



Strengthening the Value and Performance of Health Insurance Market Conduct Examination Programs: Consumer Recommendations for Regulators and Lawmakers

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While the Affordable Care Act (ACA) has already set in motion a number of new protections for health insurance consumers, the most significant of the law's comprehensive insurance reforms go into effect on January 1, 2014. In two previous reports, the consumer representatives to the National Association of Insurance Commissioners (NAIC) have provided their perspectives and recommendations to regulators, lawmakers, and staff on consumer-friendly practices for the initial and ongoing implementation of these reforms. As attention turns to how the reforms will work for consumers in practice, the consumer representatives to the NAIC are pleased to offer this report— **“Strengthening the Value and Performance of Health Insurance Market Conduct Examination Programs: Consumer Recommendations for Regulators and Lawmakers”**—to assist regulators, lawmakers, the National Association of Insurance Commissioners, and staff at the national and state levels with a framework for considering the market conduct examination programs in their states and to help them identify best practices to improve monitoring and oversight of implementation of the ACA's new consumer protections.

To develop this resource, the consumer representatives to the NAIC commissioned Health Management Associates to research market conduct activities and examinations and identify the practices used in small, medium-sized, and large states that have demonstrated an ability to make the best use of their resources to effectively review market conduct practices in their states. This report is not intended as a blueprint for a specific model of how to review market conduct practices in the states, but rather as a resource for regulators as they continue their intensive involvement with overseeing today's rapidly changing health insurance marketplace, including ongoing efforts to evaluate and update market conduct exam standards through the NAIC Market Conduct Examination Standards (D) Working Group. Through the course of the review, many successful practices were identified and formed a pattern that represented the best use of state resources, and the most effective ways to protect consumers by state regulators. Many of the best practices identified in this report are consistent with the NAIC standards and recommendations, and illustrate the value of their contributions to improving the regulation of insurance. We hope that as implementation of the Affordable Care Act—including some of the most significant health insurance reforms in our nation's history—moves forward, this report can serve as a resource for identifying best practices for protecting consumers in every state.

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Executive Summary

State insurance regulators face daunting challenges as the primary agencies responsible for overseeing the health insurance industry and guaranteeing that consumers are protected within a complex and rapidly changing marketplace. This role has intensified with the comprehensive market reforms and new health insurance exchanges (or Marketplaces) brought about by the Affordable Care Act (ACA). Throughout the early and ongoing implementation period since the law was enacted on March 23, 2010, state insurance regulators have continued to deal methodically with a constant stream of new health insurance benefit requirements and other reforms, often accompanied by complex federal requirements in the form of draft and final regulations, guidance documents, bulletins, and other communications issued by an assortment of federal agencies. As the ACA's major reforms are implemented, and attention turns to how the law will work for consumers in practice, state regulators have a unique opportunity to maximize their role in protecting consumers by evaluating and identifying areas where oversight could be strengthened. As these reforms unfold, market conduct programs, which regulators have long used as a tool to enhance their oversight capability and safeguard consumers' rights, will play a critical and valuable role in monitoring how health insurers respond to the market changes that are occurring and making certain that consumers benefit fully from the new consumer protections under the law.

While the increased oversight responsibilities and implementation efforts have in some cases strained insurance departments already contending with limited resources, the ACA and the sweeping market changes it brings can also serve as a catalyst for states to evaluate their market conduct programs, and consider a diverse range of market conduct examination strategies that may improve their ability to appropriately and efficiently monitor the activities of insurers and protect consumers. While all states provide market conduct oversight to varying degrees, programs vary considerably among states, which can lead to gaps in consumer protections. Without a comprehensive, systematic process for monitoring and evaluating a company's behavior, fairly small problems can quickly develop into more complex, serious issues with the potential to cause significant harm to multiple consumers, whether enrollees with a particular carrier or groups of similarly-situated consumers, such as those in a particular city, county, or region. The insurance commissioner who is regularly conducting timely and effective market conduct surveys has the best chance of quickly identifying non-compliance before consumers are harmed.

Given the challenges of guaranteeing strong, fair and consistent enforcement of consumer protections in a complex and rapidly changing health insurance marketplace, this report is offered to regulators, lawmakers, the National Association of Insurance Commissioners, and staff at the national and state levels to provide consumer recommendations on market conduct programs and highlight strategies being employed or considered by states to improve monitoring and oversight of the ACA's new consumer protections. This report is not a comprehensive assessment of states' market conduct oversight, but is focused primarily on market conduct examinations and best practices we hope regulators will consider integrating into their current practices, if not already in place.

In conducting this study, we reviewed existing market conduct activities and procedures and interviewed regulators in insurance departments and looked at state websites across the country to identify some of the best practices for operating an effective program. While some of these concepts are already common practice in some states, they are not consistently used by all states, or may be used only occasionally. Some recommendations are ideas that several states strongly support but are unsure how to effectively implement; these states can benefit from learning how other states have managed to do so. We hope this report will encourage states to consider how they can improve current practices by incorporating some of these recommendations, contact their colleagues in other states to discuss strategies they are using, and consider how market conduct examinations can be used more effectively to identify problems in their earliest stages and ensure compliance with the new requirements of the ACA.

Following is a summary of the best practices identified and discussed in the following pages of this report. While we know that not every recommendation is realistic for every DOI, we believe that many of these strategies will be applicable in part or in whole to any department, regardless of size, budget or organizational structure. These suggestions are made in an effort to encourage regulators to re-evaluate their market conduct program processes and procedures and consider improvements that may be achieved with even small changes. We appreciate the input from market conduct staff throughout the country who provided examples of current strategies on which these recommendations are based and hope regulators will consider how their program may benefit from these suggestions.



Consumer Recommended Best Practices for Market Conduct Examinations

Staffing and Training of Market Conduct Examiners

- 1. Establish core state capacity within departments of insurance for health insurance market conduct programs, and ensure that contract examiners meet minimum standards.** Whenever possible, states should strive to establish a core level of internal state capacity for market conduct examinations using full-time, permanent examiners to build and retain internal state expertise and foster continuity and consistency of oversight programs. When it is not possible to use state staff due to budgetary constraints or complex examination topics requiring additional expertise, states should make certain that contract examiners meet minimum criteria, including demonstrated proficiency and expertise in specific technical areas that are the focus of the review. States who use contract market conduct examiners should also make certain that the contract examiner and/or firm does not have a conflict of interest.
- 2. Create teams of examiners for health insurance market conduct reviews.** DOIs should create teams of examiners who are specifically trained for health insurance market conduct reviews. Team members, including both market conduct analysts and examiners, should work together to share information and strategies for conducting effective reviews, and participate in regular, periodic internal training sessions. Focusing exclusively on health insurance market examinations improves the likelihood that examiners have sufficient training to develop and maintain the ongoing expertise and knowledge necessary to effectively evaluate a health insurer's performance and compliance.
- 3. Establish a formal continuing education process for examiners.** DOIs should establish a formal, internal process for ongoing training of examiners to ensure they are informed of the latest state and federal statutory and regulatory requirements applicable to the health insurance company operations and products under their review. Provide regular, periodic opportunities to collaborate with other examiners on issues related to the examination process, discuss common experiences, challenges and lessons learned, and identify areas where additional training is needed.
- 4. Train specialized examiners for specialized policy issues.** DOIs should identify highly technical areas of review such as information technology, data analytics, network adequacy, and clinical data, and train examination specialists to provide expertise in reviews of those specific activities.
- 5. Leverage inter-agency expertise and relationships.** If budgets do not allow for hiring or training of staff, for technical expertise that is outside the normal purview of the DOI, identify expertise in other state agencies and develop inter-agency relationships that allow examiners to request expert assistance when necessary.

Schedule and Frequency of Examinations

- 6. Establish a schedule for frequency of examinations.** To make certain that market conduct examinations are conducted in a timely manner and effectively identify non-compliance issues that may harm consumers, departments should establish a formal schedule for frequency of examinations, in addition to targeted exams. The schedule should include a standard time period in which every insurer undergoes either a desk review examination or a comprehensive on-site examination. All newly licensed health insurance plans should be reviewed within the first three years of operation.

- 7. Provide insurers with advance notice of regular examinations.** For regularly scheduled examinations, provide insurers with advance notice of the exam and a detailed list of information/data the insurer is required to provide. This practice will facilitate a more organized and efficient use of examiners' time, assists insurance company staff in the preparations for the examination, and contributes to a more timely completion of the review.
- 8. Coordinate examinations with other states.** When possible and appropriate based on the circumstances leading to the examination, coordinate examinations with other states to maximize use of staff, increase the number of examinations, avoid duplication of effort and unnecessary costs, and ensure a more comprehensive and consistent examination process across states. States should also participate in multi-state examinations where reasonable in order to facilitate a more expedient resolution for consumers, increase the number of reviews a state performs, and enable a more comprehensive review of an insurer's activities.

Data Resources for Market Conduct Reviews

- 9. Expedite updates to examination checklists to incorporate Affordable Care Act requirements.** DOIs should update examination checklists as early as possible to ensure current examination practices include a review of new provisions already implemented as a result of the ACA. Checklists should also be updated as early as possible in 2014 to incorporate new regulations applicable to plans beginning January 1, 2014. Through the NAIC, regulators should also work to prioritize the adoption and finalization of a health Market Conduct Annual Statement (MCAS), concurrently with ongoing work to develop shorter-term industry surveys.
- 10. Routinely review accreditation data.** Examiners should routinely review information available as part of a health plan's accreditation through the National Committee for Quality Assurance (NCQA), URAC, or other organizations to identify areas where the insurer demonstrated low performance or failure to meet certain benchmarks during their review process. Loss of accreditation or negative changes in accreditation status should be monitored as a potential indicator for scheduling a health plan examination.
- 11. Ensure access to internal data and resources.** DOIs should establish a process to ensure examiners are automatically provided access to relevant internal department resources including insurance surveys, data calls and other information collected by regulatory staff that might be useful in an examination.
- 12. Incorporate reviews of health plan quality and satisfaction data.** If available for a specific health plan, market conduct examinations should include a review of health plan HEDIS (Healthcare Effectiveness Data and Information Set) and/or CAHPS (Consumer Assessment of Health Plan Services) data, or other health plan performance data to identify deficiencies that may suggest quality of care issues or other problems that should be analyzed as part of the examination.
- 13. Use news sources to identify problems.** Market conduct examinations should include internet searches of published news stories to identify any articles that discuss problems related to an insurer under examination, or to identify companies that may require further review, including market conduct examination.

Public Information and Accountability

- 13. Make market conduct reports publicly available.** DOIs should publish reports online or provide a process for individuals to request reports in an electronic format. The Department should also prominently display on their website information on the market conduct process and a link to available reports so they may be easily located and accessed by consumers.
- 14. Provide summaries of reports.** States with statutory or regulatory prohibitions against public access to market conduct reports should consider providing access to report summaries in lieu of full reports, if allowed by law.

Engaging State Regulators and Consumers in the Market Conduct Review Process

- 15. Coordinate internal oversight and monitoring efforts.** Establish agency policies and procedures for including market conduct examiners in discussions with other internal DOI staff who oversee health insurance activities to discuss current regulatory issues, emerging trends, new regulatory processes and requirements, and other matters related to health insurer oversight. Meetings should be held on a regular basis (i.e., monthly or quarterly) and should provide an opportunity to discuss relevant activities and areas of focus for examinations of specific insurers scheduled for market conduct examinations.

16. Establish multi-agency oversight teams to conduct “grand rounds” on health insurance oversight issues.

Due to the division of regulatory oversight responsibilities for health plans among multiple agencies, DOIs should establish a multi-agency team of individuals who meet on a regular, periodic basis (no less than quarterly) to exchange health plan information within their jurisdiction and discuss any concerns related to specific insurer activities or trends among multiple insurers, similar to “grand rounds” conducted by clinicians to discuss complex medical cases and deepen their common understanding of emerging issues and best practices. The information may be used to identify potential problems that may not be observed by the DOI, or may not raise concern at the DOI on their own but, when considered in context with information from other regulatory agencies, may indicate a need for additional evaluation, including a market conduct examination.

17. Routinely solicit consumer input. Establish a process for soliciting input from consumers and consumer advocacy groups, as well as navigators and other enrollment assisters, on the market conduct review program and activities of insurers.

18. Engage insurance producers in market conduct. Establish a process for engaging insurance producers (agents and brokers) in the market conduct review process.

Importance and Appropriate Use of Consumer Complaint Data

19. Regularly update consumer complaint codes. Consumer complaint codes should be expanded and updated to identify and track complaints associated with changes required by the ACA. Codes should be sufficiently detailed to identify specific problems that require further review, including market conduct examination. States should continue to periodically review and update codes on a regular basis as needed, but no less than annually.

20. Annually review compliance issues with health insurance companies. Host an annual compliance meeting with health insurance companies to review and discuss complaint trends, compliance issues and any other regulatory concerns.

21. Increase consumer awareness of the complaint process. Because market conduct activities rely heavily on information obtained from consumers’ complaints to identify compliance problems, the DOI should use consumer outreach and education opportunities to increase awareness of the complaint process and provide clear instructions on how to file a complaint. Complaint filing information should be prominently displayed on the DOI and other state websites, such as the Attorney General website, and disseminated through outreach and education channels such as trained enrollment assisters, agents and brokers.

22. Ensure appropriate routing of complaints and create dedicated complaint investigation teams.

Insurance complaint analysts should be appropriately trained to identify complaints that should be referred to market conduct or another division of the agency for review, including complaints that reflect a general business practice rather than an isolated complaint. DOIs should create teams of analysts who focus only on health insurance complaint investigations, and should update complaint procedure manuals and guidance documents to include changes occurring as a result of the ACA.



Introduction

Market conduct analysis and examinations are among the most important tools insurance regulators have for protecting consumers. Market conduct examinations are used to determine whether insurers are offering fair and reasonably priced insurance products, complying with applicable statutes and regulations, and operating in a manner that is fair to consumers. States have historically served as the primary regulators of all health insurance products through state Departments of Insurance (DOIs) and are generally responsible for enforcing both state and federal requirements. While regulations and insurance department operations vary considerably from state to state, all DOIs perform common core functions related to licensing, financial oversight, regulation of rates and policy forms, and oversight of insurer market conduct to ensure compliance and protect consumers from abuses. When done well, these programs serve a vital role in improving insurer compliance and protecting consumers. When done poorly, states miss an important opportunity to strengthen and support their role as regulators and their responsibilities to consumers.

Market conduct analysis and examinations are designed to make certain that insurers meet statutory and regulatory requirements, operate in a way that is fair and nondiscriminatory, and comply with the legal obligations of the insurance policies they sell to consumers. Insurance market regulation today involves oversight of a wide range of complex financial and operational company activities, including licensing, policy development, underwriting, rating practices, advertising, sales, claims processing and payment of claims. As both health insurers and regulators work to adopt and integrate into their business operations the many changes required by the Affordable Care Act (ACA), and with millions more Americans expected to join the ranks of the newly insured, oversight of this industry is more critical than ever before. While mistakes and oversights will inevitably happen even among the most diligent of companies given the complexities of the reforms, even relatively minor oversights or compliance issues have the potential to affect more people than ever before, and can have results ranging from relatively minor payment issues to delays or denials of critical health care services that can literally mean the difference between life and death in extreme cases. Market conduct programs are designed specifically to identify and correct such errors before they become a problem for consumers, and are, of course, also critical for early identification of intentional noncompliance issues.

Market conduct programs have evolved and improved significantly since they were initially conceived, and many states operate extremely effective programs. Other states, however, struggle to develop effective programs due to resource limitations or opposition to rigorous market conduct examinations from the industry. This report is designed to recognize the value of market conduct programs and highlight best practices and strategies used by states with a range of sizes, budgets and resources to operate an effective and efficient market conduct program. We recognize the myriad of responsibilities regulators face as they oversee one of the most complex industries in the world, and hope the information provided here will serve as a useful resource to assist states with evaluating the effectiveness of their own programs and consider whether strategies used by other DOIs can successfully be used in their states in building the capacity of their own market conduct programs.

To establish a framework for our recommendations, we begin the report with an overview of the development of market conduct programs and some of the key factors influencing their evolution. We follow with a discussion of current practices and the challenges examiners face, with a specific focus on **health insurance** plan reviews. The report provides a brief discussion of the importance of market conduct programs with specific examples of serious problems discovered during the course examinations. Finally, we discuss the importance of updating market conduct programs in response to the increased regulatory responsibility states have assumed in response to the ACA. The report concludes with a presentation of best practices identified in the course of the study, with examples of how some states are using these processes to improve their own programs.

While we have attempted to provide a basic description of existing programs and some of the key developments over time, this report is **not** intended to provide a comprehensive assessment of market conduct programs. Our goal is to provide a general overview designed to ensure the reader has a good understanding of the process regulators use today in order to provide a context for the suggested best practices that are the primary purpose of this study. This report does not provide a comprehensive assessment of NAIC and regulators' efforts to improve market conduct programs, but acknowledges the progress that has resulted in significant improvements over time. Many of the best practices identified in this report are consistent with the NAIC standards and recommendations, and illustrate the value of their contributions to improving the regulation of insurance.



Methodology

In drafting this report, we reviewed publicly-available state insurance department market conduct reports, information on market conduct regulatory activities included in department publications and presentations, and other documents available on DOI websites. We also interviewed regulators in several states to obtain additional information and sought their input on activities they considered to be “best practices” for market conduct analysis and oversight. In selecting the states that were researched and/or interviewed, we sought to include a cross-section of states that represented various geographic regions of the country. We also selected states of varying populations, which is also generally reflected in department budgets and staffing sizes, to ensure the report took into account the strategies used by smaller insurance departments that may have more limited budgets and staff than larger states. States that were included in our research activities are California, Delaware, Florida, Illinois, Indiana, Louisiana, Maryland, Massachusetts, Michigan, Montana, Nebraska, Nevada, Ohio, New York, North Carolina, Rhode Island, Texas, Virginia, Washington, and Wyoming. We reviewed documents published by the NAIC, including published reports and white papers, meeting notes and summaries of activities related to the development of Market Conduct practices and procedures. Information from several independent studies of market conduct activities is also included. Readers who would like a more detailed description of the related NAIC initiatives or other studies of market conduct programs are encouraged to refer to the more detailed discussions included in earlier studies referenced in this report.



History of Insurance Market Conduct Oversight Programs

The business of insurance regulation is the responsibility of each state's insurance regulatory department (hereafter referred to as Department of Insurance, or DOI) and involves a wide range of complex activities such as financial oversight, licensing, policy form review and approval, rate reviews, quality of care compliance, consumer complaint resolution, and market conduct oversight. While market conduct regulation refers to a broad strategy that entails a variety of different regulatory functions, every DOI has a separate market conduct program that is responsible for performing or overseeing specific market conduct analyses and examination activities. Though individual DOI market conduct programs vary in practice and in the level of proficiency, all programs have common components that have developed over time.

The evolution of market conduct oversight has occurred primarily through activities of the NAIC. Every state and territory has an elected or appointed insurance commissioner who participates in activities of the NAIC, an organization that provides a venue for regulators and insurers to discuss common issues and problems, identify best practices, and develop standards and processes that can be adopted by states to encourage consistency in regulatory activities, some of which are adopted as model laws and regulations.² Although NAIC membership is limited to state regulators, the organization works closely with insurance companies, insurance agents and brokers, and encourages consumer participation. Most meetings are open to the public, with the exception of regulator-only meetings to discuss sensitive financial information or other issues that could jeopardize ongoing investigations of insurer activities.

The majority of initial standards developed by the NAIC involved licensing and financial oversight to ensure companies were sufficiently funded, complied with standard accounting principles, and paid policyholders' claims. The first insurance examination activities were limited to a review of financial operations. As insurance products became more complex and diversified and companies grew in size and assumed more risk, regulatory activities gradually expanded to include DOI oversight of certain marketplace practices including policy form approval, premium rating practices, underwriting of applicants, advertising and marketing.³

However, the scope of such efforts was limited and market conduct examinations were usually included as an add-on to the financial examination process. In response to growing concerns about the variability of DOIs' oversight of both financial and market conduct practices, in 1971, the NAIC contracted with McKinsey & Company to conduct a study of the financial and market conduct oversight practices. The study included extensive interviews of regulators, insurers and other experts to solicit input on financial and market conduct examination practices. The final report, completed in April 1974, largely focused on financial analysis, but also included several recommendations for market conduct oversight, including:

- Market conduct analysis should focus on companies engaging in unfair business practices, and regulators should focus on a pattern of activities rather than inadvertent or occasional errors.
- Unfair practices should be identified through a review of complaints, an examination of company materials and specific transactions, and interviews of agents and company personnel.

- The results of market conduct examinations should be well documented in a timely, action-oriented report.
- Because company activities frequently extend across state lines, interstate communication, cooperation and coordination is critical to ensure states are adequately informed and able to take appropriate action. The NAIC is a logical clearinghouse for the sharing of information among states.
- Market conduct surveillance requires significant expertise and specialization; exams should be performed by specially trained staff, who should understand the applicable laws and regulations for the type of insurance that is the subject of the exam, and regulators should ensure examiners are given sufficient time to conduct their examinations.⁴

In response to the recommendations, the NAIC created the Market Conduct Surveillance Handbook Task Force to develop standards for the market conduct review processes, which led to adoption of the first Market Conduct Surveillance Handbook. The handbook established a model for market conduct activities and included guidance on planning and conducting an examination, the kinds of practices that regulators should review, what should be included in a market conduct report, and guidance for sharing information with other states. Over time, the handbook has been periodically updated and expanded to reflect changes in the market and the increasing complexity of insurers' business activities. It was later re-titled the Market Conduct Examiners Handbook and was recently incorporated into the Market Regulation Handbook.

During the years immediately following the McKinsey report, the NAIC continued to pursue improvements in the market conduct oversight activities through various initiatives:

- **Education and Training for Market Conduct Examiners:** Ongoing training and education programs were developed and offered through the NAIC for market conduct examiners.
- **Certification for Market Conduct Examiners:** The Market Conduct Management (MCM) designation was created and offered through the Insurance Regulatory Examiners Society (IRES), which provides hands-on training, continuing education and certification requirements for individuals performing market conduct examination activities. Areas of training include:
 - o market regulation and examinations;
 - o exam management;
 - o communication and report writing;
 - o standardized data requests and technology; and
 - o the role of market analysis.⁵
- **NAIC Market Conduct Subcommittee and Market Conduct Task Force:** Through these committees, the NAIC established an ongoing process for reviewing market conduct regulatory activities and identifying recommendations for improvements in DOI oversight, including development of model laws and regulations.
- **Development of Uniform Databases for Regulators:** The NAIC also worked with regulators to create data systems to facilitate and assist with market conduct examinations. The data bases include:
 - o Regulatory Information Retrieval System;
 - o Complaint Analysis System;
 - o Special Activities Database;
 - o Insurance Regulatory Information System;
 - o Financial Analysis and Tracking System; and
 - o Examination Tracking System.

Together, these activities resulted in significant advancements in the market conduct oversight system during the next few years. But despite these improvements, adoption and utilization of these resources by states was inconsistent, with some DOIs pursuing highly developed oversight programs and others conducting minimal, if any, market conduct reviews. Several states adopted their own examination handbooks that more accurately reflected the state's regulatory philosophy. Cooperation and coordination between states was limited, and many of the goals of the NAIC remained unmet. In recognition of the continued lack of consistency, in 1999, the NAIC hired PriceWaterhouseCoopers (PwC) to conduct a follow-up study of DOIs' market conduct activities. The study included a review of each state's market conduct exam procedural manuals, laws, and regulations, and interviews of market conduct chief examiners and insurance companies who had undergone market conduct exams.⁶

The PwC report, “Insurance Market Conduct Examination Public Policy Review,” found that lack of coordination and communication between states continued to hamper market conduct oversight, and that activities varied significantly from state to state. The second phase of the report also found that examinations focused too little on internal processes and systems for maintaining compliance with laws, regulations and ethical process and looked for isolated transgressions rather than patterns of error or abuse.⁷ States commonly followed their own guidelines, creating a patchwork of regulatory programs and processes that failed to achieve the standardization envisioned by the NAIC and suggested in the McKinsey study.

Largely in response to a 2003 report by the United States Government Accountability Office (GAO) that again raised concerns about market conduct examination activities, the NAIC and regulators further increased their efforts to develop uniformity and establish minimum standards. The GAO study found that market conduct examinations provide “the most systematic assessment of insurers’ behavior and practices” and are an important tool for identifying misbehavior by insurance companies and for protecting consumers from unfair practices.⁸ But the study concluded that market analysis and on-site market conduct examinations were used inconsistently, if at all, resulting in potential gaps in important consumer protections. Other significant findings from the report include:

- very few states had a formal program, and those that did used very different approaches;
- states performed few examinations relative to the size of their market and devoted significantly different levels of resources to the examinations;
- regulators used different standards for selecting companies for examination and in the scope of their review, which meant some companies were subject to multiple reviews while others avoided examination entirely; and
- inconsistencies among states make it difficult for states to share relevant information and rely on each other for shared oversight responsibilities.

The GAO also reported the NAIC recognized the need to improve market conduct oversight but that progress had been slow. For example, in the spring of 2000, the NAIC had planned to review the merits of establishing national standards for market conduct examinations and enforcement actions. Those activities were delayed due to other priorities. Previously, the NAIC had adopted the Market Conduct Regulatory Guidelines in 1995, but acknowledged that after eight years, states were unable to reach agreement on the minimum resources and national standards necessary to achieve effective market conduct examination programs. In conclusion, the GAO recommended the NAIC and state DOIs should give increased priority to development of standards for a uniform market conduct oversight program that includes all states. The GAO also urged adoption and implementation of the standards by state legislatures and insurance departments.

In 2009, the GAO issued a follow-up report in response to questions raised by Members of Congress and industry participants who were concerned about various state insurance regulatory activities.⁹ With regard to market conduct activities, the GAO made the following observations:

- In 2003, the NAIC established a Modernization Plan to provide regulators a guide and series of goals for improving uniformity of market conduct oversight. The plan called for each state to adopt uniform market analysis standards and procedures and integrate market analysis—which encompasses a broader range of activities than market conduct

Market conduct examinations provide “the most systematic assessment of insurers’ behavior and practices” and are an important tool for identifying misbehavior by insurance companies and for protecting consumers from unfair practices.

(Source: U.S. Government Accountability Office, “Insurance Regulation: Common Standards and Improved Coordination Needed to Strengthen Market Regulation,” September 30, 2003.)

Varying examination processes mean insurers may be subject to multiple exams, leading to increased costs for the insurer which are passed on to consumers in the form of higher premiums.

examinations, similar to “health insurance marketplace ‘environmental scanning’” —into their overall regulatory functions. Despite these steps, the GAO reported that variations among state standards continued to exist.

- In 2008, the NAIC created a set of 99 core competency standards proposed to be part of a market conduct accreditation program and in 2006 produced the Market Regulation Handbook which combined market analysis and examination guidance. The tools and guidance provided in the handbook were designed to move states from reliance on broad examinations for identifying market conduct issues to using market data and analysis to identify problems and responses. However, compliance with the standards and use of the Handbook was optional, and was not adopted consistently across states. The GAO concluded that without requirements to comply with key parts of the Handbook, it was unclear whether the program would ensure strong market conduct practices and encourage uniform examination procedures.
- The NAIC also created the market Conduct Annual Statement (MCAS), a data collection tool designed to collect market conduct data. However, the MCAS was (and still is) only available for automobile, homeowners, annuities, life, and more recently, long-term care insurance. Regulators using the MCAS reported the information helped them perform baseline analysis, identify insurer conduct that might require attention or an examination, and monitor company and industry trends. The MCAS also allowed regulators to identify potential problems and to target their response rather than perform a comprehensive review of a company. However, the GAO reported state adoption of the MCAS was inconsistent, limiting its effectiveness. In addition, states could not agree on what data should be reviewed or whether the information should be available to the public, resulting in variations among states as to the availability of MCAS information.
- Market analysis and examination uniformity is limited by budget resources. States with larger budgets and staff resources are better equipped to conduct detailed analysis compared to states with fewer staff and lower budgets.
- Variations in staff training and expertise contribute to inconsistencies in market conduct reviews.
- The variations in state laws, resources, and review processes result in inefficiencies for regulators and insurers and uneven consumer protections across states. Varying examination processes mean insurers may be subject to multiple exams, leading to increased costs for the insurer which are passed on to consumers in the form of higher premiums.
- Insurers operating in states with stronger market conduct surveillance standards may be subject to more scrutiny and oversight than states with less stringent requirements, which leads to uneven levels of consumer protections.

Insurers operating in states with stronger market conduct surveillance standards may be subject to more scrutiny and oversight than states with less stringent requirements, which leads to uneven levels of consumer protections.

The NAIC noted in its comments that they generally agreed with recommendations in the report, and would continue to work on improvements. Nonetheless, many of the GAO’s conclusions appear to still exist as current deficiencies and vulnerabilities nearly five years later. While our federalist system virtually guarantees continued state-by-state variability in health insurance laws and regulations, inconsistent health insurance market oversight and enforcement across states undermines the ACA’s promise of a basic set of protections for consumers, regardless of their geography. With the stakes higher for consumers now than ever before, establishing strong, fair and consistent enforcement of these protections should be a top priority for regulators.



Overview of Current Health Insurance Market Conduct Review and Examination Process

Despite the inconsistencies and proficiency variations in DOI market conduct programs, the *basic process* of market conduct review and examination is fairly standardized across states. While earlier studies generally did not differentiate between practices as they relate to specific lines of insurance, most market conduct programs initially focused primarily on property and casualty insurance products, including automobile and homeowners insurance. Because these products use standardized policy forms and are typically subject to more stringent and uniform rating restrictions than life or health insurance plans, regulators chose to initially focus their market conduct oversight on these plans rather than other insurance lines. The relative standardization makes it easier to evaluate and compare business practices across companies and identify outliers that may suggest problems warranting additional investigation.

Over time, however, the focus on health insurance companies at the NAIC level increased, resulting in the development of more detailed standards and processes for health insurance and Health Maintenance Organization (HMO) reviews. The guidance for market conduct reviews included in the Market Regulation Handbook was expanded and now includes a separate chapter titled “Conducting the Health Examination” that provides more detailed suggestions for reviewing various regulatory requirements associated with health insurance plans.¹⁰

Under a typical review, market analysis begins with a baseline analysis to identify companies which should be subject to further review. The process will vary depending on whether state law or regulations establish requirements mandating a periodic review and/or examination on a regular basis, or allow the DOI sole discretion to decide frequency of reviews and which companies are examined. Though frequency varies significantly among states, companies subject to a Level One review undergo a “formulaic” analysis which is used to determine whether additional review is necessary.¹¹

If determined necessary, a Level Two analysis is performed to permit a more detailed review. The analysis may include a closer look at complaint files, information from other DOI divisions, insurance filings, or other data. Level Two analysis may determine no further action is required, or may indicate additional action is appropriate. Analysts following the prescribed NAIC process may choose one or more responses from a “continuum of market conduct responses” to identify the next step, including telephoning or meeting with company officials, issuing an interrogatory, conducting a policy and procedure review, issuing a data call, performing a desk audit or scheduling an examination.¹²

The most comprehensive type of market conduct review is the market conduct examination. The NAIC has identified four basic elements required for an effective market conduction examination program:

- a system for scheduling examinations;
- examination procedures tailored to the nature of the examinee’s operations;
- timely, action-oriented reporting; and
- cooperation and coordination among the jurisdictions.¹³

The areas of health insurer operations reviewed by an examiner will vary depending on the preliminary findings, but may include some or all of the following:

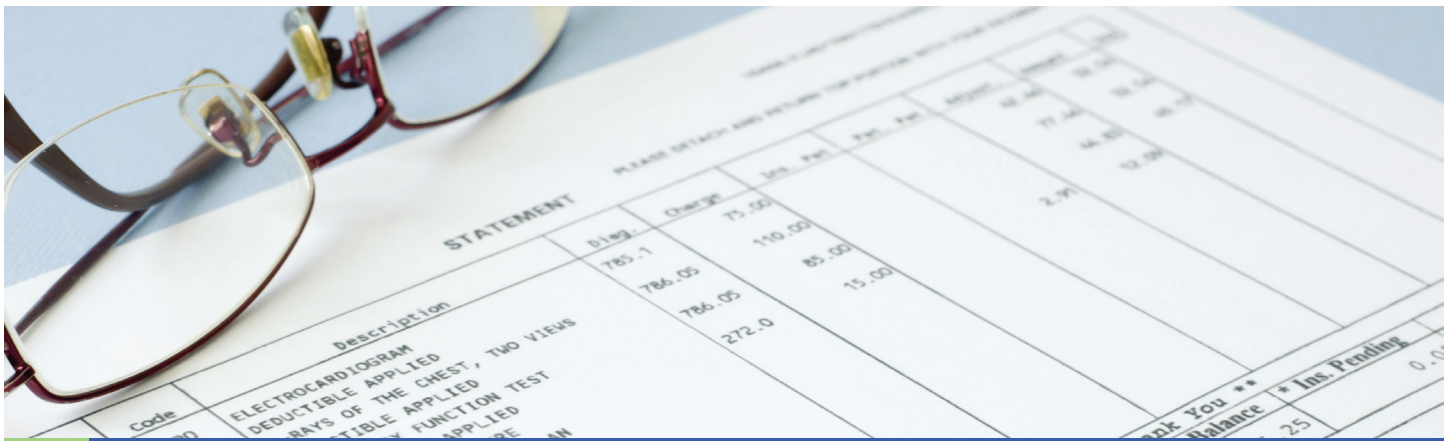
- company operations and management;
- marketing and sales;
- underwriting and rating;
- policyholder services;
- claims handling;
- complaint processing and resolution;
- grievance procedures;
- network adequacy;
- provider credentialing;
- quality assessment and improvement;
- utilization review;
- external review; and
- producer licensing.

While the majority of examinations are conducted in the DOI's offices and are based on material submitted by the insurer, on-site market conduct examinations provide an opportunity for regulators to conduct more detailed reviews of company practices and activities, and allow an examination of company documents and business practices that generally are not otherwise available to examiners. The first on-site market conduct examinations were conducted in Illinois to determine how insurers were treating policyholders and evaluate premium rates. The practice proved to be such an effective approach that the Illinois Department of Insurance convinced other states to initiate similar programs.

Frequency of examinations is also a critical component of the regulatory process that varies among states. In some states, the Legislature dictates through statute how often and under what circumstances market conduct examinations occur. In others, the commissioner has authority to determine the frequency and timing of examinations. In both cases, decisions may also be influenced by agency budgets and staffing, size of the industry and number of carriers licensed, and other agency activities related to market oversight. Some states take a more pro-active approach that requires the DOI to conduct periodic, regularly scheduled routine examinations of health insurers. Others, however, have no requirement to conduct routine examinations. In some states, market conduct examinations of health insurers are rare and infrequent. A review of several states that publish market conduct examinations reveals that it is not unusual for states to go several years without conducting a market conduct examination of a single health insurer.

State regulators perform many daily activities that provide ongoing consumer protections but are outside the market conduct review and examination process. For example, to varying degrees, DOIs review and approve policy forms, review and may approve or disapprove premium rates, receive and process complaints, monitor claims payment practices and promptness, and oversee advertising products used by insurers and health plans to be certain they are not misleading and comply with state requirements. For managed care plans, regulators may also review the provider network, practices related to the authorization and denial of medical services, quality of care, and other activities of the health plan.

While these activities on their own are excellent tools for the Department and provide valuable protections for consumers, they are not a substitute for a regular market conduct examination. Many of the routine activities of DOIs are performed only initially when the insurer applies for licensure or submits new forms for review. Once approved, the state may have limited if any ongoing monitoring in place to ensure continued compliance with state requirements. The market conduct examination is a comprehensive process that was specifically designed to provide an opportunity for periodic evaluation of an insurer's practices and activities and is intended to provide a level of oversight that extends beyond the day-to-day activities of the DOI. When used infrequently, regulators miss an important opportunity to confirm consumers are treated fairly and insurers are complying with the terms of their contracts.



Importance of Health Insurance Market Conduct Examinations

While the development and adoption of the market conduct review and examination process has been rather slow and the subject of much debate regarding the specific requirements and processes, the value of the process has been clearly established. As stated in the 2003 and 2009 GAO reports:

“Among other things, market analysis can provide information on insurance companies’ compliance with applicable laws and regulations, highlight practices that could have a negative effect on consumers and help identify problem companies for examination.”¹⁴

“Clearly NAIC recognizes that a combined system of market analysis and market conduct examinations is the best way to oversee the behavior of insurance companies in the marketplace.”¹⁵

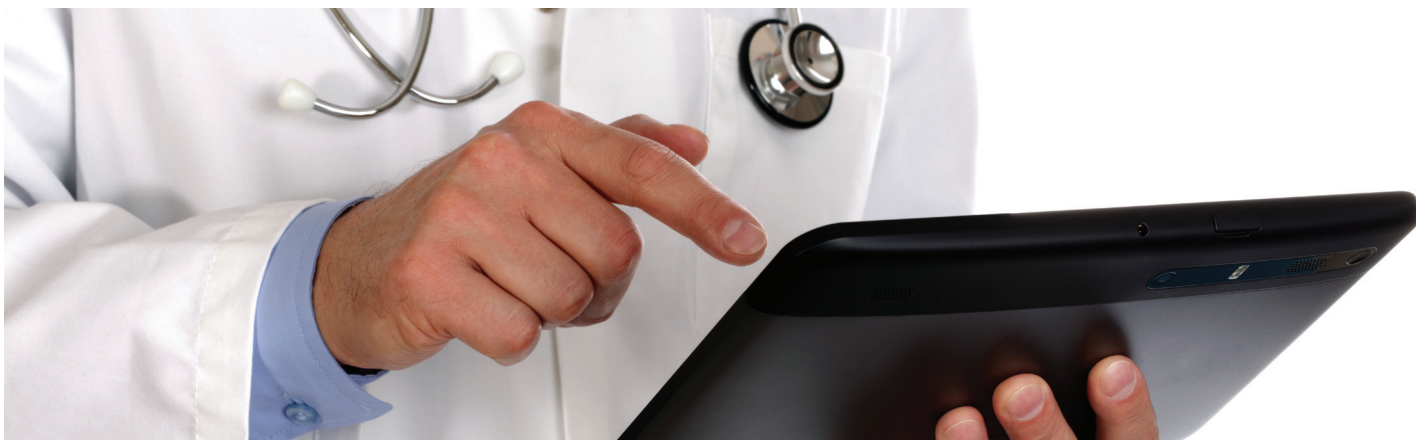
As previously discussed, while insurance departments oversee various activities in divisions across an agency, the market conduct examination is unique in that it provides an opportunity to review the overall operations of an insurance company, its practices, and compliance with any and all regulatory and statutory requirements. Though some insurers argue that such examinations are unnecessary and costly to perform, a review of several market conduct examination reports posted on DOI websites identifies significant problems uncovered that would likely otherwise go unnoticed, underscoring the valuable consumer protections provided as a result of the process. Some examples include:

- In 2012, Illinois market conduct examinations resulted in more than \$10 million in fines; the department announced its intent to continue to ramp up market conduct examinations and enforcement efforts in 2013 in order to better protect Illinois consumers.¹⁶
- An Indiana market conduct examination revealed a group of companies were using a premium methodology that resulted in higher premiums and larger rate increases for small employers than were allowed. The exam led to a reduction in rates, refunds of \$2.75 million to over-charged consumers, and a penalty of \$200,000.¹⁷
- A multi-state examination of an insurer identified a number of practices and violations, including delays and errors in claims processing, failure to explain policy limitations and restrictions, use of unlicensed insurance brokers to sell products, and other compliance violations that resulted in more than \$50 million in penalties and an extensive corrective action plan that included a 2 year monitoring period by regulators and a potential \$21 million in additional penalties if the company failed to comply with stipulated requirements.¹⁸
- The Vermont Department of Financial Regulation determined an insurer violated more than a dozen insurance regulations, including failure to refund credits and/or premiums due to cancelled policies, failure to reprocess and pay denied claims once the required information related to health care authorizations was received, and failure to maintain claims files as required.¹⁹

- A California Department of Insurance market conduct examination revealed extensive violations in claims handling and rescissions of benefits by one of the largest insurers in the State.²⁰ The examination resulted in significant market changes related to underwriting practices and policy rescission activities, a penalty of more than \$1,000,000, an agreement to provide restitution to harmed consumers that included reinstatement of coverage for individuals whose benefits were cancelled illegally and an agreement to pay consumers for past medical expenses, and compliance with a comprehensive corrective action plan.²¹ More recently, the California Department of Managed Health Care fined an insurer \$4 million after identifying deficiencies in patient access to mental health benefits during a market conduct survey.²²

A recent article on market conduct examinations lists the top 10 areas of compliance issues for life and health insurers, which further underscores the seriousness of the most frequent types of violations discovered during a market conduct examination:

- failure to properly acknowledge, pay, investigate, or deny claims within specified time frames;
- using unapproved or unfiled forms;
- failure to adhere to advertising requirements;
- failure to adhere to policy replacement requirements;
- failure to notify the DOI of changes in contracts with agents and brokers;
- using unapproved or unfiled premium rates;
- failure to comply with consumer grievance and appeals requirements;
- failure to provide consumers with required policy disclosures;
- improper documentation of claims policies; and
- failure to properly terminate a policy.²³



Impact of Affordable Care Act on Market Conduct Examinations

As millions of Americans purchase health insurance – many for the first time – as a result of the Affordable Care Act (ACA), the importance of market conduct analysis and examinations has never been greater. As a result of significant reforms and new standards for health insurance, insurers must adapt to significant changes in the way they do business. Key operations, insurer policies and procedures will change significantly as they design new health plans that include new benefits, develop and implement new underwriting procedures, comply with new premium rating requirements, expand their provider networks to include new providers and services, and work to comply with a daunting list of complex state and federal requirements.

Depending on a state's structure and the types of plans an insurer offers, insurers may be subject to oversight by not only the state insurance department, but the state Medicaid agency and the agency operating the health insurance Exchange. To some extent, all health plans sold in the exchange will be subject to federal oversight in addition to any state-specific exchange requirements. These requirements may vary significantly by state, depending on what role the state has assumed and what they have chosen to delegate to the federal government. While states are the primary insurance regulator, federal regulations under the ACA provide that CMS has enforcement authority over insurers if the state notifies CMS that it has not enacted legislation to enforce or is not enforcing a provision of the ACA.²⁴ For example, six states (Alabama, Arizona, Missouri, Oklahoma, Texas and Wyoming) deferred the enforcement of specific ACA provisions to the federal government while all other states and territories will perform those activities at the state level.²⁵ For insurers participating in multiple states, complying with the varying regulations issued by multiple agencies will create even more confusion and opportunities for mistakes.

The ACA has prompted significant activity by the NAIC and regulators to ensure regulations and regulatory oversight activities are revised to reflect changes required of health insurers. Through the work of the NAIC Market Conduct Examination Standards Working Group, regulators have begun the process of updating health plan market conduct examination standards to reflect changes required by the ACA. These revisions are necessary to ensure examinations include a review of company activities to confirm insurers are compliant with ACA requirements. Some of the specific provisions the Working Group has identified that will require review by examiners include:

- coverage of and cost-sharing requirements for preventive services;
- restrictions on lifetime and annual limits;
- restrictions on limitations or exclusions of benefits based on pre-existing conditions;
- restrictions on policy rescissions;
- extension of coverage for adult dependent children;
- uniform explanation of coverage documents and standardized definitions;

- compliance with requirements to provide public information on certain items including claims payment policies and practices, financial disclosures, enrollment and disenrollment data, rating practices, out-of-network cost sharing and payments;
- prohibition of discrimination based on salary of employees;
- quality of care requirements;
- establishment of an internal claims appeal process and external review process;
- compliance with patient protections related to designation of a primary care physician, coverage of emergency services, and access to care for obstetrics or gynecological care for women;
- compliance with new premium rate information filings and reviews; and
- compliance with nondiscrimination requirements in benefit plan designs.

Other areas of health plan regulation impacted by the ACA and requiring changes to the market conduct review process include network adequacy requirements, new marketing rules, utilization review, provider credentialing, and privacy and security protections.

Until the NAIC completes development of the examination standards, state DOIs and market conduct examiners are left to develop their own examination review criteria, resulting in variations in review practices among states. Because of the differences in state-based requirements, examiners will need state-specific training to ensure they fully understand the new requirements and are prepared to integrate those new regulations into their market conduct review. For example, if insurers are subject to new network adequacy requirements, examiners will need to know the details of the new requirements and how to discern whether the company is compliant or is failing to meet the new state/federal requirements. Contract examiners who work in several states must be familiar with the unique requirements of each state in which they work.

An additional challenge under the ACA is the division of certain insurance regulatory oversight among several agencies. While state DOIs continue to maintain their role as the primary regulator of insurers, insurers are also subject to regulations issued by the federal Department of Health and Human Services, the Treasury Department through the Internal Revenue Service (IRS) agency, Department of Homeland Security, and the Department of Labor.

While the NAIC, regulators, and health plans have made some progress to revise and update regulatory requirements and ensure a smooth transition for the many changes occurring in the health insurance market, much work remains to be prioritized to accommodate the demands of the ACA. The volume and complexity of the insurance reforms and new regulatory requirements have the potential to pose problems for even the most diligent insurer and regulators must ensure they are prepared to meet the demands associated with enforcement of the new ACA provisions. Though some departments have already updated examination criteria, others are waiting on adoption of standards by the NAIC. Smaller states and DOIs with limited market conduct staff may not have the resources to develop new criteria, which makes quick action by the NAIC even more important. Despite insurers' best efforts, mistakes and lapses in oversight will happen. During the next few years as regulators and insurers adapt to these changes, market conduct review and examination is one of the strongest assets a DOI has for identifying and correcting compliance problems and protecting consumers.



Challenges of Health Insurance Market Conduct Examinations

Despite the importance of consistent market conduct standards across states, regulators acknowledge that the development of such standards for health insurance examinations is challenging due in part to the complexity of health insurance products, the lack of standardization and the continued changes within the market. The use of many different forms and the adoption of regulations that, by necessity, differ for each type of health insurance plan create challenges that do not exist for other lines of insurance. State regulations vary, for example, depending on whether the plan is an HMO benefit plan, a Preferred Provider Organization (PPO) plan, an Exclusive Provider Organization (EPO) plan, a traditional indemnity plan, a limited benefit plan, a student health plan, a catastrophic plan, or a children's health plan, as well as numerous other categories of coverage. While the examination review process is similar regardless of the type of plan, the criteria for evaluating an insurer's compliance with specific various regulatory requirements will differ significantly depending on the type of product, which requires an examiner to be trained to review a myriad of complex requirements in order to conduct an accurate evaluation of an insurer's compliance with state laws and regulations.

Unlike many other insurance products which do not change frequently, health insurance benefit plans and regulatory provisions are also subject to almost constant change as new laws and regulations – both state and federal – are enacted. With the advent of the comprehensive market reforms under the Affordable Care Act over the last several years, in addition to any state-enacted statutes and regulations, market conduct examiners must also be retrained and educated to understand these new provisions in order to determine whether a health plan is in compliance.

Other factors that contribute to the unique challenges for health insurance market conduct examinations include:

- lack of a Market Conduct Annual Statement for health insurance examinations;
- obtaining and reviewing data from multiple agencies that may have oversight of health plan operations due to the division of responsibilities for health plan regulation in some states;
- length of time required to conduct a comprehensive examination due to the complexity of the product, and pressure to keep examinations brief so they may move on to the next assignment;
- coordinating the regular, timely exchange of information among individuals within the DOI who oversee varying aspects of health insurance regulation;
- need for frequent training to ensure examiners are informed of the varying and changing requirements for health insurers, and are able to identify potential problems; and
- health insurance market conduct examiners who are under constant pressure by insurers to expedite examinations and limit the areas of review since longer, more detailed examinations are more expensive and insurers pay most of the costs.



Best Practices for Market Conduct Examinations

While many operational similarities exist among DOIs, every agency is unique in its organizational structure, internal oversight, program requirements and staffing, all of which affect oversight functions of the Department. Equally important are the significant differences in agency budgets and legislative authority that directly impact key operational decisions. These variations contribute in part to the differences in policies and regulatory oversight of market conduct activities, and some of the inconsistencies mentioned in previous studies of market conduct programs. In identifying the Best Practices included in this section, we took into account these critical differences and recognize the limitations regulators often face in managing what is an extremely complex and demanding regulatory process. Though some of these recommendations may seem obvious to those DOIs already following them, other states have not implemented similar procedures and may find the experience and guidance of other states especially helpful.

One of the benefits of state regulation is the flexibility to develop unique solutions to problems and try new approaches that may not be possible under a federal oversight structure. In evaluating their approach to market conduct and considering additional strategies for achieving the highest possible standards for market conduct practices, Departments of Insurance need not adopt every strategy listed here, but can evaluate and tailor these strategies according to the resources available to their departments.

Staffing and Training of Market Conduct Examiners

Because of the complexity of health insurance plans and the frequent changes in state and federal regulatory requirements, frequent training of health insurance market conduct examiners is necessary to ensure they stay current on laws, regulations and market changes applicable to the company activities under their review. Examiners interviewed as part of this study reported that training was a critical need that is often difficult to meet due to lack of time, limited staffing, and lack of coordination within other departments of the DOI. In addition, some examiners conduct examinations of multiple types of insurers and are not dedicated to one particular type of review. For those examiners, not only must they keep up with the latest health insurance changes, but also must do the same for automobile, homeowners, and/or life insurance, for example. And in a few cases, some examiners perform a mix of both financial and market conduct reviews.

Development of a comprehensive strategy for examiner training and staffing policies should be a priority of regulators. Given the significant value of market conduct examinations in protecting consumers and identifying problems in their earlier stages, examiners should be well trained and prepared to provide examinations in the most comprehensive and efficient manner possible. Outcomes should not vary depending on whether the examiner is a staff employee or a contractor. Focusing on these priorities will contribute to a review process that is productive, minimizes intrusions on insurers, and results in positive outcomes for consumers, regulators and insurers.

Best Practices Recommendations:

1. Whenever possible, states should strive to establish a core level of internal state capacity for market conduct examinations using full-time, permanent examiners to build and retain internal state expertise and foster continuity and consistency of oversight programs. When it is not possible to use state staff due to budgetary constraints or complex examination topics requiring additional expertise, states should make certain that contract examiners meet minimum criteria, such as a demonstrated level of technical expertise and knowledge of the state's particular insurance market.

For targeted examinations that focus on specific business practices, when using contract examiners, states should recruit examiners who have demonstrated expertise in these targeted areas. For example, the Rhode Island Office of the Insurance Commissioner commonly identifies targeted review topics when hiring contractors and seeks examiners with the specific skills and experience required for each examination. Similarly, the Illinois Department of Insurance looks for more seasoned contract examiners and requires potential examiners to provide detailed examples of their previous work to determine they have the qualifications and expertise necessary for more complex examinations. This approach ensures the Department is using the best trained staff and contributes to a more proficient and cost-effective examination, which benefits the insurer as well as consumers. States who use contract market conduct examiners should also make certain that the contract examiner and/or firm does not have a conflict of interest. For example, it would be a clear conflict for a consulting firm to provide compliance consulting advice and services to an insurance carrier and then engage with a state regulator to do a market conduct examination of that same insurance carrier or one of its related companies, for compliance with state and federal laws.

2. Create teams of examiners who are specifically trained for health insurance market conduct reviews. Team members, including both market conduct analysts and examiners, should work together to share information and strategies for conducting effective reviews, and participate in regular, periodic internal training sessions. Focusing exclusively on health insurance market requirements improves the likelihood that examiners have sufficient training to develop and maintain the ongoing expertise and knowledge necessary to effectively evaluate a health insurer's performance and compliance.

In some states, market conduct examiners perform examinations for all types of carriers, including homeowners, auto, title, annuities, life insurance, and other lines of insurance rather than assigning examiners exclusively to specific types of company reviews. While the examination process is similar across types of insurance, the subject matter that is reviewed is distinctly different for each type of insurance and requires a high degree of technical knowledge to conduct a thorough examination. Examiners must devote significant time to understanding the state-specific market requirements and the many applicable state and federal requirements that are relevant to a successful examination. Creating examination teams exclusively devoted to health insurance reviews is an ideal situation for examiners, insurers, and the consumers who depend on their expertise, and is more critical now than ever before due to the growing market and increasing regulatory requirements associated with the Affordable Care Act. If exclusivity is not reasonable due to agency staff and budget constraints, the additional training activities described below are even more important to ensure examiners are proficient in the work they perform.

3. Establish a formal, internal process for ongoing training of examiners to ensure they are informed of the latest state and federal statutory and regulatory requirements applicable to the health insurance company operations and products under their review. Provide regular, periodic opportunities to collaborate with other examiners on issues related to the examination process, discuss common experiences, challenges and lessons learned, and identify areas where additional training is needed.

The New York Department of Insurance provides periodic, ongoing training throughout the year and holds monthly meetings of examination field supervisors to discuss and resolve problems, consider changes in procedures, identify issues that need further investigation, and provide status updates on projects.

Conducting market conduct examinations is not a quick process, nor is it easy. An effective examination requires highly trained staff with detailed technical expertise and at least a basic understanding of the hundreds of health insurance regulatory requirements that may be involved in an examination. Beginning in 2014, the training needs will expand considerably to accommodate additional changes applicable to health insurers as part of the ACA. While examiners have opportunities to participate in national training programs provided by certification organizations and the NAIC, the training is often more general in nature, may focus on multiple lines of insurance, and does not address the unique requirements of a specific state or states where the examiner may work. Depending on various factors, participation in existing training sessions and in activities of the NAIC also varies widely among examiners.

Regulators frequently mentioned that state-based training is a critical requirement to ensure examiners are continually prepared, but states struggle to establish a structured training program due to the sporadic schedules of examinations and the frequent travel required for examiners performing on-site reviews of insurers. While most states do not provide a process for examiners to meet and discuss their work on a regular basis, states that do report it serves a valuable opportunity for examiners to discuss specific projects, the challenges they encounter, and share suggestions or best practices for improving the examination process. For example, the New York Department of Insurance provides periodic, ongoing training throughout the year and holds monthly meetings of examination field supervisors to discuss and resolve problems, consider changes in procedures, identify issues that need further investigation, and provide status reports on current examinations. Supervisors regularly share information with their examination teams and receive suggestions for future training and discussions.

Periodic, state-specific training of examiners is a challenge every department struggles with, but they agree it is a critical need. States should make regularly scheduled, on-site training of all examiners – including both DOI staff and contract examiners – a priority and requirement, and should create a formal agency program for ensuring compliance. States with small staff and limited budgets, or who often use contract examiners, may want to consider joining with DOIs in neighboring states to host joint training sessions, which may be particularly beneficial for states that share contractors who work in multiple states.

4. Identify highly technical areas of review, and train examination specialists in topical areas to provide expertise in reviews of these specific activities. When using contract examiners, require contractors to demonstrate proficiency and experience in specific technical areas that are the focus of the review.

Two areas that examiners specifically mentioned where they feel especially lacking in expertise are examinations of activities related to clinical practices or processes, or those requiring a high level of computer/IT proficiency. Whereas examinations in the past relied primarily on personal interviews and reviews of paper-based protocols, processes and documentation, many of the examination activities performed today require a fairly sophisticated understanding of computer/IT practices or programming. Examples of insurance functions regulators mentioned that may require additional technical expertise and training beyond what a typical examiner receives include:

- automated claims payment procedures and data analysis;
- evaluation of privacy and security protections and processes to ensure consumers' confidential data are secure;
- company activities related to clinical decisions such as approvals or denials of health care services;
- analysis of provider networks to determine compliance with network adequacy requirements;
- on-line enrollment and marketing activities, including the use of social media by both insurers and their agents; and
- insurer data mining practices and how the data are used.

All of these processes are likely to be automated and even a slight error in programming, failure to follow established protocol, or a lapse in oversight can have significant repercussions for consumers. Examination of these activities is an important part of the market conduct review process but examiners reported receiving minimal if any training in these areas, and may not be adequately prepared to provide the level of analysis that is warranted. For these and other highly technical activities, states should consider delegating these specific review activities to examiners who receive advanced training specifically for these areas of analyses. At the least, DOIs should provide additional training for all examiners to be sure they meet a minimum proficiency level necessary to perform a preliminary assessment. As noted above, DOIs should also make sure that contract examiners used for specialized examinations have demonstrated expertise in these targeted areas.

5. If budgets do not allow for hiring or training of staff, for technical expertise that is outside the normal purview of the DOI, identify expertise in other state agencies and develop inter-agency relationships that allow examiners to request expert assistance when necessary.

As described above, the level of technical expertise required of examiners is substantial, and examiners may not be adequately prepared for certain review activities. Several of the new health plan requirements under the ACA may require advanced understanding and/or analyses of clinical information and company practices in order to accurately identify violations of certain provisions. For example, the ACA prohibits insurers from structuring health plans in a way that would discriminate against certain populations. While some discriminatory actions are obvious, others are more subtle and may be a result of such practices as imposing more rigorous preauthorization requirements for specific services that apply only to individuals with certain diagnoses, or limiting the availability of prescription drugs used to treat specific medical conditions.

Both of these policies could inhibit access to care for individuals with particular medical conditions, which is a way of discouraging those individuals from selecting a particular health plan. Many examiners are not sufficiently trained to conduct a review of the preauthorization criteria, drug formulary benefits or other medical criteria for approving or denying services. However, other state agencies, such as the state health department, may have staff that could provide technical assistance on an as-needed basis when the DOI suspects such activity may be occurring. This approach makes better use of both agencies' resources while providing the support examiners need to provide the level of review that may be warranted for some examinations.

Schedule and Frequency of Examinations

As noted in the 2003 GAO study of market conduct activities, states generally perform few examinations relative to the size of the insurance industry.²⁶ Based on a review of state websites that publish examination reports and discussions with regulators, this statement remains true today in many states, some of which conducted no examinations of health insurers for several years at a time. Regulators emphasize that other processes are in place to protect consumers and an absence of market conduct examinations does not mean states are not providing other oversight functions. However, as previously noted, market conduct examinations may provide the only opportunity regulators have for identifying serious problems that will go undiscovered through other routine oversight processes. Market conduct examinations provide the only mechanism for reviewing many of the day to day practices of an insurer. While staffing and budget limitations will dictate in some cases the volume and frequency of examinations, states should be encouraged to maximize the authority and resources they have to support a robust market conduct program.

Best Practices Recommendations:

6. Unless otherwise prohibited by statute, establish a schedule for frequency of examinations. The schedule should include a standard time period in which every insurer undergoes either a desk review examination or a comprehensive on-site examination. All newly licensed health insurers should be examined with the first three years of operation.

Authority to schedule market conduct examinations varies among states. In some, state law dictates when and under what circumstances an examination is performed, which may or may not include specific requirements for the frequency of exams (i.e., at least once every five years). In others, the insurance commissioner has varying degrees of authority to schedule examinations. These factors contribute to the significant lack of consistency in which health insurance examinations are scheduled across states. Even in states where examinations are required on a regular basis, compliance is not always consistent. Due to budget and staffing constraints, required examinations may be delayed or limited in scope.

While states must balance the value of an examination with the cost and inconvenience such activities may create for insurers, examinations are a valuable consumer protection and enable regulators to identify problems before they become more serious. To ensure the market examination program fulfills its intended purpose, unless prohibited, states should implement and adhere to a schedule that ensures every company is examined on a regular basis. In addition, all newly licensed health insurers should be examined during the first three years of operation to confirm the company has successfully implemented the required processes and procedures, meets all functional and operational requirements, and is in full compliance with benefit plan requirements. Due to their lack of experience and the challenges associated with building and operating a new company, newly licensed insurers are particularly vulnerable to oversights or mistakes, and should be more closely monitored during the initial years of operation.

Examination schedules may be established and adjusted as necessary based on staff availability and funding, but companies should be on notice that an examination will be performed at some point. The mere fact that a company knows they **will** be reviewed may incentivize them to implement a more comprehensive compliance program to avoid any violations which could be discovered through an examination. Companies are also more likely to be better prepared for the requests associated with an examination, which facilitates a more efficient and less costly review process. Absence of a schedule and the infrequency of examinations in most states may contribute to a sense of complacency as most insurers have little expectation they will be reviewed.

In addition to regularly scheduled exams, states also conduct targeted examinations. Targeted examinations comprise the majority of market conduct examinations and provide a limited, focused review of company activities related to a specific line of business or business practice, such as underwriting activities, premium rate setting, marketing and sales, complaint handling activities, advertising materials, consumer/policyholder services, claim handling, or policy forms and filings. Targeted exams are limited to the specific areas of interest and are typically conducted through an off-site review of documents and information. Factors that may trigger a targeted examination include an increase in overall complaints or a particular type of complaint, specific problems identified by department staff as a part of regular oversight activities (such as use of non-approved policy forms), information provided by brokers and agents describing questionable activities, delays in claim payments, a significant change in a provider's network, a decline in enrollment, or knowledge of prohibited activities or compliance issues occurring in other states.

7. For regularly scheduled examinations, provide insurers with advance notice of the exam and a detailed list of information and data the insurer is required to provide. This practice will facilitate a more organized and efficient use of examiners' time, assists insurance company staff in the preparations for the examination, and contributes to a more timely completion of the review. While this may appear to be an obvious step in the preparation for an examination and is one of the recommendations of the NAIC, this strategy is not used consistently by all states or is inadequate in the level of detail that is provided to insurers. As a result, examiners may arrive at an insurer's office to find them unprepared, which can be frustrating for both examiners and insurers. A lack of preparation by insurers may create unnecessary delays and can prevent an examiner from performing a thorough review due to time restrictions and the pressure to complete one review in order to move on to another examination. Regulators reported that better preparation by both the DOI and the insurer contributes to a more streamlined and effective review process. (Note: this recommendation may only apply to regularly scheduled reviews and not targeted exams. Examiners note that the level and extent of an advance notification may not be practical for targeted exams depending on the nature and subject matter of the examination.)

The Florida Office of Insurance Regulation assigns to every examination a department staff project coordinator who works with contractors to develop a detailed examination plan that helps both examiners and insurers prepare for the review, and enables the department to provide better oversight of the process.

While some states indicated the notification process may vary depending on whether staff or contract examiners are used, other states said the notification process is important regardless of who conducts the examination. For example, the Florida Office of Insurance Regulation relies primarily on contract examiners but assigns a project coordinator who works closely with examiners to develop a detailed examination plan that includes both procedures and guidance for specific areas of review with all relevant statutes. A version of the plan is shared with insurers with instructions and a list of information and documents the company should be prepared to submit for the review.

8. When possible, coordinate examinations with other states to maximize use of staff, increase the number of examinations that may be performed, avoid duplication of effort and unnecessary costs, and ensure a more comprehensive and consistent evaluation across states. States should also participate in multi-state examinations where reasonable in order to facilitate a more expedient resolution for consumers, increase the number of reviews a state performs, and enable a more comprehensive review of an insurer's activities.

The GAO and NAIC have advocated for increased coordination among states in the scheduling and performance of examinations in order to improve efficiency, avoid repetition and unnecessary duplication of effort, and promote consistency in the examination process. As insurers' operations have expanded and frequently extend across multiple states, coordination makes more sense for both regulators and insurers. However, some states have been reluctant to coordinate reviews due in part to variations in processes and in the depth and detail of reviews in other states. Regulators must have confidence in the analytical and examination review activities in other states in order to participate in joint reviews.²⁷ The GAO determined that inconsistencies in examination activities made it difficult for states to depend on each other, leaving each state with the virtually impossible task of performing examinations for all insurers.²⁸

Improvements in recent years in the examination process and the more widespread adoption of standardized processes should make reliance on other states more acceptable to states. In addition, the NAIC Market Actions Working Group (MAWG) was created specifically to oversee and provide a mechanism for conducting joint market conduct examinations. As regulators' budgets are reduced and states have fewer resources for market conduct examinations and oversight, participation in multi-state reviews provides opportunities for regulators to join ranks to review insurers operating in multiple states.²⁹ Under these arrangements, each state may negotiate penalties and restitution agreements for their state's consumers to ensure enforcement is based on the uniqueness of each state's laws and requirements as well as variances in the number of consumers impacted in each state.

Coordination of exams is a logical approach for expanding the reach of regulators and improving the effectiveness of market conduct programs, and can enable DOIs with more limited budgets to conduct a more thorough examination of companies targeted for review. If full coordination is not realistic due to scheduling conflicts, states should review previous or ongoing examination reports or work papers, or discuss examination activities with the initial examiner to obtain information on relevant findings, concerns or compliance issues that may help subsequent examinations focus on key areas of concern.

Data Resources for Market Conduct Reviews

Examiners use a wide variety of data and information resources in the course of a market conduct examination. Because the majority of examinations are limited desk-reviews that rely largely on a review of documents and data, the type of information reviewed by examiners can significantly affect the effectiveness of the review and whether or not the examiner is able to identify anomalies in the company's activities. Typical resources used in the health insurance examination process can include:

- complaint data, including both DOI information and records of the insurer;
- premium rate information;
- company financial reports and filings;
- policy forms and required filings with the DOI;
- insurer underwriting manuals;
- company policies and procedures;
- DOI and company data on prompt claims payment policies, procedures and compliance with state requirements;
- records related to agent training and oversight of agent activities; and
- DOI records on any enforcement actions or investigations.

Examiners also rely extensively on information collected by the NAIC. Regulators have spent years developing these data and information collection systems which are based largely on information submitted by regulators and insurers. These data allow examiners to compare an insurer's performance to other companies, identify outliers or anomalies in data that may suggest problems, identify compliance issues in one state that could suggest similar patterns in other states, and conduct other analyses that would not otherwise be possible. While not all departments or examiners use all of these resources, or may use them only for certain reviews, NAIC data available for use in health insurance market conduct examinations include:

- Complaints Database Systems (CDS) – includes information on complaints against licensed insurance entities, including agents and brokers;
- Examination Tracking System (ETS) – allows examiners and regulators to track financial and market conduct examinations and results;
- Market Analysis Prioritization Tool (MAPT) – provides a score for companies based on both market and financial data, allowing analysts to compare similar companies;
- Market Analysis Review System (MARS) – provides regulators and examiners with a series of questions to assist in the analysis of a company's market and financial data;
- Market Initiative Tracking System (MITS) – allows regulators to track and share information concerning actions they take when investigating the business practices of a company or group of companies, or a general market issue;
- Regulatory Information Retrieval System (RIRS) – contains records of official regulatory actions taken by participating insurance departments; and
- Special Activities Database (SAD) – includes information on market activities and legal actions, including suspicious activities, legal cases, indictments, and issues of regulatory concern.³⁰

Additional detail on the above databases is included in the Appendix.

One of the primary tools used by regulators for certain types of market conduct reviews is the Market Conduct Annual Statement (MCAS). As previously mentioned, the MCAS was developed by the NAIC in response to criticisms by the GAO regarding lack of standardization and consistency among state regulators. Over a period of years, the NAIC worked with regulators from several states, insurance companies and consumer representatives to develop a data collection tool that would help regulators identify, assess and prioritize market conduct reviews.³¹ The MCAS allows regulators to collect standardized information that is analyzed by regulators to identify potential problems or concerns and identify companies for further review, which could include a market conduct examination.

In 2011, the NAIC launched the online MCAS, a web-based application that allows companies to submit examination documents electronically.³² Information is stored in an NAIC database and is available to all state regulators. This tool streamlines the MCAS submission process for insurers while also providing regulators access to extensive information and data analytics not available in a paper-based system. Regulators can, for example, compare companies in a side-by-side report of various data elements and quickly obtain company rankings that allow identification of outliers or relatively-low performing insurers. The data system also allows regulators to develop their own ad-hoc inquiries that may help identify companies for more targeted market conduct reviews.

However, while development of the MCAS is a significant accomplishment, the tool is used by most but not all states, and varies by line of insurance. Equally important, the MCAS is not available for all types of insurance. So far, MCAS forms have been developed for automobile, homeowners, life and annuity, and long term care lines of insurance. Despite several years of work, the NAIC has not yet completed development of the health insurance MCAS and is still likely several years away from adoption and implementation. Even then, it will be up to each state to decide whether they will use it. The NAIC should place an increased amount of emphasis on completion of the MCAS for health insurance, concurrently with the ongoing development of survey tools to capture market conduct data in the nearer future, in light of the importance of the market conduct examinations under the new ACA requirements.

Examiners also rely extensively on internal documents provided by the insurer. An examination may include a review of company policies and procedures, training manuals and guidelines related to operations such as claims processing and payments, underwriting, advertising and marketing, broker and agent activities, network development and adequacy,

health care referrals and authorizations, privacy and security, and any other internal operating procedures. For desk examinations, regulators rely primarily on company-provided documents, which may take time and can delay the examination process, particularly if examiners need to request additional information. For on-site examinations, examiners will review many of the same documents, but several examiners report information is easier to obtain and allows for more ad-hoc requests than is practical for off-site exams. On-site exams also allow them to observe whether insurers actually comply with the described processes, interview employees for additional information, and more easily identify compliance issues that are not apparent in documents.

While examiners generally agreed that on-site examinations allow for a more detailed review of an insurer's operations, limited resources require DOIs to rely primarily on desk exams. As such, the accuracy, reliability and level of detail provided through document reviews are extremely important, and examiners should have access to as many resources as possible. Because the success of an examination relies extensively on data and the ability to proficiently analyze and interpret the information, examiners should maximize the resources they have but continue to look for additional resources that may become available or are used in other states. Under the ACA, insurers must meet new reporting requirements which may provide additional information for examiners. Additionally, because so many functions of insurers are now automated and continue to produce new information, examiners should also consider periodic reviews of the new data and analytic processes used by insurers to identify new information that could be useful for an examination.

Best Practices Recommendations:

While the resources listed above are the ones most frequently used by examiners, not all examiners use all of the sources listed, or may use them inconsistently. In addition, some DOIs have identified additional data sources that can provide valuable information, as described below.

9. DOIs should update examination checklists as early as possible to ensure current examination practices include a review of new provisions already implemented as a result of the ACA. Checklists should also be updated as early as possible in 2014 to incorporate new regulations applicable to plans beginning January 1, 2014, as well as new information/data resources that may become available as a result of the ACA and related insurance reporting requirements. Through the NAIC, regulators should also work to prioritize the adoption and finalization of a health Market Conduct Annual Statement (MCAS), concurrently with ongoing work to develop shorter-term industry surveys.

Although the NAIC is working methodically to provide updates to the examination requirements, the process will take time. The examination changes that will be required to incorporate new ACA requirements are complex and extensive and understandably take time to develop. And while uniformity and consensus among regulators is a laudable goal, states cannot afford to wait any longer to update examination processes and review criteria to reflect the changes that have already incurred in the health insurance market and will be taking effect in the next few years.

The NAIC Market Conduct Examination Standards (D) Working Group has invested significant time in the development of examination standards for reviewing ACA-related requirements and has already drafted valuable information that states can use in updating their own checklists and criteria. A summary listing of ACA provisions identified for inclusion in examinations was incorporated in the *Market Regulation Handbook* to provide notice to examiners of these changes, but the actual examination review standards are still under development.³³ Drafting of these standards has been ongoing for several years, and has entailed numerous meetings and multiple draft versions, but a deadline for completion of the standards has not been set, despite the fact that many of the ACA requirements have been in place for several years. As noted in an August 6, 2013 update issued by the Working Group, the NAIC identified 10 "Phase 1" ACA requirements that are already effective. Phase 2 ACA requirements will take effect January 1, 2014. The NAIC is still developing Phase 1 examination standards but will not begin development of Phase 2 until Phase 1 is completed.

Without a national standard for updating examination processes to reflect the ACA requirements, states have taken various approaches, resulting in inconsistent oversight. Of the states we interviewed, several reported they were relying on completion of the NAIC standards before making any changes to their review process and had made minimal changes to the current review criteria to reflect ACA requirements. Others have made more extensive updates, but did not know to what extent the changes accurately reflect the majority of new ACA provisions. One state reported they and others are primarily relying on contract examiners to update their processes, with limited assistance from the state.

Rather than wait for final adoption of the NAIC revisions, DOIs should immediately update their own market conduct examination guidelines and procedures to reflect ACA changes that have already occurred and should be included in health insurance examinations. For future changes effective in 2014 or later, regulators should develop a process for periodic review of the examination standards for additional updates, and should include procedures by which agency staff in other departments that perform health insurance regulation activities notify the examination division when additional regulatory changes are enacted.

We also recommend that the NAIC emphasize the completion of the MCAS for health insurance, concurrently with the ongoing development of survey tools to capture market conduct data in the nearer future, in light of the importance of the market conduct examinations under the new ACA requirements.

10. Examiners should routinely review information available as part of a health plan's accreditation or ranking through the National Committee for Quality Assurance (NCQA), URAC, or other organizations to identify areas where the insurer demonstrated low performance or failed to meet certain benchmarks during their review process. Loss of accreditation or other negative changes in status should be monitored as a potential indicator for scheduling a health plan examination, particularly given the requirement that all Qualified Health Plans sold through health insurance exchanges be accredited.

Insurers who obtain NCQA³⁴ or URAC³⁵ accreditation are required to provide significant information and undergo reviews of company activities related to functions such as quality assurance, credentialing, utilization management, complaint processing and other operational activities.³⁶ Some states rely on the accreditation process as a proxy for certain regulatory reviews by the DOI, which may exempt the insurer from undergoing analysis of certain activities. While this policy may be an effective way for regulators to expedite certain regulatory functions, it also eliminates an opportunity for the department to conduct their own evaluation using criteria developed by staff. A market conduct examination provides an additional opportunity for examiners to review and confirm insurer compliance with department regulations while using information that has already been compiled by the insurer as part of the accreditation process.

States should ensure examiners are familiar with accrediting organizations, the role they provide in assessing health plans' activities, and the types of information developed by insurers as part of the evaluation process. As part of the examination process, examiners should review health plans' accreditation status and determine whether additional information related to the accreditation process should be requested. Changes in an insurer's status, including loss or suspension of accreditation, may indicate serious problems that could be a trigger for scheduling a targeted or comprehensive examination. Because health plans participating in the Exchange are required to obtain accreditation by 2016, including a review of relevant information will be even more important in future years.³⁷

11. DOIs should establish an internal procedure to ensure examiners are automatically provided access to relevant insurance surveys, data calls, financial regulation reports, annual statements, and other information collected by regulatory staff that might be useful in an examination.

Data calls and insurer filings are a relatively common occurrence within DOIs and are used to collect information such as mandated benefit utilization, enrollment data by type of benefit plan, prompt payment compliance, or information related to specific regulatory reviews or legislative inquiries. However, examiners are frequently unaware of these activities that occur in other divisions of the DOI and are unlikely to request or have access to the information unless the DOI has a process for routinely informing examiners of these resources. Though several regulators reported information is provided upon request, information is typically not automatically provided and relies on an examiner's knowledge that another division has collected the data. The lack of interaction and regular communication with department staff outside the market conduct examination team creates gaps in information and can contribute to unnecessary and duplicative requests for data that insurers have already provided to another division within the insurance department. More importantly, it may preclude an examiner's review of valuable information that is directly relevant to the examination. Establishing a regular process for communication and interaction among departmental staff ensures examiners will have access to a broader scope of information, be better prepared and informed, which will contribute to a more effective market conduct examination.

12. If available for a specific health plan, market conduct examinations should include a review of health plan HEDIS and/or CAHPS data, or other health plan performance data, to identify deficiencies that may suggest quality of care issues or other problems that should be analyzed as part of the examination.

Numerous states require HMOs to report HEDIS (Healthcare Effectiveness Data and Information Set) and/or CAHPS (Consumer Assessment of Health Plan Services) data to measure health plans' performance in both clinical care and consumer satisfaction, and health insurance exchanges will be required to collect and report on health plan quality data by 2016. HEDIS reporting includes clinical quality measures that more than 90 percent of health plans use to measure performance on up to 75 measures.³⁸ The CAHPS survey tool is used to survey consumers and patients to obtain information on their healthcare experience, including their satisfaction with health insurers.³⁹ Measures are available for commercial, Medicare and Medicaid health plans. State reporting requirements vary and not all states require that information be reported to the DOI. For example, HEDIS and CAHPS information in Texas is reported to the Texas Department of State Health Services and the Texas Office of Public Insurance Counsel but the DOI has no oversight role in the reporting or analysis of either data set. However, health plans that collect the data as part of their accreditation, to meet other state agency reporting requirements, or to satisfy the requests of employers could provide the information to DOIs if requested for a market conduct examination. In addition, profiles of accredited health plans are available on the NCQA website, and could be accessed and reviewed by market conduct examiners.⁴⁰ Survey results are often available on public websites and are fairly simple to access.⁴¹

The New York Department of Financial Services routinely reviews HEDIS data to identify potential problems for inclusion in a health plan's market conduct examination or to identify companies that should be scheduled for examination.

Depending on the reporting metrics required in a state, both HEDIS and CAHPS data may include extensive information that could indicate performance issues related to quality of care, access to care, network adequacy, or consumer satisfaction. For example, a plan with low scores for immunization rates relative to other health plans could have an insufficient number of pediatric providers, which results in delayed access to immunizations. Or a company with a sudden drop in scores from one year to the next may have experienced a surge in enrollment that created a demand for services they were not prepared to meet. While there may be valid reasons why a plan has poorer scores, a review of these data is a useful, frequently untapped resource that can help examiners quickly identify health plan performance issues that warrant further review.

The New York Department of Financial Services routinely reviews HEDIS data to identify potential concerns for inclusion in a health plan's market conduct examination, or to assist in the identification of companies that should be scheduled for examination. The Department has found the data to be extremely useful, and provides a level of detail regarding a health plan's performance that would not otherwise be available. When HEDIS and/or CAHPS data are available, states should establish a standard protocol for ensuring examiners have access to the data and are trained to understand how it should be used in the examination process.

13. Market conduct analysis and examinations should include internet searches of published news stories to identify any articles that identify problems or concerns with an insurer under examination, or to identify companies that may require further investigation, include scheduling an examination.

While consumers are encouraged to contact the DOI directly with any complaints or concerns they may have, in some cases consumers go directly to the media, particularly if the problem is especially egregious, concerns the denial of critical health care services, or results in expensive unpaid medical bills. While the DOI may be aware of the story and the issue in some cases, the information may not be available to the examiner. In other cases, the DOI may have no knowledge of the story, or may be aware of the problem but not the extent of its impact on consumers. To ensure such incidents are not overlooked, the Indiana Department

The market conduct staff of the Indiana Department of Insurance routinely conducts searches of media reports that identify any problems of insurers under examination or to identify carriers who may need further review.

of Insurance routinely reviews a variety of media sources to identify potential problems of insurers under examination, or identify carriers who may need further review, including an examination. The examiner will request additional information from the company when indicated and may choose to expand the level of review based on their initial findings.

Several states reported their department collects media stories on a daily basis through the public affairs office, but news stories do not always make their way to the examinations staff. Examiners would prefer to make their own determination regarding the value of the story and whether it warrants additional investigation. One state pointed out that the news services tracked by the Department are limited to a few of the more prominent publications, and are limited in scope. While useful for other purposes, the limited information should not be considered a substitute for a more robust search as part of an investigation, which may identify stories from sources not typically monitored by the DOI, including publications in other states. A search for relevant media reports can be conducted fairly quickly and is another data resource that is easy to access and should be routinely incorporated into a market conduct examination.

Public Information and Accountability

The merits of publicizing activities related to market conduct examinations have been the subject of debate since market conduct reviews were first initiated. Examinations in some states are intentionally low profile; consumers are generally never aware that such reviews take place and reports are considered confidential. Some states make reports available only upon request, sometimes in the form of an official open records request. In other states, examination reports are publicly available upon completion and are routinely posted online for public review.⁴² However, requesting the reports is only of value to those individuals who know the reports exist and are able to locate the link to request or download the report. The vast majority of consumers are not aware of the market conduct process, the type of information available from an examination report, or the opportunity to review such reports when looking for information about an insurer.

While some regulators and insurers question the value of publishing the availability of market conduct reports given the technical nature of the information, the mere fact that such reports are publicly available may encourage insurers to be more conscientious of market behavior to avoid unflattering publicity. With the increased emphasis on consumer education and comparison of available health plans as a result of the implementation of the health insurance exchanges, consumers are likely to become more sophisticated shoppers and will be better positioned to compare and evaluate their health plan options. The report may provide important information for consumers that, taken into account with other factors, could influence a purchasing decision.

Some regulators point out that many market conduct examinations find no problems or issues, and that making these reports available to consumers is of little value. However, the fact that the DOI identified no concerns is just as important to a consumer as knowing that problems were identified. Additionally, most insurers would likely welcome the positive publicity associated with a report that states the company is compliant. States should ensure that reports are easily accessible to the public.

Best Practices Recommendations:

14. Market Conduct reports should be publicly available. DOIs should publish reports online or provide a process for individuals to request reports in an electronic format. The Department should also prominently display on their website information on the market conduct process and a link to available reports so they may be easily located and accessed by consumers.

Providing access to market conduct examination reports is another important step towards improving transparency in health care and health insurance purchasing decisions. While some reports may be lengthy and discuss technical issues, consumers are becoming much more sophisticated in their purchasing decisions and appreciate the resources regulators provide as they consider which health plan is best for their needs. Consumer advocacy and health policy research organizations also have the technical expertise to appropriately evaluate the findings, and can be trusted intermediaries for consumers. To ensure consumers are aware of the availability of examination reports, DOIs should include a link to reports and a brief explanation of market conduct activities on pages designed to assist health insurance

California, Florida, Indiana, Illinois, New York, Rhode Island and Washington are among the states that ensure consumers have access to market conduct examination reports by posting copies on their public website and directing consumers to the reports through their consumer webpages.

consumers. DOIs should also invite consumers to provide input on market conduct issues in a separate link available from the DOI's market conduct home page as well as pages related to complaints or health insurance consumer information.

15. States with statutory or regulatory prohibitions against public access to market conduct reports should consider providing access to report summaries in lieu of full reports, if allowed by law, and should work to remove administrative or regulatory barriers to full transparency.

When market conduct examinations were first initiated as a regulatory activity, insurers were concerned that negative information could significantly impact their business and potentially jeopardized the financial solvency of the company. This concern was shared by many regulators, particularly given the newness of the process and the uncertainty of what types of violations would be discovered. As the market conduct review process has evolved and public access to government information has become a commonly accepted philosophy by both legislators and regulators, many states have adapted to these changes by amending confidentiality provisions and requiring that market conduct examination reports be publicly available. While some states have statutory restrictions that prohibit publication of reports, regulators may have flexibility to publish summaries. Where possible, regulators should publish summaries on their website and should make documents easily accessible to consumers. Where applicable, DOIs should also work towards removing administrative or regulatory barriers to full transparency.

Engaging DOI Staff, Other Regulators, and Consumers in the Market Conduct Examination Process

Due to the variations in health plan benefits and regulatory requirements applicable to managed care plans and traditional indemnity health insurance, regulation of commercial health plans is often shared by several DOI divisions and, in a few cases, entirely separate agencies. For example, the California Department of Managed Health Care oversees Health Maintenance Organizations (HMOs), the California Department of Insurance regulates traditional insurance plans, and the two agencies share oversight of Preferred Provider Organization (PPO) managed care plans offered by insurers.⁴³ Other states, including Maryland, Minnesota, New Jersey and New York, have granted primary regulatory oversight of HMOs to agencies other than the DOIs.⁴⁴ States that use managed care plans to serve their Medicaid enrollees may also share health plan oversight responsibilities with the state Medicaid agency, with the DOI responsible for licensing and financial regulation and the Medicaid agency responsible for overseeing compliance with most day to day operations of the health plans, including quality of care standards, network adequacy, prompt payment, and enrollee complaints. In addition, activities of health plans participating in a state's health insurance exchange may also be regulated by the Exchange entity, creating additional challenges for market conduct examiners' trying to evaluate an insurer's operations. Coordinating a review that involves data and information dispersed among several agencies can be much more difficult, particularly if the agencies are not coordinating their efforts or sharing information that would be useful to an examination.

In most cases, DOIs maintain primary responsibility for oversight of all types of health insurance plans, including managed care and indemnity. Divisions within the Department are responsible for performing various technical tasks that may be specific to a certain type of health plan or regulatory function, so that oversight of an insurer is commonly provided by dozens of different people depending on the size of an agency and the number and types of health plans operating in a state. Each of these regulatory divisions has information on health plan performance and compliance issues that should be routinely shared with the market conduct examination staff. Market conduct officials agree that internal communication is critical to ensuring an effective and comprehensive regulatory environment, but establishing and maintaining those connections is sometimes difficult given the many competing and often more pressing priorities within an agency.

Equally important to a robust market review program is inclusion of regulators from other agencies that have authority over certain health plan activities. For insurers, the regulatory variations among multiple agencies can be especially confusing and in some cases conflicting depending on the type of health plan, particularly in those cases where the DOI and other agencies have limited communication or coordination. Insurers that market commercial HMO, PPO and indemnity plans must comply with different requirements for each type of plan, and in each state where they offer coverage. Health insurers that participate in the commercial market, the Medicaid program, and the Exchange may be subject to at least three different sets of regulations. The division of oversight and lack of coordination among some states can compromise the effectiveness of a market conduct examination if certain functions or areas of a company's business are outside the examiner's review. Coordination and exchange of information is critical to a successful market conduct program, and will become increasingly important as more insurers and more consumers enter the market through the insurance Exchange.

Best Practice Recommendations:

16. Establish agency policies and procedures for including market conduct examiners in discussions with other internal DOI staff who oversee health insurance activities to discuss current regulatory issues, emerging trends, new regulatory processes and requirements, and other matters related to health insurance oversight. Meetings should be held on a regular basis (i.e., monthly or quarterly) and should provide an opportunity to discuss relevant activities and areas of focus for examinations of specific insurers scheduled for market conduct examinations.

Market conduct examination is a separate organizational unit within the DOI infrastructure, and examiners typically have limited interaction with other agency staff. They frequently travel and are often disconnected from other activities at the DOI, making it difficult for them to keep up with current health insurance-related issues within the department. Several examination staff described their limited communication with other areas within the DOI as a key challenge and suggested a more structured process for internal communication would improve their ability to remain current on changes in regulations and ensure their examinations address existing concerns they would otherwise have no knowledge of.

Florida, Indiana and Washington are among several states that have a structured process for engaging internal staff outside the market conduct team to receive input on market conduct examinations. The Florida Office of Insurance Regulation solicits internal information on activities related to companies under review using surveys and discussions with key staff. Examination staff in the Indiana Department of Insurance routinely meets with other agency divisions prior to an examination and obtain input on specific issues or areas on which they should focus. The Washington Office of the Insurance Commissioner's examination staff meets regularly with several divisions within the agency to discuss examination activities, and uses an electronic spreadsheet to track information on various regulatory activities that is shared with multiple divisions to facilitate communication of important data and coordinate oversight functions.

While these examples demonstrate how departments have taken a proactive approach to sharing of information, other states that infrequently hold internal discussions related to examinations may find those meetings of limited value due to a lack of focus. States that have not already done so should adopt a formalized process that includes regularly scheduled meetings between market conduct examiners and key staff to provide regulatory updates and discuss upcoming examinations to identify areas that should be targeted in the review. Potential representatives may include employees from the following areas:

- legal/enforcement, including producer investigation units;
- consumer affairs/complaints processing;
- advertising;
- quality performance and evaluation;
- utilization review;
- network adequacy;
- policy and form approval;
- rate review and approval staff;
- financial regulation staff; and
- other managed care activities.

The Florida Office of Insurance Regulation, the Indiana Department of Insurance and the Washington Office of the Insurance Commissioner have each established internal procedures that ensure examination staff regularly meet with other staff within the department to discuss issues relevant to ongoing and future examinations.

The workgroup should meet no less than quarterly to discuss developing issues and exchange information related to the health insurance entities scheduled for market conduct examinations. The workgroup may also identify other health insurers and HMOs that should be considered for further analysis. This process will also provide a forum for the exchange of information and concerns which, on their own, may not raise any concerns, but taken together may signal a need for further review.

17. Due to the division of regulatory oversight responsibilities for health plans, DOIs should establish a multi-agency team of individuals who meet on a regular, periodic basis (no less than quarterly) to exchange health plan information within their jurisdiction, discuss any concerns related to specific insurer activities or trends among multiple insurers. The information may be used to identify potential problems that may not be observed by the DOI, or may not raise concern at the DOI on their own but, when considered in context of information from other regulatory agencies, may indicate a need for additional evaluation, including a market conduct examination.

Coordinating oversight of market conduct activities poses additional challenges when regulation is shared among multiple agencies. Health plan compliance issues or significant changes in operations may go undetected by the DOI, delaying opportunities to resolve problems in their earliest stages. Establishing a process for sharing information on a regular basis with an appointed team of state agency representatives provides regulators an important opportunity to identify issues which, on their own may be of little concern, but when considered in a broader context could raise concerns. For example, a sudden increase in complaints for a particular commercial Exchange plan may be dismissed as an anomaly, or may be relatively insignificant given the size of the plan. However, if the Medicaid agency is seeing a similar increase for the same insurer's Medicaid managed care plan, and also observed delays in paying some higher cost claims, the combination of these events may suggest additional investigation is warranted. Without the scheduled meeting to discuss health plan activities, the significance of these events may go undetected until they become more serious and more difficult to address.

18. Establish a process for soliciting input from consumers, exchange navigators and assisters, and consumer advocacy groups on the market conduct review program and activities of insurers.

Due to confidentiality provisions that may apply while an examination is ongoing, soliciting input on specific companies while reviews are in progress may be prohibited. However, as the DOI interacts with consumers in various forums throughout the year, the agency could include information on the market conduct program and encourage consumers to contact the department if they are aware of activity they believe the DOI should be aware of. Most consumers are likely to only contact the department if they have a specific complaint related to a particular claim or episode of care and may not be aware that the Department also oversees activities such as advertising and marketing, network adequacy or quality of care. However, consumers are often in the best position to identify potential problems and may have valuable information to contribute to the market conduct review process. Soliciting their input on areas other than complaints is an important information resource for examiners that should be encouraged when possible.

DOIs should also invite consumers to provide input on insurers' activities through a separate link available from the market conduct home page as well as pages related to complaints or other health insurance information webpages that consumers frequently visit. While consumers may be motivated to file a complaint if an insurer's decision has a personal financial impact or prevents their ability to obtain medical care, consumers may not be motivated to report other types of problems they have knowledge of but do not feel the complaint process is the best option. The Texas Department of Insurance encourages consumers to provide reports of potential market conduct issues through a notice that appears on the Consumer Protection home page.⁴⁵ Complaints may be filed either through an on-line form or may also be submitted by standard mail. Provided an opportunity and encouraged to do so, consumers are more likely to provide information on insurer activities through a separate process that invites them to notify the Department of activities they believe regulators should be aware of.

The Texas Department of Insurance encourages consumers and brokers to provide reports of potential market conduct issues through a notice that appears on both the Consumer Protection and Financial home pages.

DOIs also have a new potential source of information regarding health insurance company conduct and compliance. The ACA provides for the establishment of navigators, certified application counselors, and in person assisters to provide assistance to consumers who apply for coverage through exchanges. These in person assisters will have a view of current activities in the new health insurance marketplace which may be of use to market conduct regulators.

19. Establish a process for engaging insurance producers (agents and brokers) in the market conduct review process.

Insurance agents and brokers are in an excellent position to provide examiners with information on insurer practices, yet few states engage agents and brokers in the market conduct review process. Because of their unique relationship with both consumers and insurers, agents may be able to provide valuable insight on an insurer's marketing activities, claims payment processes, complaints handling, broker training and instructions, or activities of other appointed agents of the insurer.

While all states allow or encourage brokers and agents to contact DOIs at any time with information concerning a company's compliance issues or problems, most states do not actively solicit their input. Some agents may not be familiar with the market conduct review process or recognize the value of their experience in identifying potential problems. To reduce any barriers and encourage agents to report relevant information, the Texas Department of Insurance asks agents and brokers to report potential carrier violations through an on-line form that goes directly to market conduct analysts for investigation.⁴⁶ Adoption of a similar process that allows agents to report possible violations without fear of retribution by insurers may provide examiners with information that would otherwise be unavailable, and is an effective tool for engaging agents/brokers in the market conduct review process.

Importance and Appropriate Use of Consumer Complaint Data

One of the primary sources of information for both market conduct reviews and enforcement investigations is the DOI consumer complaint data. Regulators have long relied on information obtained from complaints to identify business practices or unusual trends among individual insurers as well as industry wide patterns that warrant investigation. Complaints are also one of the earliest indicators used by DOIs to identify companies for market conduct examinations since they are the primary method of communication for consumers with problems.

While all DOIs have maintained a process for receiving and investigating consumer complaints for years, the size and scope of complaint tracking systems and the level of detail collected varies widely. Tracking systems may be limited by the sophistication of software programs, the number of data fields that can be accommodated, or storage capacity. Departments with more limited resources and smaller staff may not have the technical support to conduct more advanced analytics that can be helpful in identifying trends or potential problems. States with more resources may also have teams of staff that focus on one type of insurance complaints. Others may not have that luxury, and analysts must investigate and make critical decisions regarding complaints related to not only health insurance plans, but other products such as life, annuities, or homeowners.

States also use different complaint codes and categories which not only impedes efforts to coordinate and compare complaints across multiple states, but requires complaint technicians to make decisions regarding the classification of each complaint. Complaints improperly entered or misclassified may prohibit a state from identifying complaint trends that should be further investigated or referred to market conduct.

Recognizing the value and importance of a systematic process for monitoring complaint data, the NAIC created the Complaints Database System (CDS) to facilitate standards for complaint data collection and analysis, and the sharing of data among regulators. The data base allows regulators to review data trends on a geographic basis, which can be particularly useful in urban markets where consumers work in one state and live in an adjoining state. While regulators in both states have an interest in protecting consumers regardless of where they live or work, working closely together can be particularly important for consumers who may not even realize the health plan provided by their employer is subject to regulatory oversight in their state of employment rather than their state of residence. In a best case scenario, regulators will regularly monitor complaints in neighboring states to identify potential problems that may go undetected in their own state due to differences in complaint tracking systems.

To address the need to track complaints related to new provisions under the ACA, the NAIC is developing additional complaint coding fields to help regulators monitor and identify compliance problems that may arise. In the most recent draft, more than 90 additional complaint codes have been identified, which is a reflection of the many opportunities for mistakes or compliance issues. While these codes are still in the draft stage, once they are finalized, states should move swiftly to adopt them.

Best Practices Recommendations:

20. Consumer complaint codes should be expanded and updated to identify and track complaints associated with changes required by the ACA. Codes should be sufficiently detailed to identify specific problems that require further review, including market conduct examination. States should continue to periodically review and update codes on a regular basis as needed, but no less than annually.

While the requirements for health insurance plans have changed significantly in the past three years and will continue to do so in coming years in response to the ACA, complaint tracking systems used by many DOIs have not kept up with these changes and may not be sufficiently detailed to provide the information regulators need to adequately identify emerging problems related to ACA compliance. Department practices vary widely as to the frequency of coding updates; while some DOIs regularly update or add new complaint codes as needed, others rarely make changes and have no standard protocol for requiring regular, periodic reviews.

Although the NAIC's efforts to expand complaint coding and tracking in response to the ACA will provide welcome guidance for regulators, the initiative will take time before final adoption, and not all states will adopt the NAIC recommendations. Because tracking of complaints is such a critical process, regulators cannot afford to delay updating their internal tracking systems. Rather than wait for NAIC final recommendations, DOIs should make the addition of new codes for ACA-related complaints a priority, and develop an internal process for adopting changes as early as possible.

As the health insurance market continues to evolve in the coming years, DOIs should regularly evaluate their existing complaint codes and determine whether additional codes are needed. Regulators should also engage staff throughout the DOI to identify new issues or concerns that the Department would like to monitor and solicit input on the addition of new complaint codes. Recommendations from staff should be requested at least annually, or more frequently as determined appropriate by the Department. The Texas Department of Insurance (TDI) holds agency-wide bi-weekly meetings with key staff to discuss emerging concerns, new regulations, market conduct activities, legislative inquiries, and any other issues that staff should be aware of. The discussion may include identification of appropriate action that should be taken by various divisions to monitor potential areas of concern, which may include the addition of new complaint codes. This process increases the responsiveness of the consumer complaint staff and the effectiveness of the complaint tracking system by enabling the TDI to better monitor changing market conditions and make timely changes when needed.

The Texas Department of Insurance complaints investigation staff work with health care regulators throughout the agency to identify potential complaint issues on an ongoing basis. New complaint codes are added routinely as new needs are identified through staff input, or based on contact with stakeholders outside the agency.

21. Host an annual compliance meeting with health insurance companies to review and discuss complaint trends, compliance issues and any other regulatory concerns.

Ideally, these meetings would be individual, one-on-one meetings with insurers, depending on the Department's staff resources and the size of their market. States where only a few companies write health insurance may be better equipped to host annual meetings where states with a large number of health plans may need to be more selective due to limited availability. In those cases, the DOI may want to require meetings bi-annually, or may limit meetings to companies with annual premiums above a minimum threshold.

If one-on-one meetings are not possible, another alternative is to host an annual compliance conference with all health insurers to discuss complaint trends and common compliance problems, as well as other regulatory issues, including new legislative and regulatory requirements for insurers. This practice would provide insurers and regulators an opportunity to discuss specific areas of complaints that may not rise to a level serious enough to warrant an investigation or examination, but could do so in the future if left unchecked. Meetings are beneficial not only for the Department, but also for the insurer as it raises their awareness of issues that should be addressed. Everyone wins under this scenario – the Department resolves an issue

that could require additional staff resources and investigation; the insurer may avoid or minimize an enforcement action, financial penalty or market conduct examination; and consumers may avoid problems that could delay health care services or prevent them from receiving benefits covered under their policy.

The Rhode Island Office of Health Insurance Commissioner meets quarterly with health insurers to discuss compliance issues, complaint trends, new regulatory requirements and other issues related to activities of the department and the insurer. Insurance companies welcome the opportunity to meet with regulators and discuss their concerns and any issues the department has identified. While the size of the Texas market and number of health plans prohibits the Texas Department of Insurance from meeting individually with insurers, the Department holds periodic compliance conferences with all health plans. The meeting is an opportunity to hold detailed discussions on a range of issues, and provides an opportunity for one-on-one meetings as needed. This pro-active approach enables insurers to identify potential problems early on, and prepares them for any upcoming regulatory changes they will need to incorporate into their operations in order to avoid future compliance issues.

The Virginia Bureau of Insurance publishes a report on the most common problems detected in market conduct examinations as a way of advising insurers of compliance areas that may warrant additional focus to ensure they are not making the same mistakes. The report, “Common Problems Identified During Life and Health Market Conduct Examinations,” identifies multiple issues under such categories as Ethics and Fairness, Advertising/Marketing Communications, Policies and Other Forms, Underwriting, Unfair Discrimination, Privacy Protections, Claims, and Complaints, including:

- failure to maintain records of written complaints;
- failure to adhere to minimum standards in claims handling;
- failure to file and receive approval of policy forms as required;
- failure to license and appoint agents;
- failure to provide required information to consumers when an adverse underwriting decision is issued;
- failure to adopt and implement reasonable standards for the prompt investigation of claims;
- failure to make prompt, fair and equitable settlements of claims, or provide a reasonable explanation for denial of a claim; and
- failure to provide prompt and appropriate premium refunds when a policy is terminated .

While not a substitute for a one-on-one discussion with insurers or an annual conference that covers a wide range of issues, the report may be more realistic for some DOIs, and provides another opportunity to possibly avoid potential problems for both insurers and consumers.

22. Because market conduct activities rely heavily on information obtained from consumers’ complaints to identify compliance problems, the DOI should use consumer outreach and education opportunities to increase awareness of the complaint process and provide clear instructions on how to file a complaint. Complaint filing information should be prominently displayed on the DOI website.

To enhance consumers’ awareness of and access to the DOI’s complaint process, the department’s website should prominently and clearly display information on how consumers may file a complaint. Consumers may not be aware of their right to file a complaint with the DOI or the procedures for filing a complaint, particularly newly insured consumers who have little or no experience with commercial insurance plans. Others may be intimidated by the process or may be under the impression that filing a complaint with the DOI is pointless if the insurer has already ruled against them. Because complaints are a primary

The Rhode Island Office of Health Insurance Commissioner and the Texas Department of Insurance have implemented processes for meeting periodically with health insurers to discuss compliance issues, complaint trends and other regulatory matters in an attempt to improve health plan performance and prevent minor concerns from developing into serious problems.

resource used by many DOIs to initially identify companies for market conduct examinations, ensuring consumers can easily submit a complaint through various means (i.e., by phone, mail, or electronically via e-mails or internet) is extremely important. DOIs should provide obvious, direct links to the complaint filing instructions and ensure the process for completing the necessary forms is clear and simple to follow.

23. Insurance complaint analysts should be appropriately trained to identify complaints that should be referred to market conduct or another division of the agency for review, including complaints that reflect a general business practice rather than an isolated complaint. DOIs should create teams of analysts who focus only on health insurance complaint investigations, and should update complaint procedure manuals and guidance documents to include changes occurring as a result of the ACA.

While it is common for states to consider further action when complaints against an insurer reach a certain level that reflects a trend, some complaints are serious enough that they warrant initial investigation at a much lower level. Even a relatively small number of certain types of complaints can indicate more risk for consumers or suggest more serious violations. Complaint analysts should be trained to identify which types of complaints warrant closer scrutiny or should be considered for higher level review, including referral to market conduct examination staff.

With implementation of new requirements associated with the ACA, analysts should also be trained to identify complaints that may suggest an insurer has not implemented changes required by the ACA. Complaints indicating denial of certain newly required services such as preventive health services or mental health care, limitations in benefits, or problems finding a doctor in the health plan's network may all suggest an insurer is not compliant with ACA provisions. Complaint analysts will require training on ACA requirements and how those vary by type of health plan, and the use of new complaint codes developed by the DOI in response to the ACA. Staff should be surveyed regularly to identify areas where they feel additional training is needed. To ensure analysts can focus on the complexities of health insurance plans and are adequately trained to fully investigate complaints, states should create teams of complaint analysts who work exclusively on health insurance complaints. Doing so will allow a more efficient and comprehensive investigation, and is likely to provide better results for both consumers and insurers.



Conclusion

Market conduct analysis is a technical, complex regulatory activity that requires highly trained, competent staff. Recent budget cuts in state government agencies have forced many DOIs to “do more with less,” resulting in staff reductions and fewer market conduct examinations, despite the growth in health insurance enrollment and premium volume. As regulators continue to work on ACA implementation, many departments will continue to struggle with competing demands for resources and must make difficult decisions regarding allocation of resources. However, states with varying sizes and budgets can incorporate a range of strategies into their market conduct examination programs. We hope the information in this report will encourage regulators to consider the opportunities for improving and possibly expanding market conduct programs given the critical role they play in protecting consumers and in helping identify problems in their earliest stages, allowing both insurers and regulators to implement corrections in an expedient and more cost-effective manner.

Appendix: Summary Description of NAIC Databases Available to Market Conduct Examiners

Complaints Database Systems (CDS) – The CDS is used by regulators to obtain information on consumer complaints filed against insurers and brokers/agents. The database includes information on closed complaints only; data on pending complaints is not included. Four types of consumer complaint reports are available, including Closed Complaint Counts by Code; Closed Complaint Counts by State; Closed Complaint Trend Report, and Closed Complaint Index. Information is submitted electronically by state DOI staff. DOIs are encouraged, but not required, to submit complaint reports on a frequent, regular basis, but participation and frequency of updates varies among states. While some complaint data is publicly available through the Consumer Information Source (CIS) website, the CDS is not available to the public.

Examination Tracking System (ETS) – the ETS provides a mechanism for recording and tracking market conduct and financial examination activities and results. The system includes functions that allow regulators to obtain information on scheduled examinations and reporting dates, and provides identification of the individuals involved in an examination so other regulators may contact them for additional information. The database relies on information submitted by DOIs, who are encouraged but not required to provide updates on a regular basis as information becomes available. Participation in the ETS is strongly encouraged, but is not required and varies by state. The ETS is available only to regulators.

Market Analysis Prioritization Tool (MAPT) – the MAPT allows DOI market analysts and examiners to compare similar insurance companies on a national and state basis. The database provides an overall score, a national score and a state score for the following lines of insurance: Credit, Group Accident and Health, Group Annuity, Group Life, Homeowner, Individual Accident and Health, Individual Annuity, Individual Life, Long Term Care, Medicare Supplement and Private Passenger. The scores are based on as many as 100 or more data elements, depending on the type of insurance company. The types and volume of data vary by line of insurance and whether MCAS (Market Conduct Annual Statement) data are available. Analysts may use the data to create a spreadsheet that includes both the scoring system and the underlying data, which analysts can adjust to provide greater weight to information that is more important to the examiner's specific data needs. While the underlying data is based primarily on information provided by insurers at least annually, the database and scoring system are available only to regulators. Participation by all states is encouraged by the NAIC, but participation is voluntary.

Market Analysis Review System (MARS) – the MARS is used to assist analysts with both Level 1 and Level 2 market conduct reviews. Through MARS, analysts access templates that include a series of questions that guides analysts through a comprehensive review of data available in the NAIC's market and financial information system. Twelve sections of data are included in the review: operations and management; financial ratios; special activities; regulatory actions; examinations; market initiatives; premiums; market share; loss and expense ratios; resisted and unpaid claims; complaints and MCAS results. Level 1 reviews located in MARS can be reviewed by analysts in other jurisdictions. Because Level 2 reviews rely on data that is more specific to the state in which the examination is conducted, data is often only accessible to regulators located in the state. Only analysts with the proper security authorization are able to enter and access reviews in MARS. Information is not publicly available. While all state DOIs are encouraged to utilize MARS, participation is optional.

Market Initiative Tracking System (MITS) – MITS provides regulators with a method for tracking and sharing information related to actions taken when investigating the business practices of a particular company, a group of companies, or a general issue. The system provides data on market initiatives that may impact other jurisdictions and may include research, investigations or analysis. These initiatives may include single state, multistate, or collaborative activities, or activities initiated by the NAIC Market Analysis Working Group (MAWG). Activities may be linked across jurisdictions; for example, an initiative that begins in a single state may be linked to other single-state efforts. Information is available only to regulators. All DOIs are encouraged but not required to participate in MITS.

Regulatory Information Retrieval System (RIRS) – the RIRS database includes information on regulatory actions taken by participating DOIs against insurance companies, agents and brokers, or other regulated entities engaged in the business of insurance. The data allows regulators to share information on individuals or companies suspected of illegal or questionable activities and prevent expansion of illegal activities into other jurisdictions. Information submitted by regulators may include, but is not limited to, the following: administrative complaints, cease and desist orders, settlement agreements

and consent orders, receiverships, license suspensions or revocations, corrective action plans, restitutions, closing letters and letter agreements. Only final adjudicated actions are included. States are encouraged but not required to report information as it becomes available. While some information included in RIRS may be publicly available, access to the database is limited to regulators. Participation by all DOIs is encouraged, but not all states participate.

Special Activities Database (SAD) – The SAD is a confidential database that includes information on suspicious market activities and ongoing legal actions involving entities engaged in the business of insurance. SAD data may be contributed by both DOI and NAIC staff. The database may also include information on disciplinary actions taken by regulatory agencies other than a state insurance department. The database is only available to regulators. While participation by all DOIs is encouraged, not all states participate.

Sources include 1) NAIC and the Center for Insurance Policy and Research, “*The Market Conduct Analysis Framework*,” CIPR Newsletter, October 2012; 2) National Association of Insurance Commissioners, “*Revisions to Section B.3.b of Chapter 7 – Market Regulation Investigation Guidelines of the Market Regulation Handbook*,” 2012; 3) NAIC and the Center for Insurance Policy and Research, “*The Evolution of Market Regulation*,” December, 2011; 4) email from the NAIC helpdesk, November 2013.

- ¹ The NAIC and the Center for Insurance Policy Research, “*The Evolution of Market Regulation*,” December 5, 2011. Available at: http://www.naic.org/documents/index_financial_reform_fio_111207_agenda.pdf
- ² See the NAIC website for additional information on activities of the organization: <http://www.naic.org/>
- ³ PriceWaterhouseCoopers, LLP, “*Insurance Market Conduct Examination Public Policy Review*,” July 2000.
- ⁴ McKinsey & Company, Inc., “*Strengthening the Surveillance System*,” Final Report, April 1974.
- ⁵ See Insurance Regulatory Examiners Society certification requirements at <http://www.go-ires.org/accreditation>.
- ⁶ PriceWaterhouseCoopers, LLP, “*Insurance Market Conduct Examination Public Policy Review*,” July 2000.
- ⁷ Price WaterhouseCoopers, LLP, “*The Path to Reform-The Evolution of Market Conduct Surveillance Regulation*,” May, 2003.
- ⁸ U.S. Government Accountability Office, “*Insurance Regulation: Common Standards and Improved Coordination Needed to Strengthen Market Regulation*,” September 30, 2003. Available at <http://www.gao.gov/products/GAO-03-433>
- ⁹ U.S. Governmental Accountability Office, “*Insurance Reciprocity and Uniformity: NAIC and State Regulators Have Made Progress in Producer Licensing, Product Approval, and Market Conduct Regulation, but Challenges Remain*,” GAO-09-371. April 6, 2009. Available at: <http://www.gao.gov/products/GAO-09-372>
- ¹⁰ National Association of Insurance Commissioners, “*Market Regulation Handbook*,” Table of Contents, available at: http://www.naic.org/documents/store_pub_supplementary_mrh_toc.pdf.
- ¹¹ Op. Cit., NAIC and the Center for Insurance Policy and Research, “*The Evolution of Market Regulation*.”
- ¹² Ibid.
- ¹³ Ibid.
- ¹⁴ Op. Cit., U.S. General Accounting Office, “*Insurance Regulation: Common Standards and Improved Coordination Needed to Strengthen Market Regulation*.”
- ¹⁵ Op. Cit., U.S. Governmental Accountability Office, “*Insurance Reciprocity and Uniformity: NAIC and State Regulators Have Made Progress in Producer Licensing, Product Approval, and Market Conduct Regulation, but Challenges Remain*.”
- ¹⁶ See press release issued by the Illinois Department of Insurance at <http://insurance.illinois.gov/news/2013/02/MarketConductExams2012.pdf>
- ¹⁷ See market conduct examination report for John Alden Life Insurance Company at: http://www.in.gov/doi/files/enforcement/11325%20assurant%20mc%20exam%20%20settlement_201206271454.pdf
- ¹⁸ See California Department of Insurance news release at <http://www.insurance.ca.gov/0400-news/0100-press-releases/2013/upload/Chartis-RSA-9-19-12-2.pdf>
- ¹⁹ Vermont Department of Financial Regulation, Market Conduct Examination report, available at: <http://www.dfr.vermont.gov/sites/default/files/BCBSVT-consentorder.pdf>
- ²⁰ California Department of Insurance, <http://www20.insurance.ca.gov/epubacc/REPORT/98969.htm>
- ²¹ California Department of Insurance, Enforcement Action Agreement with Anthem Blue Cross Life and Health Insurance Company. 2009. Available at: <http://www20.insurance.ca.gov/epubacc/Graphics/122926.PDF>
- ²² Terhune, Chad. LA Times, “*California fines Kaiser \$4 million over access to mental care*,” June 2013, <http://articles.latimes.com/2013/jun/25/business/la-fi-mo-kaiser-health-california-fine-20130625>
- ²³ PR Newswire Services, “*Wolters Kluwer Financial Services Identifies Top 10 Criticisms on Insurance Market Conduct Exams*,” June, 2013. Available at: <http://www.prnewswire.com/news-releases/wolters-kluwer-financial-services-identifies-top-10-criticisms-on-insurance-market-conduct-exams-58512627.html>
- ²⁴ See Federal Regulation 78 FR 13406, Section 150.101; available at: <http://www.gpo.gov/fdsys/pkg/FR-2013-02-27/pdf/2013-04335.pdf>
- ²⁵ See CCIIO compliance update at <http://www.cms.gov/ccio/programs-and-initiatives/health-insurance-market-reforms/compliance.html>. In Arizona, CMS is collecting and reviewing policy forms in the group PPO market only.
- ²⁶ Op. Cit., GAO, “*Insurance Regulation: Common Standards and Improved Coordination Needed to Strengthen Market Regulation*.”
- ²⁷ Randy A. Helder, NAIC and the Center for Insurance Policy and Research, “*The Market Conduct Analysis Framework*”, October 2012.
- ²⁸ Op. Cit., GAO, “*Common Standards and Improved Coordination Needed to Strengthen Market Regulation*.”
- ²⁹ Thomson Reuters, “*Multistate Examinations – Trends and Observations*,” November 2011. Available at: <http://accelus.thomsonreuters.com/sites/default/files/L-372161.pdf>
- ³⁰ Op. Cit., NAIC and the Center for Insurance Policy Research, “*The Evolution of Market Regulation*.”
- ³¹ Op. Cit., R. Helder., “*The Market Conduct Annual Statement: Comes of Age*.”
- ³² Ibid.
- ³³ National Association of Insurance Commissioners, “*Summary of PPACA Related Changes to Chapter 20 – Conducting the Health Examination of the Market Regulation Handbook*,” available at http://www.naic.org/documents/committees_d_market_conduct_exam_standards_130619_draft_aca_provisions.pdf
- ³⁴ The National Committee for Quality Assurance (NCQA) operates numerous initiatives that provide health plan evaluations, rankings, and/or accreditation based on a review of clinical performance, member satisfaction, and other standardized criteria. Additional information on health plan ranking and accreditation programs through NCQA is available at: <http://www.ncqa.org/InformationOnHealthPlans.aspx>
- ³⁵ URAC is a nonprofit agency that develops performance standards, benchmarking activities and provides more than 30 accreditation and certification programs for health plans, organizations performing utilization review activities, and other providers and organizations. Additional information is available at <https://www.urac.org/>
- ³⁶ The National Committee for Quality Assurance (NCQA) operates several initiatives that provide health plan evaluations, rankings, and/or accreditation based on a review of clinical performance, member satisfaction, and other standardized criteria. Additional information on health plan ranking and accreditation programs through NCQA is available at: <http://www.ncqa.org/InformationOnHealthPlans.aspx>
- ³⁷ See § 156.275, CMS-9965-P, 77 Fed. Reg. 33133-142 for additional information on accreditation requirements for all Qualified Health Plan issuers under the ACA.
- ³⁸ The Healthcare Effectiveness and Data Information Set is used by health plans to measure performance on clinical health care services and outcomes. For additional information, see: <http://www.ncqa.org/HEDISQualityMeasurement/WhatIsHEDIS.aspx>
- ³⁹ The Consumer Assessment of Healthcare Providers and Systems (CAHPS) program is a multi-year initiative of the Agency for Healthcare Research and Quality (AHRQ) to support and promote the assessment of consumers’ experiences with health care and includes several different survey tools. For additional information regarding the health plan survey, see: https://cahps.ahrq.gov/health_plan/
- ⁴⁰ NCQA rankings and summary data for health plans reporting in 2013 are available at: <http://healthplanrankings.ncqa.org/default.aspx>
- ⁴¹ For an example of a HEDIS report and the type of data collected, see: <http://www.opic.state.tx.us/health/guide-to-texas-hmo-quality>

⁴² For an example of websites that provide access to market conduct reports, please see the following links:

California: <http://www.insurance.ca.gov/0100-consumers/0275-market-conduct/>

Florida: http://www.floir.com/sections/marketinvestigations/is_market_inv_index.aspx

Illinois: http://insurance.illinois.gov/Reports/Report_Links.asp

Indiana: <http://www.in.gov/idoi/2615.htm>

New York: <http://www.dfs.ny.gov/insurance/examfileheal.htm>

Rhode Island: http://www.dbr.state.ri.us/documents/divisions/insurance/examinations/Market_Conduct_Examinations-Since_1992.pdf

Washington: <http://www.insurance.wa.gov/companies/market-conduct/market-conduct-reports/>

⁴³ California Department of Managed Care, *Agencies that Oversee Health Plans*, available at: http://www.dmhc.ca.gov/dmhc_consumer/hp/hp_agencies.aspx

⁴⁴ NAIC's Compendium of State Laws on Insurance Topics, "*Departmental Regulation of HMOs*," August, 2011.

⁴⁵ See Texas Department of Insurance link at: <http://www.tdi.texas.gov/consumer/index.html>

⁴⁶ See reporting form at <http://www.tdi.texas.gov/financial/mcviolations.html>

⁴⁷ Commonwealth of Virginia, Bureau of Insurance, "*Common Problems Identified During Life and Health Market Conduct Examinations*," Revised 2010; available at: http://www.scc.virginia.gov/boi/co/mkt_conduct/lh_prob.pdf

