with or without cause:
  - For covered persons referred to specialty physicians; and
  - For covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;
- The health carrier's process for enabling covered persons to change primary care professionals, if applicable;
- The health carrier's process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, hospitalist care and pathology/laboratory services at the health carrier's participating hospitals.

Verify the health carrier monitors the performance of its provider network(s) in accordance with its approved access plan and state statutes and regulations, as applicable, and records such activities.

Verify the health carrier has implemented necessary provider network changes, including but not limited to contracting with additional or replacement providers for its provider network(s) required to maintain its provider network(s), as established within its approved access plan(s) and as required under applicable state [and federal] statutes and regulations.

Verify that the health carrier has notified the state insurance department [or other state regulator] of material changes to its access plan.

Verify the health carrier has received any required approvals necessitated by changes to the health carrier's provider network(s) or enrollment.

Verify the health carrier has implemented any requirements established by the state insurance department required by any changes to the access plan or the health carrier's enrolled policyholder and enrolled life membership counts, including any insured, beneficiary, prospective purchaser, or provider notice, education or other communication(s).

Review health carrier policies and procedures related to network adequacy and plan design to verify that the health carrier maintains a network that is sufficient in number and appropriate types of providers, including providers who serve predominantly low-income, medically underserved individuals, to assure that all covered services to covered persons, including children and adults will be accessible without unreasonable travel or delay, and that emergency services are accessible 24 hours per day, 7 hours per week, in compliance with final regulations established by HHS, the DOL and the Treasury state [and federal] statutes and regulations.

~~Note: Examiners need to give particular attention to network sufficiency, marketing and disclosure in certain health carrier network plan designs, such as tiered, multi tiered, layered or multi level network plans, which include different access to benefits and cost sharing based on a covered person's choice of provider. Examiners need to carefully review health carrier network filings to ensure that the network plan design is not potentially discriminatory for children and adults with serious, chronic or complex health conditions and that carriers will disclose information in a clear and conspicuous manner so that the covered person can understand the use of the tiered, multi-tiered, layered or multi level network plan to access the benefits offered within the health benefit plan.~~

~~A state insurance commissioner determines network sufficiency in accordance with applicable state statutes, rules and regulations Note: With regard to conflict of network adequacy provisions in state statutes, rules and regulations with final guidance on network adequacy set forth by HHS, the DOL and the Treasury, examiners may need to consult with state insurance department legal staff, regarding whether state provisions add to or create a more generous benefit than the network adequacy health reform requirements in final regulations established by HHS, the DOL and the Treasury, and are thus not preempted, as set forth in federal law.~~

Verify that the health carrier has established and implemented a process, including written policies and procedures, to assure that a covered person obtains a covered benefit at an in-network level of benefits, including an in-network level of cost-sharing, from a non-participating provider, or shall make other arrangements acceptable to the insurance commissioner ~~of the applicable state, when~~ as required under state statutes and regulations:

- ~~• The health carrier has a sufficient network, but does not have a type of participating provider available to provide the covered benefit to the covered person or it does not have a participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay; or~~
- ~~• The health carrier has an insufficient number or insufficient type of participating provider (e.g. specialists) available to provide the covered benefit to the covered person without unreasonable travel or delay.~~

Verify that the health carrier specifies and informs covered persons of the process a covered person may use to request access to obtain a covered benefit from a non-participating provider ~~when; and that such requests are documented, processed in a timely fashion and, for approved requests, that cost-sharing and out-of-pocket maximums are accurately applied, as required under state statutes and regulations.~~

- ~~• The covered person is diagnosed with a condition or disease that requires specialized health care services or medical services; and~~
  - ~~• The health carrier:~~
    - ~~• Does not have a participating provider of the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease;~~
- ~~or~~

- ~~• Cannot provide reasonable access to a participating provider with the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable travel or delay.~~

~~Verify that with regard to the process in which a covered person may use to request access to obtain a covered benefit from a non-participating provider, the health carrier addresses requests to obtain a covered benefit from a non-participating provider in a timely fashion appropriate to the covered person's condition. In order to determine what may be considered "in a timely fashion," examiners may wish to review the timeframes and notification requirements in applicable state statutes, rules and regulations regarding utilization review.~~

~~Verify that the health carrier treats the health care services the covered person receives from a non-participating provider as if the services were provided by a participating provider, including counting the covered person's cost sharing for such services toward the maximum out-of-pocket limit applicable to services obtained from participating providers under the health benefit plan.~~

Verify that the health carrier has a system in place that documents all requests to obtain a covered benefit from a non-participating provider and verify that the health carrier provides this information to the insurance commissioner of the applicable state upon request as required under state statutes and regulations.

~~Note: Examiners need to be aware that the process which a covered person uses to request access to obtain a covered benefit from a non-participating provider is not intended to be used by health carriers as a substitute for establishing and maintaining a sufficient provider network in accordance with applicable state statutes, rules and regulations, nor is it intended to be used by covered persons to circumvent the use of covered benefits available through a health carrier's network delivery system options. A covered person is not precluded from exercising the rights and remedies available under applicable state or federal law relating to internal and external claims grievance and appeals processes.~~

~~Verify that the health carrier establishes and maintains adequate arrangements to ensure covered persons have reasonable access to participating providers located near their home or business address. In determining whether the health carrier has complied with this provision, the insurance commissioner of the applicable state may give due consideration to the relative availability of health care providers with the requisite expertise and training in the service area under consideration.~~

Verify that that the health carrier monitors, on an ongoing basis, the ability, clinical capacity and legal authority of its participating providers to furnish all contractual covered benefits to covered persons.

#### General Review Procedures and Criteria

~~Review complaint register/logs and complaint files to identify complaints pertaining to network adequacy and plan design.~~

Review complaint records to ~~verify that~~ determine if the health carrier has not met minimum network adequacy standards contained within its access plan or required under applicable state [or federal] statutes and regulations or has improperly applied network adequacy standards; and whether the health carrier has taken appropriate corrective action/adjustments ~~regarding the removal of network adequacy limitations~~ for the covered person(s) in a timely and accurate manner.

Ascertain if ~~the health carrier error~~an **y** examination adverse determination finding could ~~have been~~**be** the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier **has** implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence supporting corrective action provided to a covered person, including website notifications, as applicable.

Verify that ~~any health carrier communication and educational and~~ marketing materials provided to insureds, beneficiaries and prospective purchasers ~~by the health carrier~~ provide complete and accurate information about network adequacy.

~~Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about network adequacy.~~

Verify that the health carrier has established training programs designed to inform its employees and ~~producers agents~~ about ~~HHS, the DOL and the Treasury provisions applicable state [and federal] laws and final regulations pertaining to network adequacy.~~

Review health carrier employee training materials to verify that information provided **therein** is complete and accurate with regard to network adequacy.

Review producer records and health carrier communication with producers to verify that information provided by producers to applicants/proposed insureds is complete and accurate with regard to network adequacy.

~~Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.~~

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek legal advice and assistance from the state insurance department.

**STANDARDS**  
**NETWORK ADEQUACY**

**Standard 2**

~~A health carrier offering individual and group market health insurance network plans shall develop and file an access plan with the insurance commissioner in accordance with requirements regarding content and filing of network access plans set forth in applicable state statutes, rules and regulations.~~

~~Apply to: All individual and group health products (non-grandfathered products) for policy years and plan years beginning on or after Jan. 1, 2014~~

~~This standard does not apply to grandfathered health plans in accordance with §147.140~~

~~This standard does not apply to transitional plans~~

~~Priority: Essential~~

**Documents to be Reviewed**

~~Health carrier policies and procedures related to content of access plans~~

~~Health carrier policies and procedures related to filing of access plans and material changes to access plans~~

~~Copy of access plan filed in the applicable state and copy of access plan in use by health carrier~~

~~Health carrier communication and educational materials related to access plans provided to applicants, enrollees, policyholders, certificate holders and beneficiaries, including communications with producers~~

~~Training materials~~

~~Producer records~~

~~Applicable state statutes, rules and regulations~~

**Others Reviewed**

~~\_\_\_\_\_~~  
~~\_\_\_\_\_~~

**NAIC References**

~~Health Benefit Plan Network Access and Adequacy Model Act (#74)~~

## ~~Other References~~

~~===== HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials~~

## ~~Review Procedures and Criteria~~

~~Verify that the health carrier has established and implemented written policies and procedures regarding the health carrier's filing of access plans at the time it files a newly offered provider network, with the insurance commissioner of the applicable state, for individual and group market health insurance health benefit network plans, in accordance with final regulations established by HHS, the DOL and the Treasury.~~

~~Verify that a health carrier files with the insurance commissioner of the applicable state for review (or for approval) prior to or at the time it files a newly offered network, in a manner and form defined by rule of the insurance commissioner, an access plan meeting the requirements of applicable state statutes, rules and regulations regarding network adequacy.~~

~~Note: Examiners need to be aware that requirements for access plans will vary by state. A state may require that a health carrier file access plans with the insurance commissioner of the applicable state for approval before use, or a state may require a health carrier to file access plans with the insurance commissioner for review, but permit the health carrier to use the access plan while it is subject to review. In addition, a health carrier may request an insurance commissioner to deem sections of an access plan as [proprietary, competitive or trade secret] information that shall not be made public. Verify that the health carrier makes access plans, absent [proprietary, competitive or trade secret] information, available online, at its business premises, and to any person upon request. Information is considered [proprietary or competitive or a trade secret] if revealing the information would cause the health carrier's competitors to obtain valuable business information. Applicable state statutes, rules and regulations should be reviewed to determine which term "proprietary," "competitive" or "trade secret" is being used in the applicable state.~~

~~Verify that when a health carrier prepares an access plan prior to offering a new network plan, the health carrier notifies the insurance commissioner of the applicable state of any material change to any existing network plan within fifteen (15) business days after the change occurs. Verify that the notice to the insurance commissioner provided by the health carrier includes a reasonable timeframe within which the health carrier will submit to the insurance commissioner, for approval or file with the insurance commissioner, as appropriate, an update to an existing access plan.~~

~~Note: Examiners need to be aware that the definition of "material change" will vary by state. For example, a "material change" may be a certain percentage change, as determined by a state, in the health carrier's network of providers or type of providers available in the network to provide health care services or specialty health care services to covered persons or it may be any change that renders the health carrier's network noncompliant with one or more network adequacy standards.~~

~~Verify that the health carrier's access plan describes or contains at least the following:~~

- ~~• The health carrier's network, including how the use of telemedicine or telehealth or other technology may be used to meet network access standards, if applicable;~~
- ~~• The health carrier's procedures for making and authorizing referrals within and outside its network, if applicable;~~

- ~~The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in network plans;~~
- ~~The factors used by the health carrier to build its provider network, including a description of the network and the criteria used to select [and/or tier] providers;~~
- ~~The health carrier's efforts to address the needs of covered persons, including, but not limited to children and adults, including those with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, physical or mental disabilities, and serious, chronic or complex medical conditions. This includes the carrier's efforts, when appropriate, to include various types of essential community providers (ECPs) in its network;~~
- ~~The health carrier's 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 covered services and features, including but not limited to:~~
  - ~~The plan's grievance and appeals procedures;~~
  - ~~Its process for choosing and changing providers;~~
  - ~~Its process for updating its provider directories for each of its network plans;~~
  - ~~A statement of health care services offered, including those services offered through the preventive care benefit, if applicable; and~~
  - ~~Its procedures for covering and approving emergency, urgent and specialty care, if applicable (Note: Examiners need to be aware that a state may have an existing definition of "urgent" care in applicable state statutes, laws and regulations.)~~
- ~~The health carrier's system for ensuring the coordination and continuity of care in situations where the health carrier, or its intermediary due to insolvency or other cessation of operations, and when a participating provider is being removed or leaving the network with or without cause:~~
  - ~~For covered persons referred to specialty physicians; and~~
  - ~~For covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;~~
- ~~The health carrier's process for enabling covered persons to change primary care professionals, if applicable;~~
- ~~The health carrier's 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 transitioned to other providers in a timely manner;~~
- ~~The health carrier's process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, hospitalist care and pathology/laboratory services at the health carrier's participating hospitals. (Note: Examiners need to be aware that if a limited-scope dental and/or vision uses hospitals and/or other type of facility in its provider network, then the limited-scope dental and/or vision plan shall comply with applicable state statutes, rules and regulations regarding network adequacy pertaining to hospitals and/or other type of facility); and~~
- ~~Any other information required by the insurance commissioner of the applicable state to determine compliance with applicable state statutes, rules and regulations regarding network adequacy.~~

~~Note: Examiners need to be aware that for dental network plans, some states may not require the preparation and submission of a so-called “access plan” for purposes of determining the sufficiency of a dental provider network. These states may require other documentation to be included in the form filings to accomplish this purpose in order to review and determine the sufficiency of a dental and/or vision provider network. Examiners, however, need to be aware that dental carriers seeking certification to offer limited scope dental plans on a health insurance exchange or exchange use the term “access plan.”~~

~~General Review Procedures and Criteria~~

~~Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about network access plans.~~

~~Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, the DOL and the Treasury provisions and final regulations pertaining to network access plans.~~

~~Review health carrier training materials to verify that information provided therein is complete and accurate with regard to network access plans.~~

~~Review producer records and health carrier communication with producers to verify that information provided by producers to applicants/proposed insureds is complete and accurate with regard to network access plans.~~

~~Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.~~

## STANDARDS NETWORK ADEQUACY

### Standard 3

A health carrier's contractual arrangements with participating providers shall comply with requirements regarding health carrier/participating provider contractual requirements set forth in applicable state statutes, ~~rules~~ and regulations.

**Apply to:** ~~Those individual and group health products and related provider networks as set forth in the state's statutes and regulations. For state examinations being conducted in the absence of state statutes and regulations addressing Affordable Care Act provisions, to Qualified Health Plan products that use a provider network. All individual and group health products (non-grandfathered products) for policy years and plan years beginning on or after Jan. 1, 2014.~~

~~This standard does not apply to grandfathered health plans in accordance with §147.140~~

~~This standard does not apply to transitional plans~~

**Priority:** Essential

#### Documents to be Reviewed

~~State [and federal] statutes and regulations addressing network adequacy and plan design~~

~~Approved health carrier network access plan(s)~~

~~Health carrier policies and procedures related to applicable contractual arrangements between health carriers and participating providers~~

~~Health carrier/Provider contracts with providers~~

~~Network plans~~

~~Complaint register/logs/files/Health carrier complaint records relating to administrative, payment or other complaints/ or other disputes made by participating providers, policyholders or enrollees relating to health carrier/participating network provider contractual arrangements/matters~~

~~Health carrier complaint records concerning health carrier/participating provider contractual arrangements (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response/resolution)~~

~~Health carrier communication, education and educational training materials related to health carrier/participating provider contractual arrangements provided to participating providers~~

~~Health carrier employee and agent training materials related to network provider contractual matters~~

~~Applicable state statutes, rules and regulations~~

Others Reviewed

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## NAIC References

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

## Other References

~~HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials~~  
Federal regulations, including FAQs and other regulatory guidance

## Review Procedures and Criteria

Verify that the health carrier's network provider contracts comply with state [and federal] statutes and regulations and with approved network access plan(s).

Review how the health carrier markets or represents its network plans to consumers, particularly for those health carriers that market or represent to consumers as using quality as at least one method of assessing whether to include providers in the network. In addition, for such network plans, review the health carrier's provider selection standards to verify that quality is actually being used to assess whether to include providers in the network.

Verify that the health carrier has established and implemented written policies and procedures regarding compliance ~~of individual and group market health insurance~~ health benefit network plans with state [and federal] requirements relating to health carrier/participating provider contractual arrangements, in accordance with final regulations established by HHS, the DOL and the Treasury. Review records related to the written policies and procedures for any instances, indicating health carrier performance, that did not comply with such policies and procedures.

Verify that the health carrier has established a ~~mechanism-process~~ by which ~~a participating provider~~contracting network providers will be notified ~~on an ongoing basis~~ of the specific covered health care services for which the provider will be responsible, including any limitations or conditions on services, on an ongoing basis. Review process records to confirm that the health carrier in fact provides such notifications in a timely manner.

Verify that contracts between a health carrier and a participating provider set forth a hold harmless provision specifying protection for covered persons in the event of nonpayment or insolvency of the health carrier or its intermediary, as required under state statutes or regulations. ~~This requirement can be met by including a provision within the contract, substantially similar to the following:~~

~~"Provider agrees that in no event, including but not limited to nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation,~~

~~remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health carrier or intermediary) acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons. Nor does this agreement prohibit a provider (except for a health care professional who is employed full-time on the staff of a health carrier and has agreed to provide services exclusively to that health carrier's covered persons and no others) and a covered person from agreeing to continue services solely at the expense of the covered person, as long as the provider has clearly informed the covered person that the health carrier may not cover or continue to cover a specific service or services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy."~~

Verify that contracts between the health carrier and a participating provider set forth that in the event of a health carrier or intermediary insolvency or other cessation of operations, the provider's obligation to deliver covered services to covered persons without balance billing will continue until the earlier of as required under state statutes or regulations.:

- ~~• The termination of the covered person's coverage under the network plan, including any extension of coverage provided under the contract terms or applicable state or federal law for covered persons who are in an active course of treatment or totally disabled. (Note: Examiners need to be aware that the reference to termination may encompass all the circumstances in which a covered person's coverage can be terminated, e.g. nonpayment of premium, fraud or intentional misrepresentation of material fact in connection with the coverage); or~~
- ~~• The date the contract between the health carrier and the provider, including any required extension for covered persons in an active course of treatment, would have terminated if the health carrier or an intermediary had remained in operation.~~

~~Note: Examiners need to be aware that contractual arrangements between health carriers and providers that satisfy the above requirements (1) are to be construed in favor of the covered person, (2) shall survive the termination of the contract regardless of the reason for termination, including the insolvency of the health carrier, and (3) shall supersede any oral or written contrary agreement between a provider and a covered person or the representative of a covered person if the contrary agreement is inconsistent with the hold harmless and continuation of covered services provisions as set forth in the above standards relating to health carrier/provider contractual requirements. The hold harmless obligation does not apply to services rendered after the termination of the provider contract, except in the event that a network relationship is extended to provide continuity of care.~~

Verify that the participating provider does not collect or attempt to collect from a covered person any money owed to the provider by the health carrier. Review the contract provisions within the health carrier/participating provider contract with regard to periodic reconciliation/audit of itemized bills related to claims to health carrier reimbursement amounts. Review explanation of benefits (EOB) documents to verify that the provider is collecting the appropriate amount from the covered person.

Verify that the health carrier has developed, for providers and each health care professional specialty, selection standards for selecting [and tiering], as applicable, of participating providers, as required under the health carrier's approved access plan and in accordance with state statutes and regulations. Verify that the health carrier uses the selection standards in determining the selection [and tiering] of participating providers by the health carrier and its intermediaries with which it contracts. ~~Verify that the~~

~~selection standards meet the requirements of applicable state statutes, rules and regulations equivalent to the Health Care Professional Credentialing Verification Model Act.~~

Verify that the health carrier does not establish selection [and tiering] criteria in a manner:

- That would allow a health carrier to discriminate against high-risk populations by excluding [and tiering] providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health care services utilization; or
- That would exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health care services utilization.

Verify that the health carrier's selection criteria ~~does~~ not discriminate, with respect to participation under the health benefit plan, against any provider who is acting within the scope of the provider's license or certification under applicable state law or regulations. ~~Note: Examiners need to be aware that a health carrier is not prohibited from declining to select a provider who fails to meet other legitimate selection criteria of the health carrier. The provisions of applicable state statutes, rules and regulations regarding network adequacy do not require a health carrier, its intermediaries or the provider networks with which they contract (1) to employ specific providers acting within the scope of their license or certification under applicable state law that may meet their selection criteria, or (2) to contract with or retain more providers acting within the scope of their license or certification under applicable state law than are necessary to maintain a sufficient provider network.~~

Verify that consistent with state statutes and regulations, the health carrier makes its standards for selection and tiering, as applicable, of participating providers for its network(s) available for review [and approval] by the insurance commissioner ~~of the applicable state~~.

Verify, if applicable, that a description in plain language of the standards the health carrier uses for selecting and tiering, as applicable, for its network providers is made available to the public.

~~Note: Examiners need to review how a health carrier markets or represents its network plans to consumers, particularly for those network plans that health carriers market or represent to consumers as using quality as at least one method of assessing whether to include providers in the network. In addition, for such network plans, examiners also need to review a health carrier's provider selection standards to ensure that quality is actually being used to assess whether to include providers in the network.~~

Verify that the health carrier notifies participating providers of the providers' responsibilities with respect to the health carrier's applicable administrative policies and programs, including but not limited to payment terms; utilization review; quality assessment and improvement programs; credentialing; grievance and appeals procedures; data reporting requirements; reporting requirements for timely notice of changes in practice, such as discontinuance of accepting new patients; confidentiality requirements; and any applicable federal or state programs.

~~Verify that the health carrier does not offer~~Review health carrier policies, procedures, programs, provider communications and other materials that may document or record health carrier activities related to provider networks, and policy provisions to identify if a health carrier offers an inducement to a provider that would encourage or otherwise incentivize the provider to deliver less than medically necessary services to a covered person.

Verify that the health carrier does not prohibit a participating provider from discussing any specific or all treatment options with covered persons irrespective of the health carrier's position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance or appeals processes established by the health carrier or a person contracting with the health carrier or in accordance with any rights or remedies available under applicable state ~~or federal law~~ [and federal] law and regulations. Examiners may need to review network provider contract forms and network provider communications, policies and other written materials. Review health carrier network provider records including communications that could contain complaints from network providers raising such concerns.

Verify that contracts between a health carrier and a participating provider require the provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of covered persons, and to comply with applicable state and federal laws related to the confidentiality of medical and health records and the covered person's right to see, obtain copies of or amend their medical and health records.

Verify that the health carrier and participating provider provide ~~at least sixty (60) days~~ the requisite advance written notice to each other as required under state [and federal] statutes and regulations before the provider is removed or leaves ~~the a~~ network without cause.

~~Verify that for providers who have asked to be removed from the network, the health carrier maintains and can provide examiners with such notices received from the provider.~~

~~With regard to providers who have been asked by the health carrier to no longer be part of the network, verify that the health carrier maintains and can provide to the examiner the notices it sent to the provider.~~

Verify that the health carrier maintains network provider participation records, including records pertaining to former network providers, to include records documenting provider status, status notices, renewals and terminations as required by state statutes and regulations.

Verify that the health carrier makes a good faith effort to provide written notice of a provider's removal or leaving the network within ~~thirty (30) days of receipt or issuance of a notice to all covered persons who are patients seen on a regular basis by the provider being removed or leaving the network, irrespective of whether it is for cause or without cause~~ state [and federal] statutory or regulatory time frames for health carrier notices to all persons entitled to such notice under state [and federal] statutes or regulations.

~~When a provider who is a primary care professional is being removed or is leaving the provider network, verify that the health carrier's contract with the participating provider requires the provider to provide the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier.~~

Verify that when a provider who is a primary care professional has been removed, or has left a provider network, the provider provides the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier, as required by the health carrier's contract with the participating provider. If the list is not provided to the health carrier by the primary care physician who has been removed or who has left a provider network, ascertain why the health carrier has not enforced the contractual provision regarding such notice.

Verify that when the provider being removed or leaving the network is a primary care professional, the health carrier provides notice related to the termination to all covered persons who are patients of that primary care professional. –

When a covered person’s provider leaves or is removed from the network, verify that the health carrier establishes reasonable procedures ~~to transition~~addressing those a-covered persons who ~~is-are~~ in an active course of treatment, including procedures to assist transitions to ~~a-~~participating providers in a manner that provides for continuity of care, in accordance with applicable state [and federal] statutes or regulations.

Verify that the health carrier makes available to the covered person ~~a list of~~information concerning available participating providers in the same geographic area who are of the same provider type, and information about how the covered person may request continuity of care.

Verify that the health carrier’s procedures outlining how a covered person may request continuity of care ~~provide that include all provisions required under state [and federal] statutes or regulations,~~ including:

- ~~Any request for~~Individuals eligible to request continuity of care ~~can be made to the health carrier by the covered person or the covered person’s authorized representative on behalf of patients;~~
- ~~Requests for continuity of care shall be reviewed by the health carrier’s medical director after consultation with the treating provider for patients who meet the criteria “active course of treatment,” “life-threatening health condition,” and “serious acute condition” as defined in applicable state statutes, rules and regulations, and are under the care of a provider who has not been removed or leaving the network for cause. Any decisions made with respect to a request for continuity of care shall be subject to the health benefit plan’s internal and external grievance and appeal processes in accordance with applicable state or federal law or regulations;~~
- ~~The continuity of care period for covered persons who are in their second or third trimester of pregnancy shall extend through the postpartum period; and~~
- ~~The continuity of care period for covered persons who are undergoing an active course of treatment shall extend to the earlier of:~~
  - ~~The termination of the course of treatment by the covered person or the treating provider;~~
- ~~[Ninety (90) days] unless the health carrier’s medical director determines that a longer period is necessary~~Individuals eligible to receive continuity of care;
- The length of the continuity of care period;
- Health carrier decision-making processes on continuity of care requests; and
- Enrollee grievance and appeal rights regarding continuity of care decisions.
- ~~The date that care is successfully transitioned to a participating provider;~~
- ~~Benefit limitations under the plan are met or exceeded; or~~
- ~~Care is not medically necessary.~~

~~Note: Examiners need to be aware that while ninety (90) days is the current accreditation standard for the length of a continuity of care period, a state, when determining the length of time for the continuity of care period, may take into consideration the number of providers, especially specialty providers who are available to treat serious health conditions within the state.~~

~~• Verify that the health carrier's procedures for continuity of care ensure that providers. In addition to the above referenced continuity of care provisions, a continuity of care request may only be granted when:~~

- ~~• The provider agrees in writing to accept the same payment from and abide by the same terms and conditions with respect to the health carrier for that patient as provided in the original provider contract, and~~
- ~~• The provider agrees in writing not to seek any payment from the covered person for any amount for which the covered person would not have been responsible if the physician or provider were still a participating provider.~~

~~Verify that Review~~ health carrier contractual arrangements with participating providers ~~to verify~~ensure that the rights and responsibilities under a contract between a health carrier and a participating provider are not assigned or delegated by either party without the prior written consent of the other party.

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

Verify that the health carrier assumes responsibility for notifying participating providers (1) of their obligations, if any, to collect applicable coinsurance, copayments or deductibles from covered persons pursuant to the evidence of coverage, and (2) of their obligations, if any, to notify covered persons of their personal financial obligations for non-covered services.

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

Verify that the health carrier has established a mechanism by which a participating provider may determine in a timely manner, at the time services are provided, whether or not an individual is a covered person or is within a grace period for payment of premium during which the health carrier may hold a claim for services rendered, pending receipt of payment of premium.

Verify that the health carrier has established written policies and procedures for resolution of administrative, payment or other disputes between providers and the health carrier for plans that use a provider network.

Review contractual arrangements between the health carrier and participating providers to ascertain if such contracts contain provisions that conflict with the provisions contained in the network approved access plan(s) and/or the requirements of applicable state [and federal] statutes, ~~rules~~ and regulations regarding network adequacy.

Verify that, at the time a contract is signed, the ~~health carrier and, if appropriate, an intermediary, notifies a participating network provider, receives a copy of or access to the network contract~~ in a timely manner, ~~of including~~ all ~~provisions and other~~ documents incorporated by reference ~~into the contract~~. The ~~language of the contract/provider contract~~ shall define what is to be considered timely notice.

Verify that, while a provider contract is in force, the health carrier notifies a participating provider in a timely manner, of any changes to those provisions or documents that would result in material changes in the contract. The language of the contract shall define what is to be considered timely notice and what is to be considered a material change.

Verify that a health carrier informs a provider of the provider's network participation status, in a timely manner, on any health benefit plan in which the health carrier has included the provider as a participating provider.

#### General Review Procedures and Criteria

~~Review complaint register/logs and complaint files to identify complaints/disputes made by participating providers relating to health carrier/participating provider contractual arrangements.~~

Review complaint/dispute records to ~~verify that~~determine if the health carrier has not complied with the contractual provisions of, ~~or fulfilled its obligations contained within~~ the health carrier/participating provider contract, and whether the health carrier has provided appropriate corrective action/adjustments to the participating provider(s) in a timely and accurate manner.

Ascertain if ~~the health carrier error any~~ examination adverse determination finding could have been the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, ~~supporting related to~~ any corrective action provided to a participating provider.

Verify that health carrier communication and educational materials provided to participating providers provide complete and accurate information about health carrier/participating provider contractual arrangements.

~~Verify that the health carrier has established training programs designed to inform its employees about HHS, the DOL and the Treasury provisions and final regulations pertaining to health carrier/participating provider contractual arrangements.~~

Review health carrier training materials to verify that information provided therein is complete and accurate with regard to health carrier/participating provider contractual arrangements and state [and federal] statutes and regulations.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek legal advice and assistance from the state insurance department.

DRAFT

## STANDARDS NETWORK ADEQUACY

### Standard 4

A health carrier offering individual and group market health insurance network plans shall comply with requirements regarding balance billing in accordance with applicable state statutes, ~~rules~~ and regulations.

**Apply to:** ~~Health carriers issuing individual and group market health insurance network plans (ACA and non-ACA compliant). Those individual and group health products and related provider networks as set forth in the state's laws and regulations. For state examinations being conducted in the absence of state statutes and regulations addressing Affordable Care Act provisions, to all Qualified Health Plan products that use a provider network~~

Note: Standard 4 is based on Section 7 of the Health Benefit Plan Network Access and Adequacy Model Act (#74). In states that have not adopted Section 7 of the Model Act, examiners should look at the state statutes and regulations that pertain to balance billing

**Priority:** Essential

### Documents to be Reviewed

- ~~\_\_\_\_\_ State statutes and regulations addressing balance billing within health carrier provider networks~~
- ~~\_\_\_\_\_ Approved health carrier network access plan(s)~~
- ~~\_\_\_\_\_ Health carrier policies and procedures related to balance billing, including contractual arrangements between health carriers and participating providers~~
- \_\_\_\_\_ Health carrier policyholder service policies and procedures related to balance billing
- \_\_\_\_\_ Policyholder service files and supporting documentation regarding balance billing, including letters, notices, telephone scripts, etc., within health carrier provider network plans
- \_\_\_\_\_ Non-emergency out-of-network services written disclosures issued by facility-based providers, if set forth in state statutes or regulations for health carrier provider networks
- \_\_\_\_\_ Out-of-network emergency services billing notices issued by facility-based providers, if set forth in state statutes or regulations for health carrier provider networks
- \_\_\_\_\_ Non-participating facility-based provider-issued payment responsibility notices/billing statements, if set forth in state statute or regulations for health carrier provider networks
- \_\_\_\_\_ Health carrier's provider mediation processes, including ~~(policy policies~~ and procedures), if set forth in state statutes or regulations for health carrier provider networks
- ~~\_\_\_\_\_ Records of requests for provider mediation~~

\_\_\_\_ Records of open and completed provider mediations, if set forth in state statutes or regulations for health carrier provider network plans

~~\_\_\_\_\_ Complaint register/logs/files~~

\_\_\_\_ Health carrier complaint records concerning balance billing (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response) for health carrier provider network plans

\_\_\_\_ Health carrier communication and educational materials related to balance billing provided to insureds, beneficiaries and prospective purchasers applicants, enrollees, policyholders, certificateholders and beneficiaries of health carrier provider network plans

\_\_\_\_ Employee Training materials related to balance billing for health carrier provider network plans

~~\_\_\_\_\_ Applicable state statutes, rules and regulations~~

**Others Reviewed**

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

### NAIC References

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

### Other References

~~\_\_\_\_\_ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials  
\_\_\_\_\_ Federal regulations, including FAQs and other regulatory guidance~~

### Review Procedures and Criteria

~~Note: Examiners need to be aware that for purposes of this examination standard, “facility-based provider” means a provider who provides health care services to patients who are in an in-patient or ambulatory facility, including services such as pathology, anesthesiology, emergency room care, radiology or other services provided in an in-patient or ambulatory facility setting. These health care services are typically arranged by the facility by contract or agreement with the facility-based provider as part of the facility’s general business operations, and a covered person or the covered person’s health benefit plan generally does not specifically select or have a choice of providers from which to receive such services within the facility. Examiners need to review the applicable state’s definition of “facility-based provider” to make sure it includes any provider who may bill separately from the facility for health care services provided in an in-patient or ambulatory facility setting.~~

Verify that the health carrier has established and implemented written ~~policyholder service~~ policies and procedures regarding compliance ~~of individual and group market health insurance health benefit~~

network plans with requirements in approved provider networks and as set forth in applicable state statutes, rules and regulations regarding balance billing.

Verify for ~~With regard to~~ non-emergency out-of-network services, at the time a participating facility schedules a procedure or seeks prior authorization from a health carrier for the provision of non-emergency services to a covered person, the facility ~~shall~~ provides the covered person with an out-of-network services written disclosure ~~that states the following:~~ in accordance with any requirements set forth in state statutes or regulations.

- ~~• That certain facility-based providers may be called upon to render care to the covered person during the course of treatment;~~
- ~~• That those facility-based providers may not have contracts with the covered person's health carrier and are therefore considered to be out-of-network;~~
- ~~• That the service(s) therefore will be provided on an out-of-network basis;~~
- ~~• A description of the range of the charges for the out-of-network service(s) for which the covered person may be responsible;~~
- ~~• A notification that the covered person may either agree to accept and pay the charges for the out-of-network service(s), contact the covered person's health carrier for additional assistance or rely on whatever other rights and remedies that may be available under state or federal law; and~~
- ~~• A statement indicating that the covered person may obtain a list of facility-based providers from his or her health benefit plan that are participating providers and that the covered person may request those participating facility-based providers.~~

Verify that ~~At~~ the time of admission in the participating facility where the non-emergency services are to be performed on the covered person, ~~the~~ a facility ~~shall~~ provides a covered person with ~~the a~~ a written disclosure, ~~as outlined above,~~ and obtains the covered person's or the covered person's authorized representative's signature on the disclosure document acknowledging that the covered person received the disclosure document ~~in advance prior to~~ before the time of admission.

Verify for ~~With regard to~~ out-of-network emergency services, a non-participating facility-based provider ~~shall~~ includes a statement on any billing notice sent to a covered person for services provided, informing the covered person that he or she is responsible for paying ~~their~~ the applicable in-network cost-sharing amount, but has no legal obligation to pay the remaining balance. Such statement also shall inform the covered person of his or her obligation to forward the bill to their health carrier for consideration under ~~the provider mediation process described below if the difference in the billed charge and the plan's allowable amount is more than \$500.00. Note: Examiners need to be aware that the applicable dollar amount threshold may vary by state. A covered person is not precluded from agreeing to accept and pay the charges for the out-of-network service(s) and not using the provider mediation process described below~~ a provider mediation process as set forth in state statutes or regulations.

~~In instances~~ Verify that where a non-participating facility-based provider sends a billing notice directly to a covered person for the non-participating facility-based provider's service(s), the billing notice ~~shall~~ includes the Payment Responsibility Notice ~~below. The Payment Responsibility Notice shall state the following or substantially similar language: as set forth in state statutes or regulations.~~

~~“Payment Responsibility Notice—The service[s] outlined below was [were] performed by a facility based provider who is a non-participating provider with your health care plan. At this time, you are responsible for paying your applicable cost sharing obligation—copayment, coinsurance or deductible amount—just as you would be if the provider is within your plan's network. With regard to the remaining balance, you have three~~

~~choices: 1) you may choose to pay the balance of the bill; OR 2) if the difference in the billed charge and the plan's allowable amount is more than [\$500.00], you may send the bill to your health care plan for processing pursuant to the health carrier's non-participating facility-based provider billing process or the provider mediation process required by applicable state statutes, rules and regulations; OR 3) you may rely on other rights and remedies that may be available in your state."~~

Verify that Non-participating facility-based providers ~~may do~~ not attempt to collect payment, excluding appropriate cost-sharing, from covered persons when the provider has elected to trigger the health carrier's non-participating facility-based provider billing process.

Verify that Non-participating facility-based providers who do not provide a covered person with a Payment Responsibility Notice, ~~as outlined above,~~ may not balance bill the covered person.

~~A covered person is not precluded from agreeing to accept and pay the bill received from the non-participating facility based provider and not using the provider mediation process described below.~~

~~Regarding Verify that for health carrier out-of-network facility-based provider payments: health carriers develop a program for payment of non-participating facility-based provider bills and may elect to pay non-participating facility-based provider bills as submitted, or the health carrier may pay in accordance with the benchmark for non-participating facility-based provider payments established in applicable state statutes and regulations, and that non-participating facility-based providers who object to such payment(s) may elect the provider mediation process described in applicable state statutes and regulations. Payments to non-participating facility-based providers shall be presumed to be reasonable if a payment is based on the higher of the health carrier's contracted rate or [XX] percentage of the Medicare payment rate for the same or similar services in the same geographic area.~~

- ~~• Health carriers shall develop a program for payment of non-participating facility based provider bills;~~
- ~~• Health carriers may elect to pay non-participating facility based provider bills as submitted or the health carrier may pay in accordance with the benchmark for non-participating facility based provider payments established in applicable state statutes, rules and regulations;~~
- ~~• Non-participating facility based providers who object to the payment(s) made in accordance with the above may elect the provider mediation process described in applicable state statutes, rules and regulations; and~~
- ~~• This section does not preclude a health carrier and an out-of-network facility-based provider from agreeing to a separate payment arrangement.~~

~~Payments to non-participating facility based providers shall be presumed to be reasonable if a payment is based on the higher of the health carrier's contracted rate or [XX] percentage of the Medicare payment rate for the same or similar services in the same geographic area. Note: Examiners need to be aware that a state may use a percentage of the Medicare payment that a state considers appropriate. A state may alternatively use as a benchmark some percentage of a public, independent, database of charges for the same or similar services in the same geographic area; or b) some percentage of usual, customary and reasonable (UCR) charges in the state, if defined in state law or regulation.~~

Verify that the health carrier has established a provider mediation process for payment of non-participating facility-based provider bills for providers objecting to the application of the established payment rate outlined in applicable state statutes, ~~rules~~ and regulations or that the health carrier

~~otherwise complies with any state statutes and regulations regarding mediation or arbitration processes for payment of non-participating provider bills.~~ The health carrier's provider mediation process shall be established in accordance with ~~one of the following recognized~~ mediation standards as set forth under state statute and regulations.:-

- ~~• The Uniform Mediation Act;~~
- ~~• Mediation.org, a division of the American Arbitration Association;~~
- ~~• The Association for Conflict Resolution (ACR);~~
- ~~• The American Bar Association Dispute Resolution Section; or~~
- ~~• The applicable state dispute resolution, mediation or arbitration section.~~

Verify that following completion of the provider mediation process, the cost of mediation ~~shall be~~ split evenly and paid by the health carrier and the non-participating facility-based provider or that the health carrier otherwise follows any state statutes or regulations regarding its share of the cost for the process.

Verify that a health carrier provider mediation process is not used when the health carrier and the non-participating facility-based provider agree to a separate payment arrangement or when the covered person agrees to accept and pay the non-participating facility-based provider's charges for the out-of-network service(s).

Verify that a health carrier maintains records on all requests for mediation and completed mediations during a calendar year and, upon request, submits a report to the insurance commissioner ~~of the applicable state~~ in the format specified by the insurance commissioner.

~~The rights and remedies set forth in applicable state statutes, rules and regulations regarding balance billing shall be in addition to and may not preempt any other rights and remedies available to covered persons under state or federal law.~~

~~With regard to enforcement of state specific requirements regarding balance billing, the appropriate state agency with hospital/provider oversight, consumer protection division, or attorney general and the applicable state insurance department shall be responsible for enforcement of the requirements of applicable state statutes, rules and regulations pertaining to balance billing.~~

~~Note: Examiners need to be aware that state specific requirements regarding balance billing 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 applicable 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 insurance commissioner of the applicable state 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.~~

~~Balance billing requirements do not apply to providers or covered persons using the process set forth in applicable state statutes, rules and regulations to assure that a covered person obtains a covered benefit at an in network level of benefits, including an in network level of cost sharing, from a non-~~

~~participating provider, or makes other arrangements acceptable to the insurance commissioner of the applicable state.~~

~~The requirements set forth in applicable state statutes, rules and regulations regarding balance billing do not apply to facilities that have made arrangements with facility based providers they employ or with whom they have contracts which prevent balance bills from being sent to persons covered by the same health benefit plans with which the facility contracts.~~

~~The insurance commissioner of the applicable state and the appropriate state agency with hospital/provider oversight, consumer protection division, or attorney general may, after notice and hearing, promulgate reasonable regulations to carry out the provisions set forth in applicable state statutes regarding balance billing. The regulations shall be subject to review in accordance with the applicable state statutory citation providing for administrative rulemaking and review of regulations.~~

#### General Review Procedures and Criteria

~~Review complaint register/logs and complaint files to identify complaints pertaining to balance billing.~~

Review complaint records (including complaint records to other state agencies, if applicable) to verify that if a non-participating facility-based provider attempts to collect payment, excluding appropriate cost-sharing, from a covered person for health care services, ~~the above reasons for noncompliance notwithstanding,~~ **the** non-participating facility-based provider has taken appropriate corrective action/adjustments regarding the removal of the requirement of the covered person's payment for health care services, in a timely and accurate manner.

Ascertain if ~~the health carrier error any~~ examination adverse determination finding could ~~have been be~~ the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier **has** implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, supporting corrective action provided to a covered person(s), including website notifications.

Verify that health carrier communication and educational materials provided to insureds, applicants, enrollees, policyholders, certificateholders and beneficiaries and prospective purchasers provide complete and accurate information about balance billing.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, the DOL and the Treasury provisions state [and federal] statutes and final regulations pertaining to balance billing.

Review health carrier training materials for its employees and appointed agents to verify that information provided ~~therein~~ is complete and accurate with regard to balance billing.

**Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.**

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek legal advice and assistance from the state insurance department.

DRAFT

## STANDARDS NETWORK ADEQUACY

### Standard 5

A health carrier offering individual and group market health insurance network plans shall develop and issue written disclosures or notices to be provided to covered persons regarding balance billing, in accordance with applicable state statutes, ~~rules~~ and regulations.

**Apply to:** ~~Health carriers issuing individual and group market health insurance network plans (ACA and non-ACA compliant) Those individual and group health products and related provider networks as set forth in the state's laws and regulations. For state examinations conducted in the absence of state statutes and regulations addressing Affordable Care Act provisions, to all Qualified Health Plan products that use a provider network~~

Note: Standard 5 is based on Section 8 of the *Health Benefit Plan Network Access and Adequacy Model Act* (#74). In states that have not adopted Section 8 of the Model Act, examiners should look at the state's statutes and regulations that pertain to written disclosures or notices regarding balance billing

**Priority:** Essential

### Documents to be Reviewed

- ~~State and [federal] statutes and regulations addressing balance billing within health carrier provider networks~~
- ~~Approved health carrier network access plan provisions related to written disclosures and notices regarding balance billing~~
- ~~Provisions within health carrier contracts with network providers related to written disclosures and notices regarding balance billing~~
- Health carrier policyholder service policies and procedures related to written disclosures and notices of balance billing
- Policyholder service files and supporting documentation regarding balance billing, including letters, notices, telephone scripts, etc.
- ~~Written disclosures for Out-of-network services ~~written disclosures~~ provided by health carriers regarding balance billing~~
- ~~If set forth in state statutes or regulations, written disclosures for Non-emergency services ~~written disclosures~~ provided by facility-based providers regarding balance billing~~
- ~~Complaint register/logs/files~~

\_\_\_\_\_ Health carrier complaint records concerning balance billing (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

\_\_\_\_\_ Health carrier communication and educational materials related to written disclosures/notices of balance billing provided to ~~applicants, enrollees, policyholders, certificateholders and insureds,~~ beneficiaries, prospective purchasers and producers

\_\_\_\_\_ Training materials for health carrier employees and appointed agents related to balance billing

~~\_\_\_\_\_ Applicable state statutes, rules and regulations~~

#### Others Reviewed

\_\_\_\_\_

\_\_\_\_\_

#### NAIC References

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

#### Other References

~~\_\_\_\_\_ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials~~  
Federal regulations, including FAQs and other regulatory guidance

#### Review Procedures and Criteria

~~Verify that the health carrier has established and implemented written policyholder service policies and procedures regarding the content and issuance of written disclosures or notices to covered persons regarding balance billing, in compliance with requirements set forth in applicable state statutes, rules and regulations.~~

Verify that, as set forth in state [or federal] statute or regulation, the health carrier develops a written disclosure or notice to be provided to a covered person or the covered person's authorized representative at the time of pre-certification, ~~if applicable,~~ and other time frame(s) as set forth in state [or federal] statutes or regulations for a covered benefit to be provided at a facility that is in the covered person's health benefit plan network, that there is the possibility that the covered person could be treated by a health care professional that is not in the same network as the covered person's network.

Verify, as set forth in state [and federal] statutes or regulations, that the health carrier has established and implemented written policies and procedures regarding the content and issuance of written disclosures or notices to covered persons regarding balance billing.

Verify, as set forth in state [and federal] statutes or regulations, that the health carrier's disclosure or notice indicates that the covered person may be subject to higher cost-sharing, as described in the covered person's plan summary of coverage and benefits documents, including balance billing, if the covered services are performed by a health care professional, who is not in the covered person's plan

network even though the covered person is receiving the covered services at a participating facility, and that information on what the covered person's plan will pay for the covered services provided by a non-participating health care professional is available on request from the health carrier. Verify that the notice includes other content as set forth in state [or federal] statutes or regulations pertaining to the treatment of costs incurred due to care provided by out-of-network providers. Verify that the disclosure or notice also informs the covered person or the covered person's authorized representative of options available to access covered services from a participating provider.

Verify, as set forth in statutes or regulations, that for non-emergency services, as a requirement of its provider contract with a health carrier, a facility develops a written disclosure or notice to be provided to a covered person of the carrier within ten (10) days of an appointment for in-patient or outpatient services at the facility or at the time of a non-emergency admission at the facility that confirms that the facility is a participating provider of the covered person's network plan and informs the covered person that a health care professional, such as an anesthesiologist, pathologist or radiologist, who may provide services to the covered person while at the facility may not be a participating provider in the same network as the covered person's network.

#### General Review Procedures and Criteria

~~Review complaint register/logs and complaint files to identify complaints pertaining to content and issuance of written notices or disclosures regarding balance billing.~~

Verify that the health carrier has established processes to count the cost sharing paid by a covered person for an essential health benefit provided by an out-of-network provider in an in-network setting towards the enrollee's annual limitation on cost sharing in instances in which the carrier does not provide requisite notice to the covered person, as required under state [and federal] statutes and regulations.

Review complaint records to verify that if the health carrier has issued a written notice or disclosure of balance billing not in compliance with the content requirements of applicable state [and federal] statutes, ~~rules~~ and regulations, and the approved access plan has improperly issued such notice or has not issued such notice, the health carrier has taken appropriate corrective action/adjustments regarding the issuance of a proper written notice or disclosure to the covered person(s).

Ascertain if ~~the health carrier error~~any examination adverse determination finding could ~~have been be~~ the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains ~~proper documentation for~~ correspondence, ~~supporting records documenting~~ corrective ~~action provided to~~actions taken on behalf of a covered person(s), including website notifications.

Verify that health carrier communication and educational materials provided to ~~applicants, enrollees, policyholders, certificateholders and insureds,~~ beneficiaries, prospective purchasers and producers provide complete and accurate information about content and issuance of written notices or disclosures pertaining to balance billing.

Verify that the health carrier has established training programs designed to inform its employees and ~~producers appointed agents~~ about ~~HHS, the DOL and the Treasury provisions state~~ [and federal] and

~~final~~ regulations regarding content and issuance of written notices or disclosures pertaining to balance billing. Review the health carrier's training materials to verify that the information provided is complete and accurate.

~~Review health carrier training materials to verify that information provided therein is complete and accurate with regard to content and issuance of written notices or disclosures pertaining to balance billing.~~

~~Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.~~

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek legal advice and assistance from the state insurance department.

DRAFT

## STANDARDS NETWORK ADEQUACY

### Standard 6

A health carrier offering individual and group market health insurance network plans shall comply with requirements set forth in applicable state statutes, ~~rules~~ and regulations regarding content, accessibility, transparency, accuracy, and completeness of printed and electronic provider directories.

**Apply to:** ~~Those individual and group health products and related provider networks as set forth in the state's laws and regulations. For state examinations being conducted in the absence of state statutes and regulations addressing Affordable Care Act provisions, to all Qualified Health Plan products that use a provider network.~~ All individual and group health products (non-grandfathered products) for policy years and plan years beginning on or after Jan. 1, 2014

~~This standard does not apply to grandfathered health plans in accordance with §147.140~~

~~This standard does not apply to transitional plans~~

**Priority:** Essential

### Documents to be Reviewed

~~State [and federal] statutes and regulations related to network provider directories~~

~~Approved health carrier network access plan(s)~~

~~Hard copies and web-based copies of network provider directories~~

~~Provisions within health carrier network provider contract(s) entered into pursuant to the approved network access plan(s) addressing provider directories~~

~~Health carrier policies and procedures related to network provider directories, including policies and procedures for maintaining accurate and timely directories~~

~~Files and supporting documentation regarding frequency of network provider directory revisions and updates~~

~~Provider directory (print copy provided to covered persons)~~

~~Web-based provider directory~~

~~Health carrier self-audits of provider directories, in accordance with state statutes and regulations~~

~~Complaint register/logs/files regarding inaccessibility, inaccuracy and incompleteness of provider directories~~

\_\_\_\_\_ Health carrier complaint records concerning the accessibility, accuracy and completeness of network provider directories ~~(as well as~~ supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

\_\_\_\_\_ Health carrier marketing and sales policies and ~~procedures' references~~ procedures that refer to provider directories and networks

\_\_\_\_\_ Health carrier ~~communication marketing~~ and educational materials related to provider directories and networks provided to ~~applicants, enrollees, policyholders, certificateholders and insureds,~~ beneficiaries and prospective purchasers, including communications with producers

\_\_\_\_\_ Health carrier Ttraining materials for employees and appointed agents

\_\_\_\_\_ Producer records related to network provider directories

\_\_\_\_\_ Applicable state statutes, rules and regulations

#### Others Reviewed

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

#### **NAIC References**

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

#### **Other References**

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

#### **Review Procedures and Criteria**

Verify that the health carrier has established and implemented written policies and procedures regarding compliance of ~~individual and group market health insurance health benefit all~~ network plans with provider directory requirements in accordance with ~~final regulations established by HHS, the DOL and the Treasury~~ state [and federal] requirements.

Verify that the health carrier posts electronically a current and accurate provider directory for each of its network plans, ~~to include the following information in a searchable format: including specified information required under state [and federal] statutes and regulations for health care professionals, hospitals and other facilities. To the extent required under state statutes and regulations, verify that this information is available in a searchable format.~~

- ~~For health care professionals:~~
  - ~~Name;~~
  - ~~Gender;~~

- ~~Participating office location(s);~~
- ~~Specialty, if applicable;~~
- ~~Medical group affiliations, if applicable;~~
- ~~Facility affiliations, if applicable;~~
- ~~Participating facility affiliations, if applicable;~~
- ~~Languages spoken other than English, if applicable; and~~
- ~~Whether accepting new patients.~~
- ~~For hospitals:~~
  - ~~Hospital name;~~
  - ~~Hospital type (i.e. acute, rehabilitation, children's, cancer);~~
  - ~~Participating hospital location; and~~
  - ~~Hospital accreditation status; and~~
- ~~For facilities, other than hospitals, by type:~~
  - ~~Facility name;~~
  - ~~Facility type;~~
  - ~~Types of services performed; and~~
  - ~~Participating facility location(s).~~

~~In addition, Verify for electronic provider directories, for each network plan, verify that the health carrier makes available the followingspecified additional information in addition to all of the information above:required under state statutes or regulations for health care professionals, hospitals and other facilities.~~

- ~~For health care professionals:~~
  - ~~Contact information;~~
  - ~~Board certification(s); and~~
  - ~~Languages spoken other than English by clinical staff, if applicable.~~
- ~~For hospitals: telephone number; and~~
- ~~For facilities other than hospitals: telephone number.~~

Verify that in making ~~the a provider~~ directory available electronically, the health carrier ensures that the general public is able to view all of the current providers for a plan ~~via-through~~ a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number.

~~Verify that the health carrier makes it clear for both its electronic and print directories what provider directory applies to which network plan, such as including the specific name of the network plan as marketed and issued in the applicable state.~~

Verify that the health carrier updates each network plan provider directory at least monthly ~~or within the specified time frame stated under applicable state statutes or regulations.~~

Verify that the health carrier periodically audits at least a reasonable sample size of its provider directories for accuracy and retains documentation of such an audit to be made available to the insurance commissioner of the applicable state upon request ~~or complies with any other provider directory audit requirements as applicable under state statutes or regulations.~~

Verify that the health carrier provides a print copy, or a print copy of the requested directory information, of a current provider directory with ~~the information listed belowspecified information for~~

health care professionals, hospitals and other facilities, in accordance with state [and federal] statutes and regulations, upon request of a covered person or a prospective covered person.

- ~~For health care professionals:~~
  - ~~Name;~~
  - ~~Gender;~~
  - ~~Participating office location(s);~~
  - ~~Specialty, if applicable;~~
  - ~~Medical group affiliations, if applicable;~~
  - ~~Facility affiliations, if applicable;~~
  - ~~Participating facility affiliations, if applicable;~~
  - ~~Languages spoken other than English, if applicable; and~~
  - ~~Whether accepting new patients.~~
- ~~For hospitals:~~
  - ~~Hospital name;~~
  - ~~Hospital type (i.e. acute, rehabilitation, children's, cancer);~~
  - ~~Participating hospital location; and~~
  - ~~Hospital accreditation status; and~~
- ~~For facilities, other than hospitals, by type:~~
  - ~~Facility name;~~
  - ~~Facility type;~~
  - ~~Types of services performed; and~~
  - ~~Participating facility location(s).~~

Verify, via sample testing of the provider directory relative to network providers; Determine the following that the network provider:

- Is still practicing;
- Is currently participating in the insurer's health carrier's network;
- Office is located at the address designated in the provider directory;
- Is practicing in accordance with the designation (i.e. pediatrics, nurse midwife, cardiology) as listed in the provider directory;
- Is currently accepting new patients;
- Has not been sanctioned or prohibited from participation in federal health care programs under Section 1128 or Section 1128A of the Social Security Act; and
- Has not had his/her license suspended or revoked by a state agency.

With regard to residential treatment facilities (mental health treatment and substance abuse), verify that residential treatment facilities for mental health treatment and substance abuse are included in the provider directory on the health carrier's website and in hardcopy.

Verify that for each network plan, a health carrier includes in plain language in both the electronic and print directory, the following general information; if applicable, describing

- ~~In plain language, a description of~~ the criteria the health carrier has used to build its provider network;
- ~~If applicable, in plain language, a description of describing~~ the criteria the health carrier has used to tier providers;
- ~~If applicable, in plain language, describing~~ how the health carrier designates the different provider tiers or levels in the network and identifies for each specific provider, hospital or other type of facility in the network which tier each is placed, for example by name, symbols or

grouping, in order for a covered person or a prospective covered person to be able to identify the provider tier; and

- ~~If applicable, note~~ing that authorization or referral may be required to access some providers.

~~Verify that the health carrier makes it clear for both its electronic and print directories what provider directory applies to which network plan, such as including the specific name of the network plan as marketed and issued in this state.~~

Verify that the health carrier includes in both its electronic and print directories a customer service email address and telephone number or electronic link that covered persons or the general public may use to notify the health carrier of inaccurate provider directory information.

Verify that for all of the pieces of information required to be included in a printed or electronic provider directory pertaining to a health care professional, a hospital or a facility other than a hospital, the health carrier makes available through the directory the source of the information and any limitations, if applicable.

Verify that the health carrier's provider directory, whether in electronic or print format, accommodates the communication needs of individuals with disabilities, and includes a link to or information regarding available assistance for persons with limited English proficiency, or otherwise complies with state statutes and regulations regarding accessibility.

Note: State regulators should be aware that a Qualified Health Plan (QHP) must comply with language accessibility requirements under federal regulations 45 CFR §155.205 in order to be offered on a health insurance exchange under the federal Affordable Care Act (ACA) and implementing regulations.

Verify that the health carrier makes available in print, upon request, ~~the following provider directory specified~~ information for the applicable network plan: about

- ~~For health care professionals, hospitals and other facilities required under state statute and regulations, for the applicable network plan.:~~
  - ~~Name;~~
  - ~~Contact information;~~
  - ~~Participating office location(s);~~
  - ~~Specialty, if applicable;~~
  - ~~Languages spoken other than English, if applicable; and~~
  - ~~Whether accepting new patients.~~
- ~~For hospitals:~~
  - ~~Hospital name;~~
  - ~~Hospital type (i.e. acute, rehabilitation, children's, cancer); and~~
  - ~~Participating hospital location and telephone number; and~~
- ~~For facilities, other than hospitals, by type:~~
  - ~~Facility name;~~
  - ~~Facility type;~~
  - ~~Types of services performed; and~~
  - ~~Participating facility location(s) and telephone number.~~

Verify that the health carrier includes a disclosure in the printed directory that the information included in the directory is accurate as of the date of printing and that ~~covered persons or~~ insureds, beneficiaries,

prospective ~~covered persons~~ purchasers and producers should consult the health carrier's electronic provider directory on its website or call the health carrier's customer service telephone number to obtain current provider directory information.

#### General Review Procedures and Criteria

Review complaint register/logs and complaint files to identify complaints pertaining to ~~inaccessibility, inaccuracy and incompleteness~~ accessibility, accuracy and completeness of provider directories.

Review complaint records to verify that if the health carrier has issued a provider directory not in compliance with the content requirements of applicable state [and federal] statutes, ~~rules~~ and regulations, has improperly issued such a directory or has not issued such a directory, the health carrier has taken appropriate corrective action/adjustments regarding the issuance of a proper provider directory to covered person(s).

Ascertain if ~~the health carrier error~~ any examination adverse determination finding could ~~have been~~ be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains ~~proper documentation for~~ documenting the corrective action ~~provided to~~ taken on behalf of a covered person(s), including website notifications related to provider directories.

Verify that any marketing materials, communication and educational materials provided to insureds, beneficiaries and ~~prospective potential~~ purchasers by the health carrier provide complete and accurate information about ~~content, accessibility, transparency, accuracy, and completeness of provider directories~~.

~~Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about the network based on evaluation of the~~ content, accessibility, transparency, accuracy, and completeness of provider directories.

Verify that the health carrier has established training programs designed to inform its employees and ~~producers appointed agents~~ about HHS, the DOL and the Treasury provisions applicable state [and federal] statutes and ~~final~~ regulations pertaining to content, accessibility, transparency, accuracy, and completeness of provider directories.

Review health carrier training materials to verify that information provided ~~therein~~ is complete and accurate with regard to requirements for content, accessibility, transparency, accuracy, and completeness of provider directories.

Review producer records and health carrier communication with producers to verify that the provider directory information provided by producers to ~~applicants/proposed~~ insureds, beneficiaries and prospective purchasers is complete and accurate with regard to ~~content, accessibility, transparency, accuracy, and completeness of provider directories networks~~.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules

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

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek legal advice and assistance from the state insurance department.

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DRAFT

**PROVISION TITLE:** Network Adequacy Standards

**CITATION:** PHS §2702 (c); 45 CFR §156.230

**EFFECTIVE DATE:** Plan years and, in the individual market, policy years beginning on or after Jan. 1, 2014

**PROVISION:** The NAIC established network adequacy standards as set forth in revised Model law *Health Benefit Plan Network Access and Adequacy Model Act* (#74) for the creation and maintenance of networks by health carriers and to assure the adequacy, accessibility, transparency and quality of health care services offered under a network plan. In addition, provisions of the federal Patient Protection and Affordable Care Act (Affordable Care Act or ACA) established a requirement that a health carrier offering qualified health plans in the individual or group markets in a state must meet minimum criteria for the adequacy of provider networks delivering covered services to covered persons.

**BACKGROUND:** In November 2015, the NAIC adopted a substantially revised network adequacy model, the *Health Benefit Plan Network Access and Adequacy Model Act* (#74). The NAIC established standards for the creation and maintenance of networks by health carriers and assures the adequacy, accessibility, transparency and quality of health care services offered under a network plan. Based upon the Affordable Care Act, federal regulatory agencies, including the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury) have issued regulations and associated regulatory guidance, including frequently asked questions (FAQs) that set forth minimum criteria for network adequacy that health carriers' network plans must meet in order to be certified as Qualified Health Plans (QHP's) and stand-alone dental plans (SADPs).

Pursuant to 45 C.F.R. §156.230(a)(2), a health carrier which issues a QHP or SADP that uses a provider network must "maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to assure that all services will be accessible to enrollees without unreasonable delay." All health carriers applying for QHP certification need to attest that they meet this standard as part of the certification/recertification process.

Note: State regulators need to determine whether these examination standards are to apply to all health carriers in the individual market and to group plans, including non-grandfathered group health plans, or to only a subset of health insurance markets and policies, in accordance with state statute and regulations.

**FAQs:** See the HHS website for federal guidance.

**NOTES:** Examiners should obtain specific direction from the insurance commissioner ordering the examination as to whether there are provisions for which examiners are to apply federal statutes and regulations in addition to, or in place of, state statutes and regulations when applying these examination standards. Examiners

should familiarize themselves with specific state and federal statutes and regulations as they pertain to network adequacy. States have considerable flexibility in determining how they want to address network adequacy issues, and the federal regulatory agencies have traditionally deferred to that inherent state authority. States may therefore require examiners to refer to specific state and federal law and regulations instead of the language found in the *Health Benefit Plan Network Access and Adequacy Model Act (#74)*.

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**STANDARDS  
NETWORK ADEQUACY**

**Standard 1**

**A health carrier offering individual and group market health insurance network plans shall develop and file an access plan with the insurance commissioner in accordance with requirements regarding content and filing of network access plans set forth in applicable state statutes, rules and regulations.**

**Apply to:** Those individual and group health products and related provider networks as set forth in the state’s statutes and regulations. For state examinations, in the absence of state statutes and regulations addressing Affordable Care Act provisions, to all Qualified Health Plan products that use a provider network

**Priority:** Essential

**Documents to be Reviewed**

- \_\_\_\_\_ State [and federal] statutes and regulations and exchange requirements, addressing filing and approval of network adequacy or access plans
- \_\_\_\_\_ Approved network access plan(s)
- \_\_\_\_\_ Health carrier policies and procedures related to the implementation of access plans
- \_\_\_\_\_ Health carrier policies and procedures related to filing of access plans and material changes to access plans
- \_\_\_\_\_ Policies and/or incentives that restrict, or unduly burden an enrollee’s access to network providers, including provider specialists
- \_\_\_\_\_ Health carrier communication and educational materials related to access plans provided to applicants, enrollees, policyholders, certificateholders and beneficiaries, including communications with producers
- \_\_\_\_\_ Health carrier employees’ and appointed agent training materials
- \_\_\_\_\_ State exchange filing requirements

\_\_\_\_\_ **Applicable state statutes, rules and regulations**

**Others Reviewed**

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

## NAIC References

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

## Other References

~~HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials~~  
Federal regulations, including FAQs and other regulatory guidance

## Review Procedures and Criteria

Verify that the health carrier has established and implemented written policies and procedures regarding the health carrier's filing of access plans at the time it files a newly offered provider network

Verify that a health carrier has filed a network access plan in a compliant manner and form and obtained all necessary approvals from the appropriate state regulators prior to or at the same time it files a newly offered network.

Verify that the health carriers' network(s) comply(ies) with approved access plan(s). This verification can be performed by directly confirming active provider participation, "secret shopping," reviewing regulatory or health carrier customer service inquiries and/or complaints, surveying policyholders and enrollees, or by other tools generally employed or otherwise utilized by examiners to verify a health carrier's compliance with filings.

Verify that the health carrier makes access plans, absent [proprietary, competitive or trade secret] information, available online, at its business premises, and to any person upon request.

~~Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.~~

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek legal advice and assistance from the state insurance department.

**STANDARDS  
NETWORK ADEQUACY**

**Standard 2**

**A health carrier offering individual and group market health insurance network plans shall maintain a network that is sufficient in number and types of providers, including those that serve predominantly low-income, medically underserved individuals, to assure that all covered services to covered persons will be accessible, without unreasonable travel or delay and that emergency services are accessible 24 hours per day, 7 days per week.**

**Apply to:** Those individual and group health products and related provider networks as set forth in the state's statutes and regulations. For state examinations being conducted in the absence of state statutes and regulations addressing Affordable Care Act provisions, to all Qualified Health Products that use a provider network

**Priority:** Essential

**Documents to be Reviewed**

- \_\_\_\_\_ State [and federal] statutes and regulations addressing network adequacy and plan design
- \_\_\_\_\_ Approved health carrier network access plan
- \_\_\_\_\_ Health carrier policies and procedures related to implementing and maintaining network adequacy and access plans
- \_\_\_\_\_ Health carrier correspondence with state regulators addressing issues related to maintaining network adequacy
- \_\_\_\_\_ Health carrier policies and procedures related to filings for material changes to access plans
- \_\_\_\_\_ Provider selection [tiering] criteria and supporting documentation regarding selection [tiering] criteria for maintaining network adequacy and access plans
- \_\_\_\_\_ Documents related to recruitment and selection of providers, including following approval of network access plan
- \_\_\_\_\_ Provider directory/ies
- \_\_\_\_\_ Provider/member location reports (e.g. by ZIP code)
- \_\_\_\_\_ List of providers by specialty
- \_\_\_\_\_ Any policies or incentives that restrict access to subsets of network specialists
- \_\_\_\_\_ Health carrier complaint records concerning network adequacy, plan design and out of network service denials (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

\_\_\_\_\_ Health carrier marketing and sales policies and procedures that reference to network adequacy and plan design

\_\_\_\_\_ Health carrier marketing and educational materials related to network adequacy and plan design created for insureds, beneficiaries and prospective purchasers including communications with producers

\_\_\_\_\_ Health carrier employee training materials related to network adequacy maintenance activities

~~\_\_\_\_\_ Applicable state statutes, rules and regulations~~

**Others Reviewed**

\_\_\_\_\_

\_\_\_\_\_

### NAIC References

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

### Other References

~~\_\_\_\_\_ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials~~ Federal regulations, including FAQs and other regulatory guidance

### Review Procedures and Criteria

Verify the health carrier has maintained its provider network(s) in accordance with terms of the approved network access plan(s) and state [and federal] statutes and regulations, as applicable.

Verify the health carrier has implemented the administrative functions necessary to meet the size and performance requirements of its provider network(s), including any reasonable criteria in accordance with its approved access plan and state [and federal] statutes and regulations, as applicable.

Verify that the health carrier has established and implemented written policies and procedures regarding filings of amended access plans when necessitated by materials in its provider networks.

Verify as required by the approved access plan, and by state [and federal] statutes and regulations, that the health carrier's established network(s) address(es) at least the following:

- The use of telemedicine or telehealth or other technology to meet network access standards, if applicable; procedures for making and authorizing referrals within and outside its network, if applicable; factors used by the health carrier to build its provider network, including a description of the network and the criteria used to select [and/or tier] providers;
- The health carrier's efforts to address the needs of covered persons, including, but not limited to children and adults, including those with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, physical or mental disabilities, and serious, chronic or complex medical conditions. This includes the carrier's efforts, when appropriate, to include various types of essential community providers (ECPs) in its network;

- The health carrier's system for ensuring the coordination and continuity of care in situations where the health carrier, or its intermediary, due to insolvency or other cessation of operations, and when a participating provider is being removed or leaving the network with or without cause:
  - For covered persons referred to specialty physicians; and
  - For covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;
- The health carrier's process for enabling covered persons to change primary care professionals, if applicable;
- The health carrier's process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, hospitalist care and pathology/laboratory services at the health carrier's participating hospitals.

Verify the health carrier monitors the performance of its provider network(s) in accordance with its approved access plan and state statutes and regulations, as applicable, and records such activities.

Verify the health carrier has implemented necessary provider network changes, including but not limited to contracting with additional or replacement providers for its provider network(s) required to maintain its provider network(s), as established within its approved access plan(s) and as required under applicable state [and federal] statutes and regulations.

Verify that the health carrier has notified the state insurance department [or other state regulator] of material changes to its access plan.

Verify the health carrier has received any required approvals necessitated by changes to the health carrier's provider network(s) or enrollment.

Verify the health carrier has implemented any requirements established by the state insurance department required by any changes to the access plan or the health carrier's enrolled policyholder and enrolled life membership counts, including any insured, beneficiary, prospective purchaser, or provider notice, education or other communication(s).

Review health carrier policies and procedures related to network adequacy and plan design to verify that the health carrier maintains a network that is sufficient in number and appropriate types of providers, including providers who serve predominantly low-income, medically underserved individuals, to assure that all covered services to covered persons, including children and adults will be accessible without unreasonable travel or delay, and that emergency services are accessible 24 hours per day, 7 hours per week, in compliance with state [and federal] statutes and regulations.

Verify that the health carrier has established and implemented a process, including written policies and procedures, to assure that a covered person obtains a covered benefit at an in-network level of benefits, including an in-network level of cost-sharing, from a non-participating provider, or shall make other arrangements acceptable to the insurance commissioner as required under state statutes and regulations.

Verify that the health carrier specifies and informs covered persons of the process a covered person may use to request access to obtain a covered benefit from a non-participating provider and that such requests are documented, processed in a timely fashion and, for approved requests, that cost-sharing and out-of-pocket maximums are accurately applied, as required under state statutes and regulations.

Verify that the health carrier has a system in place that documents all requests to obtain a covered benefit from a non-participating provider and verify that the health carrier provides this information to the insurance commissioner of the applicable state upon request as required under state statutes and regulations.

Verify that that the health carrier monitors, on an ongoing basis, the ability, clinical capacity and legal authority of its participating providers to furnish all contractual covered benefits to covered persons.

Review complaint records to determine if the health carrier has not met minimum network adequacy standards contained within its access plan or required under applicable state [or federal] statutes and regulations or has improperly applied network adequacy standards and whether the health carrier has taken appropriate corrective action/adjustments for the covered person(s) in a timely and accurate manner.

Ascertain if any examination adverse determination finding could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence supporting corrective action provided to a covered person, including website notifications, as applicable.

Verify that health carrier communication and educational and marketing materials provided to insureds, beneficiaries and prospective purchasers provide complete and accurate information about network adequacy.

Verify that the health carrier has established training programs designed to inform its employees and agents about applicable state [and federal] laws and regulations.

Review health carrier employee training materials to verify that information provided therein is complete and accurate with regard to network adequacy.

Review producer records and health carrier communication with producers to verify that information provided by producers to applicants/proposed insureds is complete and accurate with regard to network adequacy.

~~Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.~~

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek legal advice and assistance from the state insurance department.

**STANDARDS  
NETWORK ADEQUACY**

**Standard 3**

**A health carrier’s contractual arrangements with participating providers shall comply with requirements regarding health carrier/participating provider contractual requirements set forth in applicable state statutes and regulations.**

**Apply to:** Those individual and group health products and related provider networks as set forth in the state’s statutes and regulations. For state examinations being conducted in the absence of state statutes and regulations addressing Affordable Care Act provisions, to Qualified Health Plan products that use a provider network

**Priority:** Essential

**Documents to be Reviewed**

- \_\_\_\_\_ State [and federal] statutes and regulations addressing network adequacy and plan design
- \_\_\_\_\_ Approved health carrier network access plan(s)
- \_\_\_\_\_ Health carrier policies and procedures related to applicable contractual arrangements between health carriers and participating providers
- \_\_\_\_\_ Health carrier contracts with providers
- \_\_\_\_\_ Health carrier complaint records relating to complaints or other disputes made by providers, policyholders or enrollees relating to network provider contractual matters
- \_\_\_\_\_ Health carrier communication, education and training materials provided to participating providers
- \_\_\_\_\_ Health carrier employee and agent training materials related to network provider contractual matters
- \_\_\_\_\_ ~~Applicable state statutes, rules and regulations~~

**Others Reviewed**

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

**NAIC References**

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

## Other References

~~HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials~~ Federal regulations, including FAQs and other regulatory guidance

## Review Procedures and Criteria

Verify that the health carrier's network provider contracts comply with state [and federal] statutes and regulations and with approved network access plan(s).

Review how the health carrier markets or represents its network plans to consumers, particularly for those health carriers that market or represent to consumers as using quality as at least one method of assessing whether to include providers in the network. In addition, for such network plans, review the health carrier's provider selection standards to verify that quality is actually being used to assess whether to include providers in the network.

Verify that the health carrier has established and implemented written policies and procedures regarding compliance health benefit network plans with state [and federal] requirements relating to health carrier/participating provider contractual arrangements. Review records related to the written policies and procedures for any instances, indicating health carrier performance, that did not comply with such policies and procedures.

Verify that the health carrier has established a process by which contracting network providers will be notified of the specific covered health care services for which the provider will be responsible, including any limitations or conditions on services, on an ongoing basis. Review process records to confirm that the health carrier in fact provides such notifications in a timely manner.

Verify that contracts between a health carrier and a participating provider set forth a hold harmless provision specifying protection for covered persons in the event of nonpayment or insolvency of the health carrier or its intermediary, as required under state statutes or regulations.

Verify that contracts between the health carrier and a participating provider set forth that in the event of a health carrier or intermediary insolvency or other cessation of operations, the provider's obligation to deliver covered services to covered persons without balance billing will continue as required under state statutes or regulations.

Verify that the participating provider does not collect or attempt to collect from a covered person any money owed to the provider by the health carrier. Review the contract provisions within the health carrier/participating provider contract with regard to periodic reconciliation/audit of itemized bills related to claims to health carrier reimbursement amounts. Review explanation of benefits (EOB) documents to verify that the provider is collecting the appropriate amount from the covered person.

Verify that the health carrier has developed, for providers and each health care professional specialty, selection standards for selecting [and tiering], as applicable, of participating providers, as required under the health carrier's approved access plan and in accordance with state statutes and regulations. Verify that the health carrier uses the selection standards in determining the selection [and tiering] of participating providers by the health carrier and its intermediaries with which it contracts.

Verify that the health carrier does not establish selection [and tiering] criteria in a manner:

- That would allow a health carrier to discriminate against high-risk populations by excluding [and tiering] providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health care services utilization; or
- That would exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health care services utilization.

Verify that the health carrier's selection criteria do not discriminate, with respect to participation under the health benefit plan, against any provider who is acting within the scope of the provider's license or certification under applicable state law or regulations.

Verify that consistent with state statutes and regulations, the health carrier makes its standards for selection and tiering, as applicable, of participating providers for its network(s) available for review [and approval] by the insurance commissioner.

Verify, if applicable, that a description in plain language of the standards the health carrier uses for selecting and tiering, as applicable, for its network providers is made available to the public.

Verify that the health carrier notifies participating providers of the providers' responsibilities with respect to the health carrier's applicable administrative policies and programs, including but not limited to payment terms; utilization review; quality assessment and improvement programs; credentialing; grievance and appeals procedures; data reporting requirements; reporting requirements for timely notice of changes in practice, such as discontinuance of accepting new patients; confidentiality requirements; and any applicable federal or state programs.

Review health carrier policies, procedures, programs, provider communications and other materials that may document or record health carrier activities related to provider networks, and policy provisions to identify if a health carrier offers an inducement to a provider that would encourage or otherwise incentivize the provider to deliver less than medically necessary services to a covered person.

Verify that the health carrier does not prohibit a participating provider from discussing any specific or all treatment options with covered persons irrespective of the health carrier's position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance or appeals processes established by the health carrier or a person contracting with the health carrier or in accordance with any rights or remedies available under applicable state [and federal] law and regulations. Examiners may need to review network provider contract forms and network provider communications, policies and other written materials. Review health carrier network provider records including communications that could contain complaints from network providers raising such concerns.

Verify that contracts between a health carrier and a participating provider require the provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of covered persons, and to comply with applicable state and federal laws related to the confidentiality of medical and health records and the covered person's right to see, obtain copies of or amend their medical and health records.

Verify that the health carrier and participating provider provide the requisite advance written notice to each other as required under state [and federal] statutes and regulations before the provider is removed or leaves a network without cause.

Verify that the health carrier maintains network provider participation records, including records pertaining to former network providers, to include records documenting provider status, status notices, renewals and terminations as required by state statutes and regulations.

Verify that the health carrier makes a good faith effort to provide written notice of a provider's removal or leaving the network within state [and federal] statutory or regulatory time frames for health carrier notices to all persons entitled to such notice under state [and federal] statutes or regulations.

Verify that when a provider who is a primary care professional has been removed, or has left a provider network, the provider provides the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier, as required by the health carrier's contract with the participating provider. If the list is not provided to the health carrier by the primary care physician who has been removed or who has left a provider network, ascertain why the health carrier has not enforced the contractual provision regarding such notice.

Verify that when the provider being removed or leaving the network is a primary care professional, the health carrier provides notice related to the termination to all covered persons who are patients of that primary care professional.

When a covered person's provider leaves or is removed from the network, verify that the health carrier establishes reasonable procedures addressing those covered persons who are in an active course of treatment, including procedures to assist transitions to participating providers in a manner that provides for continuity of care, in accordance with applicable state [and federal] statutes or regulations.

Verify that the health carrier makes available to the covered person information concerning available participating providers in the same geographic area who are of the same provider type, and information about how the covered person may request continuity of care.

Verify that the health carrier's procedures outlining how a covered person may request continuity of care include all provisions required under state [and federal] statutes or regulations, including:

- Individuals eligible to request continuity of care on behalf of patients;
- Individuals eligible to receive continuity of care;
- The length of the continuity of care period;
- Health carrier decision-making processes on continuity of care requests; and
- Enrollee grievance and appeal rights regarding continuity of care decisions.

Verify that the health carrier's procedures for continuity of care ensure that providers agree in writing to accept the same payment from and abide by the same terms and conditions with respect to the health carrier for that patient as provided in the original provider contract, and the provider agrees in writing not to seek any payment from the covered person for any amount for which the covered person would not have been responsible if the provider were still a participating provider.

Verify that health carrier contractual arrangements with participating providers ensure that the rights and responsibilities under a contract between a health carrier and a participating provider are not assigned or delegated by either party without the prior written consent of the other party.

Verify that the health carrier has written policies and procedures in place to ensure that a participating provider furnishes covered benefits to all covered persons without regard to the covered person's

enrollment in the plan as a private purchaser of the plan or as a participant in publicly-financed programs of health care services. This requirement does not apply to circumstances when the provider should not render services due to limitations arising from lack of training, experience, skill or licensing restrictions.

Verify that the health carrier assumes responsibility for notifying participating providers (1) of their obligations, if any, to collect applicable coinsurance, copayments or deductibles from covered persons pursuant to the evidence of coverage, and (2) of their obligations, if any, to notify covered persons of their personal financial obligations for non-covered services.

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

Verify that the health carrier has established a mechanism by which a participating provider may determine in a timely manner, at the time services are provided, whether or not an individual is a covered person or is within a grace period for payment of premium during which the health carrier may hold a claim for services rendered, pending receipt of payment of premium.

Verify that the health carrier has established written policies and procedures for resolution of administrative, payment or other disputes between providers and the health carrier for plans that use a provider network.

Review contractual arrangements between the health carrier and participating providers to ascertain if such contracts contain provisions that conflict with the provisions contained in the approved access plan(s) and/or the requirements of applicable state [and federal] statutes and regulations regarding network adequacy.

Verify that, at the time a contract is signed, the network provider receives a copy of or access to the network contract in a timely manner including all documents incorporated by reference. The provider contract shall define what is to be considered timely notice.

Verify that, while a provider contract is in force, the health carrier notifies a participating provider in a timely manner, of any changes to those provisions or documents that would result in material changes in the contract. The language of the contract shall define what is to be considered timely notice and what is to be considered a material change.

Verify that a health carrier informs a provider of the provider's network participation status, in a timely manner, on any health benefit plan in which the health carrier has included the provider as a participating provider.

Review complaint/dispute records to determine if the health carrier has not complied with the contractual provisions of the health carrier/participating provider contract, and whether the health carrier has provided appropriate corrective action/adjustments to the participating provider(s) in a timely and accurate manner.

Ascertain if an adverse determination finding could have been the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has

implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence related to any corrective action provided to a participating provider.

Verify that health carrier communication and educational materials provided to participating providers provide complete and accurate information about health carrier/participating provider contractual arrangements.

Review health carrier training materials to verify that information provided **therein** is complete and accurate with regard to health carrier/participating provider contractual arrangements and state [and federal] statutes and regulations.

~~Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.~~

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek legal advice and assistance from the state insurance department.

## STANDARDS NETWORK ADEQUACY

### Standard 4

**A health carrier offering individual and group market health insurance network plans shall comply with requirements regarding balance billing in accordance with applicable state statutes and regulations.**

**Apply to:** Those individual and group health products and related provider networks as set forth in the state's laws and regulations. For state examinations being conducted in the absence of state statutes and regulations addressing Affordable Care Act provisions, to all Qualified Health Plan products that use a provider network

Note: Standard 4 is based on **Section 7** the section titled "Requirements for Participating Facilities with Non-Participating Facility-Based Providers" of the *Health Benefit Plan Network Access and Adequacy Model Act* (#74). In states that have not adopted **Section 7 this section** of the Model Act, examiners should look at the state statutes and regulations that pertain to balance billing

**Priority:** Essential

### Documents to be Reviewed

- \_\_\_\_\_ State statutes and regulations addressing balance billing within health carrier provider networks
- \_\_\_\_\_ Approved health carrier network access plan(s)
- \_\_\_\_\_ Health carrier policies and procedures related to balance billing, including contractual arrangements between health carriers and participating providers
- \_\_\_\_\_ Health carrier policyholder service policies and procedures related to balance billing
- \_\_\_\_\_ Policyholder service files and supporting documentation regarding balance billing, including letters, notices, telephone scripts, etc., within health carrier provider network plans
- \_\_\_\_\_ Non-emergency out-of-network services written disclosures issued by facility-based providers, if set forth in state statutes or regulations for health carrier provider networks
- \_\_\_\_\_ Out-of-network emergency services billing notices issued by facility-based providers, if set forth in state statutes or regulations for health carrier provider networks
- \_\_\_\_\_ Non-participating facility-based provider-issued payment responsibility notices/billing statements, if set forth in state statute or regulations for health carrier provider networks
- \_\_\_\_\_ Health carrier's provider mediation processes, including policies and procedures, if set forth in state statutes or regulations for health carrier provider networks

\_\_\_\_\_ Records of open and completed provider mediations, if set forth in state statutes or regulations for health carrier provider network plans

\_\_\_\_\_ Health carrier complaint records concerning balance billing (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response) for health carrier provider network plans

\_\_\_\_\_ Health carrier communication and educational materials related to balance billing provided to insureds, beneficiaries and prospective purchasers ~~for~~ of health carrier provider network plans

\_\_\_\_\_ Employee training materials related to balance billing for health carrier provider network plans

~~\_\_\_\_\_ Applicable state statutes, rules and regulations~~

**Others Reviewed**

\_\_\_\_\_

\_\_\_\_\_

### **NAIC References**

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

### **Other References**

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

\_\_\_\_\_ Federal regulations, including FAQs and other regulatory guidance

### **Review Procedures and Criteria**

Verify that the health carrier has established and implemented written policies and procedures regarding compliance of network plans with requirements in approved provider networks and as set forth in applicable state statutes and regulations regarding balance billing.

Verify for non-emergency out-of-network services, at the time a participating facility schedules a procedure or seeks prior authorization from a health carrier for the provision of non-emergency services to a covered person, the facility provides the covered person with an out-of-network services written disclosure, in accordance with any requirements set forth in state statutes or regulations.

Verify that at the time of admission in the participating facility where the non-emergency services are to be performed on the covered person, the facility provides a covered person with a written disclosure and obtains the covered person's or the covered person's authorized representative's signature on the disclosure document acknowledging that the covered person received the disclosure document before the time of admission.

Verify for out-of-network emergency services, a non-participating facility-based provider includes a statement on any billing notice sent to a covered person for services provided, informing the covered person that he or she is responsible for paying the applicable in-network cost-sharing amount, but has no

legal obligation to pay the remaining balance. Such statement also shall inform the covered person of his or her obligation to forward the bill to their health carrier for consideration under a provider mediation process as set forth in state statutes or regulations.

Verify that where a non-participating facility-based provider sends a billing notice directly to a covered person for the non-participating facility-based provider's service(s), the billing notice includes the Payment Responsibility Notice as set forth in state statutes or regulations.

Verify that non-participating facility-based providers do not attempt to collect payment, excluding appropriate cost-sharing, from covered persons when the provider has elected to trigger the health carrier's non-participating facility-based provider billing process.

Verify that non-participating facility-based providers who do not provide a covered person with a Payment Responsibility Notice may not balance bill the covered person.

Verify that for health carrier out-of-network facility-based provider payments, health carriers develop a program for payment of non-participating facility-based provider bills and may elect to pay non-participating facility-based provider bills as submitted, or the health carrier may pay in accordance with the benchmark for non-participating facility-based provider payments established in applicable state statutes and regulations, and that non-participating facility-based providers who object to such payment(s) may elect the provider mediation process described in applicable state statutes and regulations. Payments to non-participating facility-based providers shall be presumed to be reasonable if a payment is based on the higher of the health carrier's contracted rate or [XX] percentage of the Medicare payment rate for the same or similar services in the same geographic area.

Verify that the health carrier has established a provider mediation process for payment of non-participating facility-based provider bills for providers objecting to the application of the established payment rate outlined in applicable state statutes and regulations or that the health carrier otherwise complies with any state statutes and regulations regarding mediation or arbitration processes for payment of non-participating provider bills. The health carrier's provider mediation process shall be established in accordance with mediation standards as set forth under state statute and regulations.

Verify that following completion of the provider mediation process, the cost of mediation is split evenly and paid by the health carrier and the non-participating facility-based provider or that the health carrier otherwise follows any state statutes or regulations regarding its share of the cost for the process.

Verify that a health carrier provider mediation process is not used when the health carrier and the non-participating facility-based provider agree to a separate payment arrangement or when the covered person agrees to accept and pay the non-participating facility-based provider's charges for the out-of-network service(s).

Verify that a health carrier maintains records on all requests for mediation and completed mediations during a calendar year and, upon request, submits a report to the insurance commissioner in the format specified by the insurance commissioner.

Review complaint records (including complaint records to other state agencies, if applicable) to verify that if a non-participating facility-based provider attempts to collect payment, excluding appropriate cost-sharing, from a covered person for health care services, the non-participating facility-based

provider has taken appropriate corrective action/adjustments regarding the removal of the requirement of the covered person's payment for health care services, in a timely and accurate manner.

Ascertain if any examination adverse determination **finding** could ~~have been be~~ the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier **has** implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, supporting corrective action provided to a covered person(s), including website notifications.

Verify that health carrier communication and educational materials provided to insureds, beneficiaries and prospective purchasers provide complete and accurate information about balance billing.

Verify that the health carrier has established training programs designed to inform its employees and producers about state [and federal] statutes and regulations pertaining to balance billing.

Review health carrier training materials for its employees and appointed agents to verify that information provided is complete and accurate with regard to balance billing.

~~Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.~~

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek legal advice and assistance from the state insurance department.

## STANDARDS NETWORK ADEQUACY

### Standard 5

**A health carrier offering individual and group market health insurance network plans shall develop and issue written disclosures or notices to be provided to covered persons regarding balance billing, in accordance with applicable state statutes and regulations.**

**Apply to:** Those individual and group health products and related provider networks as set forth in the state's laws and regulations. For state examinations conducted in the absence of state statutes and regulations addressing Affordable Care Act provisions, to all Qualified Health Plan products that use a provider network

Note: Standard 5 is based on ~~Section 8~~the section titled "Disclosure and Notice Requirements" of the *Health Benefit Plan Network Access and Adequacy Model Act* (#74). In states that have not adopted ~~Section 8~~this section of the Model Act, examiners should look at the state's statutes and regulations that pertain to written disclosures or notices regarding balance billing

**Priority:** Essential

### Documents to be Reviewed

- \_\_\_\_\_ State and [federal] statutes and regulations addressing balance billing within health carrier provider networks
- \_\_\_\_\_ Approved health carrier network access plan provisions related to written disclosures and notices regarding balance billing
- \_\_\_\_\_ Provisions within health carrier contracts with network providers related to written disclosures and notices regarding balance billing
- \_\_\_\_\_ Health carrier policyholder service policies and procedures related to written disclosures and notices of balance billing
- \_\_\_\_\_ Policyholder service files and supporting documentation regarding balance billing, including letters, notices, telephone scripts, etc.
- \_\_\_\_\_ Written disclosures for out-of-network services provided by health carriers regarding balance billing
- \_\_\_\_\_ If set forth in state statutes or regulations, written disclosures for non-emergency services provided by facility-based providers regarding balance billing
- \_\_\_\_\_ Health carrier complaint records concerning balance billing (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

\_\_\_\_\_ Health carrier communication and educational materials related to written disclosures/notices of balance billing provided to insureds, beneficiaries, prospective purchasers and producers

\_\_\_\_\_ Training materials for health carrier employees and appointed agents related to balance billing

===== **Applicable state statutes, rules and regulations**

Others Reviewed

## NAIC References

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

## Other References

===== **HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials**

Federal regulations, including FAQs and other regulatory guidance

## Review Procedures and Criteria

Verify that, as set forth in state [or federal] statute or regulation, the health carrier develops a written disclosure or notice to be provided to a covered person or the covered person's authorized representative at the time of pre-certification and other time frame(s) as set forth in state [or federal] statutes or regulations for a covered benefit to be provided at a facility that is in the covered person's health benefit plan network, that there is the possibility that the covered person could be treated by a health care professional that is not in the same network as the covered person's network.

Verify, as set forth in state [and federal] statutes or regulations, that the health carrier has established and implemented written policies and procedures regarding the content and issuance of written disclosures or notices to covered persons regarding balance billing.

Verify, as set forth in state [and federal] statutes or regulations, that the health carrier's disclosure or notice indicates that the covered person may be subject to higher cost-sharing, as described in the covered person's plan summary of coverage and benefits documents, including balance billing, if the covered services are performed by a health care professional, who is not in the covered person's plan network even though the covered person is receiving the covered services at a participating facility, and that information on what the covered person's plan will pay for the covered services provided by a non-participating health care professional is available on request from the health carrier. Verify that the notice includes other content as set forth in state [or federal] statutes or regulations pertaining to the treatment of costs incurred due to care provided by out-of-network providers. Verify that the disclosure or notice also informs the covered person or the covered person's authorized representative of options available to access covered services from a participating provider.

Verify, as set forth in statutes or regulations, that for non-emergency services, as a requirement of its provider contract with a health carrier, a facility develops a written disclosure or notice to be provided to

a covered person of the carrier within ten (10) days of an appointment for in-patient or outpatient services at the facility or at the time of a non-emergency admission at the facility that confirms that the facility is a participating provider of the covered person's network plan and informs the covered person that a health care professional, such as an anesthesiologist, pathologist or radiologist, who may provide services to the covered person while at the facility may not be a participating provider in the same network as the covered person's network.

Verify that the health carrier has established processes to count the cost sharing paid by a covered person for an essential health benefit provided by an out-of-network provider in an in-network setting towards the enrollee's annual limitation on cost sharing in instances in which the carrier does not provide requisite notice to the covered person, as required under state [and federal] statutes and regulations.

Review complaint records to verify that if the health carrier has issued a written notice or disclosure of balance billing not in compliance with the content requirements of applicable state [and federal] statutes and regulations and the approved access plan has improperly issued such notice or has not issued such notice, the health carrier has taken appropriate corrective action/adjustments regarding the issuance of a proper written notice or disclosure to the covered person(s).

Ascertain if any examination adverse determination **finding** could ~~have been be~~ the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier **has** implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains correspondence, records documenting corrective actions taken on behalf of a covered person(s), including website notifications.

Verify that health carrier communication and educational materials provided to insureds, beneficiaries, prospective purchasers and producers provide complete and accurate information about content and issuance of written notices or disclosures pertaining to balance billing.

Verify that the health carrier has established training programs designed to inform its employees and appointed agents about state [and federal] and regulations regarding content and issuance of written notices or disclosures pertaining to balance billing. Review the health carrier's training materials to verify that the information provided is complete and accurate.

~~Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.~~

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek legal advice and assistance from the state insurance department.

**STANDARDS  
NETWORK ADEQUACY**

**Standard 6**

**A health carrier offering individual and group market health insurance network plans shall comply with requirements set forth in applicable state statutes and regulations regarding content, accessibility, transparency, accuracy, and completeness of printed and electronic provider directories.**

**Apply to:** Those individual and group health products and related provider networks as set forth in the state's laws and regulations. For state examinations being conducted in the absence of state statutes and regulations addressing Affordable Care Act provisions, to all Qualified Health Plan products that use a provider network

**Priority:** Essential

**Documents to be Reviewed**

- \_\_\_\_\_ State [and federal] statutes and regulations related to network provider directories
- \_\_\_\_\_ Approved health carrier network access plan(s)
- \_\_\_\_\_ Hard copies and web-based copies of network provider directories
- \_\_\_\_\_ Provisions within health carrier network provider contract(s) entered into pursuant to the approved network access plan(s) addressing provider directories
- \_\_\_\_\_ Health carrier policies and procedures related to network provider directories, including policies and procedures for maintaining accurate and timely directories
- \_\_\_\_\_ Files and supporting documentation regarding frequency of network provider directory revisions and updates
- \_\_\_\_\_ Health carrier self-audits of provider directories, in accordance with state statutes and regulations
- \_\_\_\_\_ Health carrier complaint records concerning the accessibility, accuracy and completeness of network provider directories as well as supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response
- \_\_\_\_\_ Health carrier marketing and sales policies and procedures that refer to provider directories and networks
- \_\_\_\_\_ Health carrier marketing and educational materials related to provider directories and networks provided to insureds, beneficiaries and prospective purchasers, including communications with producers
- \_\_\_\_\_ Health carrier training materials for employees and appointed agents

\_\_\_\_\_ Producer records related to network provider directories

===== ~~Applicable state statutes, rules and regulations~~

| **Others Reviewed**

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### NAIC References

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

### Other References

===== ~~HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials~~  
Federal regulations, including FAQs and other regulatory guidance

### Review Procedures and Criteria

Verify that the health carrier has established and implemented written policies and procedures regarding compliance of all network plans with provider directory requirements in accordance with state [and federal] requirements.

Verify that the health carrier posts electronically a current and accurate provider directory for each of its network plans, including specified information required under state [and federal] statutes and regulations for health care professionals, hospitals and other facilities. To the extent required under state statutes and regulations, verify that this information is available in a searchable format.

Verify for electronic provider directories for each network plan, that the health carrier makes available specified additional information required under state statutes or regulations for health care professionals, hospitals and other facilities.

Verify that in making a provider directory available electronically, the health carrier ensures that the general public is able to view all of the current providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number.

Verify that the health carrier makes it clear for both its electronic and print directories what provider directory applies to which network plan, such as including the specific name of the network plan as marketed and issued in ~~this~~ the applicable state.

Verify that the health carrier updates each network plan provider directory at least monthly or within the specified time frame stated under applicable state statutes or regulations.

Verify that the health carrier periodically audits at least a reasonable sample size of its provider directories for accuracy and retains documentation of such an audit to be made available to the insurance commissioner of the applicable state upon request or complies with any other provider directory audit requirements as applicable under state statutes or regulations.

Verify that the health carrier provides a print copy, or a print copy of the requested directory information, of a current provider directory with specified information for health care professionals, hospitals and other facilities, in accordance with state [and federal] statutes and regulations, upon request of a covered person or a prospective covered person.

Verify, via sample testing of the provider directory relative to network providers, ~~Determine the following that the network provider:~~

- Is still practicing?
- Is currently participating in the insurer's health carrier's network?
- Office is located at the address designated in the provider directory?
- Is practicing in accordance with the designation (i.e. pediatrics, nurse midwife, cardiology) as listed in the provider directory?
- Is currently accepting new patients?
- Has not been sanctioned or prohibited from participation in federal health care programs under Section 1128 or Section 1128A of the Social Security Act?; and
- Has not had his/her license suspended or revoked by a state agency?

~~For Residential Treatment Facilities~~ With regard to residential treatment facilities (Mental Health Treatment and Substance Abuse), verify that residential treatment facilities for mental health treatment and substance abuse are included in the provider directory on the health carrier's website and in hardcopy.

Verify that for each network plan, a health carrier includes in plain language in both the electronic and print directory, general information, if applicable, describing the criteria the health carrier has used to build its provider network; describing the criteria the health carrier has used to tier providers; describing how the health carrier designates the different provider tiers or levels in the network and identifies for each specific provider, hospital or other type of facility in the network which tier each is placed, for example by name, symbols or grouping, in order for a covered person or a prospective covered person to be able to identify the provider tier; and noting that authorization or referral may be required to access some providers.

Verify that the health carrier includes in both its electronic and print directories a customer service email address and telephone number or electronic link that covered persons or the general public may use to notify the health carrier of inaccurate provider directory information.

Verify that for all of the pieces of information required to be included in a printed or electronic provider directory pertaining to a health care professional, a hospital or a facility other than a hospital, the health carrier makes available through the directory the source of the information and any limitations, if applicable.

Verify that the health carrier's provider directory, whether in electronic or print format, accommodates the communication needs of individuals with disabilities, and includes a link to or information regarding available assistance for persons with limited English proficiency, or otherwise complies with state statutes and regulations regarding accessibility.

Note: State regulators should be aware that a Qualified Health Plan (QHP) must comply with language accessibility requirements under federal regulations 45 CFR §155.205 in order to be offered on a health insurance exchange under the federal Affordable Care Act (ACA) and implementing regulations.

Verify that the health carrier makes available in print, upon request, specified information about health care professionals, hospitals and other facilities required under state statute and regulations, for the applicable network plan.

Verify that the health carrier includes a disclosure in the printed directory that the information included in the directory is accurate as of the date of printing and that insureds, beneficiaries, prospective purchasers and producers should consult the health carrier's electronic provider directory on its website or call the health carrier's customer service telephone number to obtain current provider directory information.

Review complaint register/logs and complaint files to identify complaints pertaining to accessibility, accuracy and completeness of provider directories.

Review complaint records to verify that if the health carrier has issued a provider directory not in compliance with the content requirements of applicable state [and federal] statutes and regulations, has improperly issued such a directory or has not issued such a directory, the health carrier has taken appropriate corrective action/adjustments regarding the issuance of a proper provider directory to covered person(s).

Ascertain if any examination adverse determination **finding** could ~~have been~~ **be** the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier **has** implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains correspondence documenting the corrective action taken on behalf of a covered person(s), including website notifications related to provider directories.

Verify that any marketing materials, communication and educational materials provided to insureds, beneficiaries and potential purchasers by the health carrier provide complete and accurate information about the network based on evaluation of the content, accessibility, transparency, accuracy, and completeness of provider directories.

Verify that the health carrier has established training programs designed to inform its employees and appointed agents about applicable state [and federal] statutes and regulations pertaining to content, accessibility, transparency, accuracy, and completeness of provider directories.

Review health carrier training materials to verify that information provided is complete and accurate with regard to requirements for content, accessibility, transparency, accuracy, and completeness of provider directories.

Review producer records and health carrier communication with producers to verify that the provider directory information provided by producers to insureds, beneficiaries and prospective purchasers is complete and accurate with regard to provider networks.

**Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.**

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek legal advice and assistance from the state insurance department.

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### PRODUCER STANDARDIZED DATA REQUEST

**Contents:** This file should be downloaded from company system(s) and contain one record for each individual or business entity representing your company, whether receiving commissions or not, in the examination state(s) at any time during the examination period. Individuals and business entities which should be listed are any producers, business entity producers, or customer service representatives (CSR) involved with the sale, solicitation or negotiation of insurance in the examination state(s).

**Uses:** Data will be used to determine if the individual is properly licensed to sell insurance and/or collect commissions. It will also be used to determine replacement rates for individuals as well as other new business practices, such as timely delivery of appropriate forms and illustrations and securing proper signatures at the time of policy application and delivery:

- Cross-reference to commissions to determine eligibility to collect commissions paid or credited;
- Cross-reference to new business and replacements to determine license status at the time new business is written and look for high replacement rates;
- Cross-reference to new business and policy loans to look for loans taken to finance new policies; and
- Cross-reference to state(s) licensing and appointment files to determine compliance with licensing and appointment regulations.

Field Name	Start	Length	Type	Decimals	Description
CoCode	1	5	A		NAIC company code
PrCode	6	9	A		Company internal producer, CSR or business entity producer identification code <b>If more than 1 producer of record, repeat this field as necessary and include a revised file layout</b>
NPN	15	7	A		National producer number
PrFirst	22	15	A		First name of producer or CSR
PrMid	37	15	A		Middle name of producer or CSR
PrLast	52	20	A		Last name of producer or CSR or name of business entity producer
PrStat	72	15	A		Status of producer, CSR or business entity producer appointment (active, inactive, terminated, etc.)
PrAddr	87	25	A		Producer's, CSR's or business entity producer's street address
PrCity	112	25	A		Producer's, CSR's or business entity producer's city
PrSt	137	2	A		Producer's, CSR's or business entity producer's state abbreviation
PrZip	139	5	A		Producer's, CSR's or business entity producer's ZIP code
LicEffDt	144	10	D		Producer license effective date [MM/DD/YYYY]
PrAptDt	154	10	D		Producer's, CSR's or business entity producer's appointment date with <b>this</b> company [MM/DD/YYYY]
PrTrmDt	164	10	D		Producer's, CSR's or business entity producer's termination date with <b>this</b> company [MM/DD/YYYY]
PrTrmRs	174	15	A		Reason for producer's, CSR's or business entity producer's termination
ResLicSt	189	2	A		Resident license state abbreviation
LOBLic	191	30	A		Lines of business licensed to write
NRLicDt	221	10	D		(Nonresident Examination State) license effective date [MM/DD/YYYY]

Field Name	Start	Length	Type	Decimals	Description
NRaptDt	231	10	D		(Nonresident Examination State) appointment date with <b>this</b> company [MM/DD/YYYY]
NRTrmDt	241	10	D		(Nonresident Examination State) license termination date [MM/DD/YYYY]
NRTrmRs	251	15	A		(Nonresident Examination State) license termination reason
EndRec	266	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.

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## MARKETING AND SALES STANDARDIZED DATA REQUEST

**Contents:** This file should be downloaded from company system(s) and contain one record for each advertisement created directly or indirectly by or on behalf of the Company related to business covered by this examination and intended for presentation, distribution, dissemination or other advertising in the examination state(s) during the examination period.

Advertisements include:

- Printed or published material, audio-visual material and descriptive literature used in direct mail, newspaper, magazines, radio and TV scripts, billboards, Internet (pop-up ads and Websites), e-mail and facsimile communications and similar displays;
- Descriptive literature and sales aids of all kinds used for presentation to members of the insurance buying public, such as circulars, leaflets, booklets, depictions, illustrations and form letters; and
- Prepared sales talks, presentations and marketing materials used by producers, brokers and solicitors.

**Uses:** Data will be used to determine if the company follows appropriate procedures with respect to records maintenance and compliance with applicable state laws with respect to advertising insurance products.

Field Name	Start	Length	Type	Decimals	Description
CoCode	1	5	A		NAIC company code
AdvID	6	30	A		Advertisement identification number
AdvName	36	50	A		Title or "name" of the advertisement
AdvDesc	86	50	A		Advertisement description
AdvAppDt	136	10	D		Date the advertising piece was approved by the company [MM/DD/YYYY]
AdvDstDt	146	10	D		First date marketing materials were used in examining state(s), if any [MM/DD/YYYY]
NoUsed	156	6	A		Number of advertisements disseminated
AdvDscDt	162	10	D		Date company discontinued use of this material in examining jurisdiction(s) [MM/DD/YYYY]
AdvTp	172	15	A		Type of advertisement (radio script, TV script, website, leaflet, etc.)
AdvDist	187	15	A		Identify the method of distribution (producer, direct mail, etc.)
AdvCvgTp	202	15	A		Type of coverage being advertised
Audience	217	15	A		Intended audience
Outlet	232	25	A		Media outlets that the advertising was published/aired through (name of periodical, social media, radio station, television station, etc.)
AdvPolFm	257	10	A		Policy form number(s) being advertised. List all policy form numbers being advertised
AdvRdEnd	267	10	A		List all form numbers of riders and endorsements related to a marketing piece
SERFFNo	277	20	A		SERFF filing number of the advertisement, if applicable

Field Name	Start	Length	Type	Decimals	Description
EndRec	297	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.

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### COMMISSION STANDARDIZED DATA REQUEST

**Contents:** This file should be downloaded from company system(s) and contain one record for each commission payment or credit made for the examination state(s) during the examination period at the policy/certificate level. This table will provide the dates and amounts of the commissionable premium payments and dates commissions were paid or credited.

**Uses:** Data will be used to determine the individuals' eligibility to collect commission payments or credits:

- Cross-reference to issued business to determine eligibility to collect commissions paid or credited; and
- Cross-reference to state(s) licensing and appointment files to determine compliance with licensing and appointment regulations.

Field Name	Start	Length	Type	Decimals	Description
CoCode	1	5	A		NAIC company code
PrCode	6	9	A		Company internal producer, CSR or business entity producer identification code <b>If more than 1 producer of record, repeat this field as necessary and include a revised file layout</b>
NPN	15	7	A		National producer number
PolPre	22	3	A		Policy prefix <b>Blank if NONE</b>
PolNo	25	10	A		Policy number
PolSuf	35	3	A		Policy suffix <b>Blank if NONE</b>
CertNo	38	10	A		Certificate number, if applicable
CommPrem	48	11	N	2	Commissionable premium amount paid on this policy or certificate
PremPdDt	59	10	D		Date commissionable premium paid [MM/DD/YYYY]
CommAmt	69	11	N	2	Commission amount paid or credited
CommPdDt	80	10	D		Date commission paid or credited [MM/DD/YYYY]
CommTyp	90	20	A		Commission type paid (first year, second year, override, service fees, contingent fees, bonuses, other monetary compensation and other non-monetary compensation)
EndRec	110	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.

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**COMMISSION STANDARDIZED DATA REQUEST**

**Contents:** This file should be downloaded from company system(s) and contain one record for each commission payment or credit made for the examination state(s) during the examination period at the policy/certificate level. This table will provide the dates and amounts of the commissionable premium payments and dates commissions were paid or credited.

**Uses:** Data will be used to determine the individuals' eligibility to collect commission payments or credits:

- Cross-reference to issued business to determine eligibility to collect commissions paid or credited; and
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Field Name	Start	Length	Type	Decimals	Description
CoCode	1	5	A		NAIC company code
PrCode	6	9	A		Company internal producer, CSR or business entity producer identification code <b>If more than 1 producer of record, repeat this field as necessary and include a revised file layout</b>
NPN	15	7	A		National producer number
PolPre	22	3	A		Policy prefix <b>Blank if NONE</b>
PolNo	25	10	A		Policy number
PolSuf	35	3	A		Policy suffix <b>Blank if NONE</b>
CertNo	38	10	A		Certificate number, if applicable
CommPrem	48	11	N	2	Commissionable premium amount paid on this policy or certificate
PremPdDt	59	10	D		Date commissionable premium paid [MM/DD/YYYY]
CommAmt	69	11	N	2	Commission amount paid or credited
CommPdDt	80	10	D		Date commission paid or credited [MM/DD/YYYY]
ComPayee	90	1	A		<u>Describes to whom the commission was actually paid. Indicate (P) if the commission was paid to the individual producer, (A) if the commission was paid to an agency, or (O) for other</u>
CommTyp	91	20	A		Commission type paid (first year, second year, override, service fees, contingent fees, bonuses, other monetary compensation and other non-monetary compensation)
EndRec	111	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.

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### COMPLAINT STANDARDIZED DATA REQUEST

**Contents:** This file should be downloaded from company system(s) and contain one record for each complaint received by the Company or any entities acting on behalf of the Company during the examination period related to business under examination in the examination state(s). A complaint means any dissatisfaction about an insurer or its contracted providers expressed by an insured, an enrollee or their authorized representative to the insurer.

**Uses:** Data will be used to determine if the company follows appropriate procedures with respect to records maintenance and proper complaint handling procedures:

- Cross-reference to state(s) licensing and appointment records to check for problems with individual licensed or appointed producers;
- Cross-reference with examining insurance department(s) complaint records to check for compliance with complaint reporting and records maintenance requirements; and
- The regulated entity takes adequate steps to finalize the complaint in accordance with applicable statutes, rules, regulations, and contract language.

Field Name	Start	Length	Type	Decimals	Description
CoCode	1	5	A		NAIC company code
PolPre	6	3	A		Policy prefix <b>Blank if NONE</b>
PolNo	9	10	A		Policy number
PolSuf	19	3	A		Policy suffix <b>Blank if NONE</b>
ClmNo	22	10	A		Claim numbers involved in complaint
CertNo	32	10	A		Certificate number, if applicable
CmpCsNo	42	10	A		Company complaint case number for the complaint
DOICsNo	52	10	A		Insurance department case number for the complaint <b>If the complaint is or has been reviewed by a state insurance department</b>
CmpSt	62	2	A		Complaint state abbreviation
CmpTyp	64	20	A		Complainant type (provider, producer, insured, claimant, agency, including insurance department etc.)
CmpOrg	84	20	A		Origin of complaint (company direct, department of insurance, Better Business Bureau, social media, Internet, etc.)
CmpFirst	104	15	A		First name of complainant
CmpMid	119	15	A		Middle name of complainant
CmpLast	134	20	A		Last name of complainant
InsFirst	154	15	A		First name of insured
InsMid	169	15	A		Middle name of insured
InsLast	184	20	A		Last name of insured <b>If group, record name of the group here</b>

Field Name	Start	Length	Type	Decimals	Description
InsSt	204	2	A		Insured's resident state
CmpCvgTp	206	10	A		Type of coverage (life, health, dental, home, auto, etc.)
CmpRes	216	30	A		Reason for complaint <b>If codes are used, please include a list of complaint reason codes along with their meanings</b>
CmpSubRs	246	30	A		Sub-reason for complaint <b>If codes are used, please include a list of complaint sub-reason codes along with their meanings</b>
CmpRecDt	276	10	D		Date complaint received [MM/DD/YYYY]
CmpTrnTp	286	5	A		The manner in which the complaint was transmitted to the company (phone, visit, letter, etc.)
Status	291	1	A		Complaint status ( <b>O = Open, C = Closed</b> )
CmpRsl	292	30	A		Complaint resolution <b>If codes are used, please include a list of complaint resolution codes along with their meanings</b>
CmpRslDt	322	10	D		Date complaint resolved, if applicable [MM/DD/YYYY]
CmpLtrDt	332	10	D		Date complaint resolution letter sent, if applicable [MM/DD/YYYY]
EndRec	342	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

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## CHAPTER 29 PROCESS REVIEW METHODOLOGY

This chapter describes a process review methodology that may be utilized in a market conduct examination as an alternative process or as a supplement to the methodology described in other chapters. It is focused on a review of the process and controls utilized by an examinee in the management of its operations. Each of the standards described in Chapters 16 through 24 of this *Handbook* are applicable under either methodology. The methodology described in those chapters will be referred to as conventional market conduct examination methodology.

The Sections in this chapter describe the process review approach and include interrogatories, process testing and suggestions for reviews conducted utilizing this methodology. The contents of this chapter include:

- A. General
- B. Enabling Statutes
- C. Review Considerations
- D. Application of the Process Review Methodology
- E. Uses of the Process Review Methodology
- F. Requests for Information
- G. Tests Common to the Structure of all Processes
- H. Tests Specific to a Particular Process Content
- I. Evaluation of Process
- J. List of Processes

### **A. General**

The material that follows is a substantial departure from what is viewed as a conventional market conduct examination methodology as described in Chapters 16 through 24 of this *Handbook*. Several states have acted as laboratories to develop these concepts. The methodology discussed in this chapter requires the increased use of an examiner's analytical skills. The testing suggested here does not necessarily result in a pass or fail, yes or no, or black or white response. Nevertheless, it represents a potential for the acquisition of better information pertinent to a regulated entity's operations and the management of those operations than does a conventional market conduct examination. This methodology utilizes a qualitative review as opposed to the quantitative review found in the conventional methodology. This methodology should not be limited to Company Operations/Management (Section A in most examination chapters), but also to each of the other areas of interest during an examination.

Briefly stated, this approach is the review of the directions provided by a regulated entity's management in the form of written procedures, directives, processes, strategies, etc., (collectively, processes). This review reveals how a regulated entity manages and controls the various processes it implements to operate its business and to comply with insurance statutes. This approach is an effective means to determine whether regulated entity management in an area or areas under review is proactive or reactive. A proactive process generally results in a

minimal level of error or violation. A reactive process has an increased propensity for error and violation. If the process is flawed, compliance is usually compromised.

The conventional method of examination as described in this *Handbook* typically reviews the results of a regulated entity operation for error or violation of statute and reacts to that result. It is generally quantitative and microscopic in nature. This approach is reasonably effective at identifying violations of state law that have already occurred. It uses sampling methodology to select files for review and then applies standards and tests to determine whether the files reviewed comply with the applied test. This results in considerable duplication when multiple states have similar concerns and conduct separate examinations. The conventional method of examination is usually cumbersome when applied on a multi-state basis unless the subject of the examination is sufficiently targeted and the state laws for the examining states are sufficiently similar. It is not particularly effective at determining causation of file failure. The principal regulatory interest in developing new tools for review is not the quantification of violation or error, but rather the qualification of the management structure and its ability to provide effective compliance. It is also particularly useful in structuring corrective action.

The conventional market conduct examination utilizes a review of events at the operational level of an insurer. These results have already occurred so the review is historical. A process review approach looks to all levels with emphasis on the management and control of those processes of interest to market regulation.

In an effort to avoid the criticism of duplication in regulation, states revisited the role of market analysis. Market analysis has existed in states actively engaging in market conduct examinations in some form or another for years. However, it did not possess the refinements that have been developed in recent years. In its current configuration, market analysis is being used to determine which of a variety of regulatory responses are appropriate to a particular set of circumstances. See chapters 1 through 5 of this *Handbook*. As this process becomes more refined, and as the states collaborate in their regulatory efforts, much of the duplication can be expected to dissipate. The challenge is to recognize more effectively and efficiently the indicators that should lead to some form of regulatory interaction.

When a state conducts a review, finds violations or errors and tells a regulated entity to fix it, a difficult condition may be established particularly in those instances where causation is not clear. The regulated entity may have no more of an idea of what has caused a violation or error than does the regulator. For that determination a qualitative review is needed, not a quantitative one. The only way to arrive at a qualitative utility is to adopt reviews that look more intensively at the process and controls affecting the process of interest. Like the reviews to which financial examiners have moved, the overall techniques are similar but rely on very different experience bases. The Financial Examiner reviews process from the viewpoint of the reviewer's background in accounting, investment and/or financial management experience. The market conduct examiner reviews process from the viewpoint of the reviewer's background in underwriting, claims, consumer services, complaint handling and/or contract review experience.

The methodology discussed in this chapter is a review of management structures and controls of areas impacting market related issues. This approach is very effective at identifying *causes* for

violations of statute. The process review market conduct examination utilizes a review of the processes and controls developed for the operations of an insurer.

The use of process review methodology has several advantages including the following:

- It can be used on a targeted or routine basis.
- It requires less time to conduct such a review.
- A considerable amount of the review work can be conducted off-site.
- The review conducted tends to be corporate-wide rather than state-specific, thus increasing the multi-state utility of the process.
- It is readily able to identify causation and potential areas of regulatory slippage.
- It tends to be less confrontational since development of violations is not the primary function.
- It is highly predictive of where violations have occurred or are likely to occur thus allowing for proactive correction activity.
- It provides an opportunity for objective regulator/regulated entity dialogue.
- It provides value for the examination costs to the regulated entity.
- It can be used as a stand-alone examination or as a supplement to a conventional examination.
- It is responsive to domestic deference concerns.
- It offers the regulated entity the opportunity to improve compliance.

In its' September 30, 2003 report, GAO-03-433 Insurance Regulation, the Government Accounting Office recognized the need to include corporate governance (process review) elements in the examination approach with the following statement in its' conclusions: "In addition, existing computerized audit tools could allow regulators to substantially change the way examinations are done by shifting the focus from file review to a review of controls, systems, and processes and possibly by shortening the time needed for the examination."

## **B. Enabling Statute**

The statute enabling a process review review is already found in state examination statutes and to some extent, in the admissions statutes. The language in the examination statutes is generally similar from state to state and provides broad authority to examine matters of regulatory interest to the states.

The provision of interest in the admissions statutes is that related to competent management. An enabling statute reads something similar to the following:

“The Commissioner shall not grant or continue authority to transact insurance in this State as to any insurer or proposed insurer the management of which is found by the Commissioner after investigation or upon reliable information to be incompetent or dishonest or untrustworthy or of unfavorable business repute or so lacking in insurance company managerial experience in operations of the kind proposed in this State as to make such operation, currently or prospectively, hazardous to or contrary to the best interests of, the insurance-buying or investing public of this State, or which the Commissioner has good reason to believe is affiliated directly or indirectly through ownership, control, reinsurance transactions or other business relations with any person or persons of unfavorable business repute or whose business operations are or have been marked, to the injury of insurers, stockholders, policyholders, creditors, or the public, by illegality, or by manipulation of assets or of accounts or of reinsurance or by bad faith.”

In some cases the reference is somewhat less direct. For example:

“It is the duty of the commissioner to examine all requests and applications for licenses to be issued under the authority of this title, and the commissioner is authorized to refuse to issue any such licenses until the commissioner is satisfied of the qualifications and general fitness of the applicant in accordance with the requirements of the insurance laws.”

In fewer cases the reference appears only in the Commissioners authority to revoke or suspend the regulated entity’s license. For example:

“The certificate of authority of an insurance company to do business in this state may be revoked or suspended by the commissioner for any reason specified in this title. Specifically, the certificate may be suspended or revoked by the commissioner for reasons that include, but are not limited to use of methods that, although not otherwise specifically proscribed by law, nevertheless render its operation hazardous, or its condition unsound, to the public or to its policyholders.”

## C. Review Considerations

An examination that utilizes the process review approach should be based on an understanding of the considerations that contribute to the efficacy of its processes. If the considerations and the logic that support the approach are not thoroughly understood, it is not likely that the method can be used effectively. This usually means that the examiner will be focusing on the written processes in use by the regulated entity.

### 1. Management Cycle

The management of a well-run regulated entity adopts processes that are similar in structure to ensure compliance. An absence or ineffective application of such processes in a regulated entity often results in an inconsistent application of the intended process. Ineffective processes are typically revealed by adverse findings in samples tested during the course of a market conduct examination. The processes include the following components:

- A planning function where direction, policy, objectives, and goals are formulated
- An execution or implementation of the planning function elements
- A measurement and control function that considers the results of the planning and execution, such as an internal audit function that looks to test and refine the effectiveness of the control or process
- A reaction function that utilizes the results of measurement to take corrective action or to modify the process to develop more efficient and effective management of the regulated entity's operations.

#### (a). Planning

The planning function in the management cycle is where direction, policy, objectives, and goals are formulated. The function is often predicated on a risk assessment and mitigation review. This function is found most often in the written policies and procedures of the regulated entity. These may also be called processes, strategies, or directives, and are tested for clarity, currency, functionality, and conflict with existing statutes. A proactive process that results in reduced error or violation is one that is clearly stated, up-to-date, fits its intended purpose, and complies with state laws. A reactive process generally results in observable errors and violations that the regulated entity can not avoid, because it is not structured to do so. Absences of policies suggest areas that need to be tested. Findings from this review are predictive of areas where an examiner's review of a sample will yield criticisms and errors. They also provide the examiner with data that helps identify whether problems found are systemic, intended, unintended, or true error. Finally, review findings aid the planners of the examination in determining what business areas may need further examiner attention.

**(b). Implementation**

When management-directed policies and written processes are disseminated throughout the regulated entity to appropriate and affected persons, implementation of the planning function in the management cycle occurs. Review of the implementation process is useful in determining whether the regulated entity is effectively distributing its directives. Testing the implementation of the planning function involves answering many questions including:

- What are your processes to ensure compliance?
- Are the processes in writing?
- Are the written processes coherent, readable, and on point?
- Are the written processes functional; that is, do they fit their intended purposes?
- Do the written processes comport with statutes and contain state exceptions where applicable?
- Are the written processes up-to-date?
- Are the written processes readily available to affected persons?
- Are the written processes utilized?
- Are affected persons trained in the use of the written processes?
- If the written processes are computerized, is the documentation for the resultant process adequate and does the process accomplish management's intent?
- If the written processes are not computerized, is the documentation for the resultant process adequate and does the process accomplish management's intent?
- Is the process periodically tested and updated?

**(c). Measurement**

The measurement function in the management cycle evaluates the results of planning and implementation. Measurements can be found in internal audits, management reports, supervisory reports, Board meeting minutes, minutes of the Compliance Committee, minutes of the Quality Review Committee, Market Conduct Examination reports, etc. The measurement function is concerned with the quality of information developed to inform the management and the Board of the results and the effectiveness of its directives. This function must develop information that confirms or refutes that the intended process is utilized, functioning and working. Without measurement, management cannot know whether its directions are being implemented effectively. The measurement process must be written, formal, and documented, and must occur with sufficient frequency to function as a reasonable tool. Without the measurement function in

place, the process used is passive or reactive, and the regulated entity will not have an effective means for knowing that errors or violations are occurring and be in a position to prevent them. This is where the regulated entity exercises the control over the intended process and is critical to the effectiveness of that process.

**(d). Reaction**

The reaction function in the management cycle is where a regulated entity has the opportunity to insert into the process what it learned through the measurement of its written processes. The process requires a means of utilizing the information arising from internal audits, management reports, and complaint systems. This is reflected in the responses to internal audits, management reports, supervisory reports, Board of Directors and Committee minutes, Market Conduct Examinations, and errors detected through the regulated entity's complaint system analysis.

This information needs to flow back directly to management so that it can use these findings to modify policies and written processes. The regulated entity should also resolve, through documented remediation, any errors that resulted in harm to policyholders and/or the public.

This information represents data that a regulated entity should know about itself. In some cases federal law insists on it. The Sarbanes-Oxley Act (SOX) essentially requires documentation that certain levels of corporate governance are in place and operating.

**2. The Cycle as a Whole**

The cycle of preparing instructions (policies and written processes), disseminating them, testing their results, and making modifications should be a continuous and ongoing cycle. A continuous and ongoing cycle is indicative of proactive management. Of course, not every regulated entity is fully proactive or fully reactive. A regulated entity can be at both ends of the proactive/reactive spectrum depending on the business area being reviewed. For example, a regulated entity with a proactive claims environment may have a reactive underwriting environment. In some cases a specific process may have components of the proactive/reactive scale. Section I describes a method to evaluate where, on a comparative scale, a particular process is located. The levels resulting from such an evaluation are described with key characteristics in Section I. The levels are:

- 0 Lack of any recognizable processes / practices.
- 1 Processes are ad hoc and disorganized.
- 2 Processes follow a regular pattern.
- 3 Processes are documented and communicated.
- 4 Processes are monitored and measured.
- 5 Good practices are followed and automated.

### 3. Policies and Procedures

Policies and procedures are two terms heard with some frequency, but they do not tend to evoke an image of how they might be used in a regulatory application. These terms in fact denote two different things.

#### (a). Definitions

“Policies” are the high-level general principles by which an entity guides the management of its affairs. It is not critical for the regulator to be concerned with policy statements except to the extent that they represent management's direction to proceed in a particular manner. Policies may be the basis for procedures. Policies are generally too vague to require any regulatory interaction unless they are obviously in conflict with a statute.

“Procedures” are the specific methods or courses of action used to implement a policy or corporate directive. Many companies have processes in place that do not derive from policy and do not really constitute procedures. In this chapter, a written procedure is referred to as a written process. How a regulated entity structures and documents its written processes tells the regulator a considerable amount about the regulated entity. Written processes indicate whether a regulated entity is proactive or reactive in the management of its operations; whether the corporate compliance activities are a cause for concern; and whether particular areas of concern to the regulator are managed in a way to avoid the need for regulatory interaction.

#### (b). Procedure Review

Throughout the *Handbook*, there are suggestions in the review criteria for the various standards to review a particular procedure. For example, Standard 2 for Operations/Management in Chapter 16 states, “Review regulated entity records, central recovery and backup procedures.” It then adds, “Review computer security procedures.” Standard 3 of the same section adds, “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.” It also adds another, “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 commissioner.” There are many other examples of a procedural or process review indicated in the *Handbook*. Unfortunately, the *Handbook* is silent concerning what constitutes such a review. The review of a procedure should determine whether the management cycle relating to the process at interest adequately considers each of the elements noted in the discussion of the management cycle.

#### (c). Testing the Process

Management analysis of written processes is a top-down look at how a regulated entity operates. It can be thought of as a vertical view of a regulated entity's operation. It represents a somewhat different skill set than typically used in the conventional market conduct examination that is more focused on a “bottom of the ladder” view or horizontal view of a regulated entity operation. Both methods

are valid and may be used in conjunction with each other. To test the validity of the use of this approach, laboratory states have conducted examinations utilizing both methods, process review and conventional including sampling. The examiners have then compared the results of the samples impacted by particular written processes with the management analysis performed relating to that process and the findings have been striking.

Since most examinations conducted during the testing phase have been comprehensive examinations with reasonable levels of sampling, the samples support the notion that the proactive/reactive analysis is a valid tool. The samplings of business areas for companies with proactive tendencies generally yield fairly “clean” results. Where the analysis indicated that there was a passive or reactive process in place or no process in place, the samples revealed considerable human error, systemic error, and certainly more deliberate errors than are seen with proactive management.

**(d). Processes to Review**

The written processes to review vary depending on the lines of business written by a regulated entity, the reason for examination (target or “baseline”), and a variety of other considerations. Each of the standards appearing in chapters 16 through 24 of the *Handbook* is a potential review subject.

**(e). Additional Considerations- The Case for Ethical Management**

In addition to the considerations noted above, ethical management, management attitude, and confirmation of management processes are appropriate.

A critical element in any scheme to develop allocation of examiner resources is ethical management. Ethical management is not a direct standard currently in the *Handbook* nor is it a statutory requirement of the regulation of the business of insurance. However, the need for ethical management is strongly implied through the structure of those statutes. For example, a pattern of misrepresentations will raise strong doubts about an insurer’s ethical base. The standards and tests found in the *Handbook* are generally objective indicators that can measure this behavior. Factors such as regulated entity attitude and negative, confrontational, or resistive reaction by regulated entity management may be more subjective, but no less apparent, to the regulator. Likewise, a regulated entity with a reputation for being a “good corporate citizen” typically demonstrates a willingness and structure that is responsive to its customers.

## **D. Application of the Process Review Methodology**

The application of a process review methodology consists of several steps with variations depending upon the particular process under review. The steps are as follows:

- Determine which processes to review
- Provide an information request to the regulated entity.
- Consider the quality and completeness of responses
- Test the structure of the process
- Test the content of the particular process
- Confirm the process is as represented
- Document the review
- Determine the maturity level of the particular process reviewed
- Determine whether issues that arise merit reporting in a report or in a management letter

### **1. Determination of Processes to Review**

The most likely use of this approach will be to apply a combination of the examination standards already outlined in the *Handbook* or state specific handbook and a process review review of selected processes. The approach will be generally driven by the reasons for conducting the examination. The examination supervisor will need to evaluate, given the information derived from market analysis, which standards in the *Handbook* require a conventional approach or quantification and which standards require a process review approach. In some cases, both methods will seem useful. In such cases, the decision to apply process review methodology should be deferred until sample results suggest a need.

### **2. The Information Request**

Reasonable structure to the information request is critical to a timely and thorough understanding of a particular process. There are a series of requests that should be made for any process reviewed. Some of these are generic to all processes while others are specific to the particular process.

#### **(a). Risk Assessment and Mitigation Document**

The examiner will want to know what led the regulated entity down a particular path in its development of a process. For this reason, the first item requested should be a copy of the risk assessment and mitigation document that formed the starting point for the process. This document should identify and enumerate the operational and regulatory risks to which the regulated entity is exposed and what it needs to do to control or mitigate that risk. In many cases this document will not exist and that will make the examiners effort a bit more difficult. This situation may be partially overcome with interviews of mid and upper management.

**(b). Written Process**

The examiner should request a complete description of the process including applicable written procedure used to operate and control the process. The regulated entity should also describe how errors are detected and corrected in the process. The regulated entity should note if the process is contained within a computerized application. If the process is computerized, the documentation for the process and how it works should be described along with any exception reports .

**(c). Process Communication and Training**

The examiner should request a description to indicate how the process is conveyed to persons affected by it and how those persons are trained in its use. The response should include how the process is accessed; describe training related to the process and how management confirms that the process is being utilized.

**(d). Monitoring the Process**

The examiner should request a description of the methods used to monitor compliance with the process to ensure it is performing as intended. The response should include a description of the frequency of measurement. Also request copies of any management reports or forms used for this purpose.

**(e). History of the Process**

The examiner should request a five-year history and description of changes to the process.

**(f). Person Responsible for the Process**

The examiner should request the name, position and title of the person in the regulated entity responsible for the effective operation of the process under review.

Additional requests should be designed for the specific process under review. For some processes the added questions will be extensive while in others none will be necessary. A good source for additional information request related to a specific process is the testing criteria for a related standard in the *Handbook*.

**3. Quality of Information Request Responses**

The examiner, where possible, should receive a number of process responses prior to arriving on-site. This provides an opportunity to determine if the regulated entity has provided complete responses of sufficient quality to be useful. The examiner should assume a lack of understanding initially as to process review generally by the Insurer. The Examiner-in-Charge might want to arrange a test of a process selected jointly with the regulated entity to assure that the level of understanding of expectations is reasonable. Since the information contained in the responses is generally sensitive, additional caution to maintain confidentiality is necessary.

#### 4. Testing the Structure of the Process Generally

The first level of testing a process is focused on the quality of the process as a process. These are tests that apply to all processes reviewed using process review methodology. They are generic tests. The items that follow are expressed as questions that should be posed to gain an understanding of review of the process. The examiner should provide responses to these questions in the documentation of his or her review.

##### (a). Policy Statement

This is a broad statement intended for adoption by management of a regulated entity. It is the basis on which procedures, standards and processes are developed for the operation of the various parts of the regulated entity.

Is there a policy statement that generally provides the overall direction is expected to take on compliance matters?

##### (b). Risk Assessment and Identification

A Risk Identification is a statement describing an element of risk that is inherent in the performance of some operation of the regulated entity. Risks may be operational, environmental, reputational or the effect of a contract provision, applicable statute, rule, regulation or court precedent. In each case failure to manage the risk identified can result in a violation of a contract provision, applicable statute, rule, regulation or a court precedent. The Review Criteria associated with a Standard are the principle source for Risk Identifications.

Has a risk assessment been conducted? Are all the risks associated with a particular function adequately identified? Does the risk assessment address compliance issues?

##### (c). Mitigation Potential

For each risk identified, there are potential mitigations available that provide the means for a regulated entity to, mitigate, reduce or avoid the risk outlined. The categories of mitigation can be used singly or more effectively in combination. Management of a regulated entity must determine which combination best achieves the result desired within the framework of their particular operations and circumstances. While a particular mitigation potential category may not be necessary for every Risk Description, it should be evaluated for applicability and potential impact. Listed below are the mitigation categories with descriptions:

- *Process* – Process is the written instruction provided to guide the affected party or parties in applying the mitigation.
- *Intent* – Intent is usually in a written form and is the basis for establishing a consistent measurement or baseline for periodic oversight and review. It can be viewed as a policy statement specific to the risk identified.
- *Structure* – Structure refers to the standards or guides that are established, monitored, tracked and enforced as they relate to mitigation of the Risk Identification.

- *Research-Internal* – Research-Internal refers to research or compilations related to the risk arising from noncompliance with the Company’s contract provisions or Company policies.
- *Research-External* – Research-External refers to research or compilations related to the risk arising from noncompliance with applicable statutes, rules, regulations or court precedent.
- *Reference* – Reference refers to the tools created for affected persons in the Company resulting from Research-Internal and Research-External.
- *Timeframe* – Timeframe refers to a mitigation that has an associated amount of time in which an activity must occur. These are frequently stated in contract provisions, and applicable statutes, rules or regulations.
- *Access* – A mitigation process cannot be effective if it is not circulated or accessible to persons expected to effect change on the process.
- *Feedback* – The effectiveness of a mitigation process is enhanced if there is a well-structured feedback mechanism at the operational level to ensure that flaws inherent in the process are identified and corrected. The same is true for errors arising from operation of the process. Flaws and errors must be corrected or remedied in order to improve the process.
- *Review* – Periodic review of the process should occur at the departmental level to assure that the mitigations designed for a particular Risk Identification are effective and working as intended.
- *Modification* – Mitigations must remain dynamic and reflect continuous improvement in order to remain effective and valid. Improvements learned from the operation, feedback and review of a mitigation process must be utilized to revise the process.
- *Training* – Personnel must be trained in the use, expectations and operation of the process if it is to be applied appropriately, consistently and effectively.

Do the mitigations provided adequately address the risk noted? Are any obvious mitigation elements missing?

**(d). Process in Writing**

A written structured process is important to consistently meet regulatory requirements; avoid violation of statute; as well as improve service quality to policyholders. These statements describe a component of a process or procedure used to address a risk identified and its accompanying mitigation. Notice that the mitigation potential described above is frequently a procedure or process component.

Is a written procedure or process in place? The absence of a written policy or procedure potentially allows for inconsistent application of the process. If not in writing, how does the regulated entity assure consistent application of the process? Exceptions should be minimal for the process to be effective.

**(e). Clarity of Description**

Is the procedure or process unambiguous, clear and readable? Does the examiner understand the process or procedure described? Would employees understand the process or procedure? Examiner should explain analysis.

**(f). Accessibility**

Is the procedure or process accessible and provided to persons subject to its provisions? How the procedure or process is made accessible to those persons? How are they made aware of the existence of the procedure?

**(g). Training**

Does the Regulated entity provide adequate training to persons affected by the procedure or process? What training is provided? How does the Regulated entity ensure those affected by the process receive training? How are employees re-trained if a problem is found? Are steps to avoid bias adequate?

**(h). Measurement and Control**

Measurement is the effort applied by the regulated entity to determine that a process is conducted in the manner expected and is working. Control is the management feature in place to guide the process in the direction intended. Most controls make deviation from the intended path difficult if not impossible. Some provide for correction of performance in order to make sure that enterprise objectives and the plans devised to attain them are accomplished. This is the method by which management assures that a process or procedure it has adopted as their mitigation to an identified risk is working as intended. The control provides the opportunity to address defects or flaws in a process and achieve continuous improvement. There are three categories of controls that a Company should utilize: feedback controls, concurrent controls and pre-controls. The difference among the categories of controls is when they occur: feedback controls focus on past performance and concurrent controls occur while work is being performed. A pre-control is a control effort made to prevent an undesirable outcome and may include setting policies, rules and procedures. Relying solely on feedback controls is a reactionary stance that may not uncover defects or flaws in a process until after they have occurred. Delayed feedback increases an organization's operational, regulatory and reputation risk. In order to obtain assurance that a process or procedure is working as intended, a Company should incorporate all three categories of controls. Some of the types of measurement and control that an examiner should expect to see include:

- Internal or external Audit;
- Checklists;
- Computer Anomaly or Error Reports (including Expert Systems Use);
- Intervention by Supervisor or Manager;
- Regular Management Reports;
- Periodic Sampling;
- Employee evaluations; and/or,
- Training or retraining.

Are appropriate measurements or controls in place to test the functioning and efficacy of the procedure or process? How often is the procedure or process reviewed, tested or audited? How does management exercise oversight and control of the process? How is the procedure or process reviewed, tested or audited?

**(i). Use of Measurement**

How does management utilize the results of its measurement structures? Explain and provide examples, how the results of measurement structures are utilized.

**(j). Performing as Intended**

Is the procedure or process performing as intended? How does the regulated entity know the procedure or process is performing as intended? If it is not, where is it deficient? Is it possible to know if the procedure or process is performing as intended?

**(k). Currency of Process**

Is the procedure or process current? When was process last modified? Have events suggested a need for update such as legislation or product line change? Revisions and their reasoning if provided should be explained. Were revisions proactive? Reactive? Are any changes the result of an examination?

**5. Testing the Content of the Specific Process**

The second level of testing a process is focused on the content of the specific process. These are tests that apply only to the specific process reviewed using process review methodology. A good source for tests applicable to a specific process is the testing criteria for a related standard in the *Handbook*. The examiner should provide responses to these questions in the documentation of his or her review.

**6. Process Confirmation**

The third level of testing a process is focused on the confirmation that the process is in operation. Often a regulated entity claims to maintain a process or procedure, but in fact it does not. In using this methodology it is important that the examiner confirm the existence **and use of** the processes a regulated entity purports to utilize. This can be accomplished in several different ways:

**(a). Walk Through**

The first exercise is conducting a “walk-through”. It provides the examiner with the opportunity to question how the process actually functions. The examiner should have questions prepared so he or she can achieve a thorough understanding of what the regulated entity does.

**(b). Interview**

The next method is the use of interviews of upper and mid-level managers and persons using the purported written process. Some companies may use an informal or undocumented process. The efficacy of such processes should also be

considered. The challenge with an undocumented process is that it is frequently without measurement, meaning that the regulated entity really does not know how that process is working. It also means that there is an increased likelihood of inconsistent application, posing potential unfair discrimination issues.

**(c). Sampling**

The final method is to actually test a sample of files to determine that the process has been applied as described.

**7. Documenting the Review**

The process review methodology can be more subjective than application of a standard that has only a pass or fail option. It is therefore especially important that examiner work be carefully documented. Worksheets are recommended to assure that consistency of application is maintained.

**8. Determine Maturity Level of the Process**

The review of procedures and processes is intended to aid in the understanding of the regulated entity efforts to comply with regulatory requirements and to manage its regulatory risks. This is done through a review of the procedures, processes and controls utilized by a Company to manage its exposure to regulatory risk and to mitigate the effects of that exposure. To be useful, a means to place processes on a comparative scale is needed. This is described in Section I.

**9. Report or Management Letter**

The discovery of flawed process may not result in a violation of statute or regulation. It may not be an actual violation but may represent a potential for violation. The risk for such an event may be low and not warrant inclusion in an examination report. Some states utilize a management letter for low risk situations when it is desirable to provide the regulated entity with an opportunity to correct or repair a system flaw. A management letter is less threatening to the regulated entity and provides an opportunity for more cordial communication and resolution.

**E. Uses of the Process review Methodology**

The use of process review methodology has a wide range of utility for insurance organizations. It can be used as a stand-alone form of examination or it can help to narrow a focused review of an area of the regulated entity's operations. It can be useful to augment a conventional examination.

**1. Domestic Baseline**

The phrase "baseline examination", as used here, contemplates an initial examination of a regulated entity conducted by a state. It is expected to provide a "baseline" of information on which to base future regulatory oversight or absence thereof.

The advantage in this instance is that the state of domicile possesses the authority to look at business areas that other states cannot. This is true whether the domestic regulated entity is a large writer in the domestic state or writes no business at all in the state. The

written processes a regulated entity utilizes are generally corporate-wide. The domicile state has the opportunity to look at how the regulated entity treats compliance on a scale that is broader than its own immediate interests and to provide other states with information of strong interest to them. This is a meaningful way to address a state's interest in achieving domestic deference. It also happens to enhance efficiency.

Typical baseline examinations are conducted on a state's domestic insurers. The examinations look at a regulated entity's total complaint population to determine if there are any detectable patterns that may suggest a need for regulatory interaction. The reviews should not be limited to a single line of business or to a single jurisdiction, but they can easily consider all jurisdictions in which the regulated entity operates. Examiners conducting the baseline examination consider complaints directed at the regulated entity, its producers, its vendors, etc. The object is to look for developing patterns anywhere and to determine if the regulated entity maintains processes to correct or repair the issues driving the patterns.

In a full scope base line, examiners will review 40 or more written processes for each regulated entity examined, unless the examination is for a group of companies using the same written processes and controls. The process should take approximately three to five days for each process in the examination scope assuming all requested materials are available and examiners are appropriately trained in the review process. Generally, half of the work can be conducted off-site, resulting in travel-related expense savings. This review also replaces the market conduct work performed as part of a financial examination. The expectation is that this will provide considerable information about each of the state's domestic companies, thereby allowing better future allocation of a state's regulatory resources. For example, this type of examination can identify companies with reactive or passive management styles and, consequently, allow a state to focus greater attention upon those companies. Data developed in this process should be incorporated into a state's market analysis efforts, thus providing a true baseline for future efforts.

It is not unusual to find a regulated entity with few, or no, written processes. Even more commonplace is finding a regulated entity that has no way to tell whether its written processes are working since measurements are non-existent. If the regulated entity writes a line of business that does not generate consumer complaints, there may be few other valid indicators of regulatory concern. Maintenance of the data in the baseline, once acquired, is easy to accomplish with minimal effort.

The baseline examination departs substantially from the definition of a conventional market conduct examination. However, in view of recent NAIC discussions, experience in proactive/reactive analysis, and the need for states to accomplish their examinations with minimal resources, states might well consider a baseline examination. Examinations that focus on the regulated entity operations and management, proactive vs. reactive analysis of each business area, and a detailed review of patterns that arise from complaint systems provide an insurance commissioner with the necessary data to determine when

and where a more limited-scope, targeted examination is appropriate in addition to enhancing data derived from market analysis.

## **2. Target Examination**

The analysis completed in the process review examination is exceptionally predictive; it lends itself to a more precise application of Department resources. Other indicators used in market analysis may suggest that a specific review of a particular process is warranted. This next level of review may be accomplished using the process review methodology as a stand-alone process or combined with a conventional market conduct examination.

## **3. Identification of Causation**

When a trade practice or repeat violation of statute is found through market analysis, a conventional examination or complaint review, using a focused application of process review methodology is useful in identifying causation. Once the cause of the violation is determined, the regulator is able to develop recommendations to repair the issue or structure remediation with precision.

## **4. Market Analysis Supplement**

Users of market analysis are seeking ways to gather and review data that are valid indicators that can be used to demonstrate the need for regulatory interaction. Process review methodology is a valuable tool that provides a means of achieving this goal. However, because the process is relatively new, it will be some time before there is an adequate database of findings from the application of process review methodology upon which states can rely.

**F. Requests for Information**

This section addresses the Requests for Information made by the examiner(s). Please note that the listed requests for a procedure are not fixed or absolute. These requests do not limit the examiner from posing additional questions, when warranted, in efforts to enhance the understanding of the Regulated Entity’s response(s). If no response is provided, the fact should be part of the examiners documentation.

1. Does the regulated entity have a (name of process) in place?
2. Please provide a copy of the most recent risk assessment and mitigation document for the regulated entity’s (name of process) process.
3. Please provide a copy of the written (name of process) process or procedure. If a written procedure does not exist, so state, and describe the process the company uses in the absence of a written procedure.
4. Please provide a complete description of the controls utilized to ensure proper operation of the regulated entity’s (name of process) process. Please provide documentation.
5. Please provide a copy of policy statement or statement of intent related to the process.
6. Please describe how errors are detected and corrected in the process. If the process is contained within a computerized application, please describe the process and how it works. Please provide documentation.
7. Please describe in detail how (a). the process is conveyed to persons affected by it. (b). persons utilizing the process are trained in its use and the content of the training. (c). the process is accessed. (d). the Company confirms that the process is being utilized.
8. Please (a). describe the methods used to monitor compliance with the process to ensure it is performing as intended. (b). describe the frequency of measurement and exercise of control. (c). provide copies of any forms used for this process. (d). provide copies of any management reports arising from this process. (e). describe what management does with measurements and reports arising from this process. (f). describe how bias within the process is detected and avoided.
9. Please provide a five-year history and description of changes to the process.
10. Please identify the person and position in the Company responsible for the effective operation of this process. Include Name, title, phone contact and email address.

In addition to the first ten requests common to all processes, there are requests to be considered that are specific to a particular process. These are listed by process. An additional column is provided to indicate the affected standard.

**Process 001 – Internal or External Audit**

<b>Source:</b>	Ch16§A01
<p><b>Note: The focus is on the internal or external audit process utilized to verify appropriate function and to perform analysis of market conduct issues including the various business areas considered in a market conduct examination. A regulated entity that has no internal or external audit function lacks the ready means to detect structural problems until after problems have occurred.</b></p>	
<p>11. Please provide a description of the frequency of application and triggering events for audit.</p>	Ch16§A01
<p>12. Please provide access to reports generated by the audit process during the Examination Period. This request encompasses audits conducted by or for the regulated entity’s internal audit department as well as other operational audits conducted by affected departments. Indicate location for access.</p>	Ch16§A01
<p><b>Note: The State and the examiners are aware that these documents may be viewed as proprietary and sensitive. The reports will be viewed on the company premises after commencement of the on-site portion of the examination. The examiners, based on the results of audit findings for which the company has taken appropriate corrective action and remediation, will not recommend administrative action. The purpose for viewing these documents is to determine that management directives are in compliance with statute and that errors found through the audit process are corrected. It is not used as a device to discover and quantify violations, rather it is used for qualitative purposes. Any special needs or concerns should be discussed with the Examiner in Charge.</b></p>	
<p>13. Please describe how recommendations made in audits are tracked until implemented or resolved. Cross reference to appropriate location in the written procedure.</p>	Ch16§A01
<p>14. Does the audit function include edit and audit procedures to screen and to check data submitted by the regulated entity’s statistical agent.</p>	Ch16§A01
<p>15. Does the regulated entity conduct periodic reviews of creditors with respect to its credit insurance business with such creditors?</p>	Ch16§A01

**Process 002 – Computer Security**

<b>Source:</b>	Ch16§A02
<b>Note: The focus is on the existence of sufficient protection to the regulated entity systems. Examiners should avoid requiring information that itself poses a threat to that protection.</b>	
11. If changes to contracts can be made electronically or verbally, please describe process for the change and who has authority to make such changes.	Ch16§A02
12. How does the regulated entity detect and respond to attempts at unauthorized access to computer data? How does the regulated entity respond to successful unauthorized access? Has the regulated entity experienced inappropriate intrusions?	Ch16§A02
13. What steps are taken to ensure there is adequate security of applicant/insured data during electronic transfer of data? Please address the security of both data "at rest" and data "in motion". Are security audits conducted and if so with what frequency.	Ch16§A02

**Process 003 – Anti fraud**

<b>Source:</b>	Ch16§A03
<b>Note: Examiners are interested in internal as well as external fraud response and detection mechanisms.</b>	
11. Please provide a copy of the fraud warning notice provided with claims processing.	Ch16§A03
12. Please describe how the regulated entity determines that its anti-fraud efforts are adequate.	Ch16§A03
13. Please describe staffing for the program and number of suspected fraud cases referred to the Commissioner during the examination period.	Ch16§A03
14. Please describe procedures in place to prevent persons convicted of a felony involving dishonesty or breach of trust from participating in the business of insurance.	Ch16§A03
15. Does the regulated entity utilize a reporting mechanism to provide information regarding fraudulent insurance acts to the insurance	Ch16§A03

commissioner?	
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**Process 004 – Disaster recovery**

<b>Source:</b>	Ch16§A04
11. Please describe any use of the regulated entity disaster recovery plan during the period of the examination.	Ch16§A04
12. Please describe how often elements of the disaster recovery plan are tested and the methods used to critique results.	Ch16§A04
13. Please describe the regulated entity’s off-site backup for its data and the frequency of update. Is the backup site sufficiently distant geographically so as not to expose primary and backup sites to a common disaster?	Ch16§A04

**Process 005 – Vendor oversight and control**

<b>Source:</b>	Ch16§A05 Ch16§A06
<p><b>Note: “Vendor” refers to a third party provider of services including but not limited to MGA’s, GA’s, and TPA’s related to one or more of the following functions:</b></p> <ul style="list-style-type: none"> <li>• <b>Complaint handling</b></li> <li>• <b>Marketing and Sales</b></li> <li>• <b>Producer Licensing</b></li> <li>• <b>Policyholder Service</b></li> <li>• <b>Underwriting and Rating</b></li> <li>• <b>Claims Handling</b></li> <li>• <b>Grievance Handling</b></li> <li>• <b>Network Adequacy</b></li> <li>• <b>Provider Credentialing</b></li> <li>• <b>Utilization Review</b></li> </ul> <p><b>It does not include supply vendors or vendors providing equipment such as computers, maintenance, landscaping, communications, etc.</b></p>	
11. Provide a list of any vendors including but not limited to MGA’s, GA’s and TPA’s used by the regulated entity to perform functions in the complaint handling, sales and marketing, producer licensing, policyholder services, underwriting and rating, claims handling	Ch16§A05 Ch16§A06

grievance handling, network adequacy, provider credentialing and utilization review areas, and describe the scope of authority extended. If license for the vendor is required, indicate the type of license held.	
12. Provide a copy of the contract(s) used by the regulated entity for vendors.	Ch16§A05 Ch16§A06
13. Please describe oversight and control by regulated entity of a vendor.	Ch16§A05 Ch16§A06
14. Provide a copy of each vendor audit completed during the Examination Period.	Ch16§A05 Ch16§A06
15. Describe how performance standards for vendors are established, monitored and documented.	Ch16§A05 Ch16§A06

**Process 006– Records, central recovery and backup (Includes maintenance, content and retention)**

<b>Source:</b>	Ch16§A07
<b>Note: The records of interest include records for complaint handling, sales and marketing, producer licensing, policyholder services, underwriting and claims handling. For Health records this also include grievance procedures, network adequacy, provider credentialing, quality assessment and utilization review functions.</b>	
11. Please describe the various media used for records affected by market regulation concerns.	Ch16§A07
12. Please describe step taken to maintain orderly organization, legibility and structure of files.	Ch16§A07
13. Please provide a copy of the regulated entity record retention schedule.	Ch16§A07
14. Please describe any failed recoveries.	Ch16§A07
15. Please describe record backup process.	Ch16§A07

**Process 007–License Authorization**

<b>Source:</b>	Ch16§A08
11. Please describe how the regulated entity avoids writing business not authorized by its certificate of authority.	Ch16§A08

**Process 008– License Authorization-Title**

<b>Source:</b>	Ch18§A01 Ch18§A02 Ch18§A03 Ch18§A04
<b>Title Insurance</b> 11. Please describe how the regulated entity avoids writing business not authorized by its certificate of authority.	Ch18§A01
<b>Title Insurance</b> 12. Explain how the regulated entity assures that no member of its board of directors may be a title agent who wrote more than 1% of its direct writings for the previous year.	Ch18§A02
<b>Title Insurance</b> 13. Please describe the errors and omissions policy and fidelity coverage (or alternative financial arrangement, where permitted) requirements to which the regulated entity is subject.	Ch18§A03
<b>Title Insurance</b> 14. Please describe all business diversification requirements to which the regulated entity is subject.	Ch18§A04

**Process 009 – Examination Facilitation**

<b>Source:</b>	Ch16§A09
11. Please describe how the regulated entity monitors its interaction with examiners to assure timely delivery of requested data.	Ch16§A09

**Process 010 – Assertions of Privilege**

<b>Source:</b>	Ch16§A09
<p><b>Note: “Assertions of Privilege” refers to the process whereby the company asserts some form of privilege to deny access to certain documents. The primary privilege of this type is the attorney-client privilege. The privilege is asserted to protect communications between an Attorney and a client. The party asserting the privilege bears the burden of demonstrating its existence and applicability of the privilege is determined on a case-by-case basis. The regulated entity should have a written policy regarding the use of attorney-client privilege, as state or federal law governs the protection afforded by the privilege. “Assertions of Privilege” may also be attempted for self-evaluative or self-critical analysis privilege and privilege may be claimed for proprietary documents, however, these forms of privilege may not be recognized by the examining state.</b></p>	
<p>11. If a document for which a privilege is claimed is critical to examiner review of an issue, to whom in the Company can an appeal be made and what is the process for appeal?</p>	Ch16§A09
<p>12. Please describe the various Assertion of Privilege types used by the regulated entity and the logic for each type.</p>	Ch16§A09

**Process 011 – Staff training**

<b>Source:</b>	None
<p><b>Note: The staff of a regulated entity includes a wide variety of job descriptions. The particular staff in whom we are interested include</b></p> <ul style="list-style-type: none"> <li>• <b>reception staff</b></li> <li>• <b>complaint handling staff</b></li> <li>• <b>sales and marketing staff</b></li> <li>• <b>producer licensing staff</b></li> <li>• <b>policyholder services staff</b></li> <li>• <b>underwriting staff and</b></li> <li>• <b>claims handling staff.</b></li> </ul> <p><b>In addition in the health insurance field the particular staff in whom we are interested include</b></p> <ul style="list-style-type: none"> <li>• <b>grievance handling staff</b></li> <li>• <b>network adequacy staff</b></li> <li>• <b>provider credentialing staff and</b></li> </ul>	

<ul style="list-style-type: none"> <li>• <b>utilization review staff.</b></li> </ul> <p><b>If the various areas noted are subject to separate procedures, so note and provide separate responses for each area.</b></p>	
<p>11. Please describe the process for determining staffing needs. Please describe the training regimen for each area listed in the opening note.</p>	

**Process 012 –Privacy Protection**

<p><b>Source:</b></p>	<p>Ch16§A10 Ch16§A12 Ch16§A13 Ch16§A16 Ch16§A17</p>
<p>11. Please describe the regulated entity's standards and security to safeguard nonpublic customer information. Please describe the factors considered in developing these safeguards.</p>	<p>Ch16§A10 Ch16§A12 Ch16§A13 Ch16§A16 Ch16§A17</p>
<p>12. Please provide a copy of all notices and disclosures provided to customers, former customers and consumers who are not customers, for the protection of consumer information and privacy including but not limited to “Notice of Information Practices”, disclosure of nonpublic personal financial information, and disclosure of nonpublic personal health information.</p>	<p>Ch16§A10 Ch16§A12 Ch16§A13 Ch16§A16 Ch16§A17</p>
<p>13. Please describe the process for correcting, amending, or deleting personal information held by the regulated entity.</p>	<p>Ch16§A10 Ch16§A12 Ch16§A13 Ch16§A16 Ch16§A17</p>
<p>14. Please describe the regulated entity feedback process that monitors for appropriate use of the “Notice of information Practices”, timely provision of notices, ensures errors are appropriately remedied, and process changes are implemented to prevent future errors.</p>	<p>Ch16§A10 Ch16§A12 Ch16§A13 Ch16§A16 Ch16§A17</p>
<p>15. Please provide a copy of the opt-out form used by the regulated entity with any instructions for its use.</p>	<p>Ch16§A10 Ch16§A12 Ch16§A13 Ch16§A16 Ch16§A17</p>
<p>16. Please explain how persons responsible for collecting personal</p>	<p>Ch16§A10</p>

information on behalf of the regulated entity in connection with insurance transactions are trained (including agents and TPA's) in the appropriate handling of such information.	Ch16§A12 Ch16§A13 Ch16§A16 Ch16§A17
17. Please describe internal limitations to access of personal information, adverse underwriting decisions and investigative consumer reports. Please describe limitations on subcontractors to access of personal information, adverse underwriting decisions and investigative consumer reports.	Ch16§A10 Ch16§A12 Ch16§A13 Ch16§A16 Ch16§A17
18. Please describe regulated entity's system for allowing production of all disclosures made, routine of otherwise.	Ch16§A10 Ch16§A12 Ch16§A13 Ch16§A16 Ch16§A17
19. Please provide specific and accurate reasons for adverse underwriting decisions.	Ch16§A10 Ch16§A12 Ch16§A13 Ch16§A16 Ch16§A17
20. Please provide a copy of the opt-out form used by the regulated entity with any instructions for its use.	Ch16§A10 Ch16§A12 Ch16§A13 Ch16§A16 Ch16§A17
21. Please provide the identity of any vendors holding and/or using personal information concerning insureds or prospective insureds of the regulated entity and their reasons for doing so. The list should also contain a contact name, phone number and email address.	Ch16§A10 Ch16§A12 Ch16§A13 Ch16§A16 Ch16§A17
22. Please describe efforts to prevent unfair discrimination against customers and consumers who are not customers who have opted out from the disclosure of nonpublic personal financial information to nonaffiliated third parties or who have not authorized disclosure of nonpublic personal health information.	Ch16§A10 Ch16§A12 Ch16§A13 Ch16§A16 Ch16§A17

**Process 013 – Management of Insurance Information**

<b>Source:</b>	Ch16§A11
<b>Note: This process applicable for states that have adopted the NAIC Insurance Information and Privacy Protection Model Act referred to as the 1982 Model Act.</b>	
11. Please provide training manuals and bulletins that address the	Ch16§A11

management of insurance information including handling, disclosing, storing or disposing of insurance information.	
12. Please describe the regulated entity's standards and security to safeguard insurance information. Please describe the factors considered in developing these safeguards.	Ch16§A11
13. Please provide a copy of the contract used by the regulated entity to share information shared with a contractor of the regulated entity.	Ch16§A11
14. Please describe the process used by the regulated entity before disclosure of information held.	Ch16§A11
15. Please provide the identity of any vendors holding and/or using personal information concerning insureds or prospective insureds of the regulated entity and their reasons for doing so. The list should also contain a contact name, phone number and email address.	Ch16§A11
16. Please provide a copy of the "Notice of Information Practices" provided to all applicants or policyholders for the protection of consumer information and privacy. If this responsibility has been delegated to the producer, please provide the contractual language that supports the delegation and a discussion of the controls utilized to assure that the delivery has occurred.	Ch16§A11
17. Please specify those questions posed by the regulated entity designed to obtain information solely for marketing or research purposes.	Ch16§A11
18. Please describe the regulated entity's use of investigative consumer reports and how reports are initiated.	Ch16§A11
19. Please describe the process for correcting, amending, or deleting personal information held by the regulated entity.	Ch16§A11
20. Please describe the controls used by the regulated entity for information or data held by vendors or producers.	Ch16§A11

**Process 014 – Nondisclosure of nonpublic personal financial information**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch16§A14 Ch16§A15
11. Identify vendors holding and/or using nonpublic personal financial information concerning insureds or prospective insureds of the	Ch16§A14 Ch16§A15

regulated entity and their reasons for doing so.	
12. Please provide a copy of all notices and disclosures provided to customers and consumers for the protection of nonpublic personal financial information.	Ch16§A14 Ch16§A15

**Process 015 – Reports to Insurance Departments**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch16§A18 Ch21§A01 Ch22§A01
<b>Note: This process impacts loss statistical reports, medical professional liability loss reports, MCAS data, state specific data calls, etc.</b>	
11. Please describe the process for resolving data errors.	Ch16§A18 Ch21§A01 Ch22§A01
12. Please explain the reconciliation process used before data is submitted.	Ch16§A18 Ch21§A01 Ch22§A01
<b>Medicare Supplement</b> 11. Provide copies of reports relating to each resident of the state for whom the entity has more than one Medicare supplement policy or certificate in force.	Ch21§A01
<b>Long Term Care</b> 11. Provide a copy of any reports by the regulated entity in compliance applicable statutes rules or regulations for Long Term Care.	Ch22§A01

**Process 016 – Title Plant Maintenance**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch18§A05
<b>Title Insurance</b> 11. Describe frequency of title plant update and testing for accuracy,	Ch18§A05

**Process 017 – Certifications**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch19§A01 Ch21§A03 Ch22§A01
<b>Life and Annuity</b> 11. Describe the specialized product training provided to producers and the frequency of the training.	Ch19§A01
<b>Medicare Supplement</b> 11. Provide a copy of the certification by the regulated entity is in compliance with standards for claims payments on the Medicare supplement insurance experience reporting form.	Ch21§A03
<b>Long Term Care</b> 11. Provide a copy of any certifications by the regulated entity in compliance applicable statutes rules or regulations for Long Term Care.	Ch22§A01

**Process 018 – Medicare Select Plan of Operation**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch21§A01
<b>Medicare Supplement</b> 11. Please provide a copy of the plan of operation.	Ch21§A01

**Process 019 – Producer Compensation - Medicare**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch21§A04
<b>Medicare Supplement</b> 11. Please explain how the determination is made that the regulated entity does not provide producer compensation that encourages replacement sales.	Ch21§A04

**Process 020 – Surplus Lines Bonds**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch24§A01
11. Please provide a listing of all statutorily required bonds.	Ch24§A01

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**Process 021 – Surplus Lines Reports**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch24§A02
11. Please provide a copy of any reports filed in compliance with applicable statutes rules or regulations.	Ch24§A02

**Process 022 – Surplus Lines Taxes**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch24§A03
11. Please describe methods used to properly allocate premium and taxes to appropriate state on a multistate placement.	Ch24§A03

**Process 023 – Surplus Lines Unearned Premium Calculations**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch24§A04
<b>Surplus Lines</b> 11. Please explain how determinations are made for unearned premiums and how refunds are made and tracked.	Ch24§A04

**Process 024 – Reserved for Future Use (TPA Financial Security)**

**Process 025 – Reserved for Future Use (Viatical Reporting)**

**Process 026 – Reserved for Future Use (Premium Finance Compensation)**

**Process 027 – Reserved for Future Use (Prevention of Anti-Competitive Practices-Advisory Organizations)**

**Process 028 – Reserved for Future Use (Development of Prospective Loss Costs – Advisory Organizations)**

**Process 029 – Reserved for Future Use (Filing of Prospective Loss Costs, Policy Forms, Endorsements, Factors, Classifications or Rating Rule Manuals - Advisory Organizations)**

**Process 030 – Reserved for Future Use (Development of Experience Rating Factors – Advisory Organizations)**

**Process 031 – Reserved for Future Use (Individual Inspection and Research - Advisory Organizations)**

**Process 032 – Reserved for Future Use (Development of Risk Classifications – Advisory Organizations)**

**Process 033 – Reserved for Future Use (Loss Control Services - Advisory Organizations)**

**Process 034 – Reserved for Future Use (Monitoring State Changes – Advisory Organizations)**

**Process 035 – Reserved for Future Use (Administration of Residual Market or Assigned Risk Assessments - Advisory Organizations)**

**Process 036 – Reserved for Future Use (Administration of Residual Market or Assigned Risk Pools - Advisory Organizations)**

**Process 037 – Reserved for Future Use (Legislative Analysis and Impact - Advisory Organizations)**

**Process 038 – Reserved for Future Use**

**Process 039 – Reserved for Future Use**

**Process 040 – Reserved for Future Use**

**Process 041– Complaint Register**

<b>Source:</b>	Ch16§B01
11. Please provide a copy of the Consumer Complaint Register.	Ch16§B01
12. Please describe the media used for the complaint register and how it is accessed.	Ch16§B01
13. Describe limitations to access.	Ch16§B01

**Process 042 – Complaint Handling**

<b>Source:</b>	Ch16§B02 Ch16§B03 Ch16§B04
11. Please describe information provided to policyholders to communicate procedures for complaint handling.	Ch16§B02 Ch16§B03 Ch16§B04
12. Please describe steps taken by regulated entity to ensure that correspondence and email received expressing a complaint or grievance is handled as a complaint and is logged and processed accordingly.	Ch16§B02 Ch16§B03 Ch16§B04
13. Please describe the regulated entity's reporting mechanism and frequency for reporting the findings on its review of complaints to senior management..	Ch16§B02 Ch16§B03 Ch16§B04
14. Please describe how the regulated entity assures that all issues raised in a complaint or grievance are fully addressed by its responses.	Ch16§B02 Ch16§B03 Ch16§B04
15. Please describe the regulated entity's standards for timely and accurate response and disposition of a complaint. Please describe the controls in place to assure that the standards are met.	Ch16§B02 Ch16§B03 Ch16§B04
16. Please describe the regulated entity's standards for logging, dating and documentation of all complaint/grievance activities. Please describe the controls in place to assure that the standards are met.	Ch16§B02 Ch16§B03 Ch16§B04
17. Provide a listing of all complaints filed with the company during the examination period including grievances filed.	Ch16§B02 Ch16§B03 Ch16§B04

**Process 043 – Reserved for Future Use**

**Process 044 – Advertising, Sales and Marketing**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch16§C01
11. Provide a copy of the regulated entity's advertising objectives statement.	Ch16§C01
12. Provide a copy of the regulated entity's producer marketing materials or solicitation kits.	Ch16§C01
13. Provide a copy of the regulated entity's advertising materials and	Ch16§C01

associated policy forms used during the Examination Period.	
14. Describe the regulated entity’s internet marketing efforts.	Ch16§C01
15. Provide a copy of the regulated entity's telemarketing scripts.	Ch16§C01
16. Describe methods of communication with producers. Is electronic media used to train, inform, communicate with producers?	Ch16§C01
17. Provide a copy of any buyer's guide in use by the regulated entity.	Ch16§C01

**Process 045 – Producer Training**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch16§C02
<b>Note: For purposes of this process, this includes, agent, broker, solicitor, surplus lines broker, general agent, managing general agent, etc.</b>	
11. Please describe the specialized product training provided to producers and the frequency of the training.	Ch16§C02
12. Please describe the regulated entity efforts to avoid producer misrepresentation.	Ch16§C02

**Process 046 – Producer Communications**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch16§C03
11. Please describe the media used for communications with producers.	Ch16§C03

**Process 047 – Mass Marketing**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch17§C01
11. Please describe how a legitimate basis for a group is determined.	Ch17§C01

**Process 048 – Controlled Business - Title**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch18§C01
11. Please describe all controlled business arrangements used by the regulated entity.	Ch18§C01

**Process 049 – Inducements Related to Referrals - Title**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch18§C02
11. Please describe process utilized to prevent inappropriate or illegal inducements related to referrals of business.	Ch18§C02

**Process 050 – Affiliated Business Arrangements - Title**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch18§C03
11. Please describe all affiliated business arrangements and their relationship to the regulated entity.	Ch18§C03

**Process 051 – Producer Replacement Rules - Life**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch19§C02
11. Please describe oversight of producers aimed at prevention of inappropriate producer replacements.	Ch19§C02

**Process 052 – Life Replacements**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch19§C03
11. Please describe steps aimed at prevention of inappropriate replacements.	Ch19§C03

**Process 053 – Life Illustrations**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch19§C04
11. Please describe quality control used to assure that life illustrations are accurate and complete. Describe process when they are not.	Ch19§C04

**Process 054 – Product Suitability - Life**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch19§C05
11. Please describe steps taken to assure product suitability.	Ch19§C05
12. Does the regulated entity allow multiple issue of policies to the same insured? If so, under what conditions or limitations.	Ch19§C05

**Process 055 – Product Suitability - Annuity**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch19§C05 Ch19§C09 Ch19§C10
11. Please describe steps taken to assure product suitability.	Ch19§C05 Ch19§C09 Ch19§C10
12. Please describe any remediation efforts during the examination period to correct any inappropriate annuity sales..	Ch19§C05 Ch19§C09 Ch19§C10
13. Please describe oversight of producers aimed at suitable of sale of annuity products.	Ch19§C10

**Process 056 – Preneed Funeral Contracts, Disclosures and Advertisements**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch19§C06
<b>No additional questions.</b>	Ch19§C06

**Process 057 – Accelerated Benefits Disclosures in Forms and Advertisements**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch19§C07 Ch19§E04
11. Please provide a copy of the disclosure made to an insured upon request for an accelerated benefit..	Ch19§C07 Ch19§E04

**Process 058 – Disclosures on Depository Institutions Insurance Sales Applications**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch19§C08
11. Please provide a copy of the notice provided and disclosures made to an insured that is related or unrelated to an extension of credit.	Ch19§C08

**Process 059 – Education and Monitoring of Producers Selling Fixed Index Annuity**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch19§C11
11. Please describe producers training regimen.	Ch19§C11

**Process 060 – Education and Monitoring of Producers Selling Indexed Life Products**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch19§C12
11. Please describe producers training regimen.	Ch19§C12

**Process 061 – Health Replacements**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch20§C01 Ch21§C01 Ch22§C06
11. Please provide a copy of your replacement register for the period covered by this Examination.	Ch20§C01 Ch21§C01 Ch22§C06
12. Please provide a copy of your application for individuals used during the period covered by this Examination.	Ch20§C01 Ch21§C01

	Ch22§C06
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**Process 062 – Outline of Coverage**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch20§C02 Ch21§C01 Ch22§C06
11. Please describe the authorization process used by the regulated entity for Outlines of Coverage it issues. List persons with approval authority within the regulated entity over Outlines of Coverage.	Ch20§C02 Ch21§C01 Ch22§C06
12. Provide copies of the Outlines of Coverage in use by the regulated entity.	Ch20§C02 Ch21§C01 Ch22§C06
13. Does the regulated entity require a receipt to affirm that the Outline of Coverage reflects the application and that it has been received?	Ch20§C02 Ch21§C01 Ch22§C06

**Process 063 – Product Suitability - Health**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch20§C03
11. Does the regulated entity allow the issue of multiple policies to a single individual and if so, under what circumstances?	Ch20§C03

**Process 064 – Medicare Guides**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch21§C04
<b>No additional questions.</b>	Ch21§C04

**Process 065 – Medicare Supplement Advertisements**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch21§C05 Ch21§C06 Ch21§C08 Ch21§C10 Ch21§C11
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	Ch21§C12 Ch21§C13 Ch21§C15 Ch21§C16
11. Are Medicare Supplement products advertised as insurance?	Ch21§C05 Ch21§C06 Ch21§C08 Ch21§C10 Ch21§C11 Ch21§C12 Ch21§C13 Ch21§C15 Ch21§C16
12. Are representations made accurate and truthful?	Ch21§C05 Ch21§C06 Ch21§C08 Ch21§C10 Ch21§C11 Ch21§C12 Ch21§C13 Ch21§C15 Ch21§C16
13. Are statistics used accurate and supported?	Ch21§C05 Ch21§C06 Ch21§C08 Ch21§C10 Ch21§C11 Ch21§C12 Ch21§C13 Ch21§C15 Ch21§C16
14. Do advertisements disparage competitors?	Ch21§C05 Ch21§C06 Ch21§C08 Ch21§C10 Ch21§C11 Ch21§C12 Ch21§C13 Ch21§C15 Ch21§C16
15. How are jurisdictions in which the regulated entity is licensed,	Ch21§C05

reflected in advertisements?	Ch21§C06 Ch21§C08 Ch21§C10 Ch21§C11 Ch21§C12 Ch21§C13 Ch21§C15 Ch21§C16
16. Do advertisements indicate name of regulated entity?	Ch21§C05 Ch21§C06 Ch21§C08 Ch21§C10 Ch21§C11 Ch21§C12 Ch21§C13 Ch21§C15 Ch21§C16
17. Please explain how misleading incentives are prevented?	Ch21§C05 Ch21§C06 Ch21§C08 Ch21§C10 Ch21§C11 Ch21§C12 Ch21§C13 Ch21§C15 Ch21§C16
18. Are statements about the regulated entity accurate and true?	Ch21§C05 Ch21§C06 Ch21§C08 Ch21§C10 Ch21§C11 Ch21§C12 Ch21§C13 Ch21§C15 Ch21§C16

**Process 066 – Association, Trust or Discretionary Groups**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch21§C07 Ch21§C14
11. Is a separate and distinct application for membership of the group and another for the insurance coverage required? Please explain.	Ch21§C07 Ch21§C14
12. Please describe steps taken to assure that 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.	Ch21§C07 Ch21§C14

**Process 067 – Product Suitability - LTC**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch22§C01
11. Does the regulated entity allow the issue of multiple policies to a single individual and if so, under what circumstances?	Ch22§C01

**Process 068 – LTC Benefit Triggers**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch22§C02
11. Please describe how the regulated entity provides disclosures for the standards for benefit triggers to its insureds.	Ch22§C02

**Process 069 – Marketing of LTC Products**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch22§C03
<b>No additional questions.</b>	Ch22§C03

**Process 070 – LTC Advertisements**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch22§C04
<b>No additional questions.</b>	Ch22§C04

**Process 071 – Producer Replacement Rules - LTC**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch22§C05
11. Please describe oversight of producers aimed at prevention of inappropriate producer replacements.	Ch22§C05

**Process 072 – LTC Replacements**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch22§C06
11. Please describe steps aimed at prevention of inappropriate replacements.	Ch22§C06

**Process 073 – Consumer Credit Disclosures and Advertisements**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch23§C01
<b>No additional questions.</b>	Ch23§C01

**Process 074 – Consumer Credit Limits**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch23§C02
<b>No additional questions.</b>	Ch23§C02

**Process 075 – *Reserved for Future Use***

**Process 076 – *Reserved for Future Use***

**Process 077 – Reserved for Future Use**

**Process 078 – Reserved for Future Use**

**Process 079 – Reserved for Future Use**

**Process 080 – License Records Agree with DOI Records**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch16§D01
<b>No additional questions.</b>	Ch16§D01

**Process 081 – Producer Selection and Appointment**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch16§D02
11. Please describe steps aimed at assuring that producers is licensed before submission of business and appointed within 15 days of submission.	Ch16§D02
12. Please provide a sample producer contract and commission schedule.	

**Process 082 – Producer Termination**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch16§D03 Ch16§D04 Ch16§D05
11. Please provide a listing of acceptable reasons for termination of a producer contract.	Ch16§D03 Ch16§D04 Ch16§D05
12. Are terminations and reasons for the termination provided to the state?	Ch16§D03 Ch16§D04 Ch16§D05
13. Please describe the steps taken to prevent unfair discrimination when considering a termination.	Ch16§D03 Ch16§D04 Ch16§D05
14. Please describe the documentation required for a termination.	Ch16§D03

	Ch16§D04 Ch16§D05
15. Provide a listing of all producers that were terminated during the examination period. List reasons.	Ch16§D03 Ch16§D04 Ch16§D05

**Process 083 – Producer Defalcation**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch16§D06
11. Are criminal reports made when a defalcation occurs?	Ch16§D06
12. Does the producer contract used by the regulated entity require that premiums be held in a fiduciary capacity?	Ch16§D06
13. Provide a listing of producer accounts current where the remittance of premiums due has not been made according to contract.	Ch16§D06

**Process 084 – Reserved for Future Use**

**Process 085 – Reserved for Future Use**

**Process 086 – Premium Billing**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch16§E01
11. Please provide sample copy of billing notice.	Ch16§E01
12. Please provide a description of the timing of billings.	Ch16§E01

**Process 087 – Policy Issuance and Insured Requested Cancellations**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch16§E02 Ch16§F06
11. Please describe the regulated entity standards for timely policy issuance.	Ch16§E02 Ch16§F06
12. Please describe the regulated entity standards for timely insured requested cancellations.	Ch16§E02 Ch16§F06

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**Process 088 – Correspondence Routing**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch16§E03
11. Please describe the regulated entity’s standards for identifying and directing incoming correspondence.	Ch16§E03

**Process 089 – Assumption Reinsurance**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch16§E04
<b>Note: According to the model act, “assumption reinsurance agreement” means any contract which both;</b> <ul style="list-style-type: none"> <li>• <b>transfers insurance obligations and/or risks of existing or enforce contracts of insurance from a transferring insurer to and assuming reinsurer; and</b></li> <li>• <b>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.</b></li> </ul>	
11. Does the regulated entity enter into assumption reinsurance agreements?	Ch16§E04
12. What notifications are provided to affected policyholders?	Ch16§E04

**Process 090 – Policy Transactions**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch16§E05
11. Please describe the regulated entity’ standards for timeliness and accuracy of all transactions.	Ch16§E05
12. Please describe the regulated entity’s standards for documentation of all transactions.	Ch16§E05
13. Please describe the regulated entity’ standards for processing of mature endowments when due.	Ch16§E05

<p><b>Life Products</b> 14. Please describe the regulated entity’ standards for processing premium refunds for modifying the guaranteed life products. Special requirements may exist, under policy provisions or state law, for calculation of refunds involving “10 day day right to return” periods for life products, which include a separate account.</p>	Ch16§E05
<p><b>Credit Insurance</b> 14. Please describe the regulated entity’ standards for handling of credit insurance where the debt is refinanced prior to the scheduled maturity date.</p>	Ch16§E05

**Process 091 – Locating Missing Policyholders or Beneficiaries**

<p><b>Source:</b> <b>This Process Review Still Under Construction</b></p>	Ch16§E06
<p>11. Please describe the steps taken to locate beneficiaries, policyholders and recipients of unclaimed properties.</p>	Ch16§E06

**Process 092 – Return Premium**

<p><b>Source:</b> <b>This Process Review Still Under Construction</b></p>	Ch16§E07
<p>11. Does the Company have a process to return unearned premium?</p>	Ch16§E07
<p>12. Please describe how the regulated entity verifies that refunds provided to a producer are properly distributed.</p>	Ch16§E07

**Process 093 – Provision of Claim History and Loss Information to Insured**

<p><b>Source:</b> <b>This Process Review Still Under Construction</b></p>	Ch17§E01
<p>11. Does the regulated entity have standards for providing claim history and loss information in a timely manner when requested?</p>	Ch17§E01

**Process 094 – Reinstatement – Life and Annuity**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch19§E01
11. Please provide sample copy of reinstatement notice.	Ch19§E01
12. Please describe under what circumstances would reinstatement be denied.	Ch19§E01
13. Please describe the regulated entity standard for timely reinstatement notice.	Ch19§E01

**Process 095 – Communication of Nonforfeiture Options – Life and Annuity**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch19§E02
<b>No additional questions.</b>	Ch19§E02

**Process 096 – Annual Report of Policy Values - Life and Annuity**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch19§E03
<b>No additional questions.</b>	Ch19§E03

**Process 097 – Reinstatement - Health**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	
11. Please provide sample copy of reinstatement notice.	Ch20§E01
12. Please describe under what circumstances would reinstatement be denied.	Ch20§E01
13. Please describe the regulated entity standard for timely reinstatement notice.	Ch20§E01

**Process 098 – Credible Coverage**

<p><b>Source:</b>  <b>This Process Review Still Under Construction</b></p>	<p>Ch20§E02</p>
<p><b>Note: Title I of HIPAA regulates the availability and breadth of group health plans and certain individual health insurance policies. It amended the Employee Retirement Income Security Act, the Public Health Service Act, and the Internal Revenue Code.</b></p> <p><b>Title I also limits restrictions that a group health plan can place on benefits for preexisting conditions. Group health plans may refuse to provide benefits relating to preexisting conditions for a period of 12 months after enrollment in the plan or 18 months in the case of late enrollment. (29 U.S.C. § 1181(a)(2))</b></p> <p><b>However, individuals may reduce this exclusion period if they had group health plan coverage or health insurance prior to enrolling in the plan. Title I allows individuals to reduce the exclusion period by the amount of time that they had “creditable coverage” prior to enrolling in the plan and after any “significant breaks” in coverage. (29 U.S.C. § 1181(a)(3))</b></p> <p><b>“Creditable coverage” is defined quite broadly and includes nearly all group and individual health plans, Medicare, and Medicaid. (29 U.S.C. § 1181(c)(1))</b></p> <p><b>A “significant break” in coverage is defined as any 63 day period without any creditable coverage. (29 U.S.C. § 1181(c)(2)(A))</b></p> <p><b>Documents that may establish creditable coverage include a certificate of coverage or, in the absence of a certificate of coverage, any of the following:</b></p> <ul style="list-style-type: none"> <li><b>• Explanations of benefits or other correspondence from a plan or issuer indicating coverage</b></li> <li><b>• Pay stubs showing a payroll deduction for health coverage</b></li> <li><b>• Health insurance identification card</b></li> <li><b>• Certificate of coverage under a group health policy</b></li> <li><b>• Records from medical care providers indicating health coverage</b></li> <li><b>• Third-party statements verifying periods of coverage</b></li> <li><b>• Benefit termination notice from Medicare or Medicaid</b></li> <li><b>• Other relevant documents that evidence periods of health coverage</b></li> </ul>	
<p>11. Please provide a sample Creditable Coverage certificate.</p>	<p>Ch20§E02</p>

12. Does the regulated entity issue certificates upon request?.	Ch20§E02
13. Does the regulated entity adequately process certificated received?.	Ch20§E02

**Process 099 – Policy Renewals - LTC**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch22§E01
<b>No additional questions.</b>	Ch22§E01

**Process 100 – Application of Nonforfeiture - LTC**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch22§E02
<b>No additional questions.</b>	Ch22§E02

**Process 101 – Communication of Nonforfeiture Options -LTC**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch22§E03
<b>No additional questions.</b>	Ch22§E03

**Process 102 – Policyholder Service - LTC**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch22§E04
<b>No additional questions.</b>	Ch22§E04

**Process 103 – *Reserved for Future Use***

**Process 104 – *Reserved for Future Use***

**Process 105 – *Reserved for Future Use***

**Process 106 – Premium Determination and Quotation**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch16§F01 Ch16§F03
11. Please provide a copy of all rating manuals in use during the Examination Period.	Ch16§F01 Ch16§F03
12. Please describe method of rating policies. Indicate if rating is done manually, electronically, or a combination of both. If different systems used for new business versus renewal business, describe differences.	Ch16§F01 Ch16§F03
13. Please describe steps taken by regulated entity to detect and prevent illegal rebating, commission-cutting or inducements.	Ch16§F01 Ch16§F03
14. Please describe steps taken by regulated entity to determine that the basis of premium is correct.	Ch16§F01 Ch16§F03

**Process 107 – Policyholder Disclosures**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch16§F02
11. Please provide a copy of all disclosures made to policyholders during the examination period. Describe how disclosures made are documented.	Ch16§F02
12. Is notice if the existence of pools provided where required?	Ch16§F02
13. Are help phone numbers provided to policyholders?	Ch16§F02

**Process 108 – Underwriting and Selection**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch16§F04 Ch17§F08 Ch17§F10
11. Please provide a copy of all underwriting manuals and guidelines in use during the Examination Period.	Ch16§F04 Ch17§F08 Ch17§F10
12. Do applications form a part of the contract of coverage in all cases? Specify.	Ch16§F04 Ch17§F08

	Ch17§F10
13. Provide a copy of each policy form and rider used by the regulated entity during the Examination Period.	Ch16§F04 Ch17§F08 Ch17§F10
14. Describe process for handling adverse underwriting decisions. Include copies of form letters used.	Ch16§F04 Ch17§F08 Ch17§F10
15. Provide a copy of all bulletins, notices, orders, and newsletters, etc. provided to or accessible by underwriters to guide them in their selection of business. If materials are voluminous, please provide an index.	Ch16§F04 Ch17§F08 Ch17§F10
16. Describe latitude given to underwriters to deviate from selection or rating criteria and circumstances under which it may be exercised.	Ch16§F04 Ch17§F08 Ch17§F10
17. Describe commission structure including any variances permitted on an individual agent basis. Does the regulated entity use multilevel commission schedule and if so describe conditions under which variances are used and how are they applied?	Ch16§F04 Ch17§F08 Ch17§F10
18. Describe verification process used by the regulated entity to determine accuracy of application information.	Ch16§F04 Ch17§F08 Ch17§F10
19. Describe process used by Company to assure that underwriting, rating and classification efforts on auditable policies is developed at or near inception of the coverage rather than near or after expiration or following a claim.	Ch16§F04 Ch17§F08 Ch17§F10
20. Please provide a copy of each application for coverage used by the Company.	Ch16§F04 Ch17§F08 Ch17§F10
21. Describe controls in place to monitor declination/rejection by underwriters.	Ch16§F04 Ch17§F08 Ch17§F10

**Process 109 – Form Filing or Certification**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch16§F05
11. Please provide a list of forms filed during the examination period. If any were disapproved, so indicate.	Ch16§F05
12. Please provide a copy of any form certifications made during the Examination Period.	Ch16§F05

**Process 110 – Termination of Coverage**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch16§F07 Ch16§F08 Ch16§F09
<b>Note: Termination includes rejections, declinations, cancellations, nonrenewals and rescissions.</b>	
11. Please provide a list of reasons used by the Company for termination.	Ch16§F07 Ch16§F08 Ch16§F09
12. Please provide an explanation of conditions that allow a producer to terminate coverage and the specific controls the company has in place to assure that such terminations are appropriate.	Ch16§F07 Ch16§F08 Ch16§F09
13. Please explain the Company standards for materiality utilized before exercising a decision to rescind coverage.	Ch16§F07 Ch16§F08 Ch16§F09

**Process 111 – Deviations**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch17§F01
11. Please explain how the regulated entity assures consistent application of its credits and deviations.	Ch17§F01

**Process 112 – Schedule Rating or Individual Risk Modification Plans**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch17§F01 Ch17§F02
11. Please explain how the regulated entity assures consistent application of its schedule rating plan.	Ch17§F01 Ch17§F02
12. Please explain how the regulated entity documents its use of the schedule rating plan and describe what constitutes adequate support for the various categories of credit and debit.	Ch17§F01 Ch17§F02

**Process 113 – Use of Expense Multipliers**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch17§F03
11. Please provide the regulated entity’s filed (and approved if applicable) expense multipliers during the examination period.	Ch17§F03
12. Please explain how the expense multiplier is developed for each line of business affected.	Ch17§F03

**Process 114 – Premium Audit Accuracy**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch17§F04 Ch17§F09
11. Please describe the regulated entity’s standard for timely premium audit.	Ch17§F04 Ch17§F09
12. Please explain under what circumstances and conditions are premium audits waived.	Ch17§F04 Ch17§F09
13. Please describe the process utilized when the auditor finds a significant difference in the classifications used or the estimated premium basis.	Ch17§F04 Ch17§F09
14. How does the Company assure that premium audit data is accurately reflected in the unit statistical report. (Workers Compensation)	Ch17§F04 Ch17§F09

**Process 115 – Experience Modification – Workers Compensation**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch17§F05
11. Does the regulated entity reconcile experience modification to the unit statistical reports made to NCCI?	Ch17§F05
12. Does the regulated entity insist on timely development of experience modifications and what is the process when modifications are not applied within the first thirty days of the policy period affected?	Ch17§F05
13. How does the Company assure that the correct experience modification is applied accurately and timely?	

**Process 116 – Loss Reporting – Workers Compensation**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch17§F06 Ch17§F07
11. How does the regulated entity assure timely and accurate reporting of the unit statistical reports made to NCCI?	Ch17§F06 Ch17§F07
12. How does the regulated entity assure timely and accurate reporting of data calls made by NCCI?	Ch17§F06 Ch17§F07

**Process 117 – NCCI Call on Deductibles**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch17§F07
11 Please describe verification process for data submitted on deductible calls.	Ch17§F07

**Process 118 – Timing of Underwriting, Rating and Classification**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch17§F08
<b>Note: 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, after the policy has expired.</b>	Ch17§F08

<b>No additional questions.</b>	Ch17§F08
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**Process 119 – Listing of Forms and Endorsements**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch17§F11
<b>Note: All forms and endorsements forming a part of a contract must be listed on the declaration page unless added after inception in which case the attaching clause must be completed.</b>	Ch17§F11
11. Does the regulated entity conduct a control review before a policy is released to assure that all forms and endorsements forming part of the contract are itemized on the declaration page?	Ch17§F11

**Process 120 – Verification of VIN Numbers**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch17§F12
11. Does the regulated entity utilize a third party to test the VIN numbers of the vehicles it insures for validity?	Ch17§F12
12. Describe how the regulated entity verifies the physical damage symbols it uses.	Ch17§F12

**Process 121 – Prohibited Anticompetitive Underwriting Practices**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch17§F13
<b>Note: Examiners are instructed to refer any practice suggesting anti-competitive behavior to the Insurance Department legal counsel. This includes engaging in collusive underwriting practices that may inhibit competition.</b>	Ch17§F13
<b>No additional questions.</b>	Ch17§F13

**Process 122 – Mass Market Underwriting**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch17§F14
11. Please explain the differences between the underwriting guidelines for mass-marketed business and individually marketed business.	Ch17§F14
12. Please explain the regulated entity’s treatment of nonpayment of premium for mass marketed business.	Ch17§F14
13. Please describe the method used to disclose the right to continue for members of the group who leave employment or the group.	Ch17§F14

**Process 123 – Group Personal Lines**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch17§F15
11. Please describe the conversion options when an individual terminates coverage.	Ch17§F15
12. What are the differences between the group coverage written and the coverage offered under a conversion option?	Ch17§F15
13. What are the conditions or rules for participation in a group program?	Ch17§F15
14. Is group coverage contingent on the purchase of any other insurance, product or service?	Ch17§F15
15. How are experience refunds or dividends distributed?	Ch17§F15

**Process 124 – Cancellation/Nonrenewal Notices**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch17§F16
11. Please provide a copy of the Notice of Cancellation and the Notice of Nonrenewal used by the regulated entity.	Ch17§F16
12. Are reasons for cancellation or nonrenewal given with the notice?	Ch17§F16

**Process 125 – Policy Coding**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch17§F17
11. How does the regulated entity assure that codes are current?	Ch17§F17
12. How does the regulated entity assure that codes provided by producers are correct and current?	Ch17§F17

**Process 126 – Underwriting File Documentation**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch17§F18
11. Are applications maintained in the underwriting file?	Ch17§F18
12. When and under what conditions does the regulated entity require a physical inspection, a motor vehicle report (MVR), an inspection report, a credit report or other underwriting information to confirm exposure or premium basis?	Ch17§F18
13. When a policy is issued on a basis other than applied for, does the regulated entity provide an adverse underwriting decision? If not, please explain.	Ch17§F18

**Process 127 – Title - Reissue and Refinance Credits**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch18§F01
<b>Note:</b>	
11. <b>Under Construction</b>	

**Process 128 – Title - Collusive or Anti-competitive Underwriting Practices**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch18§F02
<b>Note:</b>	

11.	
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**Process 129 – Title - Other Charges and Fees**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch18§F03
<b>Note:</b>	
11.	

**Process 130 – Title - E&O for Closing**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch18§F04
<b>Note:</b>	
11.	

**Process 131 – Title - Closing and Settlement**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch18§F05
<b>Note:</b>	
11.	

**Process 132 – Title - Reports and Disclosures**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch18§F06
<b>Note:</b>	
11.	

**Process 133 – Title - Recording, Reporting and Validation of Revenue, Loss and Expense Experience**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch18§F07
<b>Note:</b>	
11.	

**Process 134 – Title- Coding.**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch18§F08
<b>Note:</b>	
11.	

**Process 135 – L&A - Pertinent Information on Applications.**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch19§F01
<b>Note:</b>	
11.	

**Process 136 – L&A - AIDS-Related Concerns.**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch19§F02
<b>Note:</b>	
11.	

**Process 137 – Health - Cancellation Practices.**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch20§F01
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<b>Note:</b>	
11.	

**Process 138 – Health - Information on Applications.**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch20§F02
<b>Note:</b>	
11.	

**Process 139 – Health - Continuation of Benefits.**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch20§F03
<b>Note:</b>	
11.	

**Process 140 – Health - Genetic Information Nondiscrimination Act.**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch20§F04
<b>Note:</b>	
11.	

**Process 141 – Health - Protection of Health Information.**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch20§F05
<b>Note:</b>	
11.	

**Process 142 – Health - Use of Preexisting Exclusions.**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch20§F06
<b>Note:</b>	
11.	

**Process 143 – Health - Improperly Deny Coverage.**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch20§F07
<b>Note:</b>	
11.	

**Process 144 – Health - Guaranteed-Issue Requirements.**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch20§F08
<b>Note:</b>	
11.	

**Process 145 – Health – Portability.**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch20§F09
<b>Note:</b>	
11.	

**Process 146 – Health - Self-funded Benefit Plans.**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch20§F10
<b>Note:</b>	

11. <b>This Process Review Still Under Construction</b>	
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**Process 147 – LTC - Appeal of Adverse Benefit Trigger Determination.**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch22§F01
<b>Note:</b>	
11. <b>This Process Review Still Under Construction</b>	

**Process 148 – Consumer Credit - Effective and Termination Dates.**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch23§F01
<b>Note:</b>	
11.	

**Process 149 – Consumer Credit – Terminations.**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch23§F02
<b>Note:</b>	
11.	

**Process 150 – Consumer Credit - Creditor Submitted Premium.**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch23§F03
<b>Note:</b>	
11.	

**Process 151 – Consumer Credit - Payment of Compensation.**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch23§F04
<b>Note:</b>	
11.	

**Process 152 – Consumer Credit - Unfair Methods of Competition**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch23§F05
<b>Note:</b>	
11.	

**Process 153 – Reserved for Future Use**

**Process 154 – Reserved for Future Use**

**Process 155 – Reserved for Future Use**

**Process 156 – Reserved for Future Use**

**Process 157 – Claims Handling**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch16§G01 Ch16§G02 Ch16§G03 Ch16§G06 Ch16§G10 Ch16§G11
11. What timeframes are utilized by the regulated entity for initial contact?	Ch16§G01
12. What timeframes are utilized by the regulated entity for timely investigation?	Ch16§G02 Ch16§G11
13. What timeframes are utilized by the regulated entity for resolution?	Ch16§G03
14. Describe regulated entity standards for use of claim releases, if any. Are releases used? If so provide a sample of each type of release	Ch16§G03

used.	
15. How does regulated entity assure that claim is settled in accord with policy provisions?	Ch16§G06
16. Does the regulated entity utilize fraud detection measures in its review of claims?	Ch16§G06
17. Indicate whether claims are paid by check or by draft. If by draft describe clearance process.	Ch16§G10

**Process 158 – Response to Claim Correspondence**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch16§G04
11. What timeframes are utilized by the regulated entity for response to claim correspondence?	Ch16§G04

**Process 159 – Claim File Documentation.**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch16§G05
11. Describe the claim file retention/destruction requirements.	Ch16§G05

**Process 160 – Appropriate Claim Forms Use.**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch16§G07
11. Please provide a copy of each claim form in use by the regulated entity.	Ch16§G07

**Process 161 – Claims Reserving.**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch16§G08
11. Please provide a copy of the claims guidelines used by the adjuster or claim processor to establish reserves.	Ch16§G08

12. Please provide a copy of all bulletins, notices, orders, and newsletters, etc. provided to or accessible by adjusters to guide them in their adjustment of claims.	Ch16§G08
13. Please describe controls in place to detect reserve inadequacies or redundancies and to make adjustments.	Ch16§G08

**Process 162 – Denied and Closed Without Payment Claims.**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch16§G09
11. Does the regulated entity provide claimants with instructions for having rebuttals to denials reviewed by the Insurance Department or the regulated entity?	Ch16§G09

**Process 163 – Catastrophe Claim Handling.**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch16§G01 Ch16§G02 Ch16§G03 Ch16§G06
<b>Note: This procedure is concerned with catastrophe incidents where there is catastrophic loss to property such as may occur in a hurricane or multiple hurricanes, a major earthquake in a heavily populated area or a series of tornados or a tsunami. Also major loss of life from such an event or terrorist attack. From a health point of view, a pandemic. Each of these cause additional burdens on an insurer’s systems that may not be contemplated in the normal claim handling process</b>	Ch16§G01 Ch16§G02 Ch16§G03 Ch16§G06
11. Please describe differences in the claim handling process necessitated by a catastrophic event.	Ch16§G01 Ch16§G02 Ch16§G03 Ch16§G06
12. Describe source of adequate claim adjustment or claim adjudication resources needed to address loss arising from a catastrophic event.	Ch16§G01 Ch16§G02 Ch16§G03 Ch16§G06

**Process 164 – Reservation of Rights and Excess of Loss letter.**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch17§G01
11. Who makes the determination to send a reservation of rights letter or an excess of loss letter?	Ch17§G01

**Process 165 – Deductible Reimbursement.**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch17§G02
11. What methods are used to refund recovered deductible amounts to insureds?	Ch17§G02
12. For long term subrogation cases, describe refund methodology.	Ch17§G02

**Process 166 – Loss Statistical Coding.**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	Ch17§G03
11. How does the regulated entity assure that codes are current?	Ch17§G03
12. Does the regulated entity assure that loss amounts are separated from expense amounts?	Ch17§G03

**Process 167 – Title - Indemnification for Loss of Settlement.**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	
<b>Note:</b>	
11.	

**Process 168 – L&A - Accelerated Benefit Payment disclosures.**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	
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<b>Note:</b>	
11.	

**Process 169 – L&A - Discrimination - Qualifying Events.**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	
<b>Note:</b>	
11.	

**Process 170 – Health - Newborns’ and Mothers’ Health Protection Act.**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	
11.	

**Process 171 – Health - Mental Health Parity and Addiction Equity Act.**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	
<b>Note:</b>	
11.	

**Process 172 – Health - Women's Health and Career Rights Act.**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	
<b>Note:</b>	
11.	

**Process 173 – Health - Group Coverage Replacements.**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	
<b>Note:</b>	
11.	

**Process 174 – Consumer Credit - Proof of payments reflect appropriate claim-handling.**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	
<b>Note:</b>	
11.	

**Process 175 – Consumer Credit - Claim files establish events and dates.**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	
<b>Note:</b>	
11.	

**Process 176 –**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	
<b>Note:</b>	
11.	

**Process 177 –**

<b>Source:</b> <b>This Process Review Still Under Construction</b>	
<b>Note:</b>	

11.	
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**G. Tests Common to the Structure of All Processes.**

This section addresses the testing of the process to determine that features common to all processes exist. The tests are phrased in question form. These tests are applicable to each process identified in Section F and I. Please note that the listed tests for a process are not fixed and absolute. They do not limit the examiner from posing additional questions, when warranted, in efforts to enhance the understanding of the Regulated Entity’s response(s). If no response is provided, the fact should be part of the examiners documentation.

1. Is a written procedure or process in place? Refer to response for Section F.1	
<b>Note: The absence of a written policy or procedure potentially allows an inconsistent application of the process. If not in writing, how does the Company assure consistent application of the process? The complete lack of any recognizable process indicates Level 0.</b>	
2. Has a risk assessment been conducted? If so, does it address compliance issues? Refer to response for Section F.2	
<b>Note: The absence of a risk assessment and mitigation document for the process may indicate that the regulated entity has not recognized that the issues exist or need to be addresses. This is a level 0 characteristic. If there is a document, the Level is likely to be Level 1 or higher.</b>	
3. Do the mitigations noted adequately address the risk noted? Are any obvious mitigation elements missing? Refer to response for Section F.2.	
<b>Note: The absence of a risk assessment and mitigation document for the process may indicate that the regulated entity has not recognized that the issues exist or need to be addresses. This is a level 0 characteristic. If there is a document, the Level is likely to be Level 1 or higher. If appropriate mitigations are not reflected the maturity level should not exceed Level 1.</b>	
4. Is the procedure or process unambiguous, clear and readable? Refer to response for Section F.3.	
<b>Note: If there are no standardized processes, and ad hoc approaches that tend to be applied on an individual or cases by case basis, the maturity level can be no higher than Level 1. When the procedures themselves are not sophisticated but are the formalization of existing practices, the maturity level can be no higher than Level 3.</b>	
5. Are appropriate measurements or controls in place to test the functioning and efficacy of the procedure or process? How often is the procedure or process reviewed, tested or audited? How does management exercise oversight and control of the process? Refer to response for Section F.4 & F.8.	
<b>Note: If the overall approach to management is disorganized, the maturity level</b>	

<p>can be no higher than Level 1. Processes that have developed to the stage where similar procedures are followed by adherent people undertaking the same task indicate a Level 2 maturity. If there is a high degree of reliance on the knowledge of individuals then errors are likely and the maturity level is Level 2 or lower. It is a maturity Level 3 characteristic when it is mandated that these processes should be followed; however, it is unlikely that deviations will be detected.</p>
<p>6. How are errors in the process detected and corrected? Is the detection method timely? Refer to response for Section F.7.</p>
<p><b>Note: When management monitors and measures compliance with procedures and takes action where processes appear not to be working effectively, this is a Level 4 characteristic. When processes are under constant improvement and provide good practice, this is a Level 4 characteristic. When Automation and tools are used in a limited or fragmented way, the maturity level should not exceed Level 4.</b></p>
<p>7. How are persons subject to its provisions of the process or procedure made aware of its existence? How is the procedure or process made accessible to those persons subject to its provisions? Refer to response for Section F.7.</p>
<p><b>Note: The absence of communication of the process is a characteristic of maturity Level 2 or lower. If learning of the process is left to individual responsibility, the maturity level is Level 2 or lower. When procedures have been standardized and documented, and communicated through training, the maturity level characteristic is Level 3.</b></p>
<p>8. Does the Company provide adequate training to persons affected by the procedure or process? How? Refer to response for Section F.7.</p>
<p><b>Note: The absence of formal training in the process is a characteristic of maturity Level 2 or lower. When procedures have been standardized and documented, and communicated through training, the maturity level characteristic is Level 3.</b></p>
<p>9. Is the procedure or process performing as intended? How do you know? Are any deficiencies noted? Refer to response for Section F.8(a).</p>
<p><b>Note: When processes have been refined to a level of good practice, based on the results of continuous improvement and maturity modeling with other enterprises, this is a maturity Level 5 characteristic.</b></p>
<p>10. How does management utilize the results of its measurement structures? Refer to response for Section F.8(e).</p>
<p><b>Note: The When processes have been refined to a level of good practice, based on the results of continuous improvement and maturity modeling with other enterprises, this is a maturity Level 5 characteristic. When IT tools are used in an integrated way to automate the workflow, providing tools to improve quality and effectiveness, making the enterprise quick to adapt, this is a</b></p>

<b>maturity Level 5 characteristic.</b>
11. Is the procedure or process current? Refer to response for Section F.9.

# This Section Still Under Construction

## H. Tests Specific to a Particular Process Content

This section addresses the testing of the process to determine that those features specific to a particular process do exist and are adequately addressed. The tests are phrased in question form. These tests are applicable to the particular process identified. Please note that the listed tests for a process are not fixed and absolute. They do not limit the examiner from posing additional questions, when warranted, in efforts to enhance the understanding of the Regulated Entity’s response(s). Pertinent responses for the examined process should be reviewed and carefully considered before responding to the following questions. If no response is provided, the fact should be part of the examiners documentation.

### Process 001 – Internal or External Audit –

All chapters referencing General (Ch16) and Advisory Organizations (Ch25).

<b>Note: The focus is on the internal or external audit process utilized to verify appropriate function and to perform analysis of market conduct issues including the various business areas considered in a market conduct examination. A regulated entity that has no internal or external audit function lacks the ready means to detect structural problems until after problems have occurred.</b>
12. Does the Regulated Entity have an Audit function? Do Audits address market regulation reputational and compliance issues?
13. How often are audits performed? Does the Regulated Entity have a standard for frequency of audit? What audits are on a routine of regular basis?
<b>Note: The State and the examiners are aware that these documents may be viewed as proprietary and sensitive. The reports will be viewed on the company premises after commencement of the on-site portion of the examination. The examiners, based on the results of audit findings for which the company has taken appropriate corrective action and remediation, will not recommend administrative action. The purpose for viewing these documents is to determine that management directives are in compliance with statute and that errors found through the audit process are corrected. It is not used as a device to discover and quantify violations, rather it is used for qualitative purposes. Any special needs or concerns should be discussed with the Examiner in Charge.</b>
14. Do audit reports provide meaningful information to management? Describe.
15. How is management using the audit reports?
16. How is the audit process activated?
17. Is the audit process compliant with applicable statutes or regulations?
18. Are audit recommendations resolved? How?

### Process 002 – Computer Security

<b>Note: The focus is on the existence of sufficient protection to the regulated entity systems. Examiners should avoid requiring information that itself poses a threat to that protection.</b>
12. Does the Regulated Entity have a Computer Security function? Is it sufficiently robust to protect personal information?
13. How is access to data controlled and limited?
14. How are changes to data in the system authorized and supervised? Describe.
15. How are unauthorized attempts detected and deflected? Have there been any successful unauthorized access to Regulated Entity data? What was done? Was it reported?
16. How is the system protected during data transfers?
17. Are security audits conducted and if so with what frequency?

### Process 003 – Anti Fraud

<b>Note: Examiners are interested in internal as well as external fraud response and detection mechanisms.</b>
12. Does the Regulated Entity use a fraud warning notice? Is a fraud warning notice used with the filing of a claim? Does the notice comply with governing statute and regulation.
13. Does the Regulated Entity have a designated unit to deal with its antifraud initiatives? How is it staffed?
14. Are Anti Fraud activities adequate?
15. Does the Regulated Entity process require the reporting of fraudulent activities to the insurance commissioner and was such an action taken during the Examination period?
16. Does the regulated entity have a process in place to prevent persons convicted of a felony involving dishonesty or breach of trust from participating in the business of insurance?

### Process 004 – Disaster recovery

12. Was the regulated entity disaster recovery plan used or tested during the period of the examination?
13. How frequently are the elements of the disaster recovery plan tested? How are the results critiqued.
14. What is the regulated entity's off-site data backup process? What is the frequency of update? Is the backup site sufficiently distant geographically so as not to expose primary and backup sites to a common disaster?


**Process 005 – Vendor Oversight and Control**

12. Has the regulated entity adequately described the scope of authority extended to its vendors and memorialized that extension in a contract? How does the regulated entity assure that a vendor is not exceeding the authority extended? Does the vendor maintain a license appropriate to its extension of authority and convey that information to the regulated entity?
13. Do vendor contracts adequately describe the extension of authority and its limitations? Are recordkeeping requirements of the vendor adequately stated?
14. Does the regulated entity exercise reasonable oversight and control of the vendor?
15. Does the regulated entity perform regular audits of the activities by the vendor on behalf of the regulated entity?
16. Are vendor performance standards established in the contract. Do the standards comply with performance requirements in state law or regulation? Is vendor performance monitored by the regulated entity? Is documentation adequate? Is vendor failure to meet performance standards grounds for contract termination.

**Process 006 – Records, Central Recovery and Backup**

12. Are records maintained in an appropriate file structure with orderly organization and legibility? Refer to response for Section 1.3, 1.11 and 1.12.
13. Does the regulated entity record retention schedule comport with state record retention requirements? Refer to response for Section 1.3 and 1.13.
14. Has the regulated entity experienced any failure to recover records that are within the record retention schedule? Refer to response for Section 1.3 and 1.14.
15. Is regulated entity record backup process adequate? Refer to response for Section 1.3 and 1.15.

**Process 007 – License Authorization**

12 Does the business written by the regulated entity exceed the authority granted by its state of domicile and that which it is licensed to write in accordance with applicable statutes, rules and regulations?
13. Does the regulated entity monitor its financial statements to determine that its' writing in all states reported are authorized?

**Process 008 – License Authorization-Title**

<b>Title Insurance</b> 12. Does the business written by the regulated entity exceed the authority granted by its state of domicile and that which it is licensed to write in accordance with applicable statutes, rules and regulations?
<b>Title Insurance</b> 13. Does the regulated entity monitor its financial statements to determine that its' writing in all states reported are authorized?
<b>Title Insurance</b> 14. Does the regulated entity have a member of its board of directors who is a title agent that wrote more than 1% of its direct writings for the previous year? Are the measures of the regulated entity adequate to prevent such occurrences?
<b>Title Insurance</b> 15. Does the regulated entity meet all of the errors and omissions policy and fidelity coverage (or alternative financial arrangement, where permitted) requirements made by the state?
<b>Title Insurance</b> 16. Does the regulated entity meet all diversification requirements made by the state?

**Process 009 – Examination Facilitation**

12 Does the regulated entity have an Examination Facilitation function? Does the regulated entity adequately cooperate with the examiners? Does the regulated entity respond to data requests in a timely fashion? Are responses to examiner requests on point, correct, accurate and truthful?
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**Process 010 – Assertions of Privilege**

12. Does the regulated entity have an appeal process available when access to a document for which a privilege is claimed and is critical to examiner review of an issue is denied?
13. Does the regulated entity assert privilege for self-evaluative or self-critical analysis? Does the regulated entity assert privilege for proprietary documents?

**Process 011 – Staff Training**

12 Is the regulated entity process for determining staffing needs adequate? Is the training regimen adequate?

**Process 012 –Privacy Protection**

12. Does the regulated entity adequately safeguard consumer information?
<b>Note: In making this assessment, was the size and complexity of regulated entity considered and was the nature and scope of the regulated entity's activities considered.</b>
<b>In making this assessment, consider factors such as:</b> <ul style="list-style-type: none"><li>• the products and services offered by the regulated entity;</li><li>• the methods of distribution for the products and services;</li><li>• the types of information maintained by the regulated entity;</li><li>• the size of the regulated entity (which may include the number of employees and the volume of business, etc.);</li><li>• the marketing arrangements; and</li><li>• the extent to which, or methods by which, the regulated entity communicates electronically with customers, producers and other third parties.</li></ul>
13. Does the regulated entity provide a “Notice of Information Practices” on a timely basis that contains the required information? Is the content compliant with statute and regulations?

**Note: The 2000 NAIC Model Privacy Regulation provides that notices should include:**

- **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 the NAIC model regulation, 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 the NAIC model regulation, if applicable;**
- **If a regulated entity discloses nonpublic personal financial information to a nonaffiliated third party under Section 14 of the NAIC model regulation, 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 U.S.C. 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 the NAIC model regulation, a statement that indicates the regulated entity makes disclosures to other affiliated or nonaffiliated third parties, as applicable, as permitted by law.**

14. Does the regulated entity provide a copy of its privacy notice to its producers?

15. Are privacy disclosures made in a "clear and conspicuous" format?

16. Is the regulated entity compliant with the frequency of notice required in statutes or regulations?

17. Is the process for correcting, amending, or deleting personal information held by the regulated entity clear and unambiguous?
18. Does the regulated entity feedback process that monitors for appropriate use of the “Notice of information Practices”, provide timely notices, ensure errors are appropriately remedied, and implement process changes to prevent future errors?
19. Is the regulated entity's use of investigative consumer reports appropriate?
20. Are persons responsible for collecting personal information on behalf of the regulated entity in connection with insurance transactions properly trained (including agents and TPA’s) in the appropriate handling of such information?
21. Are internal (employees or staff) limitations to access of personal information, adverse underwriting decisions and investigative consumer reports adequate? Are external (subcontractors and others) limitations to access of personal information, adverse underwriting decisions and investigative consumer reports adequate?
22. Has the regulated entity established specific and accurate reasons for adverse underwriting decisions? Are the reasons compliant with statutes and regulations? Is the recipient of an adverse underwriting decision notified of the reasons for the decision?
23. Does the regulated entity provide and allow for consumer opt-out for sharing of the information it gathers or acquires?
24. Does the regulated entity take adequate steps to prevent unfair discrimination against customers and consumers who are not customers who have opted out from the disclosure of nonpublic personal financial information to nonaffiliated third parties or who have not authorized disclosure of nonpublic personal health information?

**Process 013 – Management of Insurance Information**

12. Does the regulated entity adequately train and inform its staff and vendors how to address the management of insurance information including handling, disclosing, storing or disposing of insurance information?
13. Does the regulated entity adequately safeguard consumer information?
<b>Note: In making this assessment, was the size and complexity of regulated entity considered and was the nature and scope of the regulated entity's activities considered.</b>

<p><b>In making this assessment, consider factors such as:</b></p> <ul style="list-style-type: none"><li><b>• the products and services offered by the regulated entity;</b></li><li><b>• the methods of distribution for the products and services;</b></li><li><b>• the types of information maintained by the regulated entity;</b></li><li><b>• the size of the regulated entity (which may include the number of employees and the volume of business, etc.);</b></li><li><b>• the marketing arrangements; and</b></li><li><b>• the extent to which, or methods by which, the regulated entity communicates electronically with customers, producers and other third parties.</b></li></ul>
14. Does the contract used by the regulated entity to share information shared with a contractor of the regulated entity provide for adequate protection of information shared by the regulated entity?
15. Are the standards used by the regulated entity adequate to protect the information from non-compliant disclosure?
16. Does the regulated entity provide a “Notice of Information Practices” on a timely basis that contains the required information? Is the content compliant with statute and regulations? Has this responsibility been delegated to the producer? Are controls to assure provision of notice adequate?
17. Does the regulated entity feedback process that monitors for appropriate use of the “Notice of information Practices”, provide timely notices, ensure errors are appropriately remedied, and implement process changes to prevent future errors?
18. Does the regulated entity provide a copy of its “Notice of information Practices” to its producers?
19. Are the questions posed by the regulated entity that are designed solely for marketing or research purposes reasonable and non-invasive and is the customer given the opportunity to opt out of response to those questions?
20. Is the regulated entity's use of investigative consumer reports appropriate?
21. Is the process for accessing, correcting, amending, or deleting personal information held by the regulated entity clear and unambiguous?
22. Are persons responsible for collecting information on behalf of the regulated entity in connection with insurance transactions properly trained (including agents and vendors) in the appropriate handling of such information?
23. Are the controls for the management of insurance information adequate and working?


**Process 014 –**  
**This Process Review Still Under Construction**

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**Process 041– Complaint Register**

12. Does the regulated entity maintain a Consumer Complaint Register?
13. Does the register include direct consumer complaints and insurance department complaints?
14. Are there appropriate limitations relating to access of the complaint register?

**Process 042 – Complaint Handling**

12 Does the regulated entity have a formal Complaint Handling process function?
13. Is the information provided to policyholders to communicate procedures for complaint handling adequate?
14. Are the steps taken by the regulated entity to ensure that correspondence and email received expressing a complaint or grievance is handled as a complaint and is logged and processed correctly?
15. How is management using the complaint handling reports?
16. How does the regulated entity assure that all issues raised in a complaint or grievance are fully addressed by responses?

17. (a) Does the regulated entity have its own standards for timely and accurate response (b) How does it assure that it meets them? (c) Does it comply with state statutes and regulations? Refer to response for Section 1.3 and 1.15.
18. Are all complaint/grievance activities logged, dated and documented?

**Process –**  
**This Process Review Still Under Construction**

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**Process –**  
**This Process Review Still Under Construction**

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## I. Evaluation of Process.

This section considers how to evaluate the results of the testing done in sections G and H. Based on the results of the testing done in those sections, the examiner should arrive at a determination concerning where on the matrix noted below, the process is generally described. This determination should be supported with the examiners evaluation of the process describing the reasons for the selection.

This review utilizes a maturity model to evaluate the efficacy of a procedure or process reviewed. Levels of maturity are generally not mandated by statute or regulation, but the evaluation does assist in identification of those areas where a procedure or process is non-existent, weak or insufficient. The maturity levels used in this report are identified numerically on a scale of 0 to 5, with 0 being the weakest and 5 the strongest. The definitions of these levels are:

Level	Description	Characteristics
0	Lack of any recognizable processes / practices.	<ul style="list-style-type: none"> <li>- Complete lack of any recognizable processes.</li> <li>- The enterprise has not even recognized that there is an issue to be addressed.</li> </ul>
1	Processes are ad hoc and disorganized.	<ul style="list-style-type: none"> <li>- There is evidence that the enterprise has recognized that the issues exist and need to be addressed.</li> <li>- There are however, no standardized processes; instead, there are ad hoc approaches that tend to be applied on an individual or case by case basis.</li> <li>- The overall approach to management is disorganized.</li> </ul>
2	Processes follow a regular pattern.	<ul style="list-style-type: none"> <li>- Processes have developed to the stage where similar procedures are followed by adherent people undertaking the same task.</li> <li>- There is no formal training or communication of standard procedures, and responsibility is left to the individual.</li> <li>- There is a high degree of reliance on the knowledge of individuals and, therefore errors are likely.</li> </ul>
3	Processes are documented and communicated.	<ul style="list-style-type: none"> <li>- Procedures have been standardized and documented, and communicated through training.</li> <li>- It is mandated that these processes should be followed; however, it is unlikely that deviations will be detected.</li> <li>- The procedures themselves are not sophisticated but are the formalization of existing practices</li> </ul>
4	Processes are monitored and measured.	<ul style="list-style-type: none"> <li>- Management monitors and measures compliance with procedures and takes action where processes appear not to be working effectively.</li> <li>- Processes are under constant improvement and provide good practice.</li> <li>- Automation and tools are used in a limited or fragmented way.</li> </ul>

5	Good practices are followed and automated.	<ul style="list-style-type: none"> <li>- Processes have been refined to a level of good practice, based on the results of continuous improvement and maturity modeling with other enterprises.</li> <li>- IT tools are used in an integrated way to automate the workflow, providing tools to improve quality and effectiveness, making the enterprise quick to adapt.</li> </ul>
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When applying this evaluation to examination results, the examiner should recognize that some processes and procedures will contain characteristics of a more advanced level of maturity but the characteristics as a whole do not necessarily rise to that level of maturity. For example, some ad hoc processes may contain more advanced IT functions than might otherwise be expected given the state of process development.

Also note that expectation for some areas of risk may not be as high as others.

## This Section Still Under Construction

### J. List of Processes.

This section lists the various processes that can be tested using a process review methodology. The third column is a cross reference to an applicable standard in the Handbook. The fourth column lists the number of interrogatories listed in this chapter.

P#	Process Description	Related Standard(s)	Section F
001	Internal or External Audit	CH16§A01	1-15
002	Computer Security	CH16§A02	1-13
003	Anti fraud	CH16§A03	1-15
004	Disaster recovery	CH16§A04	1-13
005	Vendor oversight and control	CH16§A05, §A06, K07, L11; Ch23§A01	1-15
006	Records, central recovery and backup. Includes maintenance, content and retention.	CH16§A07	1-15
007	Regulated entity licensure	CH16§A08; Ch18§A01 & A02	1-11
008	Insurance for Agents and Employees	Ch18§A03	1-14
009	Examination cooperation	CH16§A09	1-11
010	Assertions of privilege	CH16§A09	1-12
011	Staff training	None	1-11
012	Customer and consumer privacy protection	CH16§A10, §A12, §A13, §A16, §A17	1-22
013	Management of insurance information	CH16§A11	1-20
014	Nondisclosure of nonpublic personal financial information	CH16§A14, §A15	1-12
015	Reports to insurance departments	CH16§A18; Ch21§A02; Ch22§A01	1-12

<b>016</b>	Title Plant Maintenance	Ch18§A03	1-11
<b>017</b>	Certifications	Ch19§A01; Ch21§A03; Ch22§A01	1-11
<b>018</b>	Medicare Select Plan of Operation	Ch21§A01	1-11
<b>019</b>	Producer Compensation - Medicare	Ch21§A04	1-11
<b>020</b>	Surplus Lines Bonds	Ch24§A01	1-11
<b>021</b>	Surplus Lines Reports	Ch24§A02	1-11
<b>022</b>	Surplus Lines Taxes	Ch24§A03	1-11
<b>023</b>	Surplus Lines Unearned Premium Calculation	Ch24§A04	1-11
<b>024</b>	<i>Reserved for future use.</i>		
<b>025</b>	<i>Reserved for future use.</i>		
<b>026</b>	<i>Reserved for future use.</i>		
<b>027</b>	<i>Reserved for future use.</i>		
<b>028</b>	<i>Reserved for future use.</i>		
<b>029</b>	<i>Reserved for future use.</i>		
<b>030</b>	<i>Reserved for future use.</i>		
<b>031</b>	<i>Reserved for future use.</i>		
<b>032</b>	<i>Reserved for future use.</i>		
<b>033</b>	<i>Reserved for future use.</i>		
<b>034</b>	<i>Reserved for future use.</i>		
<b>035</b>	<i>Reserved for future use.</i>		
<b>036</b>	<i>Reserved for future use.</i>		
<b>037</b>	<i>Reserved for future use.</i>		
<b>038</b>	<i>Reserved for future use.</i>		
<b>039</b>	<i>Reserved for future use.</i>		
<b>040</b>	<i>Reserved for future use.</i>		
<b>041</b>	Complaint register	Ch16§B01	1-13
<b>042</b>	Complaint handling	Ch16§B02, §B03, §B04, §B05	1-17
<b>043</b>	<i>Reserved for future use.</i>		
<b>044</b>	Advertising, sales and marketing including agent produced advertising.	Ch16§C01; Ch19§C01	1-17
<b>045</b>	Producer training	Ch16§C02	1-12
<b>046</b>	Producer communications	Ch16§C03	1-11
<b>047</b>	Mass Marketing	Ch17§C01	1-11
<b>048</b>	Controlled Business - Title	Ch18§C01	1-11
<b>049</b>	Inducements Related to Referrals – Title	Ch18§C02	1-11
<b>050</b>	Affiliated Business Arrangements – Title	Ch18§C03	1-11
<b>051</b>	Producer Replacement Rules - Life	Ch19§C02	1-11
<b>052</b>	Life Replacements	Ch19§C03	1-11
<b>053</b>	Life Illustrations	Ch19§C04	1-11
<b>054</b>	Product Suitability - Life	Ch19§C05	1-12
<b>055</b>	Product Suitability - Annuity	Ch19§C05, §C09 & §C10	1-13
<b>056</b>	Preneed Funeral Contracts, Disclosures and Advertisements	Ch19§C06	1-10

057	Accelerated Benefits Disclosures in Forms and Advertisements	Ch19§C07	1-10
058	Disclosures on Depository Institutions Insurance Sales Applications	Ch19§C08	1-11
059	Education and Monitoring of Producers Selling Fixed Index Annuity	Ch19§C11	1-11
060	Education and Monitoring of Producers Selling Indexed Life Products	Ch19§C11	1-11
061	Health Replacements	Ch20§C01; Ch21§C01	1-12
062	Outline of Coverage - Health	Ch20§C02; Ch21§C02, §C03	1-13
063	Product Suitability - Health	Ch20§C03	1-11
064	Medicare Guides	Ch21§C04	1-10
065	Medicare Supplement Advertisements	Ch21§C05, §C06, §C08, §C10, §C11, §C12, §C13, §C15, §C16	1-18
066	Association, Trust or Discretionary Groups	Ch21§C07, §C14	1-12
067	Product Suitability - LTC	Ch22§C01	1-11
068	LTC Benefit Triggers	Ch22§C02	1-11
069	Marketing of LTC Products	Ch22§C03	1-10
070	LTC Advertisements	Ch22§C04	1-10
071	Producer Replacement Rules - LTC	Ch22§C05	1-11
072	LTC Replacements	Ch22§C06	1-11
073	Consumer Credit Disclosures and Advertisements	Ch23§C01	1-10
074	Consumer Credit Limits	Ch23§C02	1-10
075	Reserved for future use.		
076	Reserved for future use.		
077	Reserved for future use.		
078	Reserved for future use.		
079	Reserved for future use.		
080	License Records Agree with DOI Records	Ch16§D01	1-10
081	Producer Selection and Appointment	Ch16§D02	1-12
082	Producer Termination	Ch16§D03, §D04, §D05	1-15
083	Producer Defalcation	Ch16§D06	1-13
084	Reserved for future use.		
085	Reserved for future use.		
086	Premium Billing	Ch16§E01	1-12
087	Policy Issuance and Insured Requested Cancellations	Ch16§E02	1-12
088	Correspondence Routing	Ch16§E03	1-11
089	Assumption Reinsurance	Ch16§E04	1-12
090	Policy Transactions	Ch16§E05	1-14
091	Locating Missing Policyholders or Beneficiaries	Ch16§E06	1-11
092	Return Premium	Ch16§E07	1-12

093	Claim History	Ch17§E01	1-11
094	Reinstatement - Life and Annuity	Ch19§E01	1-13
095	Communication of Nonforfeiture Options - Life and Annuity	Ch19§E02	1-12
096	Annual Report of Policy Values - Life and Annuity	Ch19§E03	1-10
097	Reinstatement - Health	Ch20§E01	1-13
098	Credible Coverage	Ch20§E02	1-13
099	Policy Renewals - LTC	Ch22§E01	1-10
100	Application of Nonforfeiture - LTC	Ch22§E02	1-10
101	Communication of Nonforfeiture Options – LTC	Ch22§E03	1-10
102	Policyholder Service - LTC	Ch22§E04	1-10
103	Reserved for future use.		
104	Reserved for future use.		
105	Reserved for future use.		
106	Premium Determination and Quotation	Ch16§F01, §F03	1-14
107	Policyholder Disclosures	Ch16§F02	1-13
108	Underwriting and Selection	Ch16§F04	1-21
109	Form Filing or Certification	Ch16§F05	1-12
110	Terminations	Ch16§F07, §F08, §F09	1-13
111	Deviations	Ch17§F01	1-11
112	Schedule Rating or Individual Risk Modification Plans	Ch17§F01, §F02	1-12
113	Use of Expense Multipliers	Ch17§F03	1-12
114	Premium Audit Accuracy	Ch17§F04	1-13
115	Experience Modification - Workers Compensation	Ch17§F05	1-12
116	Loss Reporting - Workers Compensation	Ch17§F06	1-12
117	NCCI Call on Deductibles	Ch17§F07	1-11
118	Timing of Underwriting, Rating and Classification	Ch17§F08	1-10
119	Listing of Forms and Endorsements	Ch17§F11	1-11
120	Verification of VIN Numbers	Ch17§F12	1-12
121	Prohibited Anticompetitive Underwriting Practices	Ch17§F13	1-10
122	Mass Market Underwriting	Ch17§F14	1-13
123	Group Personal Lines	Ch17§F15	1-15
124	Cancellation/Nonrenewal Notices	Ch17§F16	1-12
125	Policy Coding	Ch17§F17	1-12
126	Underwriting File Documentation	Ch17§F18	1-13
127	Title - Reissue and Refinance Credits	Ch18§F01	UC
128	Title - Collusive or Anti-competitive Underwriting Practices	Ch18§F02	UC
129	Title - Other Charges and Fees	Ch18§F03	UC
130	Title - E&O for Closing	Ch18§F04	UC
131	Title - Closing and Settlement	Ch18§F05	UC
132	Title - Reports and Disclosures	Ch18§F06	UC
133	Title - Recording, Reporting and Validation of Revenue, Loss and Expense Experience	Ch18§F07	UC

134	Title- Coding	Ch18§F08	UC
135	L&A - Pertinent Information on Applications	Ch19§F01	UC
136	L&A - AIDS-Related Concerns	Ch19§F02	UC
137	Health - Cancellation Practices	Ch20§F01	UC
138	Health - Information on Applications	Ch20§F02	UC
139	Health - Continuation of Benefits.	Ch20§F03	UC
140	Health - Genetic Information Nondiscrimination Act	Ch20§F04	UC
141	Health - Protection of Health Information	Ch20§F05	UC
142	Health - Use of Preexisting Exclusions	Ch20§F06	UC
143	Health - Improperly Deny Coverage	Ch20§F07	UC
144	Health - Guaranteed-Issue Requirements	Ch20§F08	UC
145	Health – Portability	Ch20§F09	UC
146	Health - Self-funded Benefit Plans	Ch20§F10	UC
147	LTC - Appeal of Adverse Benefit Trigger Determination	Ch22§F01	UC
148	Consumer Credit - Effective and Termination Dates	Ch23§F01	UC
149	Consumer Credit – Terminations	Ch23§F02	UC
150	Consumer Credit - Creditor Submitted Premium	Ch23§F03	UC
151	Consumer Credit - Payment of Compensation	Ch23§F04	UC
152	Consumer Credit - Unfair Methods of Competition	Ch23§F05	UC
153	Reserved for Future Use		
154	Reserved for Future Use		
155	Reserved for Future Use		
156	Reserved for Future Use		
157	Claims Handling	Ch16§G01; Ch16§G02; Ch16§G03; Ch16§G06; Ch16§G10; Ch16§G11	1-17
158	Response to Claim Correspondence	Ch16§G04	1-11
159	Claim File Documentation	Ch16§G05	1-11
160	Appropriate Claim Forms Use	Ch16§G07	1-11
161	Claims Reserving	Ch16§G08	1-13
162	Denied and Closed Without Payment Claims	Ch16§G09	1-11
163	Catastrophe Claim Handling	Ch16§G01; Ch16§G02; Ch16§G03; Ch16§G06	1-12
164	Reservation of Rights and Excess of Loss letter	Ch17§G01	1-11
165	Deductible Reimbursement	Ch17§G02	1-12
166	Loss Statistical Coding	Ch17§G03	1-12
167	Title - Indemnification for Loss of Settlement		UC
168	L&A - Accelerated Benefit Payment disclosures		UC
169	L&A - Discrimination - Qualifying Events		UC
170	Health - Newborns' and Mothers' Health Protection Act		UC
171	Health - Mental Health Parity and Addiction Equity Act		UC
172	Health - Women's Health and Career Rights		UC

	Act		
<b>173</b>	Health - Group Coverage Replacements		<b>UC</b>
<b>174</b>	Consumer Credit - Proof of payments reflect appropriate claim-handling		<b>UC</b>
<b>175</b>	Consumer Credit - Claim files establish events and dates		<b>UC</b>

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DRAFT

TO: Director Bruce Ramage, Chair  
Market Conduct Examination Standards (D) Working Group

FROM: Brent Kabler, Chair  
Market Information Systems Research and Development (D) Working Group

DATE: 7/12/16

SUBJECT: Market Regulation Handbook Proposed Changes and Recommendations

Earlier this year the Market Information Systems Research and Development (D) Working Group (MIS R&D) reviewed the *Market Regulation Handbook* for potential changes to reflect the retirement of the Examination Tracking System (ETS) and Market Initiative Tracking System (MITS) and the introduction of the Market Action Tracking System (MATS). During this review other, unrelated changes were also proposed. These are described in detail below. Included with some proposed changes are comments from Working Group members.

The first section contains system-related changes that the MIS R&D Working Group recommends that your Working Group consider. The second section contains other non-technical changes that are being referred for consideration.

I would be happy to answer any questions. Thank you for your consideration.

## **Recommended System-Related Changes**

### **Chapter 11 – Automated Examinations Tools and Techniques**

#### ***Recommended Change 11.1***

**Location:** B. Automation Tools / 1. NAIC Systems

**From:**

d. Special Activities Database (SAD)

SAD is available to regulators only and has been operational since 1989. [This system records information regarding suspicious or investigative activities related to individuals and companies in the insurance industry.](#)

**To:**

d. Special Activities Database (SAD)

SAD is available to regulators only and has been operational since 1989. [The use of SAD has been somewhat limited in recent years. Plans are underway to eliminate SAD and develop a new 1033 State Decision Repository.](#)

**Reviewer comment: As of 2015**

#### ***Recommended Change 11.2***

**Location:** B. Automation Tools / 1. NAIC Systems

e. State Producer Licensing Database (SPLD)

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

To search for producers via iSite+:

- Log onto myNAIC and select iSite+ from the login categories;

- Select the [Market Individual Search category](#);
- Enter the known criteria for the entity (e.g., last name, first name) and select Search; and
- Select the [Producer Licensing](#) link next to the appropriate entity.

**To:**

To search for producers via iSite+:

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

**Proposed Change 11.3**

**Location:** B. Automation Tools / 4. Spreadsheets

**From:**

4. Spreadsheets

Spreadsheet applications are computer programs for creating and manipulating spreadsheets. Data in a spreadsheet can be defined and formulas created for calculations, etc. [Examples of spreadsheet applications are made utilizing Microsoft Excel software. Lotus 1-2-3 is another popular spreadsheet package.](#)

**To:**

4. Spreadsheets

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

**Recommended Change 11.4**

**Location:** B. Automation Tools / 5. Databases

**From:**

5. Databases

Database software provides for queries and reports to be created against a database. [Database examples are included utilizing Microsoft Access.](#)

**To:**

5. Databases

Database software provides for queries and reports to be created against a database. [One example of a database application is Microsoft Access®.](#)

**Recommended Change 11.5**

**Location:** B. Automation Tools / 9. Computer System Size Limitations

**From:**

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

Another option available to examiners is [to burn a file to a CD; however, this option would be the slowest option compared to other available options.](#)

**To:**

If an email cannot be sent due to server limitations on file size, there are other options available to the examiner. Sending the file through File Transfer Protocol (FTP) is another option. The only drawback to this method [is acquiring a password](#), which can sometimes pose time restrictions. The best solution is to post the file on [a secure Internet](#) website. The examiner

could send the file to a Web server, create a link to that file and other examination team members may be allowed access to the file. If the information is sensitive, the examiner will need to establish a secure site, with the file available only for people who have access to the secured site.

Another option available to examiners is [to copy the file to a portable electronic device](#).

### **Proposed Change 11.6**

**Location:** C. Reference Tools, Training and Assistance / 1. NAIC-Sponsored Training

#### **From:**

1. NAIC-Sponsored Training

The NAIC provides a variety of training opportunities and educational events which may prove beneficial to examiners. Available training includes classes for Introduction to ACL, Introduction to ACL—Market Conduct and Advanced ACL. In addition, Web-based instruction for NAIC systems is available, as well as regularly scheduled events such as the annual NAIC/NIPR Insurance Summit Conference. Information on technical training may be found on the Education and Training website [http://www.naic.org/education\\_technical\\_training.htm](http://www.naic.org/education_technical_training.htm).

#### **To:**

1. NAIC-Sponsored Training

The NAIC provides a variety of training opportunities and educational events which may prove beneficial to examiners. Available training includes classes for Introduction to ACL, Introduction to ACL—Market Conduct and Advanced ACL. In addition, Web-based instruction for NAIC systems is available, as well as regularly scheduled events such as the annual NAIC/NIPR Insurance Summit Conference. Information on technical training may be found on the Education and Training website [http://www.naic.org/education\\_technical\\_training.htm](http://www.naic.org/education_technical_training.htm). **Application technical training includes:**

- [TeamMate Course Description: Students will learn the basics of working a TeamMate™ Financial Exam with EWP.](#)
- [Using Microsoft Access to Query NAIC Course Description: Students will gain exposure to the structure of the NAIC's Financial database and learn efficient query techniques in order to retrieve data and generate customized reports.](#)

### **Recommended Change 11.7**

**Location:** D. Data Requests and Access / 2. Data Formats

#### **From:**

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

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

#### **To:**

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

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

**Recommended Change 11.8**

**Location:** D. Data Requests and Access / 2. Data Formats

**From:**

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

**To:**

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

**Recommended Change 11.9**

**Location:** D. Data Requests and Access / 2. Data Formats

**From:**

**Microsoft Excel**—Using the Data Definition Wizard, Microsoft Excel data can be imported and defined directly, without the need for pre-processing. ACL maintains the integrity of the source data and lets the user specify whether to keep field header information. The user can also specify which Microsoft Excel worksheet to be utilized. Installation of Microsoft Excel on a computer to use files of these formats is not necessary. [Problems with Microsoft Excel include: Microsoft Excel tends to corrupt date fields, and Excel 2003 is limited to 65,536 rows or records in any one file.](#) Unless ODBC is used to read Microsoft Excel data in ACL, dates can display incorrectly. When Microsoft Excel data is imported, Microsoft Excel and the transferring technology use the system date format. If this format differs from the **Date Display Format** that the user sets in ACL, the dates from the Microsoft Excel data may display incorrectly in ACL. To avoid this problem, in ACL, select **Tools » Options**, then click the **Date** tab and enter a date display format to match the system date. To find the system date, select **Start » Settings » Control Panel » Regional Options**.

**To:**

**Microsoft Excel**—Using the Data Definition Wizard, Microsoft Excel® data can be imported and defined directly, without the need for pre-processing. ACL maintains the integrity of the source data and lets the user specify whether to keep field header information. The user can also specify which Microsoft Excel® worksheet to be utilized. Installation of Microsoft Excel® on a computer to use files of these formats is not necessary. [Problems with Microsoft Excel® include a tendency to corrupt date fields.](#) Unless ODBC is used to read Microsoft Excel® data in ACL, dates can display incorrectly. When Microsoft Excel® data is imported, Microsoft Excel® and the transferring technology use the system date format. If this format differs from the **Date Display Format** that the user sets in ACL, the dates from the Microsoft Excel® data may display incorrectly in ACL. To avoid this problem, in ACL, select **Tools » Options**, then click the **Date** tab and enter a date display format to match the system date. To find the system date, select **Start » Settings » Control Panel » Regional Options**.

**Recommended Change 11.10**

**Location:** F. Sampling / 2. Example of Pull Lists

**From:**

If utilizing Microsoft Excel, a pull list can be created as follows:

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

**To:**

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

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

**Recommended Change 11.11**

**Location:** I. Marketing and Sales / 1. Advertisement Approvals

**From:****1. Advertisement Approvals**

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

**Assumption #1**—Insurance department records [include hardcopy originals](#) of approved advertising and electronic tracking by form number and approval date.

1. Secure an electronic listing of approved form numbers and date of approval.
2. Secure from the company a corresponding electronic listing of advertising form numbers and dates first used.
3. Run a comparison that would produce a listing of all company-identified advertising forms, which do not match with the insurance department's listing.
4. Run a comparison that would produce a listing of all company-identified advertising forms which were utilized prior to the date of approval in the insurance department's listing.

**To:****1. Advertisement Approvals**

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

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

1. Secure an electronic listing of approved form numbers and date of approval.
2. Secure from the company a corresponding electronic listing of advertising form numbers and dates first used.
3. Run a comparison that would produce a listing of all company-identified advertising forms, which do not match with the insurance department's listing.
4. Run a comparison that would produce a listing of all company-identified advertising forms which were utilized prior to the date of approval in the insurance department's listing.

**[Chapter 12 – Scheduling, Coordinating and Communicating](#)****Proposed Change 12.1**

**Location:** R. Market Conduct Uniform Examination Outline / 1. Examination Scheduling

**From:**

- b. States shall utilize the NAIC Market Action Tracking System (MATS).
  1. As soon as scheduled, each state shall enter the examination into MATS, which is administered by the NAIC; and
  2. Each state shall adopt a system for ensuring proper implementation and maintenance of the MATS system.

**To:**

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

## **Proposed Editorial Changes**

### **Chapter 1 – Introduction**

#### ***Proposed Change 1.1***

**Location:** D. The Players and Their Tools / Core Competencies

**From:**

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

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

**To:**

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

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

**Comment:** The change from continuum options to MATS doesn't make sense in this instance. Suggest removing reference to MATS and replace with language similar to the following:

*Continuum Options - Standards regarding the use of focused inquiries, non-exam regulatory interventions, market conduct examinations, investigations and consumer complaints; and ...*

#### ***Proposed Change 1.2***

**Location:** D. The Players and Their Tools / NAIC Staff/Research Resources

**From:**

The NAIC offers financial, actuarial, legal, computer, research, market conduct and economic expertise. The NAIC Market Regulation Department supports state insurance regulators in fulfilling the state insurance departments’ responsibility of

protecting the interests of insurance consumers by helping coordinate state market regulatory functions, such as consumer complaints, market analysis, producer licensing and regulatory [interventions](#).

**To:**

The NAIC [staff](#) offers financial, actuarial, legal, computer, research, market conduct and economic expertise. The NAIC Market Regulation Department supports state insurance regulators in fulfilling the state insurance departments' responsibility of protecting the interests of insurance consumers by helping coordinate state market regulatory functions, such as consumer complaints, market analysis, producer licensing and regulatory [actions](#).

## **Chapter 2 – Continuum of Regulatory Response**

### ***Proposed Change 2.1***

**Location:** First paragraph

**From:**

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

“Insurance regulators can access a broad continuum of regulatory responses when determining the appropriate regulatory response to an identified issue or concern.

**To:**

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

“Insurance regulators can access a broad continuum of regulatory responses when determining the appropriate regulatory response to an identified issue or concern.

**Comment: The addition of the word “choice” is awkward. I’d recommend retaining the original phrase, or substitute something like “range of regulatory responses.”**

### ***Proposed Change 2.2***

**Location:** A. Considerations / 1. Questions to Evaluate

**From:**

Consumers

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

**To:**

Consumers

- How immediate is the concern? What is the likelihood or severity of any potential consumer harm?
- What is the nature and potential scope of the harm to consumers?
- How extensive is the issue? Does the concern involve one regulated entity or multiple regulated entities?
- [Is it confined to one state, one region, or is it nationwide?](#)

### ***Proposed Change 2.3***

**Location:** B. Regulatory Responses

**From:**

The continuum of regulatory responses can be roughly divided into four categories: Contact, Examination, Enforcement and Market Actions (D) Working Group. The continuum is [not](#) a “ladder,” whereby one step must be taken prior to advancing to the next. Rather, it should be viewed as a range of decision-making options.

A brief discussion of each category follows. Examples are provided only for clarity and should **not** be considered the sole use for each type of response. Note: The principles outlined in Section D Confidentiality in Chapter 8—Examination Introduction of this handbook can also be applied to the continuum of regulatory responses.

**To:**

The continuum **or choice** of regulatory responses can be roughly divided into four categories: Contact, Examination, Enforcement and Market Actions (D) Working Group. The continuum is **NOT** a “ladder,” whereby one step must be taken prior to advancing to the next. Rather, it should be viewed as a range of decision-making options.

A brief discussion of each category follows. Examples are provided only for clarity and should **NOT** be considered the sole use for each type of response. Note: The principles outlined in Section D Confidentiality in Chapter 8—Examination Introduction of this handbook can also be applied to the continuum of regulatory responses.

**Comment: The addition of the word “choice” is awkward. I’d recommend retaining the original phrase, or substitute something like “range of regulatory responses.”**

**Proposed Change 2.4**

**Location:** B. Regulatory Responses / 1. Contact with the Regulated Entity

**From:**

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

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

**To:**

The **choices begin** with the contact category, dealing with various opportunities to connect directly with the regulated entity, such as:

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

**Chapter 6 – Collaborative Actions**

**Proposed Change 6.1**

**Location:** A. Collaborative Action Guidelines / 3. Assumptions

**From:**

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

- a. Collaborative actions will be considered when there is an issue or area of concern that impacts multiple jurisdictions. Collaboration would not be appropriate when the issue involves compliance with a state-specific law if other states do not have similar statutes.

- b. Collaborative actions can be conducted for both nationally significant and non-nationally significant regulated entities.
- c. All impacted states will be encouraged to participate in the collaborative regulatory response when possible.
- d. The collaborative action, depending on the severity of the problem and the level of the response taken, can be handled by one designated state who reports to the other states, or by a group of Lead States, where one state is designated as the Managing Lead State, others are designated as additional Lead States and together the “Lead States” work collaboratively while other states may passively participate in the process.
- e. States retain the ability to choose to participate in a collaborative action and may designate another state to review the information on their behalf. However, if a Participating State does designate another state to review information on their behalf, it is the Participating State’s responsibility to outline their interpretation of their own laws they would like included in the review.
- f. Participating states retain their authority to initiate their own regulatory response if a collaborative action does not cover the scope of an area of concern to that state.
- g. The collaborative review will follow the guidelines and standards outlined in this handbook. Lead States should agree on the appropriate standards to be applied during the review.
- h. Each Participating State will determine if state-specific recommendations and actions are needed at the end of the collaborative action process, based on the findings by the Lead States.
- i. Verification that the regulated entity has complied with findings and recommendations of a final report is a separate administrative function that may or may not occur through either a collaborative or individual state follow-up effort, [continuum response](#), examination or re-examination.

**To:**

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

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

**Proposed Change 6.2**

**Location:** A. Collaborative Action Guidelines / 4. Determinations / a. Determining Need for Collaboration

**From:**

4. Are there any entries in the NAIC Market Information Systems or the Market Regulation electronic bulletin boards?

Yes  No

*If there are, the CAD should contact CADs in states that appear to have common concerns and/or where there is a new, open or called examination status. The CADs can discuss whether there are common issues and the interest of other states to assist with regulatory responses to the area(s) of concern. Note: All new, open or called examinations, Level 1 or Level 2 Market*

Analysis reviews and [initiatives](#) should be reviewed and the state CAD contacted to consider collaborations, even if the examination is a financial examination or appears to be unrelated to the topic of concern.

**To:**

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

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

**Proposed Change 6.3**

**Location:** C. Market Actions (D) Working Group (MAWG) / 2. Request for Review (RFR) / MAWG Request for Review Workflow/ Last flow chart object

**From:**

Lead States conduct exam or [continuum action](#) and propose resolution.

**To:**

Lead States conduct exam or [non-examination regulatory intervention](#) and propose resolution.

**Comment:** For consistency's sake, in the last flow chart object, "continuum action" should be changed to "non-examination regulatory intervention;" also continuum action technically includes examinations.

**Proposed Change 6.4**

**Location:** D. Multistate Examination Process / 1. Document the Need for an Examination

**From:**

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

## Steps:

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

## Deliverable:

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

**To:**

The state Collaborative Action Designee (CAD) will work with the Market Analysis Chief (MAC) to determine which entities should be the focus of attention for the state. Through internal decision-making processes, the CAD and other state staff should ascertain that [a non-examination regulatory intervention is](#) not adequate or appropriate. At the point of determining the need for an examination, the CAD should take the following steps.

## Steps:

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

## Deliverable:

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

**Proposed Change 6.5**

**Location:** D. Multistate Examination Process / 10. Finalize the Examination Report

**From:****Examination Report**

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

Steps:

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

**To:****Examination Report**

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

Steps:

- a. Each Participating State CAD sends the state's final examination report to the company:
  - Receive and evaluate company response; and
  - Include company response as part of the report.
- b. Each state CAD finalizes their state's examination report; and
- c. Each Participating State should record the applicable administrative resolution for their state in the [Market Action Tracking System](#).

**Comment:** Is use of MATS appropriate in this instance or should it be RIRS? My understanding is that only the state that entered an action in MATS can make changes to that item. Should there be a comment that the participating state would need to enter a separate MATS item or the lead state could insert a note in the main action on that state's behalf?

**[Chapter 7 – Market Regulation Investigation Guidelines](#)****Proposed Change 7.1**

**Location:** B. Guidelines for Conducting Market Regulation Investigations / Enforcement Options

**From:**

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

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

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

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

**To:**

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

...

- Information-sharing with other states.  
All states should report any significant findings to other affected states, through their Collaborative Action Designee (CAD) and through the Market Actions (D) Working Group. Depending on the confidentiality of the investigation, the results may be entered into the MATS and/or RIRS databases, to demonstrate to other interested jurisdictions the material findings and monetary payments concerning the action.

**Comment:** Why is this paragraph eliminated?

## Chapter 10 – Types of Examinations

### *Proposed Change 10.1*

**Location:** A. Types of Examinations / Target Examinations

**From:**

#### Target Examinations

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

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

**To:**

#### Targeted Examinations

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

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

**Comment:** Should the references to Target examinations in the text also be updated?

**Proposed Change 10.2**

**Location:** A. Types of Examinations/ Limited-Scope Examinations

**From:**

**Limited-Scope Examinations**

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

Examples of a limited-scope examination are as follows:

- Interrogatories—A compilation of written questions regarding a specific subject, procedure or product submitted to the company in order to obtain information. Verification of the information is accomplished by a review either in-house or during an on-site examination.
- Re-examinations or compliance examinations—These types of examinations confirm compliance with a previously issued order of the director/commissioner or other administrative action and serve to verify that the company has initiated corrective actions for adverse findings detailed in a prior examination report.
- Desk examinations—Used as a means of follow-up on an issue found during an examination that did not rise to the level of a clear violation, but still caused the insurance department some concern.
- Small company examinations (small is defined as county mutual companies, fraternal organizations or a company that has written a predetermined premium volume)—An opportunity to review a small company’s practices when the expense and time required for a traditional examination might not be warranted. Because of the potentially smaller field sizes, this is an opportunity to use ACL and other computer programs to conduct portions of the review.

**To:**

**Limited-Scope Examinations**

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

Examples of a limited-scope examination are as follows:

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

**Comment:** Interrogatories are addressed in continuum chapter; Re-examinations or compliance examinations refer to a sequence; and Desk examinations are addressed in methods.

**Proposed Change 10.3**

**Location:** F. Use of Hierarchical Description

**Delete:**

**F. Use of Hierarchical Description**

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

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

<u>Type Selection</u>	<u>Routine</u>	<u>Target</u>	<u>Target</u>	<u>Target</u>
<u>Exam Sequence</u>	<u>Subsequent</u>	<u>Initial</u>	<u>Initial</u>	<u>Follow-up</u>

<a href="#"><u>Specialty (LOB)</u></a>	<a href="#"><u>P&amp;C</u></a>	<a href="#"><u>Health</u></a>	<a href="#"><u>Title</u></a>	<a href="#"><u>Life</u></a>
<a href="#"><u>Scope</u></a>	<a href="#"><u>Limited (Undwr)</u></a>	<a href="#"><u>Limited (Clms)</u></a>	<a href="#"><u>Comprehensive</u></a>	<a href="#"><u>Limited (Undwr)</u></a>
<a href="#"><u>Jurisdiction</u></a>	<a href="#"><u>Single state</u></a>	<a href="#"><u>Single state</u></a>	<a href="#"><u>Single state</u></a>	<a href="#"><u>Multistate</u></a>
<a href="#"><u>Method</u></a>	<a href="#"><u>On-site</u></a>	<a href="#"><u>Desk</u></a>	<a href="#"><u>On-site</u></a>	<a href="#"><u>Combination</u></a>

## Chapter 11 – Automated Examinations Tools and Techniques

### *Proposed Change 11.1*

**Location:** D. Data Requests and Access / 1. Example of a Data Request for ABC Insurance Company

**From:**

1. Example of a Data Request for ABC Insurance Company

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

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

**To:**

1. Example of a Data Request for ABC Insurance Company

Please provide the following data files for the examination period of Jan. 1, [2016](#) through Dec. 31, [2016](#). The files will be used on a PC, so please provide the information on a CD. The files should contain fixed length records in the layouts shown. The file format requested, in the order of preference, is delimited (comma or tab) text files or a Microsoft Access database. If a company's computer systems use different field sizes, please submit the company's data files and send revised file layouts with the files.

Complaints—Please provide a list of all complaints received from [state name] policyholders from the period of Jan. 1, [2016](#) through Dec. 31, [2016](#). Please include both complaints received directly and those forwarded from the [state name] insurance department.

### *Proposed Change 11.2*

**Location:** I. Marketing and Sales / 2. Unfair Discrimination

**Note:** Currently the NAIC style guide for NAIC publications prescribes 'homeowners' (no apostrophe). A recommendation to modify that guideline can be made if appropriate.

**From:**

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

**To:**

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

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

**Proposed Change 11.4**

**Location:** K. Underwriting and Rating / 1. Comparison of Insurance Department/Company Records

**From:**

**Data File Supplied by the Company:**

Homeowners New Business Written—List of all new business [homeowners](#) policies issued in this state during the exam period, provided in the following format:

and

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

and

**Data File Supplied by the Company:**

Homeowners New Business Written—List of all new business [homeowners](#) policies issued in this state during the examination period, provided in the following format:

**To:**

**Data File Supplied by the Company:**

Homeowners New Business Written—List of all new business [homeowners'](#) policies issued in this state during the exam period, provided in the following format:

and

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

and

**Data File Supplied by the Company:**

Homeowners New Business Written—List of all new business [homeowners'](#) policies issued in this state during the examination period, provided in the following format:

**Chapter 16 – General Examination Standards**

***Proposed Change 16.1***

**Location:** A. Operations/Management / 2. Techniques / e. Antifraud Plans

**From:**

The guidelines set forth in the NAIC *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 ([SIUs](#)) or contracted SIU vendors for preparation of an antifraud plan.

**To:**

The guidelines set forth in the NAIC *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 ([SIUs](#)) or contracted SIU vendors for preparation of an antifraud plan.

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