

MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

Market Regulation and Consumer Affairs (D) Committee Aug. 12, 2022, Minutes

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Market Conduct Examination Guidelines (D) Working Group April 21, 2022, Minutes (Attachment Twelve-A1)

Speed to Market (D) Working Group April 20, 2022, Minutes (Attachment Thirteen)

Draft Pending Adoption

Draft: 8/16/22

Market Regulation and Consumer Affairs (D) Committee
Portland, Oregon
August 12, 2022

The Market Regulation and Consumer Affairs (D) Committee met in Portland, OR, Aug. 12, 2022. The following Committee members participated: Jon Pike, Chair (UT); Trinidad Navarro, Vice Chair (DE); Evan G. Daniels (AZ); Sharon P. Clark (KY); Chlora Lindley-Myers represented by Jo LeDuc (MO); Mike Causey represented by Tracy Biehn (NC); Jon Godfread represented by John Arnold (ND); Eric Dunning represented by Martin Swanson (NE); Russell Toal represented by Leatrice Geckler (NM); Barbara D. Richardson (NV); Michael Humphreys (PA); Cassie Brown (TX); and Kevin Gaffney represented by Karla Nuissl (VT). Also participating were: Michael Conway (CO); Erica Weyhenmeyer (IL); Rebecca Nichols (VA); and John Haworth (WA).

1. Adopted its July 15 Minutes

Commissioner Clark made a motion, seconded by Ms. Biehn, to adopt the Committee's July 15 minutes (Attachment One). The motion passed unanimously.

2. Adopted Revisions to the Handbook

Ms. Weyhenmeyer said revisions to Chapter 1—Introduction of the *Market Regulation Handbook* (Handbook) were adopted by the Market Conduct Examination Guidelines (D) Working Group during its July 14 meeting. She said discussion on the issue of coordination between market conduct state insurance regulators and state insurance financial examiners had been occurring since the drafting of Chapter 20—General Examination Standards of the Handbook. She said the purpose of adding the revision to Section B of Chapter 1 is to insert guidance into the Handbook to address the need for state insurance market conduct regulators to recognize domestic financial examiners as a resource available to them and market conduct examiners to coordinate with domestic financial regulators to obtain information relating to a company's group capital calculations (GCCs), liquidity stress test (LST) results, corporate governance, and Own Risk and Solvency Assessment (ORSA), as needed.

Ms. Weyhenmeyer said revisions to Chapter 20 of the Handbook were also adopted during the Working Group's July 14 meeting. The revisions align the Handbook with various provisions of the *Insurance Holding Company System Regulatory Act* (#440) and make several changes to Chapter 20.

Ms. Weyhenmeyer said revisions to Chapter 21—Conducting the Property and Casualty Examination of the Handbook were adopted during the Working Group's April 21 meeting. The revisions align the chapter with provisions of the *Real Property Lender-Placed Insurance Model Act* (#631).

Ms. LeDuc made a motion, seconded by Ms. Biehn, to adopt the revisions to Chapters 1 (Attachment Two), 20 (Attachment Three), and 21 (Attachment Four) of the Handbook. The motion passed unanimously.

3. Adopted the New Handbook Chapter 24B

Ms. Weyhenmeyer said the Market Conduct Examination Guidelines (D) Working Group adopted the new Chapter 24B—Conducting the Mental Health Parity Addiction Equity Act-Related Examination of the Handbook on July 14. She said the drafting of the new chapter was in response to the Nov. 3, 2021, letter to the Committee from 19 organizations in the mental health field. She said the letter indicated that the mental health parity examination chapter of the Handbook was outdated because of 2021 federal amendments to the federal Paul Wellstone and

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Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requirements for analyzing the parity compliance of non-quantitative treatment limitations (NQTLs).

Ms. Weyhenmeyer said a new draft of Chapter 24B entitled “Conducting the Mental Health Parity Addiction Equity Act-Related Examination” was first prepared under the guidance of the MHPAEA (B) Working Group, as its members have expertise in this subject area. She said the drafting sessions were attended by state insurance regulators and federal regulators who provided input on the updated MHPAEA chapter. She said after the Working Group reviewed the draft chapter, it was distributed to the Market Conduct Examination Guidelines (D) Working Group, interested state insurance regulators, and interested parties. Numerous comments were received on the chapter from state insurance regulators, industry representatives, and consumer representatives.

Ms. Weyhenmeyer said interested parties asked the Working Group to defer adopting the MHPAEA chapter until another federal rule is potentially issued in the fall of this year. She said those potential federal rules have not yet been drafted or presented, and the Working Group decided it was important to move forward with adoption of the chapter and then modify the chapter, as needed.

Commissioner Clark made a motion, seconded by Ms. Biehn, to adopt Chapter 24B of the Handbook (Attachment Five). The motion passed unanimously.

4. Adopted Recommendations for the Incorporation of AI in the MIS

Commissioner Conway said on June 16, the Market Information Systems (D) Task Force adopted the report of the Market Information Systems Research and Development (D) Working Group, including the “Recommendations for the Incorporation of Artificial Intelligence in the NAIC Market Information Systems.” He said the report is the final product of the Task Force’s charge to make recommendations regarding the use of artificial intelligence (AI) techniques in the NAIC Market Information Systems (MIS).

Commissioner Conway said the report was completed and adopted by the Working Group prior to the 2021 Summer National Meeting. He said the Task Force considered the report during its next three meetings and had robust discussions among regulatory, consumer, and industry stakeholders. He said the final adoption by the Task Force accepted the report with no revisions.

Commissioner Conway said the recommendations consist of five steps: 1) analyze current MIS data and identify deficiencies; 2) identify the predictive power of market analysis scoring systems, and integrate all data into a single analysis; 3) incorporate promising AI modes of analyses, as well as statistical models; 4) assess the ways AI can improve analysis and facilitate pattern recognition; and 5) systematically explore potential data sources suitable for AI techniques.

Ms. LeDuc made a motion, seconded by Director Daniels, to adopt the “Recommendations for the Incorporation of Artificial Intelligence in the NAIC Market Information Systems” (Attachment Six) The motion passed with Commissioner Brown voting against.

5. Adopted Guidelines for Amending the NAIC Uniform Applications

Commissioner Clark said the Producer Licensing (D) Task Force adopted the “Guidelines for Amending the NAIC Uniform Applications” on May 5. She said the guidelines will be used for the review and adoption of substantive changes to the NAIC’s Uniform Licensing Applications in support of the NAIC and National Insurance Producer Registry (NIPR) missions of maintaining stable and consistent NAIC Uniform Applications for producer licensing.

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Commissioner Clark said the guidelines set forth a five-step process to be followed on a biennial basis. She said any party requesting proposed changes to the NAIC's Uniform Licensing Applications would submit the proposed changes to NAIC staff by Feb. 1, and the proposed changes would be circulated for a 30-day public comment period. She said after the comment period, the Producer Licensing Uniformity (D) Working Group and the Task Force will have until the close of the next Summer National Meeting to adopt or reject the proposed changes. She said for proposed changes that are adopted, NAIC staff will coordinate with NIPR and the states, including any back-office system support vendors, to conduct an analysis of how long it will take to implement the proposed change and the cost to implement. She said this work is to be completed within 45 days. She said the Committee will then be presented with the proposed changes for consideration and consider adoption of the proposed changes by Oct. 15 for the Executive (EX) Committee and Plenary to consider adoption of the proposed changes at the Fall National Meeting.

Commissioner Clark said the guidelines are intended to provide structure around how proposed changes to the NAIC's Uniform Licensing Applications should be considered. She said the time periods set forth in the guidelines are not intended to be strict administrative rules that cannot be modified, as needed, to efficiently complete the review of proposed changes to the NAIC's Uniform Licensing Applications. She said if adopted, the guidelines will be used by the Working Group to review the proposed amendments to the NAIC's Uniform Licensing Applications from 2018.

Commissioner Clark made a motion, seconded by Commissioner Navarro, to adopt the "Guidelines for Amending the NAIC Uniform Applications" (Attachment Seven). The motion passed unanimously.

6. Adopted the Antifraud Plan Repository Workflow

Commissioner Navarro said in 2019, the Antifraud (D) Task Force began discussing the development of an NAIC antifraud plan submission and repository system to automate and streamline antifraud plan compliance nationwide. He said the topic was introduced to the Task Force after industry representatives explained how cumbersome it is to stay in compliance with state antifraud plan laws.

Commissioner Navarro said antifraud plan requirements differ tremendously from state to state, and insurance company representatives manually create and submit individual plans to states that have an antifraud plan requirement. He said to address the industry's concern, as well as to promote antifraud plan uniformity, the Task Force determined that it would be beneficial to create an antifraud plan system that works in the same way as the NIPR system.

Commissioner Navarro said Task Force members determined that a similar electronic system could be created, using a uniform antifraud plan template, to streamline the antifraud plan creation and submission process. He said as part of this project, the Task Force, with industry assistance, redesigned the *Antifraud Plan Guideline* (#1690) to ensure it included all the key elements that insurance companies should consider when developing an antifraud plan. He said the revisions of the guideline were adopted during the 2021 Spring National Meeting.

Commissioner Navarro said in the second phase of the project, the Antifraud Technology (D) Working Group, using the newly adopted guideline, worked with industry representatives to develop an Antifraud Plan Repository Workflow. He said in June, the Task Force adopted the workflows and business rules. He said the workflows and business rules, not only outline how the Task Force envisions the system working from a user perspective but will also serve as a resource for the NAIC's Information Technology (IT) Department as it works on the project.

Commissioner Richardson said she believes this is a good idea, but she is worried that using a template would make the creation of antifraud plans perfunctory, and she would have to vote against the proposal due to that concern.

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Commissioner Clark made a motion, seconded by Director Daniels, to adopt the Antifraud Plan Repository Workflow (Attachment Eight). The motion passed with Commissioner Richardson voting against.

7. Adopted it Task Force and Working Group Reports

a. Antifraud (D) Task Force

Commissioner Navarro said the Antifraud (D) Task Force met June 30 and finalized the Antifraud Technology (D) Working Group's charge concerning the development of an Antifraud Plan Repository.

b. Producer Licensing (D) Task Force

Commissioner Clark said the Producer Licensing (D) Task Force met May 5. She said the Task Force received a report from the NIPR Board of Directors, which highlighted that NIPR is now processing appointments and terminations for all states. She said the Task Force also discussed the 1033 waiver process and industry's request to simplify this process. She said in response to this request, NAIC staff were asked to work with a small group of state insurance regulators to develop suggested next steps for review by the Task Force. She said the Task Force discussed the potential development of best practices and a national solution on how states should address the submission of producer applications with errors or misstatements completed by authorized third-party submitters.

c. Market Analysis Procedures (D) Working Group

Mr. Haworth said the Market Analysis Procedures (D) Working Group met June 8 and July 13. He said on June 8, the Working Group adopted standard ratios for the travel insurance Market Conduct Annual Statement (MCAS) and the short-term limited-duration (STLD) MCAS. He said the standard ratios are calculated at the state level and publicly posted on the NAIC MCAS web page each year. He noted that during the July 13 meeting, the Working Group considered some additional standard ratios for travel insurance, and these are posted for comment.

Mr. Haworth said during both the June 8 and July 13 meetings, the Working Group began discussions on the next line of business to be added to the MCAS. The Working Group heard several suggestions, including pet insurance, credit life insurance, credit disability insurance, title insurance, and business owner's policy (BOP) insurance. He said the Working Group hopes to make a final recommendation before the Fall National Meeting.

Mr. Haworth said the Working Group has been considering enhancements to the Market Analysis Review System (MARS). He said the enhancements are focused on more quickly incorporating new MCAS data into the MARS and adding additional line of business options to be available to market analysts.

d. Market Regulation Certification (D) Working Group

Mr. Haworth said the Market Regulation Certification (D) Working Group met June 1 and July 13. He said the Working Group is working on three documents that make up the Voluntary Market Regulation Certification Program: 1) the Certification Program requirements and guidelines; 2) the Certification Program scoring matrix; and 3) the Certification Program implementation plan.

Mr. Haworth said during the Working Group's June and July meetings, the Working Group adopted the scoring matrix and began work on the requirements and implementation plan. He said a small group of state insurance regulators are reviewing the requirements and the revisions that were suggested by the pilot states. He said the small group will be meeting weekly or bi-weekly, as needed, and report back to the Working Group at each of its meetings.

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Mr. Haworth said the implementation plan is being re-drafted in its entirety since it has been quite some time since its original drafting and much of the material is dated. He said this work is being done at the Working Group level.

Mr. Haworth said the Working Group plans to complete its work in time for the Fall National Meeting.

e. Speed to Market (D) Working Group

Ms. Nichols said the Speed to Market (D) Working Group met April 20 and July 12. She said during the April 20 meeting, Working Group members were updated about the ongoing review and editing of the 2016 *Product Filing Review Handbook*. She said the drafters are editing outdated and obsolete information, such as referring to the Working Group as the Speed to Market (D) Task Force.

Ms. Nichols said the Working Group also heard an update from NAIC staff on the System for Electronic Rates & Forms Filing (SERFF) Modernization Project. She said attendees on the call were invited to attend the SERFF Product Steering Committee (PSC) meetings. She said Working Group meetings will include a standing agenda item to receive updates regarding the SERFF Modernization Project.

Ms. Nichols said during the July 12 meeting, Working Group members discussed and considered suggestions for changes to the uniform transmittal documents (UTDs) and the product coding matrix (PCM). She said a change to the Life & Health UTD was unanimously adopted by the Working Group. She said the change adds “withdrawn” as a status option. She said the change will be effective Jan. 1, 2023.

Director Daniels made a motion, seconded by Mr. Arnold, to adopt the following reports: 1) Antifraud (D) Task Force; 2) Market Information Systems (D) Task Force; 3) Producer Licensing (D) Task Force; 4) Market Analysis Procedures (D) Working Group (Attachment Nine); 5) Market Conduct Annual Statement Blanks (D) Working Group (Attachment Ten); 6) Market Regulation Certification (D) Working Group (Attachment Eleven); 7) Market Conduct Examination Guidelines (D) Working Group (Attachment Twelve); and 8) Speed to Market (D) Working Group (Attachment Thirteen). The motion passed unanimously.

8. Heard a Presentation on Dark Patterns on Websites

Birny Birnbaum (Center for Economic Justice—CEJ) said dark patterns are user interface techniques that benefit an online service by leading consumers into making decisions they might not otherwise make. He said some dark patterns deceive consumers, while others exploit cognitive biases or shortcuts to manipulate or coerce them into choices that are not in their best interests. He said dark patterns are a specific type of choice architecture in website and application design that interfere with a user’s autonomy and choice. He said dark patterns modify the presentation of choices available to users or manipulate the flow of information so users make selections they would not otherwise have chosen to their own detriment and the benefit of the website or app provider.

Mr. Birnbaum provided examples of types of dark patterns utilized by website and application developers including: 1) Nagging – repeated requests to do something the firm prefers; 2) Confirm-Shaming – a choice framed in a way that makes it seem dishonorable or stupid; 3) Forced Action – requiring opt-out of optional services and the manipulative extraction of personal information and information about other users; 4) Social Proof – false/misleading notices that others are purchasing or offering testimonials; 5) Roach Motel – asymmetry between signing up and canceling; 6) Price Comparison Prevention – difficulties in understanding and comparing prices; and 7) Hidden Information/Aesthetic Manipulation – important information visually obscured. He also said a common example of a dark pattern is the ease with which websites will allow a user to accept cookies, but if a user does not want to accept cookies, many steps are necessary. He provided results of testing on dark patterns

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that indicate that the use of dark patterns is very effective in guiding user choices to the benefit of the website provider.

Mr. Birnbaum said it is important for state insurance regulators to address the use of dark patterns by insurance providers. He noted that insurance regulatory disclosures are based on and designed for paper, not digital interfaces. He said on a digital interface, requirements such as “prominently display” and font size have no meaning. He noted that there has been a rapid increase in digital interactions in place of paper or face-to-face interactions between consumers and insurers from digital claim settlements to interactions involving insurance applications.

Mr. Birnbaum urged state insurance departments and the NAIC to: 1) train analysts and examiners to recognize dark patterns and manipulative digital design; 2) compile resources on manipulative digital design; 3) review existing disclosure requirements and whether they make sense for a digital interface and protect against dark patterns; 4) update guidance in regulations identifying dark patterns as an unfair and deceptive trade practice; and 5) develop relevant methods of regulatory review and update the Handbook accordingly.

Having no further business, the Market Regulation and Consumer Affairs (D) Committee adjourned.

[D Cmte Minutes](#)

Draft: 8/2/22

Market Regulation and Consumer Affairs (D) Committee
Virtual Meeting
July 15, 2022

The Market Regulation and Consumer Affairs (D) Committee met July 15, 2022. The following Committee members participated: Jon Pike, Chair (UT); Trinidad Navarro represented by Frank Pyle, Vice Chair (DE); Evan G. Daniels (AZ); Sharon P. Clark (KY); Chlora Lindley-Myers represented by Jo LeDuc (MO); Mike Causey represented by Tracy Biehn (NC); Jon Godfread represented by Johnny Palsgraaf (ND); Barbara D. Richardson (NV); Michael Humphreys represented by David Buono (PA); Cassie Brown represented by Matthew Tarpley (TX); and Kevin Gaffney represented by Mary Block (VT). Also participating was: Erica Weyhenmeyer (IL).

1. Adopted its Spring National Meeting Minutes

Commissioner Richardson made a motion, seconded by Commissioner Clark, to adopt the Committee's April 7 minutes. (*see NAIC Proceedings – Spring 2022, Market Regulation and Consumer Affairs (D) Committee*). The motion passed unanimously.

2. Adopted its 2022 Revised Charges

Commissioner Pike said the references to the System for Electronic Rates & Forms Filing (SERFF) Advisory Board are being deleted since this Board was disbanded at the Spring National Meeting. In addition to this charge, the Producer Licensing (D) Task Force charges are being revised to appoint a new Adjuster Licensing (D) Working Group. Commissioner Pike said this will allow for a new working group to review adjuster licensing reciprocity and uniformity issues rather than the Producer Licensing (D) Task Force.

Ms. LeDuc made a motion, seconded by Mr. Pyle, to adopt the Committee's revised charges. The motion passed unanimously.

3. Adopted Revised Homeowners MCAS, Revised PPA MCAS, Revised Life and Annuity MCAS, and New Other Health MCAS

Ms. Weyhenmeyer said the changes to the homeowners data call and definitions and the private passenger auto (PPA) data call and definitions are the same and that the Market Conduct Annual Statement (MCAS) digital claims reporting additions for home and PPA have already been adopted by the Committee for reporting in the 2023 data year. Ms. Weyhenmeyer said the interrogatories have some minor revisions since their initial adoption.

Ms. Weyhenmeyer said the Market Conduct Annual Statement Blanks (D) Working Group adopted a significant change for the lawsuits reporting within the homeowners and PPA data call and definitions. The lawsuit data elements are removed from the claims reporting section and placed into a newly created reporting section specifically created for reporting lawsuit activity. Ms. Weyhenmeyer said only claims-related lawsuits have been reported, and to keep continuity, the coverage-type reporting of claims will continue to include only claims-related lawsuits. An additional reporting category was created to capture non-claims-related lawsuits.

Ms. Weyhenmeyer said this change to the lawsuit reporting required edits to the lawsuit definition.

Ms. Weyhenmeyer said the Market Conduct Annual Statement Blanks (D) Working Group adopted edits to the life Market Conduct Annual Statement (MCAS) data call and definitions to include the reporting of accelerated

underwriting data. A new Interrogatories reporting section was created to capture basic information related to the products where accelerated underwriting is used and the types of data companies use for Accelerated Underwriting. Ms. Weyhenmeyer said the accelerated underwriting reporting breakouts were created for existing life MCAS data elements. This will allow for the reporting of individual cash value and non-cash value products with MCAS accelerated underwriting vs. other than MCAS accelerated underwriting. The data elements selected for accelerated underwriting reporting include: new policies issued; policies applied for; free looks; policies in-force at the end of the period; direct premiums; amount of insurance issued; and amount of insurance in-force at the end of the period.

Ms. Weyhenmeyer said the Market Conduct Annual Statement Blanks (D) Working Group had hoped to adopt accelerated underwriting reporting last year but delayed the adoption to ensure that the Accelerated Underwriting (A) Working Group's definition of accelerated underwriting could be considered for MCAS reporting. The Market Conduct Annual Statement Blanks (D) Working Group found that for reporting purposes, the Accelerated Underwriting (A) Working Group's adopted definition did not quite fit. At the same time, Ms. Weyhenmeyer said the definition adopted by the Accelerated Underwriting (A) Working Group is included within the life MCAS data call and definitions document to ensure consistency.

Ms. Weyhenmeyer said the Market Conduct Annual Statement Blanks (D) Working Group adopted the other health MCAS blank. With the adoption of this blank, the MCAS now collects underwriting, claims, complaint, and marketing information on health plans not subject to the federal Affordable Care Act (ACA). Those plans include the following: 1) accident only; 2) accidental death and dismemberment; 3) specified disease and critical illness; 4) hospital and other indemnity; and 5) hospital/surgical and other expense. Ms. Weyhenmeyer said the data on these policies is divided into those sold directly to individuals, those sold through associations, and those sold through employer groups. The blank is divided into five sections. The interrogatories collect information on how the company distributes its products and their relationships with associations and third-party administrators (TPAs). There are also questions regarding fees that are either included, or not included, in the premium charged to policy and certificate holders. The underwriting section collects information such as premium written, numbers of policies and covered lives, cancellations, and reasons for cancellations. The claims sections will provide market analysts with information on claims received, paid, and denied, and the reasons for the denials. The claims section will also collect information on the total dollar amount of claims paid and the timeliness of the payments or denials. The consumer complaints and lawsuits section collects data on the number of complaints and lawsuits received against the company. The marketing section collects information on the number of applications received, approved, and denied. This section also collects data on how the applications are received by the company and commissions paid or returned to the company. Ms. Weyhenmeyer said there is a \$50,000 premium threshold for reporting, and policies/certificates will be reported to the state in which the insured resides. In combination with the health MCAS blank, which collects data on plans subject to the ACA, and the short-term, limited-duration (STLD) MCAS blank, most of the health insurance marketplace will now be subject to MCAS reporting.

Mr. Pyle made a motion, seconded by Ms. LeDuc, to adopt revised homeowners MCAS, the revised PPA MCAS, the revised life and annuity MCAS, and the new other health MCAS. The motion passed unanimously.

Having no further business, the Market Regulation and Consumer Affairs (D) Committee adjourned.

[D Cmte Minutes 7.15.22](#)

B. Resources Within State Insurance Departments

Many of these resources, such as a state insurance department consumer complaint resolution unit, are discussed in detail in the body of this handbook. Other key resources include:

Market Conduct and Financial Examinations

Market conduct examinations focus on such areas as operations/management, complaint handling, marketing and sales, producer licensing, policyholder service, underwriting and rating, and claims. The financial condition examination system focuses on financial and corporate matters. Market conduct compliance issues can have a significant effect on legal and compliance risks, which in turn can create material solvency issues. Coordination with the financial examination function is an important area for market conduct examiners to understand. Guidance on financial condition examinations is provided in the *Financial Condition Examiner's Handbook* and is available through the Insurance Products and Services Division of the NAIC.

Financial Analysis

Financial reporting and analysis information is shared with the NAIC, which assembles a wide range of data compilations on a multistate basis. An insurance department's financial analysis and examination staff can provide valuable assistance in interpreting this information. [Additionally, market regulators are encouraged to coordinate with a company's domestic financial regulator to obtain information related to the company's group capital calculations, liquidity stress test results, corporate governance, and Own Risk and Solvency Assessment \(ORSA\).](#)

Rates and Forms Information

Tools such as the System for Electronic Rate and Form Filing (SERFF) and the insurance department posting of state filing review requirements provide a wide range of new data in formats that are more readily comparable across state and regional lines. As of April 2021, 53 jurisdictions including the District of Columbia, Puerto Rico, Guam and the Virgin Islands – plus more than 6,500 insurance companies, third-party filers, rating organizations and other companies—are using SERFF to efficiently and effectively speed insurance products to the market. The SERFF system provides an indicator of marketplace trends, such as overall increases in premiums or changes in coverages by the submission of filing of amendatory endorsements and exclusions.

Organized Intra-Department Communication

State insurance departments are organized differently, but all perform a range of market regulation functions, from consumer assistance to producer licensing, from rate and form review to market conduct exams, and from investigations to enforcement. All of these functions, as well as financial regulation functions, generate useful information about market problems. An effective market analysis program must include clear procedures for regularly sharing data and other information among the various divisions of an insurance department. Recommended methods of sharing internal information include holding a monthly update meeting or emailing issues that may be of concern or interest to other sections.

**STANDARDS
MARKETING AND SALES**

Standard 1

All advertising and sales materials are in compliance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ All regulated entity advertising and sales materials, including radio and audiovisual items such as television commercials, telemarketing scripts, pictorial materials, social media or other electronic medium

_____ Policy forms as they coincide with advertising and sales materials

_____ Producer's own advertising and sales materials

_____ Regulated entity policies and procedures

Others Reviewed

NAIC Model References

Unfair Trade Practices Act (#880)

Advertisements of Life Insurance and Annuities Model Regulation (#570), Section 3B

Risk-Based Capital (RBC) for Insurers Model Act (#312), Section 8B

Life Insurance Disclosure Model Regulation (#580), Section 8C

Life and Health Insurance Guaranty Association Model Act (#520), Section 19A

Long-Term Care Insurance Model Act (#640)

Life Insurance Illustrations Model Regulation (#582)

Small Employer and Individual Health Insurance Availability Model Act (#35)

Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Model Act (#171), Section 7(H)(1)(a)(I)

Advertisements of Accident and Sickness Insurance Model Regulation (#40)

Individual Health Insurance Portability Model Act (#37), Section 5

Title Insurers Model Act (#628)

Title Insurance Agent Model Act (#230)

Home Service Disclosure Model Act (#920)

Marketing Insurance Over the Internet White Paper

Group Health Insurance Standards Model Act (#100)

Medicare Supplement Insurance Minimum Standards Model Act (#650)

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

The Use of Social Media in Insurance White Paper

[*Insurance Holding Company System Regulatory Model Act \(#440\), Section 8G*](#)

IIPRC Uniform Standard References

IIPRC Standards for Individual Long-Term Care Advertising Materials (applicable to individual long-term care (LTC) products and associated advertising materials submitted and/or approved by the IIPRC)

Review Procedures and Criteria

Review advertising materials in conjunction with the appropriate policy form. If statistics are included, proper citation should be included in the documentation.

Materials should not:

- Misrepresent the dividends or share of the surplus to be received on any policy;
- Make a false or misleading statement as to the dividends or share of the surplus previously paid on the policy;
- Misrepresent any policy as being shares of stock;
- Misrepresent policy benefits forms or conditions by failing to disclose limitations, exclusions or reductions or use terms or expressions that are misleading or ambiguous;
- Make unfair or incomplete comparisons with other policies;
- Make false, deceptive or misleading statements or representations with respect to any person, regulated entity or organization in the conduct of insurance business; and
- Offer unlawful rebates or inducements.

Materials should:

- Disclose the name and address of insurer;
- Comply with applicable statutes, rules and regulations; and
- Cite the source of statistics used by the regulated entity.

Determine if the regulated entity approves producer sales materials and advertising. Determine if advertisements or lead-generating calls falsely project the image that they were sent by a government agency.

Review the regulated entity's and producer's websites with the following questions in mind:

- Does the website disclose who is selling/advertising/servicing for the website?
- Does the website disclose what is being sold or advertised?
- If required by statutes, rules or regulations, does the website reveal the physical location of the regulated entity/entities?
- Does the website reveal the jurisdictions where the advertised product is (or is not) approved, or use some other mechanism (including, but not limited to, identifying persons by geographic location) to accomplish an appropriate result?

For the review of Internet advertisements:

- Run an inquiry with the regulated entity's name;
- Review the regulated entity's home page;
- Identify all lines of business referenced on the regulated entity's home page;
- Research the ability to request more information about a particular product and verify the information provided is accurate; and
- Review the regulated entity's procedures related to producers advertising on the Internet and ensure the regulated entity requires prior approval of the producer pages, if the regulated entity name is used.

For the review of social media:

- Perform a search of social media sites with the regulated entity's name;
- Identify social media sites in which the regulated entity is active;

- Review identified social media sites and verify any product information provided by the regulated entity is accurate;
- Review the regulated entity’s policies and procedures to identify the personnel involved in monitoring the regulated entity’s marketing and sales-related social media activity;
- Review the regulated entity’s policies and procedures for tracking marketing and sales-related social media requiring regulated entity review; and
- If the regulated entity requires preapproval of producer advertising on the Internet, review the regulated entity’s preapproval procedures to determine whether the regulated entity identifies marketing and sales-related social media as also requiring regulated entity preapproval.

Automation Tip:

Enter a summary of all marketing materials of whatever description in an Excel spreadsheet. Capture the regulated entity’s name of the material; the form number, if any; the edition date, if any; source, if applicable; and media, such as Internet or direct mail. Include fields to note exceptions, such as unsupported statistics or possible misleading statements. Insert each possible violation/exception in a separate field.

Statistics and statements are likely to be repeated in more than one “piece” of marketing material. It is also possible that one piece of marketing material will contain more than one violation/exception.

The spreadsheet will make it easier to track any repeated statements and to identify any marketing material containing apparent multiple violations/exceptions.

**STANDARDS
MARKETING AND SALES**

Standard 1

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

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ New business policy forms [and certificate of insurance \(such certificates will only be requested for lender-placed insurance policies\)](#)

_____ Advertising materials

_____ Disclosure materials

_____ Marketing complaints

_____ Underwriting guidelines

Others Reviewed

NAIC Model References

Mass Marketing of Property and Liability Insurance Model Regulation (#710)

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

[Real Property Lender Placed Model Act \(#631\), Sections 5, 8 and 9](#)

Review Procedures and Criteria

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

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

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

**STANDARDS
UNDERWRITING AND RATING**

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

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

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

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

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

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

[For lender placed insurance, documentation showing regulated entity's separate rates for mortgage servicer obtained lender-placed insurance versus voluntary insurance on real estate owned property](#)

Others Reviewed

NAIC Model References

Property and Casualty Model Rating Guideline (File and Use Version) (#1775)

Property and Casualty Model Rating Guideline (Prior Approval Version) (#1780)

Property and Casualty Commercial Rate and Policy Form Model Law (Condensed) (#777)

Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)

Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

[Real Property Lender Placed Model Act \(#631\), Section 9](#)

Review Procedures and Criteria

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

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

- Premiums by classification code;
- Payroll exposure;

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

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

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

STANDARDS UNDERWRITING AND RATING

Standard 6 Verification of loss reporting.

Apply to: All workers' compensation examinations [and lender-placed insurance examinations, as applicable](#)

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

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

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

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

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

Others Reviewed

NAIC Model References

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

Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)
[Real Property Lender Placed Model Act \(#631\), Section 9](#)

Review Procedures and Criteria

Losses under each policy should be clearly and accurately maintained at the regulated entity, so that paid amounts, reserves, ~~and~~ deductibles [and, with respect to losses under lender-placed insurance policies, any excess amounts paid to the mortgagor](#) can be easily reviewed. The sample data should be compared to the unit statistical reports to verify accuracy of reporting of the following items:

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

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

STANDARDS UNDERWRITING AND RATING

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

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Application

_____ Underwriting files

Others Reviewed

NAIC Model References

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

Review Procedures and Criteria

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

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

**STANDARDS
UNDERWRITING AND RATING**

Standard 13

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

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files

[For lender-placed insurers, books and records containing compensation, contingent commissions, profit sharing and other payments dependent on profitability or loss ratios](#)

[For lender-placed insurers, third party agreements for outsourced services](#)

Others Reviewed

NAIC Model References

Unfair Trade Practices Act (#880)

[Real Property Lender Placed Model Act \(#631\), Section 6](#)

Review Procedures and Criteria

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

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

Chapter 24B—Conducting the Mental Health Parity and Addiction Equity Act (MHPAEA) Related Examination

IMPORTANT NOTE:

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

Introduction

The purpose of this chapter, Conducting the Mental Health Parity and Addiction Equity Act (MHPAEA) Related Examination, is to provide guidance for examiners when reviewing insurers whose business includes major medical policies offering mental health and/or substance use disorder coverage.

Federal law relies on state insurance regulators as the first-line enforcers of health reform provisions in the individual, small group and large group insurance markets. The examination standards in Chapter 24—Conducting the Health Examination of the *Market Regulation Handbook* provide guidance specific to all health carriers that may or may not include offering mental health and/or substance use disorder coverage. Chapter 24, Section G Claims, Standard 3 applies to examinations related to the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 found at 42 U.S.C. § 300gg-26.

The guidance found in this chapter recognizes that when developing an examination or review plan related to MHPAEA compliance, it is important to consider examination standards as applicable from Chapter 24 and Chapter 24A—Conducting the Affordable Care Act (ACA) Related Examination, as well as Chapter 20.

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

Mental Health and Substance Use Disorder Parity

1. Purpose

Mental health and substance use disorder parity compliance examinations should be designed to ensure that all health carriers are in compliance with all the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 (as amended by the Consolidated Appropriations Act of 2021) found at 42 U.S.C. § 300gg-26 and its implementing regulations found at 45 CFR § 146.136 and 45 CFR § 147.160.

These standards require health carriers to demonstrate compliance in terms of defining mental health or substance use disorder benefits, classifying benefits, financial requirements, quantitative treatment limitations (QTLs), nonquantitative treatment limitations (NQTLs), required disclosures and vendor coordination.

2. Definitions

For purposes of this Guide, except where the context clearly indicates otherwise, the following terms have the meanings indicated:

Aggregate Lifetime Dollar Limit means a dollar limitation on the total amount of specified benefits that may be paid under a health plan (45 CFR § 146.136(a)).

Annual Dollar Limit means a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a health plan (45 CFR § 146.136(a)).

Classifications of benefits used for applying parity rules:

(1) Inpatient, In-network. Benefits furnished on an inpatient basis and within a network of providers established or recognized under a plan or health insurance coverage (45 CFR § 146.136(c)(2)(ii)(A)(1)). See special rule for plans with multiple network tiers in paragraph (c)(3)(iii)(B) of 45 CFR § 146.136.

- a. If a plan provides benefits through multiple tiers of in-network providers (such as in-network preferred and in-network participating providers), the plan may divide its benefits furnished on an in-network basis into subclassifications that reflect network tiers, if the tiering is based on reasonable factors determined in accordance with the rules for NQTLs (such as quality performance, and market standards) and without regard to whether a provider provides services with respect to medical/surgical benefits for MH/SUD benefits. After the tiers are established, the plan may not impose any financial requirement or treatment limitation on MH/SUD benefits in any tier that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the tier.

(2) Inpatient, Out-of-network. Benefits furnished on an inpatient basis and outside any network of providers established or recognized under a plan or health insurance coverage. This classification includes inpatient benefits under a plan (or health insurance coverage) that has no network of providers (45 CFR § 146.136(c)(2)(ii)(A)(2)).

(3) Outpatient, In-network. Benefits furnished on an outpatient basis and within a network of providers established or recognized under a plan or health insurance coverage. See special rules for office visits and plans with multiple network tiers in paragraph (c)(3)(iii)(C) and (c)(3)(iii)(B) of 45 CFR § 146.136.

- a. A plan may divide its benefits furnished on an outpatient basis into two subclassifications: (1) office visits; and (2) all other outpatient items and services, for purposes of applying the financial requirement and treatment limitation rules.
- b. If a plan provides benefits through multiple tiers of in-network providers (such as in-network preferred and in-network participating providers), the plan may divide its benefits furnished on an in-network basis into subclassification the reflect network tiers, if the tiering is based on reasonable factors determined in accordance with the rules for NQTLs (such as quality, performance, and market standards) and without regard to whether a provider provides services with respect to medical/surgical benefits or MH/SUD benefits. After the tiers are established the plan may not impose any financial requirements or treatment limitation on MH/SUD benefits in any tier that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the tier.

(4) Outpatient, Out-of-network. Benefits furnished on an outpatient basis and outside any network of providers established or recognized under a plan or. This classification includes outpatient benefits under a plan (or health insurance coverage) that has no network of providers (45 CFR § 146.136(c)(2)(ii)(A)(4)). See special rule for office visits in paragraph (c)(3)(iii)(C) of 45 CFR § 146.136.

- a. A plan may divide its benefits furnished on an outpatient basis into two subclassifications: (1) office visits; and (2) all other outpatient items and services, for purposes of applying the financial requirement and treatment limitation rules.

(5) Emergency Care. Benefits for emergency care (45 CFR § 146.136(c)(2)(ii)(A)(5)).

(6) Prescription Drugs. Benefits for prescription drugs (45 CFR § 146.136(c)(2)(ii)(A)(6)).

Coverage Unit refers to the way in which a plan (or health insurance coverage) groups individuals for purposes of determining benefits, or premiums or contributions. For example, different Coverage Units include self-only, family, and employee plus-spouse (45 CFR § 146.136(a)).

Cumulative Financial Requirements are financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maximums. (However, cumulative financial requirements do not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements.) (45 CFR § 146.136(a))

Cumulative Quantitative Treatment Limitations are treatment limitations that determine whether or to what extent benefits are provided based on accumulated amounts, such as annual or lifetime day or visit limits (45 CFR § 146.136(a)).

Expected Plan Payments are payments expected to be paid under the plan for the plan year (45 CFR § 146.136(c)(3)(i)(C)). Any reasonable method may be used to determine the dollar amount expected to be paid under the plan for medical/surgical benefits subject to a financial requirement or QTL (45 CFR § 146.136(c)(3)(i)(E)).

Plan Payment is the dollar amount of plan payments and is based on the amount the plan allows (before enrollee cost sharing) rather than the amount the plan pays (after enrollee cost sharing) because payment based on the allowed amount covers the full scope of the benefits being provided (45 CFR § 146.136(c)(3)(i)(D)).

Financial Requirements include deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits (45 CFR § 146.136(a)).

Medical/Surgical Benefits means benefits with respect to items or services for medical conditions or surgical procedures, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law, but does not include mental health or substance use disorder benefits. Any condition defined by the plan or coverage as being or as not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the International Classification of Diseases (ICD) or State guidelines) (45 CFR § 146.136(a)).

Mental Health Benefits means benefits with respect to items or services for mental health conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any condition defined by the plan or coverage as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD, or State guidelines) (45 CFR § 146.136(a)).

Substance Use Disorder Benefits means benefits with respect to items or services for substance use disorders, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, or State guidelines) (45 CFR § 146.136(a)).

Treatment Limitations include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations (QTLs), which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations (NQTLs), which are not expressed numerically but otherwise limit the scope or duration of benefits for treatment

under a plan or coverage. A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition (45 CFR § 146.136(a)).

3. Techniques

To evaluate compliance with MHPAEA, examiners must request that the carrier submit the analyses and other underlying documentation that it has performed to determine that it meets all of the standards of MHPAEA. There must be specific documentation of how mental health conditions, substance use disorders and medical/surgical conditions were defined and how they were assigned to benefit classifications. There are specific mathematical analyses that the carrier must have performed in order to determine that it satisfies the MHPAEA requirements for financial requirements and quantitative treatment limitations QTLs. There are separate analyses the carrier must have performed in order to determine that it satisfies the MHPAEA requirement for NQTLs, which entail analyses for the “as written” component and analyses for the “in operation” component.

4. Standards and the Regulatory Tests

The mental health and substance use disorder parity review includes, but is not limited to, the following standards related to MHPAEA. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
Mental Health and Substance Use Disorder Parity Compliance

Standard 1

The health carrier shall define all covered services as mental health or substance use disorder benefits or as medical or surgical benefits. Mental health benefits or substance use disorder benefits must be defined to mean items or services for the treatment of a mental health condition or substance use disorder, as defined by the terms of the health plan and applicable state and federal law. Any definition of a condition or disorder as being or as not being a mental health condition or substance use disorder must be consistent with generally recognized independent standards of current medical practice or state guideline. (45 CFR § 146.136(a)).

Apply to: Certain group and individual health carriers offering mental health and substance use disorder coverage

Priority: Recommended

Documents to be Reviewed

_____ Applicable state and federal statutes, rules, regulations and published sub-regulatory guidance

_____ Type of generally recognized independent standards of current medical practice, state law or guidance, used to define mental health conditions, substance use disorders and medical/surgical conditions (e.g., the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Statistical Classification of Diseases and Related Health Problems (ICD code), etc.)

_____ List of specific mental health conditions or substance use disorders by diagnosis excluded from coverage as stated in the policy documents

_____ Mental health and/or substance use disorder and medical/surgical claim files

_____ Health carrier complaint/grievances/appeals records concerning mental health and/or substance use disorders (supporting documentation, including, but not limited to: written and phone records of inquiries, call center scripts, complaints, complainant correspondence and health carrier response)

_____ Internal department appeals/grievance files

_____ Applicable external appeals register/logs/files, external appeal resolution and associated documentation

Other References

Enforcement of the Public Health Services Act
42 U.S. Code § 300gg–22

Preemption relating to the Public Health Services Act
42 U.S. Code § 300gg–23

Mental Health Parity and Addiction Equity Act of 2008
42 U.S. Code § 300gg–26

Publication of summary plan description
ERISA 104(b) (29 U.S.C. § 1024(b))

The Federal Parity Self Compliance Tool: <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf>

[U.S. Department of Labor Frequently Asked Questions Guidance: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity](https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity)

Review Procedures and Criteria

Review definitions in the health carrier's policy forms and/or certificates of coverage for compliance with the definitions in 45 CFR § 146.136(a) and included in the definitions section of this chapter.

Review the health carrier's description of the independent standards it used to define mental health conditions, substance use disorders and medical/surgical conditions. These independent standards must be generally recognized independent standards of current medical practice such as the Diagnostic and Statistical Manual (DSM) or the International Classification of Diseases (ICD), or state guidelines.

Review exclusions in the health carrier's policy forms and/or certificates of coverage to identify those that involve a mental health or substance use disorder condition or diagnosis and compare it to the list of mental health and substance use disorder conditions excluded from coverage provided by the health carrier.

Verify that exclusions in the health carrier's policy forms and/or certificates of coverage identified as not a mental health or substance use disorder condition comply with state law and are consistent with generally recognized independent standards such as the International Classification of Diseases (ICD) or the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Review any attestations required by the state and submitted by the health carrier.

For services the health carrier has determined are both medical/surgical and mental health/substance use disorders, review the explanation of how they determine the correct expected dollar amount for these services (e.g., nutritional counseling, occupational therapy).

STANDARDS
Mental Health and Substance Use Disorder Parity Compliance

Standard 2

The health carrier must apply the same standards to medical/surgical benefits and to mental health or substance use disorder benefits in determining the classification in which a particular benefit belongs (or applicable sub-classification) (45 CFR § 146.136(c)(2)(ii)(A)).

Apply to: Certain group and individual health carriers offering mental health and substance use disorder coverage

Priority: Recommended

Documents to be Reviewed

- _____ Applicable state and federal statutes, rules, regulations and published sub-regulatory guidance
- _____ All policy documents (e.g., if group or association, request master policy and a sample of each certificate type issued during the examination scope)
- _____ Documentation as to how the carrier demonstrates assignment to the six classifications of benefits (and applicable sub-classifications) and the standard used
- _____ Company and vendor claim procedure manuals and bulletins/communications (if a carrier uses a behavioral health claims vendor for processing MH/SUD claims or for providing utilization management services)
- _____ Internal company claim audit reports for both mental health or substance use disorders and medical/surgical services
- _____ Provider contracts, instructions, communications and similar documents regarding coding instructions, code changes, etc.
- _____ Utilization review and managed care guidelines and procedure manuals
- _____ Mental health and/or substance use disorder and medical/surgical claim files
- _____ Mental health and/or substance use disorder and medical/surgical complaint and grievance files

Other References

Enforcement of the Public Health Services Act
42 U.S. Code § 300gg–22

Preemption relating to the Public Health Services Act
42 U.S. Code § 300gg–23

Mental Health Parity and Addiction Equity Act of 2008
42 U.S. Code § 300gg–26

Publication of summary plan description
ERISA 104(b) (29 U.S.C. § 1024(b))

The Federal Parity Self Compliance Tool: <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf>

[U.S. Department of Labor Frequently Asked Questions Guidance: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity](https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity)

Review Procedures and Criteria

Review the health carrier's list that specified the classification or sub-classification to which each benefit was assigned.

Determine whether the health carrier uses permissible sub-classifications for any benefits.

Please note that the only permissible sub-classifications are: multiple tiers for prescription drugs benefits that are based on reasonable factors¹ (45 CFR § 146.136(c)(3)(iii)(A)); multiple network tiers that are based on reasonable factors within the inpatient in-network and outpatient in-network classifications (45 CFR § 146.136(c)(3)(iii)(B)); outpatient office visits and outpatient other services within the outpatient in-network and outpatient out-of-network classifications (45 CFR § 146.136(c)(3)(iii)(C)). Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up (45 CFR § 146.136(c)(3)(iii)(A)).

Review the standard used by the health carrier to determine which classification of benefits (or applicable sub-classification) a particular benefit was assigned to and verify that the same standards were used for assigning medical/surgical benefits and mental health or substance use disorder benefits.

Review the health carrier's documentation that demonstrates that mental health or substance use disorder benefits are covered in each classification in which medical/surgical benefits are covered.

STANDARDS
Mental Health and Substance Use Disorder Parity Compliance

Standard 3

The health carrier shall not apply any financial requirement on mental health or substance use disorder benefits in any classification (or applicable sub-classification) that is more restrictive than the predominant financial requirement of that type applied to substantially all medical/surgical benefits in the same classification (or applicable sub-classification) (45 CFR § 146.136(c)(2)(i)).

Apply to: Certain group and individual health carriers offering mental health and substance use disorder coverage

Priority: Recommended

Documents to be Reviewed

- _____ Applicable state and federal statutes, rules, regulations and published sub-regulatory guidance
- _____ Health carrier list of all financial requirements applied to mental health or substance use disorder benefits and medical/surgical benefits in each classification (or applicable sub-classification) (this will include schedules of benefits and other policy documents)
- _____ Health carrier documentation of the reasonable method used to determine expected plan payments for medical/surgical benefits within each classification of benefits (or applicable sub-classification), including documentation and communications with vendors engaged to provide assistance with analyses
- _____ Documentation demonstrating the predominant and substantially tests performed by the health carrier for each applicable financial requirement applied to all benefits
- _____ Internal company claim audit reports specific to mental health or substance use disorders
- _____ Mental health and/or substance use disorder and medical/surgical claim files
- _____ Health carrier complaint records concerning mental health and/or substance use disorder (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)
- _____ Internal department appeals/grievance files concerning mental health and/or substance use disorders
- _____ Applicable external appeals register/logs/files related to concerning mental health and/or substance use disorder, external appeal resolution and associated documentation

Other References

Enforcement of the Public Health Services Act
42 U.S. Code § 300gg-22

Preemption relating to the Public Health Services Act
42 U.S. Code § 300gg-23

Mental Health Parity and Addiction Equity Act of 2008
42 U.S. Code § 300gg-26

Publication of summary plan description
ERISA 104(b) (29 U.S.C. § 1024(b))

The Federal Parity Self Compliance Tool: <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf>

Review Procedures and Criteria

Financial requirements include deductibles, copayments, coinsurance and out-of-pocket maximums (45 CFR § 146.136(c)(1)(ii)). A financial requirement is considered to apply to substantially all medical/surgical benefits in a classification of benefits if it applies to at least two-thirds of all medical/ surgical benefits in that classification (45 CFR § 146.136(c)(3)(i)(A)). The level of the financial requirement that is considered the predominant level of that type in a classification of benefits is the level that applies to more than one-half of medical/surgical benefits in that classification subject to the financial requirement (45 CFR § 146.136(c)(3)(i)(B)). The determination of the portion of medical/ surgical benefits in a classification of benefits subject to a financial requirement (or subject to any level of a financial requirement) is based on the dollar amount of all plan payments for medical/surgical benefits in the classification expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the financial requirement) (45 CFR § 146.136(c)(3)(i)(C)).

Review the health carrier's methodology for performing its analysis that determines expected plan payments within each classification of benefits (or applicable sub-classification) for medical/surgical benefits. Note: A health carrier must always use appropriate and sufficient data to perform the analysis in compliance with applicable Actuarial Standards of Practice (ACA FAQ 34 Q3).

Review the health carrier's documentation that demonstrates that any type of financial requirement applied to mental health or substance use disorder benefits in a classification (or applicable sub-classification) applies to at least two-thirds of expected plan payments on medical/surgical benefits within that classification (or applicable sub-classification) (45 CFR § 146.136(c)(3)(i)(A)). Note: If the financial requirement applies to all medical/surgical benefits in the classification, no cost analysis is required. No financial requirements shall apply only to mental health or substance use disorder benefits.

Determine whether the health carrier's documentation supports that the level of financial requirement applied to mental health or substance use disorder benefits in a classification (or applicable sub-classification) is comparable and no more restrictive than the level of financial requirement that applies to more than one-half of expected plan payments that are subject to the financial requirement within that classification for medical/surgical benefits (45 CFR § 146.136(c)(3)(i)(B)(1)).

If no single level of the financial requirement applies to more than one-half of medical/surgical benefits in the classification, determine whether the health carrier can demonstrate that it has satisfied this test (45 CFR § 146.136(c)(3)(i)(B)(2)).

STANDARDS
Mental Health and Substance Use Disorder Parity Compliance

Standard 4

The health carrier shall not apply any QTL on mental health or substance use disorder benefits in any classification (or applicable sub-classification) that is more restrictive than the predominant QTL of that type applied to substantially all medical/surgical benefits in the same classification (or applicable sub-classification) (45 CFR § 146.136(c)(2)(i)).

Apply to: Certain group and individual health carriers offering mental health and substance use disorder coverage

Priority: Recommended

Documents to be Reviewed

- _____ Applicable state and federal statutes, rules, regulations and published sub-regulatory guidance
- _____ Health carrier list of all QTLs applied to mental health or substance use disorder benefits and medical/surgical benefits in each classification (or applicable sub-classification) (this will include schedules of benefits and other policy documents)
- _____ Health carrier documentation of the reasonable method used to determine expected plan payments for medical/surgical benefits within each classification of benefits (or applicable sub-classification), including documentation and communications with vendors engaged to provide assistance with analyses
- _____ Documentation demonstrating the predominant and substantially tests performed by the health carrier for each applicable financial requirement applied to all benefits
- _____ Internal company claim audit reports
- _____ Mental health and/or substance use disorder and medical/surgical claim files
- _____ Health carrier complaint, grievance and appeals records (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, call center scripts, complainant correspondence and health carrier response)

Other References

Enforcement of the Public Health Services Act
42 U.S. Code § 300gg–22

Preemption relating to the Public Health Services Act
42 U.S. Code § 300gg–23

Mental Health Parity and Addiction Equity Act of 2008
42 U.S. Code § 300gg–26

Publication of summary plan description
ERISA 104(b) (29 U.S.C. § 1024(b))

The Federal Parity Self Compliance Tool: <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf>

Review Procedures and Criteria

QTLs include annual, episode, and lifetime day and visit limits. (45 CFR § 146.136(c)(1)(ii)). A QTL is considered to apply to substantially all medical/surgical benefits in a classification of benefits if it applies to at least two-thirds of all medical/ surgical benefits in that classification (45 CFR § 146.136(c)(3)(i)(A)). The level of the QTL that is considered the predominant level of that type in a classification of benefits is the level that applies to more than one-half of medical/surgical benefits in that classification subject to the QTL (45 CFR § 146.136(c)(3)(i)(B)). The determination of the portion of medical/ surgical benefits in a classification of benefits subject to a quantitative treatment limitation (or subject to any level of a quantitative treatment limitation) is based on the dollar amount of all plan payments for medical/surgical benefits in the classification expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the quantitative treatment limitation) (45 CFR § 146.136(c)(3)(i)(C)).

Review the health carrier's methodology for performing its analysis that determines expected plan payments within each classification of benefits (or applicable sub-classification) for medical/surgical benefits. Note: A health carrier must always use appropriate and sufficient data to perform the analysis in compliance with applicable Actuarial Standards of Practice (ACA FAQ 34 Q3).

Review the health carrier's documentation that demonstrates that any type of QTL applied to mental health or substance use disorder benefits in a classification (or applicable sub-classification) applies to at least two-thirds of expected plan payments on medical/surgical benefits within that classification (or applicable sub-classification) (45 CFR § 146.136(c)(3)(i)(A)). Note: If the quantitative limitation applies to all medical/surgical benefits within the classification, no cost analysis is required. No quantitative treatment limitations shall apply only to mental health or substance use disorder benefits.

Determine whether the health carrier's documentation supports that the level of QTL applied to mental health or substance use disorder benefits in a classification (or applicable sub-classification) is no more restrictive than the level of QTL that applies to more than one-half of expected plan payments that are subject to the quantitative treatment limitation within that classification for medical/surgical benefits (45 CFR § 146.136(c)(3)(i)(B)(1)).

If no single level applies to more than one-half of medical/surgical benefits in the classification, determine whether the health carrier can demonstrate that it has satisfied this test (45 CFR § 146.136(c)(3)(i)(B)(2)).

STANDARDS
Mental Health and Substance Use Disorder Parity Compliance

Standard 5

The health carrier shall apply non-quantitative treatment limitations (NQTLs) to mental health or substance use disorder benefits within a classification of benefits (or applicable sub-classification) so that any processes, strategies, evidentiary standards, or other factors used to apply a limitation, 1) as written and 2) in operation, are comparable to the processes, strategies, evidentiary standards, or other factors used to apply the limitation to medical/surgical benefits within the classification (or applicable sub-classification) (45 CFR § 146.136(c)(i)). The health carrier shall perform and document comparative analyses of the design and application of NQTLs in accordance with 42 U.S.C. § 300gg-26(a)(8)(A).

Apply to: Certain group and individual health carriers offering mental health and substance use disorder coverage.

Priority: Recommended

Documents to be Reviewed

_____ Applicable state and federal statutes, rules, regulations and published sub-regulatory guidance

_____ A list of all NQTLs imposed upon mental health or substance use disorder benefits within each classification of benefits (or applicable sub-classification), including the methodology used to determine those NQTLs. A state may focus its review on a subset of NQTLs rather than all NQTLs. (See reference link to DOL Self-Compliance Tool for a non-exhaustive list) Note: Due to the significant number of potential NQTLs, it is advised that the examiner selects a targeted subset or sample of NQTLs based on examination resources, state specific concerns, company common practices, etc. to avoid the review of hundreds of service variations. Additional NQTLs can be phased into the review as appropriate.

_____ Utilization management manuals and utilization review documents such as: utilization review criteria; criteria hierarchies for performing utilization review; case management referral criteria; initial screening scripts and algorithms; policies relating to reviewer discretion; processes for identifying and evaluating clinical issues and utilizing performance goals

_____ Notes and/or logs kept during utilization review, such as those describing: peer clinical review; telephonic consultations with attending providers; consultations with expert reviewers; clinical rationale used in approving or denying benefits; the selection of information deemed reasonably necessary to make a medical necessity determination; adherence to utilization review criteria and criteria hierarchy; professional judgment used in lieu of utilization review criteria; actions taken when incomplete information is received from attending providers

_____ Company claim procedure manuals and bulletins/communications

_____ Claims processor and customer services MHPAEA training materials

_____ Company fraud, waste, and abuse policies and procedures

_____ Internal company claim audit reports

_____ Prescription drug formulary for each product/plan design

_____ Prescription drug utilization management documentation

- _____ Fail-first policies or step therapy protocols
- _____ Network development/contracting policies and procedures
- _____ Standards for provider admission to participate in a network, including credentialing requirements
- _____ Standards for determining provider reimbursement rates
- _____ Samples of provider/facility contracts in use during the exam period
- _____ Plan methods for determining usual, customary and reasonable charges for each product/plan design
- _____ Mental health and/or substance use disorder and medical/surgical claim files.
- _____ Mental health and/or substance use disorder and medical/surgical utilization review procedures
- _____ Complaint files, logs and disposition notes
- _____ Documentation, including but not limited to comparative analyses, demonstrating that within each of the 6 classifications of benefits (and applicable sub-classifications), the as written and in operation processes, strategies, evidentiary standards, or other factors used in applying a NQTL are comparable to and applied no more stringently to mental health or substance disorder benefits than to medical/surgical benefits in the classification.

Other References

Enforcement of the Public Health Services Act
42 U.S. Code § 300gg–22

Preemption relating to the Public Health Services Act
42 U.S. Code § 300gg–23

Mental Health Parity and Addiction Equity Act of 2008
42 U.S. Code § 300gg–26

Publication of summary plan description
ERISA 104(b) (29 U.S.C. § 1024(b))

The Federal Parity Self Compliance Tool: <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf>

FAQs about Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 Part 45 (ACA FAQ 45): <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf>

Review Procedures and Criteria

Review the list of all NQTLs imposed on mental health/substance use disorders and choose a sample.

Review the health carrier’s comparative analyses to verify that within any classification of benefits, as written and in operation, the process, strategies, evidentiary standards, or other factors used in applying an NQTL to mental health or substance disorder benefits are comparable to, and are applied no more stringently than those used in applying the limitation with respect to medical/surgical benefits in the classification. The comparative analyses

shall include the following, for each NQTL applied to mental health or substance use disorder benefits, separately for each classification of benefits (42 U.S.C. § 300gg-26(a)(8)(A)):

- The specific coverage terms or other relevant terms regarding the NQTL and a description of all mental health or substance use disorder and medical or surgical benefits to which such NQTL applies in each respective benefits classification;
- The factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits;
- The evidentiary standards used for the factors identified, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits;
- The comparative analyses demonstrating that the processes, strategies, evidentiary standards and other factors used to apply the NQTL to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to medical or surgical benefits in the benefits classification; and
- The specific findings and conclusions reached by the health carrier with respect to the health insurance coverage, including any results of the analyses described in 42 USC 300gg-26(a)(8)(A) that indicate that the health carrier is or is not in compliance with 45 CFR 146.136(c)(4).

The health carrier's analyses must contain the following, at a minimum (ACA FAQ 45 Q2):

1. A clear description of the specific NQTL, plan terms and policies at issue;
2. Identification of the specific mental health or substance use disorder and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as mental health or substance use disorder and which are treated as medical/surgical;
3. Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both mental health or substance use disorder benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination;
4. To the extent the health carrier defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources;
5. The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the health carrier between mental health or substance use disorder and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation;
6. If the application of the NQTL turns on specific decisions in administration of the benefits, the health carrier should identify the nature of the decisions, the decision maker(s), the timing of the decisions and the qualifications of the decision maker(s);
7. If the health carrier's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the health carrier ultimately relied upon each expert's evaluations in setting recommendations regarding both mental health or substance use disorder and medical/surgical benefits;
8. A reasoned discussion of the health carrier's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the health carrier is or is not in compliance with MHPAEA; and
9. The date of the analyses and the name, title and position of the person or persons who performed or participated in the comparative analyses.

The health carrier shall avoid the following practices and procedures when responding to a request for comparative analyses (ACA FAQ 45 Q3):

1. Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis;

2. Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations;
3. Identification of processes, strategies, sources and factors without the required or clear and detailed comparative analysis;
4. Identification of factors, evidentiary standards and strategies without a clear explanation of how they were defined and applied in practice;
5. Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application; and
6. Analysis that is outdated due to the passage of time, a change in plan structure, or for any other reason.

STANDARDS
Mental Health and Substance Use Disorder Parity Compliance

Standard 6

The health carrier shall ensure that it complies with all availability of plan information and related disclosure obligations regarding: 1) criteria for medical necessity determinations; 2) reasons for denial of services; 3) information relevant to medical/surgical, mental health and substance use disorder benefits; 4) rules regarding claims and appeals, including the right of claimants to free reasonable access to and copies of documents, records and other information including information on medical necessity criteria for both medical/surgical benefits and mental health and substance use disorder benefits, as well as the processes, strategies, evidentiary standards and other factors used to apply a NQTL with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan, including any analyses performed by the carrier as to how the NQTL complies with MHPAEA.

Apply to: Certain group and individual health carriers offering mental health and substance use disorder coverage

Priority: Recommended

Documents to be Reviewed

- _____ Plan policies and procedures for responding to participant requests for medical necessity criteria for either or both mental health and substance use disorder services and medical/surgical services
- _____ Plan policies and procedures for responding to requests for information on the processes, strategies, evidentiary standards and other factors used to apply a NQTL with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan
- _____ Sample adverse benefit determination letters
- _____ Sample letters responding to disclosure requests for medical necessity criteria and information on NQTLs
- _____ Policies and procedures for classifying denials as administrative or medical necessity
- _____ Internal and external appeals files for mental health and substance use disorder services adverse benefit determinations
- _____ Log of disclosure requests, including date requested, date responses was provided, samples of documents sent in response

Other References

- 45 CFR § 146.136(d)
- ERISA 104
- 29 CFR § 2520.104b-1
- 29 CFR § 2560.503-1
- 29 CFR § 2590.715-2719

Review Procedures and Criteria

Review the health carrier's method for providing to any current or potential participant, beneficiary, or contracting provider upon request the medical necessity criteria used to make mental health or substance use disorder determinations (45 CFR § 146.136(d)(1)).

Review the health carrier's letters providing the reason for any denial of reimbursement for mental health or substance use disorder benefits and verify that the letters are dated within 30 days of the request (45 CFR § 146.136(d)(2)).

Review the health carrier's policy & procedure for responding promptly to requests for all documents, records and other information relevant to an adverse benefit determination, including medical necessity criteria and the comparative analysis required under (42 USC 300gg-26(a)(8)(A)), disclosures referenced above (45 CFR § 146.136(d)(3)) as referenced in ACA FAQ 45-Q6.

Document that the health carrier's claims processing and disclosure regarding adverse benefit determinations complies with the federal claims and appeals regulations (45 CFR § 147.136).

STANDARDS
Mental Health and Substance Use Disorder Parity Compliance

Standard 7

The health carrier as the entity is responsible for parity compliance. The health carrier shall ensure that management of mental health and substance use disorder benefits coverage as a whole complies with the applicable provisions of MHPAEA, including any vendor relationships. The carrier shall provide or require sufficient information in terms of plan structure and benefits to or from any vendor to ensure that the mental health and substance use disorder benefits are coordinated with the medical/surgical benefits for purposes of compliance with the requirements of MHPAEA.

Apply to: Certain group and individual health carriers offering mental health and substance use disorder coverage

Priority: Recommended

Documents to be Reviewed

_____ Contractual agreements between the carrier and vendors having administrative, claims and/or medical management responsibilities

_____ Policies and procedures for ensuring availability of health carrier information needed for vendor analysis of compliance with MHPAEA

_____ A narrative summary outlining how the vendor and the carrier coordinate benefit design and application to ensure compliance with MHPAEA

_____ Select written communications relevant to mental health and substance use disorder benefits between the carrier and the vendor

Other References

29 CFR § 2590.712(e).
75 FR § 5426
78 FR § 68250

Review Procedures and Criteria

Review the contractual agreements between the health carrier and any vendors providing administrative, claims and/or medical management responsibilities.

Review the health carrier's protocols and procedures to document that any contracted vendors are collaborating with the health carriers to satisfy compliance with MHPAEA. This shall include explanation of how both the design of benefits and the application of benefits, in operation, are compliant with MHPAEA.

Review any audits the health carrier has completed of its vendors to ensure compliance with MHPAEA.

Adopted by the Market Information Systems Research and Development (D) Working Group, Oct. 14, 2021

Adopted by the Market Information Systems (D) Task Force, June 16, 2022

Adopted by the Market Regulation and Consumer Affairs (D) Committee, Aug. 12, 2022

The Market Information Systems Research and Development (D) Working Group Review of Artificial Intelligence Techniques in Market Analysis

Executive Summary

This report fulfills the Market Information Systems Research and Development (D) Working Group charge to evaluate the potential benefits of artificial intelligence (AI) in relation to market analysis. After careful consideration, the Working Group concluded that there may be possible benefits to improve analysis techniques. Several caveats are discussed as well. AI may not be suitable for data currently available to state insurance regulators. In addition, some of the techniques perform complex data mining operations, which can produce results that lack a clear interpretation. Lastly, AI techniques are designed for, and many require, very large datasets. As such, AI should be contemplated in the context of a long-range plan, beginning with repairing known issues with existing data, and employing more rigorous traditional statistical techniques to assess predictive accuracy of analytical tools. Subsequently, state insurance regulators can consider the acquisition of data appropriate to AI.

Introduction

In early 2021, the Market Information Systems Research and Development (D) Working Group received a charge from the Market Information Systems (D) Task Force to explore possible applications of artificial intelligence (AI) methods in market analysis. An early difficulty encountered by the Working Group is that the term “AI” itself has a variety of contested meanings. In addition, private sector entities have adopted the term as a marketing concept and inappropriately apply the label to products simply as a selling point. As such, the term has come to acquire a variety of meanings and is an “essentially contested concept.”¹

At its most general level, the term “AI” implies machine capacities that mimic or are analogous to processes of human reasoning and learning and entail some degree of machine autonomy in which learning occurs without significant human intervention. Beyond this general description, the Working Group did not feel that an attempt to define the term more strictly would be fruitful. Rather, the term is employed simply as a shorthand reference for a collection of various techniques that algorithmically seek patterns in data that are predictive of some future outcome. Common methods include machine learning, neural networks, and decision tree analysis. These processes are often contrasted to the traditional hypothetical-deductive methods of model specification associated with classical statistics. However, there does not appear to be a bright line of demarcation so that a particular technique can be firmly fixed within either category.

¹ The term “essentially contested concept” was coined by W.B. Gallie in the seminal presentation to the Aristotelian Society in 1956.

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In addition, the Working Group focuses on what is commonly called “narrow AI,” in which machine algorithms are employed for narrowly defined and limited tasks. More advanced systems, called “general AI,” possess generalized autonomous problem-solving capacities that are comparable to the processes of the human brain, and they are able to adapt to novel situations or information (Macnish et al., 2019).

It is important to emphasize the ways in which AI modeling techniques contrast to the standard scientific model employed in classical or traditional statistics:

Classical Statistics: Method of hypothetical-deductive reasoning in which hypotheses are clearly and narrowly specified *prior* to data testing, often with a prior understanding of the underlying causal nature of the relationships between variables. **Purpose:** To further causal understanding.

AI: Often employs a type of “data mining” in which a machine pattern-seeking algorithm is released “into the wild” to identify possible correlations between variables that may be predictive of some independent variable. Hypotheses are not specified prior to data analysis, and the algorithm may very well identify correlations that would not have occurred to an analyst and whose causal relationship is constructed post-hoc (to the degree that AI users are concerned with causality at all). **Purpose:** Predict future outcomes or events.

The difference between these two approaches is not trivial, and significant disagreements about the advantages and disadvantages of AI remain. It is of note that AI did not emerge principally from university statistics departments, but rather from the field of computer science. Many statisticians remain skeptical of the techniques and have offered up a variety of caveats for their use. For example, recently the American Statistical Society (ASA) reacted to the “reproducibility crisis” afflicting some disciplines that have discovered, with much consternation, that a large volume of published works could not be replicated. The concern was that increasingly less rigorous statistical methods departing from the hypothetical-deductive approach were becoming more prominent in a variety of fields, undermining confidence on research findings. Remarking on departures from a rigorous hypothetical-deductive approach with “data mining” and like methods in which pattern seeking is largely ceded from a researcher to a machine, the ASA warned about improper inferences that might result from such techniques. The ASA centered its discussion on the p-value, related to the probability that some observed relationship occurred by chance along. A low p-value is often employed to minimize the probability that chance relationships will be misinterpreted as a relationship that is a meaningful, non-random outcome:

“Conducting multiple analyses of the data and reporting only those [analyses] with certain p-values...renders the reported p-values essentially uninterpretable. Cherry-picking promising findings, also known by such terms as data dredging, significant chasing, significance questions, selective inference and a ‘p-hacking’ leads to a spurious excess of statistically significant results...and should be vigorously avoided” (Wasserstein & Lazar, 2016).

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To translate the ASA's statement into more easily understood and less technical terms, the ASA is warning against *false positives* in which an analysis produces random or chance correlations between items that are not meaningfully related—that is, where a chance relationship is mistaken for a true causal relationship. That AI largely jettisons causal understanding as its primary goal (to the degree that causality is a concern at all) increases the probability that statistical results may be uninterpretable in any meaningful sense. This is clearly evinced by the increasing debate among state insurance regulators and insurers regarding the meaning of statistical relationships appearing in predictive models that lack intuitive or, in many cases, even plausible explanations. See Appendix A for further discussion of the ASA statement.

The discussion above is not intended to sway state insurance regulators one way or the other with respect to AI. The purpose is simply to proffer some caveats shared by many statisticians. A final caveat is the AI techniques were developed to analyze very large data sets consisting of millions of records and possibly thousands or tens of thousands of variables. It is said to have an advantage in that algorithms can perform a large volume of analyses across different constellations of variables in a way that would be highly impractical employing traditional (and manual) model building. For small data sets, such as the limited data currently available to market analysts, it is unclear whether the expense associated with developing AI techniques can be justified, nor whether AI is at all superior to traditional model building methods. This is not an unimportant point and is discussed in more depth elsewhere in this recommendation.

Current Status of Market Analysis

Quantitative market analysis relies on just a handful of data sources:

The Complaint Database System (CDS): The NAIC compiles complaints against insurers received by state insurance regulators. Thus, each state has access to a national-level database. Complaint indices are “normalized” by expressing the volume of complaints to premium, compared with the overall industry total.

The Regulatory Information Retrieval System (RIRS): Regulatory actions in relation to insurance entities are captured in the RIRS database. Actions range from intervention in financially troubled entities to violations of producers and insurance carriers. Each record identifies the cause of the action, as well as any orders, fines, or restitution amounts. The RIRS database is currently being substantially revised to capture significantly more detail.

The Market Actions Tracking System (MATS): The MATS database captures information pertaining to market conduct exams, as well as actions short of exams. Data captured include area of scrutiny (claims, underwriting, etc.) and the outcome of the market action (order, fine, etc.). By matching MATS actions with RIRS, additional detail about the nature of the violation can be assessed.

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The Market Conduct Annual Statement (MCAS): The MCAS was developed to capture data with the primary purpose of assessing an insurer's market performance and identify potential market irregularities. The data focus primarily on claims handling and underwriting, and data are scrutinized with respect to claims processing times and denials, nonrenewal and cancellation practices, and overall turnover in a book of business. Data are captured by line and coverage. To date, MCAS data are collected for life and annuities, private automobile, homeowners, health (both on and off the federally facilitated marketplace [FFM]), long-term care (LTC), lender-placed insurance, disability income, and private flood.

Miscellaneous Data Sources: Some financial data has been incorporated into market information systems. Insurers that are under financial stress, or that rapidly expand into or contract out of a line of business, or that exhibit high defense or other adjudication costs, may be subjected to additional analysis. While financial indicators are only indirect or proxy measures of potential market issues, and by themselves may have no clear market-based interpretation, interpretation within the context of a host of other indicators may be reflective of the present of a market-relevant issue.

The NAIC, in conjunction with state insurance regulators, has developed a broad scope "market score" that incorporates much of the data referenced above, which is made available to regulators via the Market Analysis Prioritization Tool (MAPT). One such data are "normalized" by the premium volume and scope of company operations as necessary. For example, several RIRS-based ratios express the volume of RIRS actions in relation to premium volume, the number of states in which they have significant premium, and a composite ratio that incorporates both premium and scope. Each ratio is given a score, and their contribution to the overall score weighted according to their perceived predictive relevance. For example, financial ratios are accorded significantly less weight than complaints, as their relationship to market misconduct is considered more speculative and indirect.

An important caveat is that predictive analytics is not well developed in market regulation. The ratios employed in the Market Analysis Review System (MARS) have not been subjected to rigorous statistical tests that demonstrate their analytic utility. While some work has been performed in this regard, such work is significantly hampered by a dearth of appropriate data. For example, future RIRS actions are often employed as the dependent variable (the outcome of interest to be predicted). However, this presents all manner of statistical challenges. While it is certainly reasonable to use prior outcomes (past RIRS actions) to predict future outcomes (the RIRS actions to be predicted), employing RIRS actions as both dependent and independent variable introduces significant complexities in the interpretation of any observed relationship between the two. One can imagine, for example, that the use of RIRS actions in market analysis invites greater scrutiny to a given insurer, and that in turn generates future regulatory actions precisely because the company received additional scrutiny. Companies that have no "prior offenses" fail to attract regulatory scrutiny, so that any infractions may escape regulatory action *for precisely that reason*. This problem is certainly not insurmountable, but it must be explicitly recognized in any model building exercise, whether with AI or with more conventional statistical techniques.

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In general, the paucity of rich data sources has significantly hampered the adoption of more rigorous analytical techniques. To return to RIRS, these data are not rich sources of detailed information. Schematics are not well designed “from the ground up.” Essential data are missing, such as line of business.

Any consideration of AI or any other analytical techniques must necessarily view the utility of such techniques within the context of available data. Regardless of the validity of a technique in general, it will have limited utility if data are themselves limited. Any recommendation to employ such methods must therefore at the same time recommend a thorough review of available data.

Importantly, results of quantitative analysis are always treated as merely suggestive and tentative and are regarded as at most a precursor to more qualitative analysis. It currently is employed to prioritize entities that may merit additional scrutiny and to narrow focus on a much more limited subset of companies out of a larger pool of companies. It therefore primarily prioritizes limited regulatory resources.

State insurance regulators avail themselves of the formal analytical processes adopted by the NAIC. Quantitative or “baseline” analysis identifies entities with anomalous indicators that significantly depart for industry-wide values. A “level 1” analysis may be pursued, in which an analyst devotes additional scrutiny to such things as complaint trends, common reasons complaints are lodged against an insurer, similarities in RIRS actions, etc. If concern still remains (or additional concerns are identified) subsequent to level 1 analysis, a structured level 2 analysis may be performed. A level 2 analysis requires a much greater commitment of time and resources. For example, rather than just manually reviewing complaint data to identify patterns, an analyst may manually review actual complaint documentation to garner a more detailed understanding of the nature of complaints.

As a preliminary to the following discussion, AI/statistical analysis may have two primary functions within the context of the current market analysis structure:

1. More accurately identify companies that merit the additional expenditure of resources necessary to perform the more labor-intensive level 1 and level 2 analyses. Analysis processes that more efficiently identify problem companies for this purpose are by definition more effective and more effectively target resources by avoiding “false positives” (for lack of a better word).
2. Potentially, AI methods could assume many of the functions that are currently performed manually. For example, many of the pattern-seeking analysis performed by analysts in a level 1 review could conceivably be more efficient if automated. Potentially, AI could identify patterns that might elude a human analysis. A very advanced level of AI could perhaps assume complex analysis involved with manually reviewing complaint files and documents. However, while the possibility is raised here, it is not further pursued. That level of AI suitable for tasks may not even exist as yet, or if it does, it may be so specialized that it may not be available to state insurance regulators. Even if available, the likely enormous costs themselves would render them highly impractical.

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Whether such AI exists, is available at a practical cost, and can actually out-perform more conventional analyses are questions that the Market Information Systems Research and Development (D) Working Group is simply unable to satisfactorily address. The Working Group merely suggests initially limiting the scope of ambitions to a few methods that are commonly, if not universally, recognized as AI, such as machine learning or neural networks. More expansive or ambitious efforts may result in a fruitless search for “unobtainium.”²

Given very large data sets, well beyond what is currently available to market analysts, AI may have clear advantages to more conventional approaches. The slow, methodical, hypothetical-deductive approach that forms the core of conventional statistics may have advantages in terms of generating valid causal conclusions. However, AI may have certain advantages with respect to confronting the enormity of modern data. As AI is well-suited to performing much more expansive analysis and pattern-seeking routines over vast quantities of data, it may well identify predictive patterns that would have escaped conventional analysis or that are counterintuitive such that some hypotheses may never have occurred to an analyst employing a standard hypothetical-deductive approach. However, there are distinct disadvantages as well, and they are shared by other approaches often termed “data mining.” The fact is that patterns may lack an intuitive meaning, and the manner in which such patterns are identified and render interpretation may be unclear. Additionally, patterns may generate numerous “false positives,” apparent patterns or correlations that are purely random and possess no meaning or any real predictive power whatsoever. This is not fatal for AI techniques, but it introduces much in the way of caveats and requires significant remedial measures to be employed. This problem is so significant that it merits a much fuller discussion in a separate section below.

The Work of Market Information Systems Research and Development (D) Working Group

The Working Group solicited input from various parties. Two parties delivered presentations to the Working Group:

1. On June 16, 2021, the Working Group discussed a presentation regarding AI methods currently being explored by NAIC staff to predict which insurers are likely to experience financial stress, including insolvency. Beginning in January 2021, an outside consulting group was retained to develop both AI as well as more traditional statistical techniques to construct predictive models of insolvency risk. The efforts are ongoing at the time of writing. Presenters believed the methods were promising and could significantly advance financial risk surveillance. Among AI and statistical models explored were decision tree analysis, generalized linear models (GLMs), and logistic regression.

² A tongue-in-cheek term originating among engineers in the 1950s. It is defined by Wikipedia as “... any hypothetical, fictional, or impossible material, but it can also mean a tangible but extremely rare, costly, or reasonably unobtainable material. Less commonly, it can refer to a device with desirable engineering properties for an application, but which are exceedingly difficult or impossible to achieve.”

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2. During the Working Group's June 21, 2021, meeting, Birny Birnbaum (Center for Economic Justice—CEJ) encouraged the Working Group to adopt a long-term perspective and develop a multiyear plan to explore AI techniques that might be beneficial to market analysis. He also indicated that state insurance regulators have to date failed to acquire granular transactional data that could be exploited by AI methods to afford a much more robust surveillance system to reduce consumer harm to the extent possible.

After the meeting, the Working Group convened a subject-matter expert (SME) group with the intent of creating a draft recommendation to be submitted to the Working Group.

Recommendations

The Working Group recommends developing a long-range plan, in a sequence of five steps.

I. Existing Market Analysis Data

As noted above, market analysis suffers from a paucity of detailed data. Some movement in expanding data and remedying deficiencies was made with a complete redesign of the RIRS data, which will facilitate analysis of factors related to an entity sanctioned by state insurance regulators. If implemented, RIRS will also capture much more detailed data related to the specific misconduct that garnered a regulatory response. The RIRS proposal is currently under discussion with the Market Information Systems (D) Task Force, to which Working Group reports.

The remainder of available data also suffers from significant deficiencies. Insurers employ a variety of definitions to produce MCAS data. Even such a fundamental concept as a “claim” is reported differently by different insurers, making market-wide analysis challenging. For example, the MCAS defines a claim in the conventional sense of “a demand for payment.” Investigation by the Missouri Department of Commerce & Insurance (DCI) has determined that the definition is interpreted in wildly divergent ways across the industry that simply makes meaningful comparison impossible and renders key market indicators or ratios largely meaningless. Some insurers set up a claim on a coverage that is reasonably related to the facts of the incident as relayed by a claimant. Other insurers set up all possible coverages on a policy as a claim in their internal systems regardless of whether those coverages might be reasonably implicated in a claim. As might be imagined, those carriers have significantly higher ratios of claims closed without payment. This and other issues remain with the MCAS and significantly impair market analysis.

Recommendation 1: Survey currently available market analysis data, and identify substantive deficiencies based on the nature and substance of the data elements collected. Ensure that all data are consistently reported across insurers to the degree practical and ensure adherence to definitions of data elements.

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II. Existing Methods of Market Analysis

Current quantitative methods of market analysis are largely based on *ad hoc* and *intuitive* understanding of how data indicators might be related to market misconduct. For example, one of the earliest indicators developed are complaints received by state insurance regulators regarding insurers. It is probably not unreasonable to interrogate complaint data to identify trends over time, as well as just overall complaint volume, to attempt to identify potential problems in a market. Similar indices consider the volume of RIRS actions, as well as the gravity of infractions in terms of potential consumer harm. It is the opinion of many state insurance regulators that such indicators possess a rational relationship to market misconduct and are relevant to identify market actors that might benefit from a heightened level of regulatory scrutiny.

While the Working Group agrees with the rationale behind such market indicators, analytical tools have not to date been subjected to more rigorous statistical methods to clearly identify the predictive power and assess their relative importance or weight. For example, the MAPT, maintained by the NAIC and available to state insurance regulators, employs overall insurer scores based on various indicators. However, the weight of these indicators employed in the score were assigned by state insurance regulators based on experience, as well as assessment of whether a likely relationship have a clear rational meaning. For example, complaint ratios are weighted significantly more heavily than things like financial indicators. The Working Group believes subjecting the scoring system to rigorous statistical analysis could yield significant benefits in identifying problem market actors.

Recommendation 2: In conjunction with recommendation 1 (assess data quality), state insurance regulators should adopt a much more rigorously statistical approach to identify the predictive power of market scoring systems, assess how each variable should be weighted in terms of its unique contribution to productiveness, and drop those that lack analytic utility. In addition, effort should be made to integrate data into a single overall analysis. For example, the MAPT does not incorporate MCAS data, which is typically subject to a separate analysis. The Working Group believes that a “piecemeal” approach is likely less effective than a more integrated approach.

It is noted that the current state of data will likely prove limiting and that such efforts may not make much progress until additional data are made available (such as the proposed revisions to the RIRS data, currently subject to NAIC discussion).

III. Available Approaches: Exploring AI

In addition to more traditional statistical tools, such as various types of regression models and correlation analyses, AI may offer additional benefits. Some commercial statistical packages have incorporated AI methods. The statistics package SAS, which is widely used in both the private and

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public sectors, makes some AI techniques available in its standard statistical module.³ In addition, SAS has developed a module called Enterprise Miner, which incorporates both data mining and some lower-level AI routines. (For those familiar with the terms, it performs such things as decision-tree analysis, neural networks, and like forms of analyses). Other modules make machine learning available—a potentially powerful type of analysis that modifies prior predictive algorithms as new data become available.

Recommendation 3: In undertaking recommendation 2, incorporate various promising AI modes of analyses, as well as traditional statistical modeling. Constantly assess the precision of model outcomes relative to objectives such as identifying potential market issues.

IV. Qualitative Analysis

The current model of market analysis incorporates a multistage hierarchical structure. First, quantitative analysis such as that produced by the MAPT identifies potential market problems and narrows focus to entities that appear to exhibit potential areas of regulatory concern. Having narrowed down the focus of analysis to a much more limited pool of candidates, market analysts in the states engage in more manual or qualitative analysis of additional information sources. For example, an analyst may review a selection of complaint files to identify additional patterns of market behavior to better understand their nature and substance.

As noted above, AI techniques such as text analysis could potentially expand such exercises and improve the identification of concerning patterns at a deeper level, as well as assess ways to improve the efficiency of other qualitative tasks.

Recommendation 4: Assess ways AI can improve both the efficiency of *qualitative* analysis and facilitate pattern recognition across larger volumes of textual evidence, including most especially complaints, but perhaps other textual sources. For example, the “level 1” analysis formalized in NAIC market system may include a review of the “management discussion and analysis” of the financial annual statement.

V. Longer-Range Planning

As noted above, data mining and AI techniques were developed primarily as tools to analyze large volumes of data. For data past a certain magnitude, including especially those containing many hundreds or even thousands of variables, the traditional hypothetical-deductive cornerstone that is the cornerstone of traditional statistical inference may be ill-suited as well as cost-prohibitive in terms of

³ SAS is markets in “modules,” each consisting of a different suite of capabilities that can be tailored to a user’s need. For example, “base SAS” provides standard data handling programs. A “statistics module” provides a wide-ranging set of analytical routines.

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time and resources. If the purpose is solely prediction as opposed to causal understanding, AI can fine-tune predictive algorithms by testing relationships that may be unlikely to occur to a statistician employing causal modeling.

Currently, such large volumes of data are unavailable to market analysts, though they could potentially be obtained. More granular data pertaining to claims, underwriting, and other areas of company operations are routinely collected via the “standard data requests” adopted as a supplement to the *Market Regulation Handbook* and commonly employed in market conduct exams.

However, AI and data mining can churn up counterintuitive statistical relationships that defy ready interpretation. In addition, it is likely to detect proxy relationships that are not understood. Proxy relationships, in which a third variable is substituted for an underlying variable of interest, are often employed in statistical models. This is often due to the accessibility or cost of obtaining data of the actual causal variable of interest. However, when employed in traditional statistical analysis, the nature of the relationship between the proxy variable and the actual variable of interest is generally well understood. This is not true of AI techniques that employ or resemble data mining.

The techniques are also likely to generate some number of purely chance relationship, where a correlation is generated by random chance. Inferential statistics seek to minimize mistaking a chance relationship for a meaningful association. Typically, the use of a p-value requirement of 0.05 or less limits the probability of accepting a random relationship to no more than 5% of occurrences. However, a 5% threshold means that over time, false, or chance relationships will be misinterpreted of a true correlation.

This fact is not fatal for the use of AI in market analysis, but it does represent a strong caveat for those employing the techniques, at least those that share elements with data mining. Careful interpretations of p-values should recognize an increased possibility of false positives. Observed relationships should be assessed and validated over time to ensure correlations are stable. In addition, once relationships are identified via AI and found useful, standard statistical models should also be employed to test whether different techniques yield superior predictive power. Additional discussion of caveats is presented in the appendix.

That said, there is much potential of AI in market analysis, *assuming that additional, more granular, data are available*. As noted, such techniques are most suited for large datasets whose very size would make a standard statistical approach impractical just given the sheer number of possible correlations available for testing.

Recommendation 5: Systematically explore potential data sources suitable for AI techniques, with an eye for discovering patterns and relationships in relation to some well-defined outcome one is attempting to predict. This may be identifying entities that may merit additional regulatory scrutiny in a way that is currently done by the less sophisticated methods employed in the MAPT or with the

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MCAS. Larger volumes of data, such as the standard data requests, can be subjected to AI to identify problematic claims handling, underwriting, and other insurer practices.

Summary of Recommendations

Recommendation 1: Survey currently available market analysis data, and identify substantive deficiencies based on the nature and substance of the data elements collected. Ensure that all data are consistently reported across insurers to the degree practical, and ensure adherence to definitions of data elements.

Recommendation 2: In conjunction with recommendation 1 (assess data quality), state insurance regulators should adopt a much more rigorously statistical approach to identify the predictive power of market scoring systems, assess how each variable should be weighted in terms of its unique contribution to productiveness, and drop those that lack analytic utility. In addition, effort should be made to integrate data into a single overall analysis. For example, the MAPT does not incorporate MCAS data, which is typically subject to a separate analysis. The Working Group believes that a “piecemeal” approach is likely less effective than a more integrated approach.

Recommendation 3: In undertaking recommendation 2, incorporate various promising AI modes of analyses, as well as traditional statistical modeling. Constantly assess the precision of model outcomes relative to objectives, such as identifying potential market issues.

Recommendation 4: Assess ways AI can improve both the efficiency of *qualitative* analysis and facilitate pattern recognition across larger volumes of textual evidence, including most especially complaints, but perhaps other textual sources. For example, the “level 1” analysis formalized in NAIC market system may include a review of the “management discussion and analysis” of the financial annual statement.

Recommendation 5: Systematically explore potential data sources suitable for AI techniques, with an eye for discovering patterns and relationships in relation to some well-defined outcome one is attempting to predict. This may be identifying entities that may merit additional regulatory scrutiny in a way that is currently done by the less sophisticated methods employed in the MAPT or with the MCAS. Larger volumes of data, such as the standard data requests, can be subjected to AI to identify problematic claims handling, underwriting, and other insurer practices.

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Appendix: Caveats

Recently, some fields of scientific inquiry have experienced much consternation and hand-wringing due to the so-called “replicability crisis” resulting from the realization that many studies published in top-tier journals could not be replicated. In 2015, Open Science Collaboration published research into the replicability of psychological studies. Of the 100 studies that were subjected to testing, replications yielded statistically significant results in only 36% compared to 97% of the original publications (Open Science Collaboration, 2015). Similar reproducibility issues were found in other fields.

Attention was directed at quantitative methods, particularly those made possible by modern computing power. Researchers can run countless variations of models, including multiple different variables, cross-effects, and other tweaks, until they eventually produce positive or statistically significant results. The inevitable outcome of the lack of rigor of such methods is that many chance correlations will be mistaken for meaningful relationships.

Think of it this way. The probability of obtaining all heads from 10 flips of a fair coin is $1/1024$. So, if a researcher actually performed the experiment 1,024 times and obtained 10 heads at least once, it would obviously be improper to infer that the coin was a two-headed coin. Without knowledge of the total number of trials, one might reject the “null hypothesis” that the coin is fair, and results would be “statistically significant” with a p-value of $(1/1,024) = 0.00098$, well below the 0.05 maximum threshold to establish statistical significance. But the true p-value can only be calculated with knowledge of the total number of trials prior to obtaining the recorded result, such that the true p-value is well above the maximum threshold.

There are no allegations of willful misconduct so much as careless and sloppy methods, producing much introspection about how statistics methods are taught to scientists at colleges and universities. The problem is so significant that the following year, the American Statistical Association (ASA) released a statement regarding misuse of p-values and practices known as “p hacking” or “data dredging.” A letter from the ASA is reprinted below, with a link to the full statement (used with permission).

Really, this is a warning for state insurance regulators not to adopt a casual attitude about apparent relationships turned up by the methods. When such methods are employed, modelers should be on constant guard against mechanical interpretations of model outputs. It is important to fully understand what is going on in the “black box” of an AI algorithm, the results of all statistical tests performed, and the totality of processes generating final results.

A high number of false positives that prompt regulatory follow-up can risk draining away regulatory resources going down blind allies.

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AMERICAN STATISTICAL ASSOCIATION RELEASES STATEMENT ON STATISTICAL
SIGNIFICANCE AND
P-VALUES

Provides Principles to Improve the Conduct and Interpretation of Quantitative Science

March 7, 2016

The American Statistical Association (ASA) has released a “Statement on Statistical Significance and P-Values” with six principles underlying the proper use and interpretation of the p -value [<http://amstat.tandfonline.com/doi/abs/10.1080/00031305.2016.1154108#.Vt2XIOaE2MN>]. The ASA releases this guidance on p -values to improve the conduct and interpretation of quantitative science and inform the growing emphasis on reproducibility of science research. The statement also notes that the increased quantification of scientific research and a proliferation of large, complex data sets has expanded the scope for statistics and the importance of appropriately chosen techniques, properly conducted analyses, and correct interpretation.

Good statistical practice is an essential component of good scientific practice, the statement observes, and such practice “emphasizes principles of good study design and conduct, a variety of numerical and graphical summaries of data, understanding of the phenomenon under study, interpretation of results in context, complete reporting and proper logical and quantitative understanding of what data summaries mean.”

“The p -value was never intended to be a substitute for scientific reasoning,” said Ron Wasserstein, the ASA’s executive director. “Well-reasoned statistical arguments contain much more than the value of a single number and whether that number exceeds an arbitrary threshold. The ASA statement is intended to steer research into a ‘post $p < 0.05$ era.’”

“Over time it appears the p -value has become a gatekeeper for whether work is publishable, at least in some fields,” said Jessica Utts, ASA president. “This apparent editorial bias leads to the ‘file-drawer effect,’ in which research with statistically significant outcomes are much more likely to get published, while other work that might well be just as important scientifically is never seen in print. It also leads to practices called by such names as ‘ p -hacking’ and ‘data dredging’ that emphasize the search for small p -values over other statistical and scientific reasoning.”

The statement’s six principles, many of which address misconceptions and misuse of the p -value, are the following:

1. *P-values can indicate how incompatible the data are with a specified statistical model.*

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2. *P-values do not measure the probability that the studied hypothesis is true, or the probability that the data were produced by random chance alone.*
3. *Scientific conclusions and business or policy decisions should not be based only on whether a p-value passes a specific threshold.*
4. *Proper inference requires full reporting and transparency.*
5. *A p-value, or statistical significance, does not measure the size of an effect or the importance of a result.*
6. *By itself, a p-value does not provide a good measure of evidence regarding a model or hypothesis.*

The statement has short paragraphs elaborating on each principle.

In light of misuses of and misconceptions concerning p -values, the statement notes that statisticians often supplement or even replace p -values with other approaches. These include methods “that emphasize estimation over testing such as confidence, credibility, or prediction intervals; Bayesian methods; alternative measures of evidence such as likelihood ratios or Bayes factors; and other approaches such as decision-theoretic modeling and false discovery rates.”

“The contents of the ASA statement and the reasoning behind it are not new—statisticians and other scientists have been writing on the topic for decades,” Utts said. “But this is the first time that the community of statisticians, as represented by the ASA Board of Directors, has issued a statement to address these issues.”

“The issues involved in statistical inference are difficult because inference itself is challenging,” Wasserstein said. He noted that more than a dozen discussion papers are being published in the ASA journal *The American Statistician* with the statement to provide more perspective on this broad and complex topic. “What we hope will follow is a broad discussion across the scientific community that leads to a more nuanced approach to interpreting, communicating, and using the results of statistical methods in research.”

About the American Statistical Association

The ASA is the world’s largest community of statisticians and the oldest continuously operating professional science society in the United States. Its members serve in industry, government and academia in more than 90 countries, advancing research and promoting sound statistical practice to inform public policy and improve human welfare. For additional information, please visit the ASA website at www.amstat.org.

For more information:

Ron

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Wasserstein

Citations

Macnish, K., Ryan, M. & Stahl, B. (2019). Understanding ethics and human rights in smart information systems: A multi-case study approach. *The Orbit Journal*, 2(2), 1–34.

Open Science Collaboration. 2015. Estimating the reproducibility of psychological science. *Science*, 349(6251). <https://science.sciencemag.org/content/349/6251/aac4716>

Wasserstein, R.L., & Lazar, N.A. (2016). The ASA statement on p-values: Context, process and purpose. *The American Statistician*, 70(2), 129–133.

Draft: 3/22/22

Adopted by Market Regulation and Consumer Affairs (D) Committee, Aug. 12, 2022

Adopted by Producer Licensing (D) Task Force, May 5, 2022

DRAFT FOR DISCUSSION
GUIDELINES FOR AMENDING THE UNIFORM LICENSING APPLICATIONS

The mission of the Producer Licensing (D) Task Force includes the development and implementation of uniform standards with a primary emphasis on encouraging the use of electronic technology. As part of this mission, the Task Force has appointed a Producer Licensing Uniformity (D) Working Group to “review and update, as needed, the NAIC’s uniform producer licensing applications and uniform appointment form.” In support of this mission and charge, the Producer Licensing (D) Task Force recognizes the importance of having stable, streamlined, and consistent NAIC’s Uniform Producer Licensing Applications, which comply with the statutes and regulations of the NAIC Membership and encourage the use of electronic technology in the most efficient manner.

In support of this mission and the importance of maintaining stable and consistent NAIC Uniform Licensing Applications, the Producer Licensing (D) Task Force will use the following guidelines for substantive changes to the NAIC’s Uniform Licensing Applications.

1. On a biennial basis, the Producer Licensing (D) Task Force will send an email communication by Dec. 1, to members of the Producer Licensing (D) Task Force, interested regulators, interested parties, and state producer licensing directors, asking for proposed changes to the NAIC Uniform Licensing Applications. The requested changes are to be submitted as a Word document using the NAIC Uniform Licensing Application Change Request form. The form should be completed in its entirety, attached to an email message, and directed and submitted to the NAIC staff providing primary support for the Producer Licensing (D) Task Force. All requests should be submitted by Feb. 1.
2. If the Producer Licensing (D) Task Force recommends further analysis of the request, the Task Force will assign the request to the Producer Licensing Uniformity (D) Working Group by the close of the NAIC Spring National Meeting. The Working Group will review the request using the following guiding questions:
 - a. Does the proposed change maintain the NAIC Membership’s mission of uniform licensing standards with a primary emphasis on encouraging the use of electronic technology?
 - b. Does the proposed change serve the regulatory purpose of strengthening consumer protection while maintaining an efficient licensing process for producer applicants? This should include documentation on why the existing Uniform Applications do not meet these objectives.
 - c. Does the proposed change comply with the statutes and regulations of the NAIC Membership and encourage the use of the NAIC’s Uniform Applications in all jurisdictions?
3. The initial comment period on exposure drafts issued by the Producer Licensing Uniformity (D) Working Group should be 30 calendar days. The Working Group may consider additional exposure periods of less than 30 days for revisions to the same draft.
4. Revisions to the NAIC’s Uniform Applications should be adopted by the Producer Licensing Uniformity (D) Working Group and the Producer Licensing (D) Task Force by the close of the NAIC Summer National Meeting.¹
5. If the Producer Licensing Uniformity (D) Working Group recommends a requested change not be pursued, the request will be updated with that decision and filed for future reference. A copy of the recommendation and decision will be provided to the requestor.
6. If the Producer Licensing Uniformity (D) Working Group recommends proceeding with a requested change, NAIC staff providing primary support for the Producer Licensing (D) Task Force will coordinate with NIPR and States, including

¹The dates and meetings set forth herein pertain only to the year in which the Producer Licensing (D) Task Force solicits proposed changes to the Uniform Licensing Applications as described in item 1.

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back-office system support vendors, during the next 45 days, conduct an analysis culminating in the provision of a time and cost estimate for the Producer Licensing (D) Task Force's review and prioritization. Using staff analysis, the Producer Licensing (D) Task Force will identify an appropriate implementation date.

7. Revisions to the NAIC's Uniform Applications should be adopted by the Market Regulation and Consumer Affairs (D) Committee by Oct. 15, and the Executive Committee and Plenary by the conclusion of the NAIC Fall National Meeting.

NAIC Uniform Application Change Request

Date Submitted: _____

Name: _____

State: _____

E-Mail: _____

Phone: _____

Change Request to Following NAIC Uniform Application (Check all that apply)

- Uniform Application for Individual License/Registration
- Uniform Application for Individual License Renewal/Continuation
- Uniform Application for Business Entity Licensing Registration
- Uniform Application for Business Entity License Renewal/Continuation

Provide Concise Description of Proposed Change

Provide Reason for the Proposed Change

Provide Supporting Information Related to the Proposed Change

To Be Completed by NAIC Staff

Change Request ID #	Date Received	Estimated Hours	Recommendation

[Guidelines for Uniform Apps](#)

Section 1:
 Company Information

Antifraud Plan
 Repository
 Workflow

Action (Select 1):
 Create A New Plan
 Continue An In Process Plan*
 (*Plan Started But Not Submitted)
 Edit A Filed Plan

Note: When "Edit A Filed Plan" is selected, the system should automatically populate the fields in the system so they can be edited accordingly.

Action:
Enter Insurer NAIC Number (Parent Company Group Code)

Note: Once company code entered, the parent company name and all subsidiary company names (and individual company codes) should be displayed with boxes to select.

Data Field :
Company Address

Note: Would like company address in NAIC database to auto populate all address fields.

Data Field :
Company City

Note: Would like company address in NAIC database to auto populate all address fields.

Data Field :
State

Note: Would like company address in NAIC database to auto populate all address fields.

Data Field :
Company Zip Code

Note: Would like company address in NAIC database to auto populate all address fields.

Action:
Name of individual submitting antifraud plan on behalf of the insurer.

Data Field :
Submitter Contact Name

Data Field :
Submitter Contact Title

Data Field :
Submitter Phone Number

Data Field :
Submitter Email Address

Action :
This antifraud plan applies to the following companies: (Check all that apply)

Option:
 Select All Feature

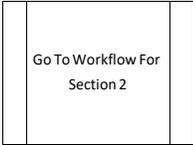
Note: Once company code entered, the parent company name and all subsidiary company names should be displayed so creator of plan can check all companies the plan applies to.

Action:
Check The Lines Of Authority For Which This Plan Applies: (Check all that apply)

Option:
 Select All Feature

Note: We would like the lines of authority associated with company code COAs selected to appear under this action item.

If it's not possible to pull the lines of authority, a check box system would be the next best option. The NAIC's COAA Lines of Authority document can be used to develop a list. We would also like companies to have the ability to file antifraud plans for different LOAs due to some companies having substantial differences in SIU operations for individual lines.



State Submission

Workflow

Action:
 This antifraud plan is to be submitted / made available to the following states / territories: (Check All That Apply)

Option:
 Select All States

Note: Would like the system to only display all states in which a company and it's subsidiaries are licensed. Would also like an asterick displayed for those states who require an anti-fraud plan.

Go To Workflow For
 Section 3

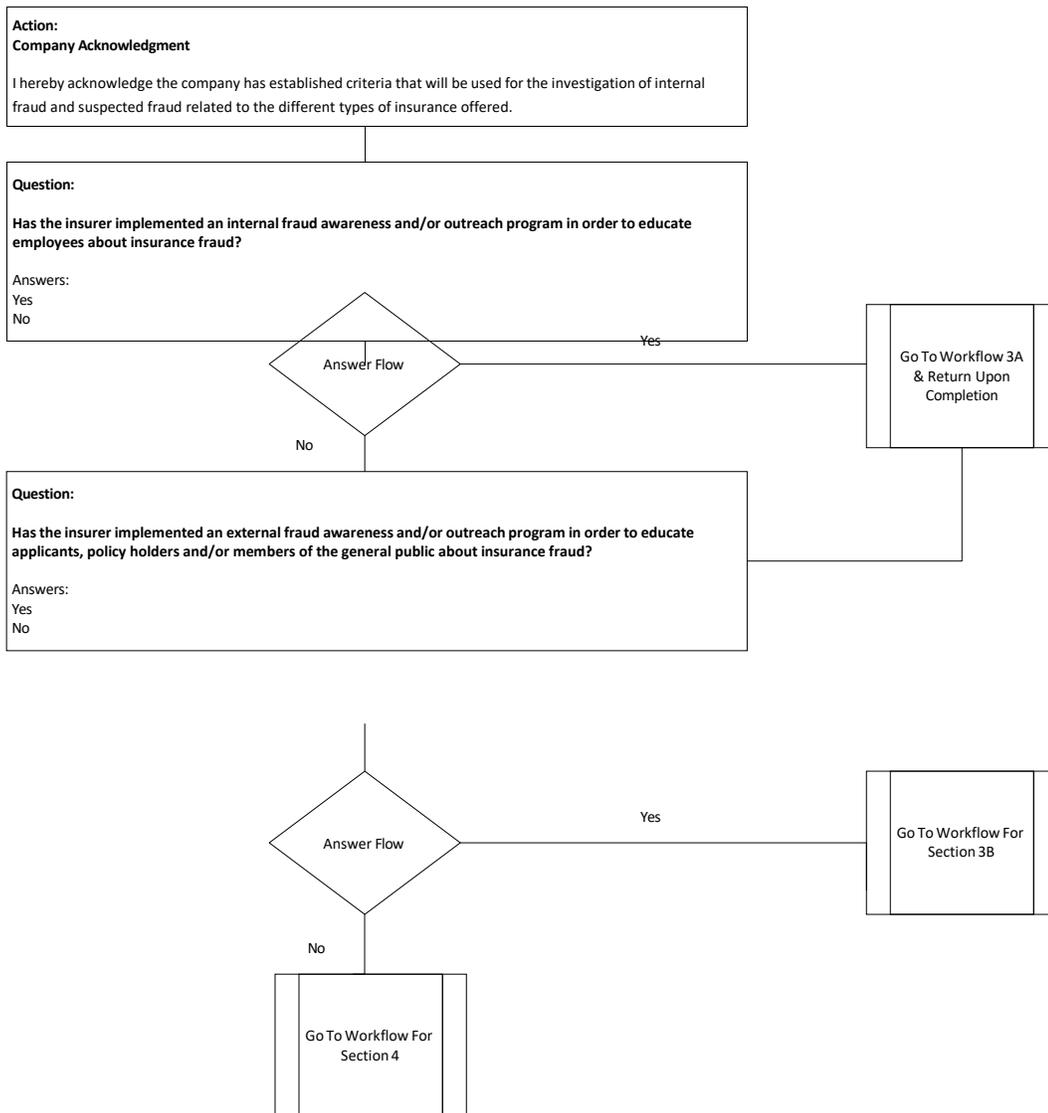
If auto-display not possible, the following states / territories should be displayed:

Alaska	Idaho	Massachusetts	North Dakota	Texas
American Samoa	Illinois	Minnesota*	Northern Mariana Islands	US Virgin Islands
Arizona	Indiana	Mississippi	Ohio	Utah*
Arkansas*	Iowa	Missouri	Oklahoma	Vermont
California*	Kansas*	Montana	Oregon	Virginia
Colorado	Kentucky*	Nebraska	Pennsylvania	Washington*
Connecticut	Georgia	Nevada	Puerto Rico	West Virginia
Delaware	Guam	New Hampshire*	Rhode Island	Wisconsin
District of Columbia*	Louisiana	New Jersey	South Carolina	Wyoming
Florida*	Maine	New Mexico	South Dakota	
		New York		

*Denotes antifraud plan required

Investigation Of Fraud

Workflow



Antifraud Plan Repository
Workflow

Section 3A (Alternate Choice):
Internal Antifraud Awareness

Action:

Provide a description of the insurer's internal awareness / antifraud education and training initiatives of any personnel involved in antifraud related efforts. Insurers should include all of the following when providing their description:

- *An overview of antifraud training provided to new employees.
- *An overview of the internal positions the insurer offers regular education and training, such as underwriters, adjusters, claims representatives, appointed agents, attorneys, etc.
- *A description of the various training topics covered with employees.
- *The method(s) in which training is provided.
- *The frequency and minimum number of training hours provided.

NOTE: A free form box with unlimited text allowance should appear beneath the overview so the insurer has the ability to provide a general narrative before getting into the added sections. The ability for spell check would be preferred as well.

Action:

Describe the various method(s) in which internal employees can report suspected fraud.

NOTE: This should be a free form box with unlimited text allowance. The ability for spell check would be preferred as well.

Go To Workflow For
Section 3B

Antifraud Plan Repository
Workflow

Section 3B:
External Awareness

Action:
Provide a description of the insurer's external fraud awareness or outreach program(s) geared towards applicants, policy holders and members of the general public.
NOTE: This should be a free form box with unlimited text allowance. The ability for spell check would be preferred as well.

Action:
Describe the various method(s) in which policyholders and members of the general public can report suspected fraud.
NOTE: This should be a free form box with unlimited text allowance. The ability for spell check would be preferred as well.

Go To Workflow For
Section 4

Corporate Policy Regarding Internal Fraud

Workflow

Action:
 Provide a description of the insurer's corporate policies for preventing, detecting and investigating suspected internal fraud committed by company employees, consultants or others, such as underwriters, claims representatives, appointed agents, etc.
 NOTE: This should be a free form box with unlimited text allowance. The ability for spell check would be preferred as well.

Action:
 Provide a description of the company's internal fraud reporting policy.
 NOTE: This should be a free form box with unlimited text allowance. The ability for spell check would be preferred as well.

Action:
 Identify the position and/or person(s) within the organization who is ultimately responsible for the investigation of internal fraud.

Data Field:
Position Title(s)
 Note: Companies may have more than one person responsible, therefore we need the ability to add multiple position titles and contact information for multiple individuals. .

Does the insurer wish to provide contact information for the individual(s) responsible?

Yes

Data Field:
Name:
Data Field:
 Note: Enable below noted data fields for contact ~~Telephone Number~~ is provided.
 Note: This field is only activated if the name of the person responsible is provided.

Data Field:
Address:
Data Field:
 Note: This field is only activated if the name of the ~~Email Address~~ is provided.
 Note: This field is only activated if the name of the person responsible is provided.

Data Field:
City:
 Note: This field is only activated if the name of the person responsible is provided.

Data Field:
State:
 Note: This field is only activated if the name of the person responsible is provided.

Data Field:
Zip Code:
 Note: This field is only activated if the name of the person responsible is provided.

Overview:
 Insurer's are required to provide a description of their standard operating procedures (SOP) for investigating internal fraud. Insurers will be able to provide a description of their SOP and/or upload an organizational chart.

Would the insurer like to provide a description?

Yes

Action:
 Provide a description of the company's standard operating procedures (SOP) for investigating internal fraud.
 NOTE: This should be a free form box with unlimited text allowance. The ability for spell check would be preferred as well.

No

Does the insurer wish to upload an SOP related to the investigation of internal fraud?

Yes

Action:
 Insurer given ability to upload documents.
 NOTE: Insurer's should have the ability to upload multiple documents.

Action:
 Provide a description of the reporting procedure the company will follow upon a criminal and/or insurance law violation being identified as the result of an internal investigation conducted (i.e. agent misconduct, referral to Fraud Unit or law enforcement, etc.).
 NOTE: This should be a free form box with unlimited text allowance. The ability for spell check would be preferred as well.

Go To Workflow For Section 5

Corporate Policy Regarding Fraud Prevention / Identification Of Suspected Fraud

Workflow

Action:

Provide a description of the insurer's corporate policies for preventing fraudulent insurance acts committed by first or third party claimants, medical or service providers, attorneys, or any other party associated with a claim.

NOTE: A free form box with unlimited text allowance should appear beneath the overview so the insurer has the ability to provide a general narrative before getting into the added sections. The ability for spell check would be preferred as well.

Action:

Provide a description of the technology and/or detection procedures the insurer has put in place to identify suspected fraud.

NOTE: This should be a free form box with unlimited text allowance. The ability for spell check would be preferred as well.

Question:

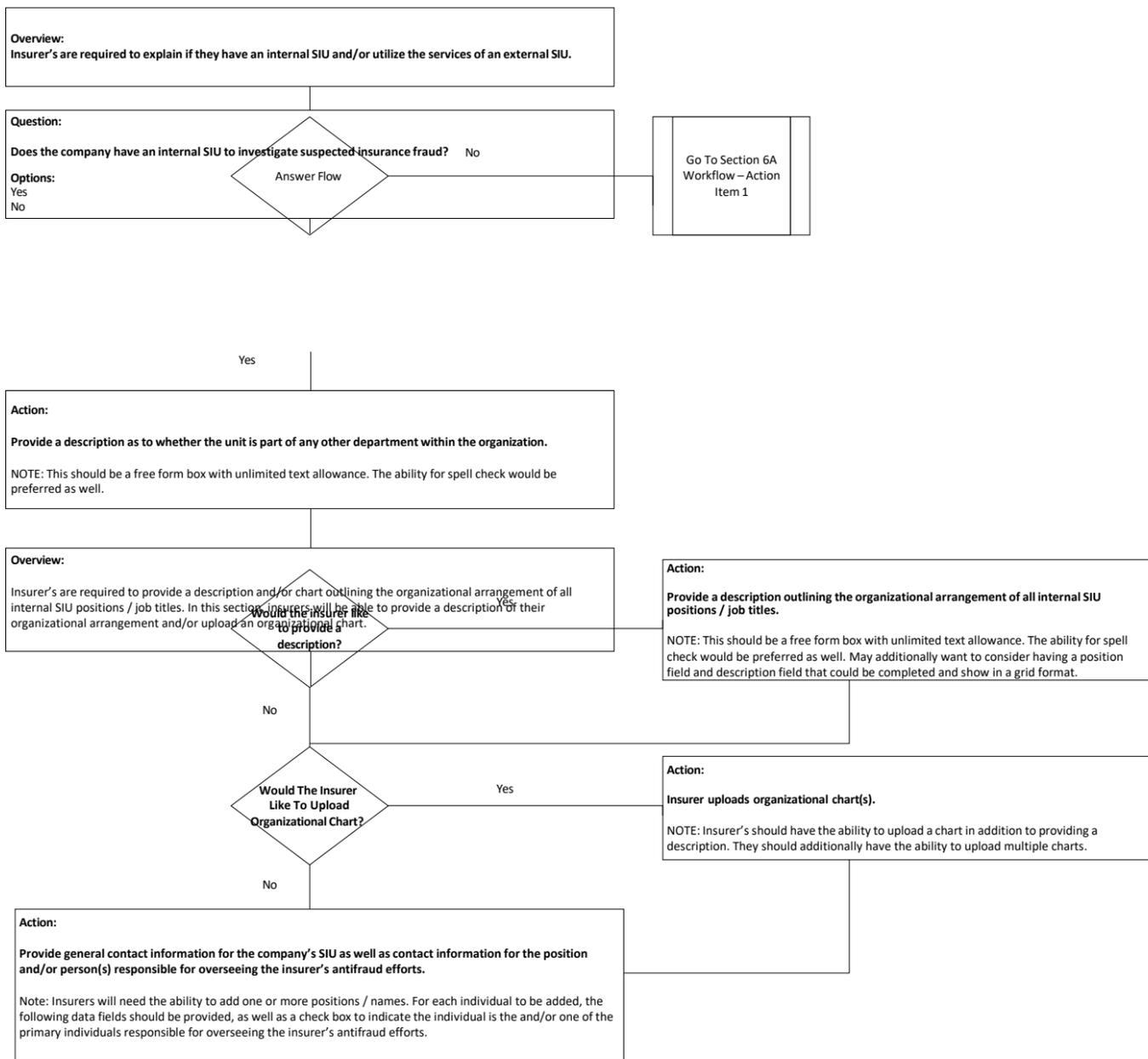
What criteria is used to report suspicious transactions and/or claims of insurance fraud for investigation to the insurer's SIU?

NOTE: This should be a free form box with unlimited text allowance. The ability for spell check would be preferred as well.

Go To Workflow For
Section 6

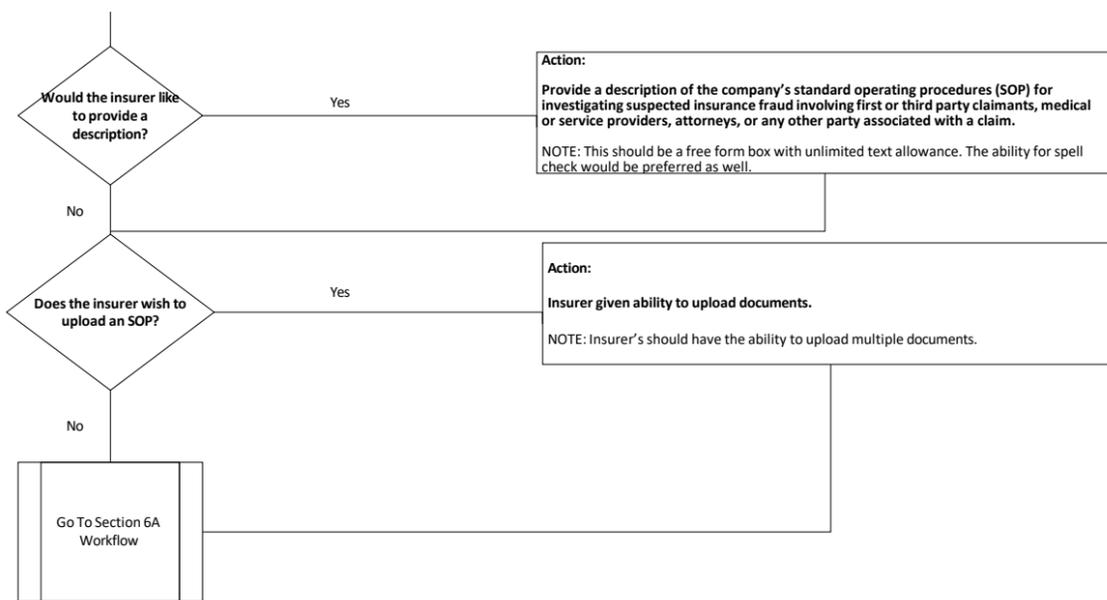
Section 6:
 SIU Overview

Antifraud Plan Repository
 Workflow



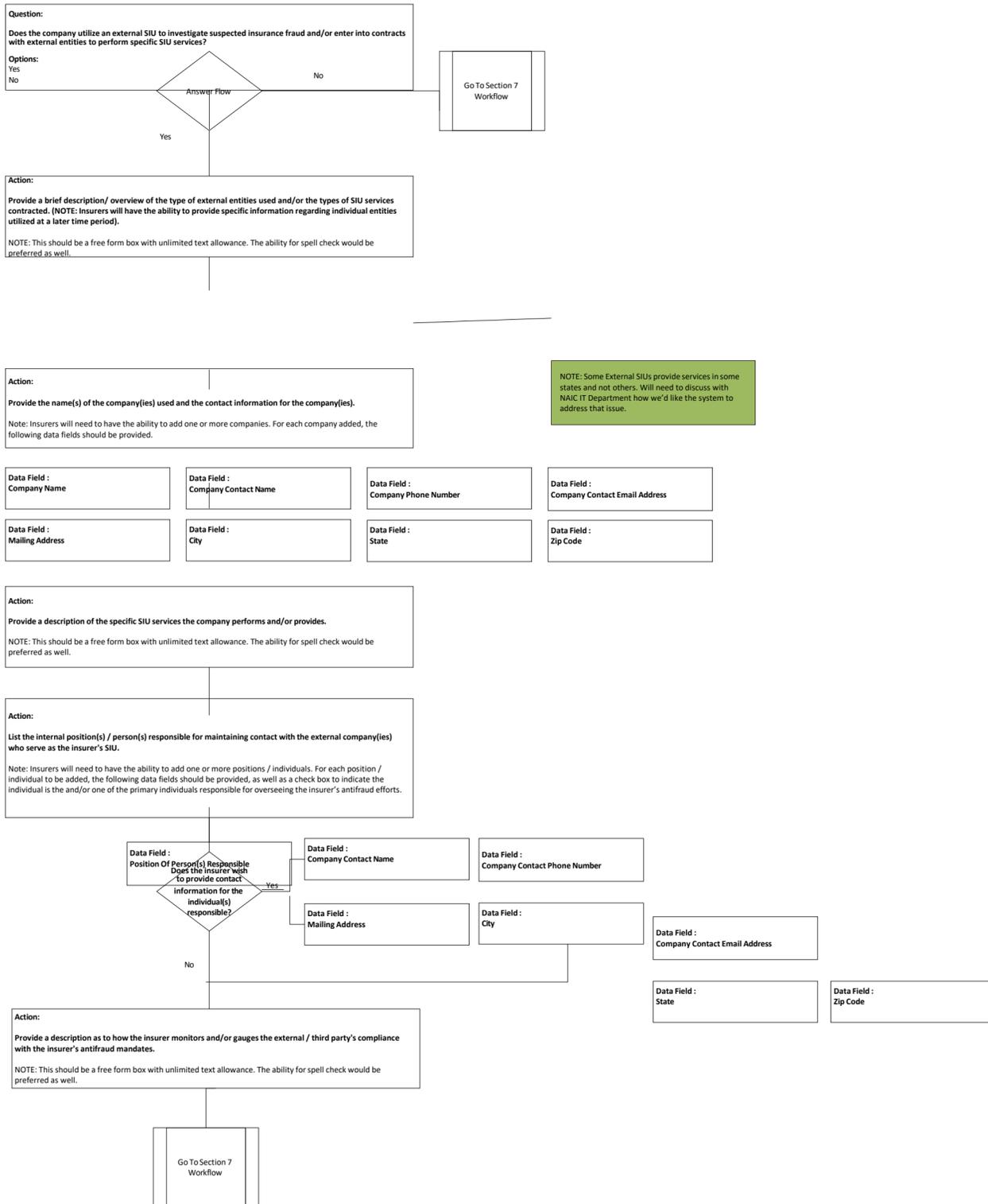
Data Field : Company Contact Title	Data Field : Company Contact Name	Data Field : Company Contact Phone Number	Data Field : Company Contact Email Address
Action: This individual is responsible for overseeing the insurer's antifraud efforts.	Data Field : City	Data Field : State	Data Field : Zip Code
Mailing Address			

Overview:
 Insurers are to provide a description of the insurer's standard operating procedures (SOP) for investigating suspected insurance fraud involving first or third party claimants, medical or service providers, attorneys, or any other party associated with a claim.
 Insurers will be able to provide a description of their SOP and/or upload their SOP for investigating suspected insurance fraud.



Section 6A:
 Overview Of External SIU

Antifraud Plan Repository
 Workflow



Methods Used To Document Referrals & Investigations

Workflow

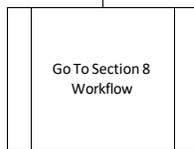
Action:

Provide a description of the method(s) used to document SIU referrals received and investigations conducted. When providing a description, the following should be included:

*An overview of any case management system and/or computer program used to memorialize SIU referrals received and investigations conducted.

*An overview regarding the manner in which the insurer tracks SIU / investigative information for compliance purposes (i.e. number of SIU referrals received, number of investigations opened, outcome of investigations conducted, etc.)

NOTE: This should be a free form box with unlimited text allowance. The ability for spell check would be preferred as well.



Reporting Of Suspected Fraud

Workflow

Action:
 Provide a description of the procedures the insurer has established to ensure suspected insurance fraud is timely reported to state departments of insurance and/or law enforcement as required by law.
 NOTE: This should be a free form box with unlimited text allowance. The ability for spell check would be preferred as well.

Action:
 Identify the position(s) and/or person(s) responsible for reporting suspected fraud on the insurer's behalf?
 (Note: In lieu of employee names, specific position descriptions may be cited.)
 Note: Insurers will need the ability to add one or more positions / names. For each individual to be added, the following data fields should be provided.
 Note: Companies may have more than one person responsible, therefore we need the ability to add multiple position titles and contact information for multiple individuals.

Data Field :
Position Title(s)

Does the insurer wish to provide contact information for the individual(s) responsible?

Yes

Data Field :
Company Contact Name
 Note: Enable below noted data fields for contact information if a name is provided.

Data Field :
Company Contact Phone Number
 Note: Enable below noted data fields for contact information if a name is provided.

Data Field :
Company Contact Email Address
 Note: Enable below noted data fields for contact information if a name is provided.

No

Data Field :
Mailing Address
 Note: Enable below noted data fields for contact information if a name is provided.

Data Field :
City
 Note: Enable below noted data fields for contact information if a name is provided.

Data Field :
State
 Note: Enable below noted data fields for contact information if a name is provided.

Data Field :
Zip Code
 Note: Enable below noted data fields for contact information if a name is provided.

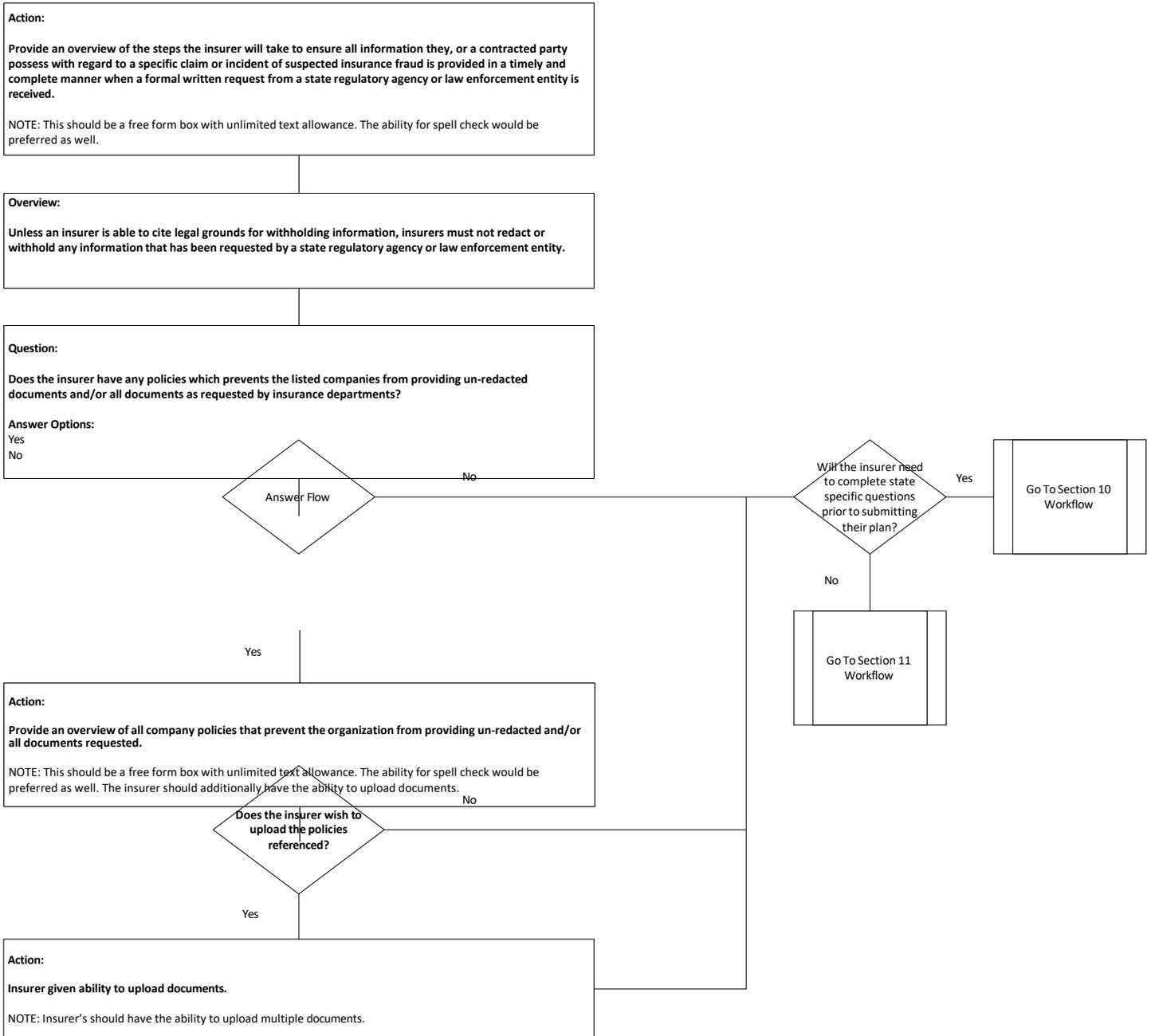
Action:
 Provide a description of the insurer's criteria or threshold for reporting fraud to state departments of insurance.
 NOTE: This should be a free form box with unlimited text allowance. The ability for spell check would be preferred as well.

Question:
 How does the insurer report suspected fraud to state departments of insurance?
Answers: (Check All That Apply)
 NAIC Online Fraud Reporting System
 NICB Isonet System
 NHCAA SIRUS System
 Electronic State System / Website
 Other
 NOTE: If "Other" selected, a free form text box should appear so the insurer can provide details.

Go To Section 9
 Workflow

Providing Of Records

Workflow



State Specific Questions

Workflow

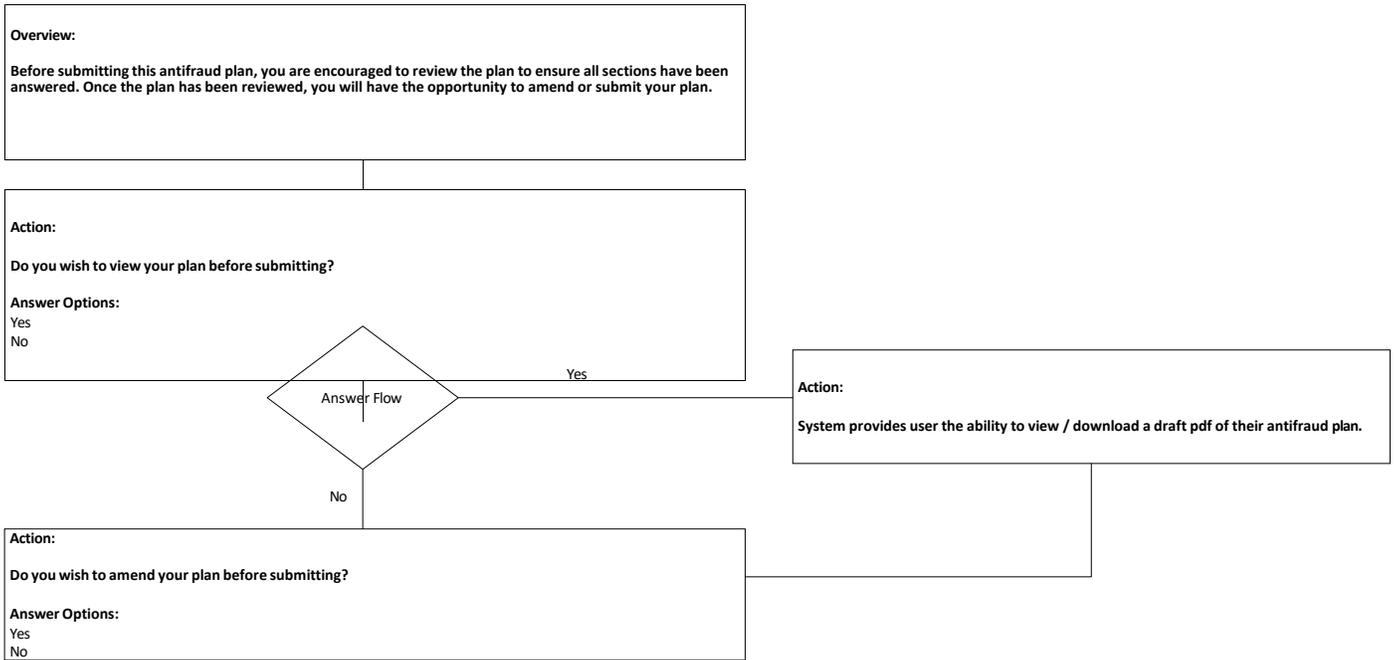
Overview:
The following states require insurers to answer state specific questions. Those states are:
i.e. Florida
Note: System to list those states checked in section 2 that have state specific questions. May wish to consult NIPR for how state specific questions are handled for producer licensing applications.

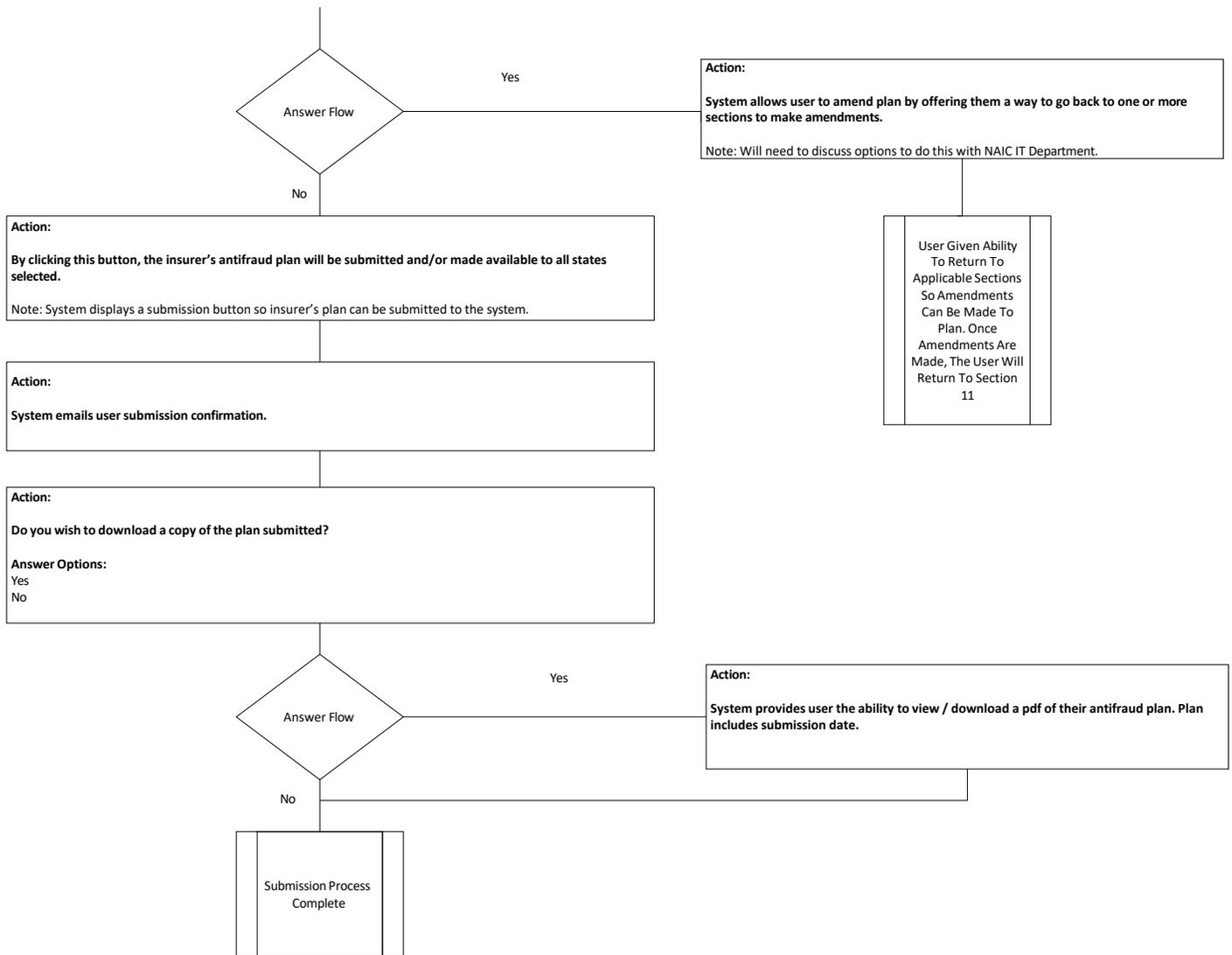
Action:
Insurer completes state specific questions for all applicable states.

Go To Section 11
Workflow

Submission Process

Workflow





Draft Pending Adoption

Attachment Nine
Market Regulation and Consumer Affairs (D) Committee
8/12/22

Draft: 7/27/22

Market Analysis Procedures (D) Working Group
Virtual Meeting (*in lieu of meeting at the 2022 Summer National Meeting*)
July 13, 2022

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met July 13, 2022. The following Working Group members participated: John Haworth, Chair (WA); Rebecca Rebholz, Vice Chair (WI); Tolanda Coker (AZ); Don McKinley (CA); Damion Hughes (CO); Steve DeAngelis (CT); Susan Jennette (DE); Scott Woods (FL); Erica Weyhenmeyer (IL); Tate Flott (KS); Sandra Stumbo (KY); Jeff Zewe (LA); Mary Lou Moran (MA); Dawna Kokosinski (MD); Timothy N. Schott (ME); Jeff Hayden (MI); Jo LeDuc, Cynthia Amann, and Teresa Kroll (MO); Martin Swanson and Robert McCullough (NE); Erin Porter (NJ); Leatrice Geckler (NM); Larry Wertel (NY); Todd Oberholtzer (OH); Shelly Scott (OK); Matt Gendron (RI); Rachel Moore (SC); Shelley Wiseman (UT); Will Felvey (VA); Karla Nuisl and Mary Block (VT); and Theresa Miller (WV). Also participating was: Shelli Isiminger (TN).

1. Adopted its June 8 Minutes

Mr. Haworth said the Working Group met June 8 and took the following action: 1) adopted the standard ratios for the Travel Insurance Market Conduct Annual Statement (MCAS) and the Short-Term Limited-Duration (STLD) MCAS; 2) considered new lines of business for the MCAS; and 3) considered improvements to the Market Analysis Review System (MARS).

Mr. Schott made a motion, seconded by Mr. Gendron, to adopt the Working Group's June 8 minutes (Attachment Nine-A). The motion passed unanimously.

2. Considered New Lines of Business in the MCAS

Mr. Haworth said suggestions have been made to add Pet Insurance, Title Insurance and business owner's policy (BOP) to the MCAS. He said the Working Group received comments from Rhode Island in support of Pet Insurance as the next line of business. He said Mr. Gendron provided some responses to the questions that need to be addressed per the "Process for Selecting New MCAS Lines of Business."

Mr. Haworth said Ms. Isiminger suggested adding Credit Life Insurance and Credit Disability Insurance to the MCAS. He said Ms. Isiminger also suggested adding data elements on Waiver of Premium (WoP) and Accelerated Death Benefits (ADB) to the Life MCAS blank.

Ms. Isiminger said credit life and credit disability insurance generate large profits for the companies writing, and the products are often marketed to and purchased by consumers least able to afford them. She said consumers often feel pressured to purchase the products even though it would be less expensive for them to shop around for the coverage. She said the lack of regulation leads to questions as to whether the consumers of the product are receiving the coverage they purchased. She noted there was very little, if any, regulation of the products.

Ms. Isiminger said WoP and ADB are either added as part of a life insurance policy or attached as a rider to the policy. She said she has seen WoP added to policies in an amount not sufficient to cover the entire premium. She said ADB coverage can be a very useful product for consumers, and the coverage keeps viatical companies at bay.

Draft Pending Adoption

Attachment Nine
Market Regulation and Consumer Affairs (D) Committee
8/12/22

She said it would be helpful to analyze whether consumers are being treated appropriately when they buy or make claims on WoP and ADB coverages.

Mr. Haworth noted that the request to add WoP and ADB data elements should be referred to the Market Conduct Annual Statement Blanks (D) Working Group.

John Euwema (Consumer Credit Industry Association—CCIA) said the suggestion to add credit insurance coverages to the MCAS was made and rejected by the Working Group in 2017 and 2018. He said nothing has changed in the credit insurance marketplace since then. He questioned why it should be considered again.

Birny Birnbaum (Center for Economic Justice—CEJ) said he supports adding credit life and credit disability insurance to the MCAS and offered his assistance.

Mr. Gendron said there are market conduct problems surrounding pet insurance. He said one issue is that the product is sold by companies that write many other lines of business, and because pet insurance is written as inland marine, there is no way to determine what premium is generated by their pet insurance products or even which companies may even be writing pet insurance without looking at all the form filings. He said pet insurance has grown rapidly in the last five years, especially as more people have purchased pets during the COVID-19 pandemic. Mr. Haworth noted that the only information available on pet insurance comes from the trade associations, and there is no way to verify the information. He said because of the uncertainty regarding the underwriters of the coverage, it is a challenge to identify what company a complaint is directed against.

Acting Superintendent Schott said Maine just passed legislation on pet insurance based on the *Pet Insurance Model Act* (#633). He said it would be very helpful to have pet insurance data.

Mr. Haworth said the Working Group would decide on the next line of business during its next meeting. Mr. Birnbaum said there was no opposition to adding pet insurance, and the suggestion has been exposed since the last Working Group meeting. Ms. LeDuc and Acting Superintendent Schott requested more time to review all proposals and John Fielding (Chubb) asked for additional time to allow the North American Pet Health Insurance Association (NAPHIA) the opportunity to comment.

Mr. Haworth asked for comments to be sent to Randy Helder (NAIC) by Aug. 12.

3. Discussed the Addition of Outstanding MCAS Lines of Business in the MARS

Mr. Haworth said since the last Working Group meeting, one comment was received from Tony Dorschner (SD) stating that South Dakota analysts often use the MARS to analyze companies seeking to expand their Certificate of Authority. He said South Dakota supports adding additional lines of business options to the MARS.

Mr. Haworth said the current lines available in the MARS are Credit, Homeowners, Long-Term Care (LTC), Medicare Supplemental, Workers' Compensation, Group Accident & Health (A&H), Individual A&H, Medical Professional, and Private Passenger Auto (PPA).

Ms. LeDuc said there are lines of business that do not have corresponding lines of business in the financial annual statement. Adding a line of business option in the MARS for those lines would be difficult. Mr. Haworth agreed, but he said state insurance regulators have MCAS data MARS does not have a designated Level 1 line of business available to perform analysis. He said this needs to be addressed.

Draft Pending Adoption

Attachment Nine
Market Regulation and Consumer Affairs (D) Committee
8/12/22

Mr. Haworth said he will work with Mr. Helder to re-draft the Working Group's Uniform System Enhancement Request (USER) form to forward to the Market Information Systems Research and Development (D) Working Group requesting an expansion of the lines of business options in the MARS and adding the outstanding MCAS data lines.

4. Discussed Other Matters

Mr. Haworth said Maria Ailor (AZ) sent a comment letter to the Working Group in support of adding the Travel Insurance loss ratio to the standard MCAS ratios for Travel Insurance. He said Ms. Ailor noted that the blank collects the total dollar amount of claims (line item 29) and the total direct written premium (line items 44, 45, and 46). He said even though some travel insurance policies are short-duration and others are long-duration, the loss ratio derived from the MCAS data would provide a good average for each state.

Mr. Oberholtzer said the Working Group should consider whether the information would have value for market analysts. He said he believes the information would be helpful for analysts in Ohio. Mr. Swanson agreed.

Mr. Birnbaum said this was originally proposed during the June 8 Working Group meeting. He said there is no annual statement line for travel insurance, and the loss ratio cannot be derived. He said the loss ratio is the accepted method for evaluating the value of an insurance product for consumers. He said calculating the loss ratio allows the market analysts to compare loss ratios across companies. Mr. Birnbaum also noted that while the public would only see a statewide loss ratio, the market analysts would have a more granular level of access, allowing for the tracking of loss ratios of time. He said this would be a very valuable ratio for analysts.

Mr. Birnbaum said the CEJ also requested that the volume of direct written premium, the average number of insureds, and the number of claims be presented along with the standard ratios for travel insurance. He said even if some market analysts may not find the information useful, other stakeholders may.

Ms. LeDuc asked what effort this would create for the NAIC to add the additional travel insurance ratio. Mr. Helder said the data elements are being created, and the work on adding the adopted ratios is still in progress, so it should not create difficulties.

Ms. LeDuc said since travel insurance consists of many different types of coverages, it may not make sense to aggregate them into one loss ratio. Mr. Birnbaum said travel insurance is sold as a package of products so the aggregate loss ratio reflects the value of the product.

Mr. Haworth asked for comments to be sent to Mr. Helder by Aug. 12.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.

Sharepoint/Member Meetings/D CMTE/2022 Summer National Meeting/MAPWG/0713/0713 MAPWG .docx

Draft: 6/16/22

Market Analysis Procedures (D) Working Group
Virtual Meeting
June 8, 2022

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met June 8, 2022. The following Working Group members participated: John Haworth, Chair (WA); Rebecca Rebholz, Vice Chair (WI); Crystal Phelps and Russ Galbraith (AR); Maria Ailor (AZ); Don McKinley (CA); Damion Hughes (CO); Kurt Swan (CT); Scott Woods (FL); Erica Weyhenmeyer (IL); Tate Flott (KS); Sandra Stumbo and Lori Cunningham (KY); Jeff Zewe (LA); Mary Lou Moran (MA); Dawna Kokosinski (MD); Timothy N. Schott (ME); Jeff Hayden (MI); Jo LeDuc and Teresa Kroll (MO); David Dachs (MT); Martin Swanson and Robert McCullough (NE); Edwin Pugsley (NH); Ralph Boeckman and Erin Porter (NJ); Peggy Willard-Ross (NV); Larry Wertel (NY); Todd Oberholtzer and Guy Self (OH); Landon Hubbard (OK); Jeffrey Arnold (PA); Brett Bache and Matt Gendron (RI); Michael Bailes (SC); Shelley Wiseman (UT); Will Felvey (VA); Karla Nuisl and Mary Block (VT); and Theresa Miller (WV).

1. Adopted its March 3 Minutes

The Working Group met March 3 and took the following action: 1) reviewed its 2022 charges; 2) discussed the proposed standard ratios for the Travel and Short-Term Limited-Duration (STLD) Market Conduct Annual Statement (MCAS) blanks; and 3) discussed incorporating the new MCAS lines into the Market Analysis Review System (MARS).

Ms. Weyhenmeyer made a motion, seconded by Ms. Rebholz, to adopt the Working Group's March 3 minutes (see *NAIC Proceedings – Spring 2022, Market Regulation and Consumer Affairs (D) Committee, Attachment Three*). The motion passed unanimously.

2. Adopted Standard Ratios for the Travel and STLD MCAS Lines of Business

Mr. Haworth said the proposed standard ratios for the Travel and STLD MCAS blanks were originally exposed prior to the Working Group's Nov. 18, 2021, meeting. He said at that time, the Working Group asked a group of subject matter experts (SMEs) to review and revise them as needed. The draft proposals are now exposed on the Working Group's web page.

Mr. Haworth said there are five proposed ratios for Travel and 11 ratios for STLD. He also noted that the drafting group made a couple suggestions for new data elements. He said the first suggestion is a new element for the Travel MCAS blank of "policies in force during the reporting period" to assist in analyzing complaint trends from year to year and company to company. He said it would enable the Working Group to add a ratio measuring cancellations to policies in force during the period. He said the second data element is recommended for the STLD MCAS blank and is the "dollar amount of claims paid during the reporting period."

Mr. Haworth said the Working Group would focus on adopting the Travel and STLD ratios and consider the new data elements later.

Birny Birnbaum (Center for Economic Justice—CEJ) said the proposed Travel ratio #5 measuring complaints to premium during the period was not useful because of the difference in the average premiums for the different products offered by different insurers. He suggested that the denominator would be more effective if the

denominator was the average of the number of individuals insured at the beginning of the period and the number of individuals insured at the end of the period.

Lisa Brown (American Property Casualty Insurance Association—APCIA) said the drafting group considered Mr. Birnbaum's suggestion, but the group decided it did not work because most policies that are written are in force for time periods under a year. The two data elements suggested by Mr. Birnbaum does not yield an average. Ms. Brown said the lack of a good denominator for this ratio is the reason the drafting group suggested a new data element of "policies in force during the reporting period."

Ms. Ailor asked if there is time available to consider the new information provided or if there is a deadline to be met for adopting the ratios. Teresa Cooper (NAIC) said it is important that these are adopted soon so they can be entered into the system for next year, but an additional month would be possible. Ms. Nuisl agreed with Ms. Ailor that additional time would be helpful. Mr. Oberholtzer said he does not believe Mr. Birnbaum's comments should delay the adoption of the ratios. He said the drafting group spent time reviewing and coming up with the ratios that are proposed. Mr. Galbraith said comments were due in April, and now the Working Group will be delayed in deciding because of written comments received one day before the meeting. He said he would not want to see the Working Group set a precedent that anyone can submit comments long after the deadline for comments.

Ms. Weyhenmeyer suggested removing ratio #5 from consideration and only voting on the first four Travel ratios. Ms. Rebholz agreed with Ms. Weyhenmeyer. She said voting on the first four ratios would make sure some ratios are adopted regardless of any later decisions. Ms. Ailor said she also agrees with the idea, and she asked when new ratios can be introduced. Randy Helder (NAIC) said new ratios or modifications to other ratios still have time to be adopted. However, Ms. Cooper said any new data elements could not be effective until the 2024 data year.

Ms. Weyhenmeyer made a motion, seconded by Ms. Ailor, to adopt the first four Travel ratios. The motion passed unanimously.

Ms. Weyhenmeyer made a motion, seconded by Mr. Schott, to adopt the STLD ratios. The motions passed unanimously.

3. Discussed the Addition of Outstanding MCAS Lines of Business Data Elements to the MARS

Mr. Haworth said during the last Working Group meeting, the Working Group agreed to submit a Uniform System Enhancement Request (USER) form to the Market Information Systems Research and Development (D) Working Group to prioritize adding the Lender-Placed Insurance and Disability Insurance MCAS data elements to the MARS Level 1 set of questions. However, he noted that all the new MCAS lines of business need to be added to the MARS in time for the first collection of the data. He also said the MARS lines of business options are not broad enough to encompass each of the new lines of business added to the MCAS. For example, the new Travel MCAS would need to be completed under one of the available property/casualty (P/C) lines in the MARS.

Mr. Haworth said the Market Information Systems Research and Development (D) Working Group would like the Market Analysis Procedures (D) Working Group to expand on what should be required for the MARS to adequately meet the analysts' needs.

Mr. Dachs said he has had to use a different line of business in the MARS to do a Level 1 analysis on a line of business that is not an option in the MARS. He said the questions and data are not really on point. He said it would be useful to expand the line of business options in the MARS. Ms. Rebholz agreed that it would be helpful, but she does not know how difficult it would be to add the lines.

Mr. Haworth asked that comments be sent to Mr. Helder by July 11.

4. Considered New Lines of Business for the MCAS

Mr. Haworth said the Working Group needs to consider a new line of business for the MCAS, and he asked that suggestions be sent to Mr. Helder by July 11.

Mr. Birnbaum suggested three possible new lines of business for the MCAS. He said pet insurance has experienced tremendous growth and has doubled in size in the last four years. He said title insurance has \$20 billion in premium, and there is little review of the underwriting and claims handling for title insurance. Some states also allow title insurance policies to contain pre-dispute mandatory arbitration provisions. Finally, Mr. Birnbaum also suggested business owners insurance, which would limit policies under \$5,000 in premium covering small businesses who are similar to personal lines policyholders.

Mr. Gendron agreed with the pet insurance suggestion as a great way to gather information on these companies for analysis. He said pet insurance is reported as inland marine, and it is difficult to get premium volumes. Ms. Moran supported Mr. Gendron. Mr. Haworth said the market is larger than just "pet insurers." He said there are only a small number of specialized pet insurers, but many companies market pet insurance under different branding. He said this is something to bear in mind if the Working Group moves forward on this.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings

Draft: 8/3/22

Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
July 21, 2022

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met July 21, 2022. The following Working Group members participated: Erica Weyhenmeyer, Chair (IL); Rebecca Rebholz, Vice Chair (WI); Maria Ailor (AZ); Scott Woods (FL); Heidi Walker (GA); October Nickel (ID); Tate Flott (KS); Lori Cunningham (KY); Dawna Kokosinski (MD); Jeff Hayden (MI); Jennifer Hopper, Jo LeDuc, and Teresa Kroll (MO); Martin Swanson (NE); Guy Self (OH); Jeffrey Arnold (PA); Rachel Moore (SC); Shelli Isiminger (TN); Shelley Wiseman (UT); Melissa Gerachis (VA); and John Haworth (WA). Also participating was: Mary Kay Rodriguez (WI).

1. Adopted its May 26 Minutes

The Working Group met May 26 and took the following action: 1) adopted its April 28 minutes; 2) adopted the life Market Conduct Annual Statement (MCAS) edits for accelerated underwriting (AU); 3) adopted the other health MCAS data call and definitions; 4) adopted edits to the lawsuit definition for the home and auto MCAS; and 5) reviewed its charges and process for submitting requests for edits to the MCAS data call and definitions.

Mr. Swanson made a motion, seconded by Mr. Haworth, to adopt the Working Group's May 26 minutes (Attachment Ten-A). The motion passed unanimously.

2. Heard a Presentation from AHIP and the BCBSA on a Filing Deadline Proposal for the Health MCAS

Samantha Burns (America's Health Insurance Plans—AHIP) stated she and Joseph Zolecki (Blue Cross Blue Shield Association—BCBSA) would be giving a presentation today, representing the health industry interested parties group. She stated the group is comprised of single and multistate licensed health insurers and administrators, representing comprehensive major medical and managed health care carriers of all sizes, across the U.S. Ms. Burns stated AHIP members share the NAIC's goal to deliver health MCAS and request having an annual filing date that is mutually satisfactory for state insurance regulators and health carriers. She stated having a uniform MCAS filing deadline should not outweigh the need for reporting useful and reliable data for the health MCAS.

Ms. Burns stated the health MCAS is fundamentally different from other MCAS lines of business; it is more complex and manual in nature and significantly more voluminous. She stated the request being made in this presentation is that the June 30 filing deadline be maintained as the permanent filing deadline for the health MCAS. She provided some history of the health MCAS and explained that in October 2019, the Working Group approved what was a compromise position to make June 30 the filing deadline for data submission years of 2020, 2021, and 2022, with an industry option to request a reevaluation of the deadline beyond 2022. She stated the filing deadline will revert to April 30 with the 2023 submissions for data year 2022 if the June 30 date is not extended. Ms. Burns stated the health line of business has more data and is less automated. She stated the health line of business has four times as many data elements as homeowners and life, three times as many as long-term care (LTC), and four or more times data stratifications as the other lines of business. She stated health carriers also processed significantly more claims than claims filed for other lines of business.

Mr. Zolecki stated health claims processing requires significant time. He stated one of the key drivers for the health MCAS is the Supplemental Health Care Exhibit (SHCE), which carriers must file by April 1. He stated this report is a baseline carriers use to determine which states and even which carriers require an MCAS report. He stated when a carrier pulls data, the data is broken out by sub-stratification, and that is a complex process because it goes across all the carriers' memberships and systems, which is why carriers typically use the account stratification from the SHCE as a starting point for the MCAS. Mr. Zolecki stated data is brought in from multiple data sources and that those processes vary by company. He explained that external data processing is a factor to consider because some of the more extensively regulated and restricted products, such as behavioral health, are disproportionately complex and time-consuming compared to other MCAS lines of business. He stated behavioral health data is often held externally, which requires initial data retrieval from external sources, data matching to existing members, and policies on carriers' internal databases, which is followed by multiple iterations of testing and validation to ensure overall data accuracy and completeness.

Mr. Zolecki stated the health line is further unique and complex due to the timing of other mandatory state and federal reporting requirements, which enhances the challenges with an April 30 deadline. He provided examples of the prescription drug data collection report, which is required by the federal Consolidated Appropriations Act, Section 204, which is due June 1, and the mandatory federal and state rate and filings that many health carriers are subject to for the federal Affordable Care Act (ACA), which further stress the carriers' resources and systems. He stated the electronic data transaction sets are significantly larger for health, which is a direct reflection of the complexity of health care as a business. Mr. Zolecki stated a lot of progress toward automating has been made, but he added that full automation is likely not possible anytime soon. He stated that each year, issuers review their business and the inputs to determine what should be considered in the annual filing, and that much of that work begins in the first quarter of the year in order to be fully inclusive. He stated extensive validation of the data is required and that extensive logic testing is performed. He stated the detailed validation is extremely time-consuming and necessary in order to produce the most accurate and complete health MCAS reporting. Mr. Zolecki stated the uploading process can be time-consuming because of file size limitations for larger carriers, and he added that the health MCAS is a statistical report, not a financial report. He stated health carriers have continued to receive requests from state insurance regulators to compare or correlate health MCAS information or scorecard ratios to financial annual statement information. He stated having additional education and training in this area would be beneficial for everyone.

Ms. Burns stated that given the vast amount of data that is required to produce the health MCAS, the June 30 deadline increases the accuracy and avoids false identification outliers that cause unnecessary and additional work for both carriers and state insurance regulators. She stated considering that market conduct exams are more targeted reviews initiated by outlier MCAS ratios, having a June 30 date to have more reliable data would be preferable and would likely decrease extension requests.

Mr. Haworth stated he thinks it would be best to proceed with the current plan to have the 2023 health MCAS deadline coincide with April 30 as that is the date that was previously discussed by the Market Regulation and Consumer Affairs (D) Committee, and it makes it a lot easier for national market analysis through other Working Groups to have it earlier in the year. He stated when data is received in June, verification goes through September. He stated they are finding companies that file their financial annual statements incorrectly and saying they offer products they do not even have, which causes issues when MCAS reviews start taking place.

Mr. Swanson stated that the health line of business is different and that the data accumulated for the health plans does take longer for it to be done right since there is so much more of it. He stated he is agreeable with keeping the June 30 deadline.

Ms. LeDuc stated the timespan between the reporting of all the other MCAS lines of business being April 30 and the health line of business being June 30 complicates things when they are trying to plan their activities for the upcoming year because they do not have the whole picture and are unable to determine how to best use their resources. She stated she would like to see an earlier date than June 30 but could see the concerns with April 30 being the deadline for the health MCAS.

Ms. Weyhenmeyer stated because there are differing opinions on this issue being presented, a comment period will be opened and that a vote will take place. She stated Working Group members should be prepared for a roll vote on this matter. Ms. Ailor asked when a decision needs to be made, and Ms. Cooper stated it needs to be made before data call letters are sent out, which is done in December, but preferably sooner.

Mr. Zolecki stated having a decision as soon as possible would be beneficial for companies. Ms. Weyhenmeyer stated the Working Group's next meeting is scheduled for Aug. 24 and that the comment period will be opened now through Aug. 19. She said a vote will take place at the next meeting regarding the health MCAS deadline. Mr. Flott asked if the slide deck shared by Mr. Zolecki and Ms. Burns could be shared, and Ms. Cooper stated the slides would be posted for review.

3. Reviewed the Travel Data Element Addition Proposed by the Market Analysis Procedures (D) Working Group

Ms. Weyhenmeyer stated the Market Analysis Procedures (D) Working Group is charged with creating standard ratios for each of the MCAS lines of business. She stated while discussing ratios for the travel line of business, the Working Group found that it would be desirable to have the "policies in force during the reporting period" added to the travel underwriting activity section of reporting within the travel MCAS blank.

Mr. Helder stated the proposal is that a data element be added for "policies in force during the reporting period." He stated the reason for this proposal is to be able to develop ratios for cancellations and complaints. He stated because of the way travel insurance is written, it is difficult to get a good number for policies unless the data element for "policies in force during the reporting period" is used as the denominator in a ratio.

Ms. Weyhenmeyer stated this data element would be added to the travel MCAS reporting in the 2024 data year reported in 2025 if adopted.

Ms. LeDuc stated that what is being collected for policy counts currently is the number in force at the beginning of the period and the number in force at the end of the period. She stated there are policies purchased during the period that are not captured in the start or the end time frame, which leaves a gap and hampers the ability to formulate some ratios. She stated travel insurance policies are unique in that someone could purchase a policy today, travel tomorrow, and then the coverage ends. She stated other than the premium written, that policy may not be reflected in the statement unless there happened to be a claim filed.

Duke de Haas (Allianz Global Assistance) asked for clarification and if the data element being sought was the total number of policies written or the total number of policies in force as of a certain date. Mr. Helder stated the travel MCAS already has data elements for policies in force at the beginning and end of the period, but that policies that may begin in February and end in February are not being captured because they began and ended during the reporting period. He stated it is the policy count in force during the reporting period that is being sought.

Ms. Weyhenmeyer stated a comment period will be opened now through Aug. 19, and a vote will take place during the Working Group's next meeting on Aug. 24 regarding whether to add this data element to the travel MCAS.

4. Reviewed the STLDI Data Element Addition Proposed by the Market Analysis Procedures (D) Working Group

Ms. Weyhenmeyer stated the Market Analysis Procedures (D) Working Group is proposing the addition of a data element for “dollar amount of claims paid during the reporting period” within the claims section of the short-term, limited-duration insurance (STLDI) MCAS blank.

Mr. Helder stated for STLDI, there is no way for analysts to get the dollar amount of claims off the financial annual statement and that if the data element for “dollar amount of claims paid during the reporting period” was added to the MCAS, the ability to calculate loss ratios for the companies would be available.

Ms. Weyhenmeyer stated this data element would be added to the STLDI MCAS reporting in the 2024 data year reported in 2025 if adopted. She stated a comment period will be opened now through Aug. 19, and a vote will take place during the Working Group’s next meeting on Aug. 24 regarding whether to add this data element to the STLDI MCAS.

Having no further business, the MCAS Blanks (D) Working Group adjourned.

SharePoint/Market Regulation - Home/D Working Groups/MCAS Blanks WG/2022/WG Mtg 0721/MCAS Blanks WG Minutes July 21

Draft: 6/10/22

Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
May 26, 2022

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met May 26, 2022. The following Working Group members participated: Erica Weyhenmeyer, Chair (IL); Rebecca Rebholz, Vice Chair (WI); Crystal Phelps (AR); Maria Ailor (AZ); Scott Woods (FL); Paula Shamburger (GA); Tate Flott (KS); Ron Kreiter (KY); Dawna Kokosinski (MD); Jeff Hayden (MI); Jennifer Hopper, Jo LeDuc, and Teresa Kroll (MO); Robert McCullough (NE); Hermoliva Abejar (NV); Guy Self (OH); Rachel Moore (SC); Tony Dorschner (SD); Joy Little and Rhonda Bowling-Black (TN); Shelley Wiseman (UT); Melissa Gerachis (VA); Jason Carr (WA); and Letha Tate (WV). Also participating was: Mary Kay Rodriguez (WI).

1. Adopted its April 28 Minutes

The Working Group met April 28 and took the following action: 1) adopted its March 17 minutes; 2) received an update on the life Market Conduct Annual Statement (MCAS) draft edits for accelerated underwriting (AU); 3) received an update on the Other Health Drafting Group; 4) discussed possible edits to the lawsuit definition for all MCAS lines of business that contain lawsuit reporting; and 5) adopted the proposed lawsuit definitions and placement of the lawsuit data elements for the homeowners and private passenger auto (PPA) MCAS.

Mr. Flott made a motion, seconded by Ms. Rebholz, to adopt the Working Group's April 28 minutes (Attachment Ten-A1). The motion passed unanimously.

2. Adopted the Life MCAS Edits for AU

Ms. Weyhenmeyer stated that the draft data call and definitions for the life MCAS edits on AU was in the meeting materials with edits shown in red. She stated that following adoption of the definition of AU by the Accelerated Underwriting (A) Working Group, the subject matter expert (SME) group reconvened to discuss the definition to be proposed for MCAS reporting. She stated that for MCAS reporting purposes, the SME group decided that only a subset of the policies fits the full AU definition. She stated that Attachment Two, page 12 of the meeting materials shows the new proposed definition of AU followed by a reference to the Accelerated Underwriting (A) Working Group definition of AU to show continuity between the working groups.

Ms. Weyhenmeyer stated that the MCAS AU definition is as follows: "For this MCAS, data should be reported as Accelerated Underwriting when artificial intelligence and/or machine learning which utilizes, in whole or in part, Other Non-medical Third-party Data and/or FCRA Compliant Non-medical Third-party Data in the underwriting of life insurance; including when used in combination with Application Data or Medical Data." She stated that following the AU definition, there are definitions of "Application data," "Medical data," "FCRA Compliant non-medical third-party data," and "Other non-medical third-party data"; and those definitions are needed for understanding within the interrogatories. She stated that the proposed MCAS AU interrogatories are shown on pages 6 and 7 of the meeting materials, and a few edits were made to them to clarify and allow for cleaner responses that will be better for analysis purposes.

Birny Birnbaum (Center for Economic Justice—CEJ) stated that the CEJ supports this proposal and asked the Working Group to adopt it.

Mr. Kreiter made a motion, seconded by Ms. Rebholz, to adopt the AU MCAS for Life Insurance. The motion passed unanimously.

3. Adopted the Other Health MCAS Data Call and Definitions

Ms. Rodriguez stated that the Other Health Drafting Group stated that comments were received from Missouri, and those comments and responses were posted on the Working Group's web page on May 11. She stated that those comments resulted in some revisions to the draft.

Rikki Pelta (American Council of Life Insurers—ACLI) stated that she has questions regarding Schedule 2 about terminations and cancellations. She asked if question 2-9 (Number of policy/certificate terminations and cancellations initiated by the policyholder/certificate holder) is the total sum of everyone who went out of force initiated by the policyholder and then broken out in questions 2-13 through 2-15. Ms. Rodriguez stated that question 2-14 (Number of covered lives on policies/certificates cancelled by the company due to non-payment of premium during the period) would not be included in question 2-9 since it is cancelled by the company, and question 2-15 (Number of policies/certificates cancelled by the company for any reason other than non-payment of premium during the period) would also not be included in question 2-9 since it is cancelled by the company. She stated that question 2-13 (Number of policy/certificate terminations and cancellations due to non-payment of premium) would also not be included since it relates to non-payment and would not be considered as initiated by the policyholder. Ms. Pelta asked where it would be reported when an insured dies. Ms. Rodriguez stated that she believes that would be considered as initiated by the policyholder or beneficiary. Ms. Pelta stated that question 2-5 (Number of new policy/certificate applications/enrollments received during the period) appears to be the same as question 5-2 (Number of applications/enrollments received during the period) in Schedule 5. Ms. Rodriguez confirmed that they are the same, and she recommended omitting the question in Schedule 5 and renumbering those questions in Schedule 5.

Samantha Burns (America's Health Insurance Plans—AHIP) stated that AHIP's membership is very broad, and it has several supplemental carriers that have been participating in the Other Health Drafting Group. She stated that AHIP also has major medical carriers that offer some of the products covered under the Other Health draft, and it has not had as much time to review the draft as its supplemental carriers have. She asked if AHIP could have another week or so to discuss the draft and submit questions. Teresa Cooper (NAIC) stated that for 2023 data to be reported in 2024, this would need to be adopted by the Working Group by June 1. Then, it would go to the Market Regulation and Consumer Affairs (D) Committee for its consideration, and it would need to be adopted by Aug. 1. Ms. Weyhenmeyer stated that the draft would likely be posted for at least one month before the Committee would vote on anything. Ms. Burns stated that she does not anticipate any substantive concerns, and she believes AHIP just needs a little more time to see if it has clarifying questions that need to be answered. Ms. Cooper stated that if this draft is adopted today, input could be provided for clarification in a frequently asked questions (FAQ) document, and Ms. Burns agreed with this suggestion. Ms. Burns asked what month in 2024 the deadline would be for the Other Health MCAS. Ms. Rodriguez stated that for new lines of business in the past, additional time has been provided, but the deadline had not been decided on yet. Ms. Pelta asked that additional time be provided than the normal deadline, especially for the first year of reporting. She recommended May or June. Ms. Burns recommended a June deadline. Ms. Ailor confirmed that additional time has been given in the past. Ms. Rodriguez stated that the short-term limited-duration (STLD) MCAS has a June 30 deadline for next year.

Ms. Hopper stated that the Products page has a variety of questions that say individual, association, and employer group, but there is nothing on the Products page that would be non-employer group products that are not issued in the association market. She believes this leaves out a big component of the Other Health market, and she asked why that is. Ms. Rodriguez asked what is missing. Ms. Hopper stated non-employer groups that are not issued

through an association, such as credit unions and banks that offer these types of coverages appear to be missing. She stated that there are a lot of other groups that do not fall into any of the buckets that are defined in the Other Health MCAS blank. Ms. Rodriguez stated that she reviewed the minutes in 2017 and 2018 when discussions for this blank began, and the reason this blank was requested is because companies were packaging different products to make it look like federal Affordable Care Act (ACA) plans and data need to be gathered to check on these plans. She stated that the products included in this draft were the ones most packaged. Ms. Hopper asked why if the goal is about understanding the association group market, and not about employer group coverage or even individual coverage, then this not just an association group data call. Ms. Rodriguez stated that some companies refer to products as individual, and some companies refer to products as group. She stated that if it appears that employer group should not be included in this blank, removing it can be considered. Ms. Hopper stated that she wants to make sure certain products have not been unintentionally omitted. Ms. Rodriguez confirmed that only the products identified in this blank need to be reported on.

Ms. Hopper stated that she provided comments to add “during the reporting period” to the end of questions 2-9, 2-13, and 2-16, and she wants to know if that comment has been considered. Ms. Rodriguez stated that the premise is that all questions are for the reporting period, but if adding that clarification to those questions would be helpful, it could be done. Ms. Hopper stated that for consistency, she believes it would be helpful since other questions have that language. Ms. Cooper stated that she would make those edits to questions 2-9, 2-13, and 2-16. Ms. Hopper stated that question 3-4 (Number of denied, rejected, or returned as non-covered or beyond benefit limitation) may be clearer if it reads “Number of denied, rejected, or returned as non-covered or maximum benefit exceeded” or something similar. Ms. Rodriguez stated that either sounds good, and the Working Group could provide feedback on that suggestion. Ms. Cooper stated that clarification on that could also be added to the FAQ document.

Ms. Hopper stated that on page 6 under “report by residency,” she noticed that the report by residency language is very different than in the Health MCAS. She stated that the language in the Health MCAS ties back to the NAIC’s *Annual Statement Instructions* for the supplemental health care exhibit, but this does not appear to. She stated that this could be complicated since the Other Health MCAS omits groups that would fall under the same premium and enrollment information as part of the annual statement. She stated that state insurance regulators frequently find it helpful to validate the MCAS by tying it back to components of the annual statement. Ms. Rodriguez asked if this could be tabled and addressed in future discussions for the FAQ document. Mr. Birnbaum stated that while it is useful to have MCAS data sort of reconcile to financial statement data, in some cases it is not possible (e.g., travel insurance since there is no travel insurance line). He stated that this issue should not be seen as an impediment to adopting the Other Health MCAS blank. Ms. Rebholz stated that the report by residency language in this blank matches the STLD blank’s language. She stated that she believes when the definition was being prepared, having the information made available through the blank was part of what was considered since the information is not available through any other source.

Ms. Hopper stated that in Schedule 1, as part of the definition, it says association/trust, and that same phrase is used in question 1-6, but everything else just says associations for those questions. She asked if trust information is also supposed to be provided or if it is just limited to associations for those questions. Ms. Rodriguez stated that she believes these questions are also similar to what is on the STLD blank. She asked if for consistency purposes, “/trust” should be added to the questions asking for information about associations, and Ms. Hopper stated that that would make sense. Ms. Hopper stated that in questions 1-17 through 1-20, adding wording for a trust would not apply, and Ms. Rodriguez stated that that would be explained.

Ms. Cooper clarified that the edits to be made before proceeding with a motion include omitting question 5-2 since it is a duplicate of question 2-5, proposing a first-year deadline of June 30 and second year deadline of April 30, adding “during the period” to the end of questions 2-9, 2-13, and 2-16, and adding “/trust” where applicable

after associations. Ms. Pelta stated that she believes changing the wording in question 3-4 to “maximum benefit exceeded” in the blank instead of adding it to the FAQ document is more appropriate.

Ms. Gerachis made a motion, seconded by Mr. Flott, to adopt the Other Health MCAS draft reflecting the edits summarized. Ms. Cooper asked if the motion includes changing the wording in question 3-4 to “maximum benefit exceeded” as suggested, and Ms. Gerachis confirmed that it does. The motion passed unanimously.

4. Adopted Edits to the Lawsuit Definition for the Home and Auto MCAS

Ms. Weyhenmeyer stated that during its last meeting, the Working Group adopted updates to the lawsuit reporting for home and auto, along with an updated definition, but there are some outstanding questions to address. She stated that there is a bullet that reads: “If one lawsuit seeks damages under two or more policies, count the number of policies involved as the number of lawsuits. For example, if one lawsuit seeks damages under three policies, count the action as three lawsuits.” Questions regarding this bullet were introduced with a letter from Lisa Brown (American Property Casualty Insurance Association—APCIA).

Ms. Weyhenmeyer stated that Ms. Brown and Mr. Birnbaum indicated that the bullet should not be included in the MCAS lawsuit definition for home and auto because one lawsuit would be counted as multiple lawsuits if more than one policy from a single insurer is involved when the intent is to get a count of actual lawsuits. She stated that Ms. LeDuc also had a question about when the bullet was added to the home and auto lawsuit definition. Ms. Cooper did some research and found that the bullet in question is included in the lawsuit definition for Life, Annuity, Long-Term Care (LTC), Lender-Placed Insurance (LPI), Disability Income, and Private Flood; and while updating the home and auto lawsuit definition, it was included in the draft for consistency purposes. Ms. Weyhenmeyer stated that the bullet in question has not been included in the home and auto lawsuit definition in the past. She stated that previously, when Ms. Cooper said it was included for all lines other than Health, she was reviewing all lines other than home and auto because the Working Group was editing the definition for home and auto.

The proposal from the SME group is to remove the bullet in question from the home and auto MCAS lawsuit definitions and review the bullet in the context of the other MCAS lines of business to determine whether it is appropriate.

Mr. Birnbaum stated that including the bullet distorts the count of lawsuits and conflicts with the instructions for class action lawsuits. He stated that the CEJ supports removing the bullet and revisiting it in the other MCAS blanks.

Ms. LeDuc made a motion, seconded by Ms. Phelps, to remove the bullet from the home and auto MCAS lawsuit definition and review the language in the other MCAS lines of business. The motion passed unanimously.

5. Reviewed its Charges and Process for Submitting Requests for Edits to the MCAS Data Call and Definitions

Ms. Weyhenmeyer stated that Attachment Five in the meeting materials lists the Working Group charges. She stated that the Working Group is charged with reviewing the data call and definitions for lines of business that have been in effect for longer than three years, which would include: Life, Annuity, Home, PPA, LTC, Health, LPI, and Home and Auto. The Working Group is also charged with developing MCAS blanks for newly approved MCAS lines of business. Ms. Weyhenmeyer stated that the Market Analysis Procedures (D) Working Group has not approved any new MCAS lines of business at this time, so the current focus will be on reviewing existing MCAS lines of business.

Ms. Weyhenmeyer stated that all state insurance regulators and interested parties can submit requests or suggestions via the Proposal Submission Form. She stated that a copy of this form is in Attachment Five of the meeting materials, and the form is also located in a fillable format on the Working Group web page under the Documents tab. She stated that if anyone has issues submitting a proposal, they should contact Ms. Cooper for assistance with filling out the form.

6. Discussed Other Matters

Ms. Weyhenmeyer stated that a letter was received by Joe Zolecki (Blue Cross Blue Shield Association—BCBSA) and the health industry interested parties regarding the filing deadline for the Health MCAS.

Mr. Zolecki stated that he has been working with Ms. Burns for the last few years, and this matter came up previously when the Health MCAS was new. He stated that there was a robust discussion about the filing date being changed from April 30 to June 30, and then moving back to April 30 in 2023. He stated that the Working Group agreed to reevaluate this, and he asked that this be discussed in more detail soon. Ms. Weyhenmeyer stated that it could be discussed during the Working Group's next meeting scheduled for June 23 or the July meeting if more time is needed.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.

SharePoint/Market Regulation - Home/D Working Groups/MCAS Blanks WG/2022/WG Mtg 0526/MCAS Blanks May 26 Minutes

Draft: 5/16/22

Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
April 28, 2022

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met April 28, 2022. The following Working Group members participated: Erica Weyhenmeyer, Chair (IL); Rebecca Rebholz, Vice Chair (WI); Alex May (FL); Tate Flott (KS); Ron Kreiter (KY); Dawna Kokosinski (MD); Jeff Hayden (MI); Jennifer Hopper (MO); Leatrice Geckler (NM); Guy Self (OH); Jeffrey Arnold (PA); Michael Bailes and Rachel Moore (SC); Tony Dorschner (SD); Shelli Isiminger (TN); Shelley Wiseman (UT); Melissa Gerachis (VA); and Letha Tate (WV). Also participating were: Shane Quinlan (NC); and Mary Kay Rodriguez (WI).

1. Adopted its March 17 Minutes

The Working Group met March 17 and took the following action: 1) adopted its Nov. 22, 2021, minutes; 2) received an update on the life Market Conduct Annual Statement (MCAS) draft edits for accelerated underwriting (AU); 3) received an update on the Other Health Drafting Group; 4) adopted the proposal for digital claims interrogatories for the homeowners and private passenger auto (PPA) lines of business; 5) discussed the proposed lawsuit definitions and placement of the lawsuit data elements for the homeowners and PPA MCAS; and 6) received guidance regarding the new number of lawsuits closed with consideration for the consumer data element for the homeowners and PPA MCAS lines of business.

Ms. Rebholz made a motion, seconded by Ms. Isiminger, to adopt the Working Group's March 17 minutes (*see NAIC Proceedings – Spring 2022, Market Regulation and Consumer Affairs (D) Committee, Attachment Four*). The motion passed unanimously.

2. Received an Update on the Life MCAS Draft Edits for AU

Ms. Weyhenmeyer stated the AU subject matter expert (SME) group met on April 13 to begin discussing the definition of AU now that the Accelerated Underwriting (A) Working Group has adopted a definition. She stated the Accelerated Underwriting (A) Working Group's adopted definition does not fit the needs of MCAS reporting, so work will need to be done with the definition. Ms. Weyhenmeyer stated since the April 13 meeting, the American Council of Life Insurers (ACLI) has submitted a draft definition that will be discussed further during the next SME call, which is scheduled for May 2.

Birny Birnbaum (Center for Economic Justice—CEJ) stated that deadlines to be aware of are June 1 for this Working Group and Aug. 1 for the Market Regulation and Consumer Affairs (D) Committee, so this Working Group would need to get something out by June 1 in order for 2023 data to be reported in 2024. Ms. Weyhenmeyer stated the SME group is planning on meeting twice in May in an effort to meet these deadlines.

3. Received an Update on the Other Health Draft Group

Randy Helder (NAIC) stated the Other Health Drafting Group posted the other health MCAS draft in early April under exposure drafts on the MCAS web page for review. He stated it is similar to other data call and definitions in terms of the scope, but he said that some of the interrogatories are devoted to gathering information on how products are marketed and the relationships of the company with the marketers. He stated there are also questions regarding how the products are administered, such as whether the company contracts with third-party

administrators (TPAs) and the identification of the TPAs used. Mr. Helder stated there are questions regarding whether the company distributes products through independent agents, captive agents, and employees. He said there are also questions regarding whether fees are included in the reported premium, and if not, what fees are charged to policyholders and certificate holders. He stated the products being covered are: accident only, accidental death and dismemberment, specified disease -limited benefit/critical illness, hospital/other indemnity, and hospital/surgical/medical expense. Mr. Helder stated the blank is intended to collect information on products that are purchased directly by individuals, purchased through an association for individuals, or through an employer group. He stated there are sections regarding policy/certificate administration and claims administration that are similar to other MCAS blanks. Mr. Helder stated there is a data element for the aggregate dollar amount of paid claims during the period because there was some discussion about developing a loss ratio based on that which could not otherwise be obtained. He stated there are also sections for consumer complaints and lawsuits, as well as marketing and sales. He stated the participation requirement is \$50,000 of health insurance premium and that a report by residency requirement is also outlined in the blank. Mr. Helder stated the definitions are similar to other MCAS blanks.

Rikki Pelta (American Council of Life Insurers—ACLI) stated it would be helpful to know how the loss ratios are being calculated and advised that this blank will require significant updates to administrative systems that collect this data by companies. She stated even if the due date is longer, companies will still have to have their systems updated by the end of this year, which is a big task.

Mr. Quinlan stated North Carolina does not have jurisdiction over policies issued in other states and expressed concern regarding reporting by residency. Ms. Rodriguez stated there are several states in the same situation and that one of the focuses of this blank is to see how consumers are finding products and being serviced, regardless of where the situs state is.

Ms. Hopper stated that on the report by residency requirement, it mentions forms issued to discretionary groups, associations, or trusts, but it does not mention other group coverage types, such as employer groups or multiple employer trusts. He stated that typically those are broken out separately. Ms. Rodriguez stated the focus was more on associations because many states felt that other health products sold through associations needed to be scrutinized more than employer group products. Ms. Hopper asked for clarification on the question related to the issuer and association's contractual relationship. She also asked why the System for Electronic Rates & Forms Filing (SERFF) filing number was being requested and why identifying the basis for not filing in a particular state was being asked. Ms. Rodriguez stated that she and Mr. Helder would review all of her questions and comments with SME group. Mr. Helder stated those responses would be posted to the MCAS blanks web page and shared prior to the next Working Group meeting.

Ms. Weyhenmeyer stated any comments related to the Other Health Draft should be submitted to Teresa Cooper (NAIC) no later than May 13.

4. Discussed Possible Edits to the Lawsuit Definition for all MCAS Lines of Business That Contain Lawsuit Reporting

Ms. Weyhenmeyer stated an SME group met to discuss edits to the home and auto MCAS definition of lawsuit to include non-claim-related suits. She stated while reviewing comments from the American Property Casualty Insurance Association (APCIA), it was found that all MCAS lawsuit definitions include a bullet that reads: "If one lawsuit seeks damages under two or more policies, count the number of policies involved as the number of lawsuits. For example, if one lawsuit seeks damages under three policies, count the action as three lawsuits." She

stated the APCIA requested that this language be clarified to account for instances where there are multiple policies involved that are issued by different insurers.

Lisa Brown (APCIA) stated the way the current bullet is written implies that a single reporting company might be responsible for reporting on another company's policies. She stated Mr. Birnbaum made a good point during an SME group meeting when he asked why a single lawsuit that touches multiple policies would be counted more than once, when what is being counted is lawsuits and not policies. She stated that if the data to be collected will continue to be lawsuits that account for multiple policies, then the language should state: "If a lawsuit seeks damages under two or more policies, count the number of policies involved as the number of lawsuits." She then stated in hindsight, counting a single lawsuit multiple times may not be appropriate. Mr. Birnbaum stated it really seems inappropriate to count a single lawsuit against more than one policy as more than one lawsuit, as it increases the actual number of lawsuits. He expressed concern about how a company would count lawsuits this way as it could require their manual involvement. Ms. Weyhenmeyer asked if this is the way the lawsuit language reads in the other blanks except for health, and Ms. Cooper confirmed that is correct.

Ms. Rebholz stated the APCIA's proposed language seems to provide clarification and that more time may be needed to review this further. Ms. Brown will send the proposed language to Ms. Cooper for the SME group to review further and bring back to the Working Group for consideration. Ms. Weyhenmeyer asked if a vote to change the lawsuit language in all of the MCAS blanks if needed and where it applies could be done in one vote, and Ms. Cooper stated it could as long as the motion was clearly outlined in that way. Ms. LeDuc stated she reviewed the 2019 Homeowners Data Call and Definitions and that she is not seeing the definition outlined there this way. She said that it may be helpful to look into the history for clarification. Ms. Cooper stated she would review this information.

5. Adopted the Proposed Lawsuit Definitions and Placement of Lawsuit Data Elements for the Homeowners and Auto MCAS

Ms. Weyhenmeyer stated the Working Group needs to discuss the Homeowner and Auto lawsuit reporting and definition edits in more depth. She stated the documentation for this discussion was in the meeting materials as Attachments Three and Four. She stated the homeowner and auto SME group first presented its lawsuit reporting and definition proposal to the Working Group in November 2021, and that the proposal simplifies the lawsuit reporting and its definition as much as possible. She stated the SME group proposed the following: 1) removal of the lawsuit data elements from the claims reporting section; 2) creation of a new reporting section for the lawsuit data elements; 3) reporting the lawsuit data elements by claims coverage type as has been done in the past; 4) adding reporting for "non-claim related lawsuits"; and 4) updating the definition of lawsuits to accommodate the new reporting structure. The SME group also proposed the addition of an interrogatory to capture comments for the newly added lawsuit section.

Ms. Weyhenmeyer stated during the Working Group's March 17 meeting, comments were heard from Lisa Brown (APCIA). She stated that as a result of Ms. Brown's comments, it was decided to reconvene the SME group to address the submitted comments. The SME group met on April 12 and April 20. Ms. Weyhenmeyer stated that one of the APCIA's comments indicated concern that the word "agent" should be defined in the bullet that reads: "Include only lawsuits brought by an applicant for insurance, a policyholder or claimant as a plaintiff against the reporting insurer or its agent as a defendant." She stated as a result of this comment, the SME group proposes that "or its agent" be removed from the bullet item in question. She stated another one of the APCIA's comments indicated concern about interpleader actions. The proposed definition provides for the exclusion of "arbitrations, mediation, appraisal, or any other form of dispute resolution not brought in a court of law." The APCIA asked for the exclusion to be amended to exclude homeowners and private passenger appraisal matters filed in a court of law and interpleader actions filed by an insurance company. Ms. Weyhenmeyer stated that after discussion, the

SME group proposes that the exclusion bullets be updated to ensure interpleader actions are excluded from reporting. Mr. Birnbaum stated that the CEJ supports the proposed changes.

Ms. Rebholz made a motion, seconded by Ms. Johnson to adopt the proposed lawsuit definition and placement of lawsuit data elements in the homeowners and auto MCAS. Ms. Brown asked if the motion includes adopting counting multiple policies as multiple lawsuits, and Ms. Weyhenmeyer stated it did not; it was only regarding the edits to remove “or its agent” and to edit the exclusion bullets to ensure interpleader actions are excluded from reporting. Ms. Cooper clarified it also includes breaking out the lawsuit reporting to include the other than claims-related lawsuits and updating the definition as shown in the meeting materials, but not to the bullet discussed in the previous agenda item, which will be considered at a later date. The motion passed unanimously.

6. Discussed Other Matters

Ms. Weyhenmeyer stated some state-specific concerns had been raised that may need some clarification in the frequently asked questions (FAQ) document. She stated contact was made with state insurance regulators in Pennsylvania and Michigan regarding the concerns raised. The Pennsylvania state insurance regulator said companies could reach out and ask questions as needed regarding their writ of summons reporting. The Michigan state insurance regulator said they would draft language to be provided in the FAQ to address lawsuits filed by a medical provider for payment under personal injury protection (PIP) coverage.

Ms. Brown stated that in Pennsylvania, the writ of summons is just a notice and does not indicate a cause of action. She asked how companies will know whether to count it as a claim or non-claim if they do not know what the potential suit is about. Ms. Cooper some additional conversation on this topic will take place to see if additional clarifying language would be helpful.

Ms. Brown stated she wanted the state insurance regulators to understand that the lawsuit definition edits would require some heavy programming and process changes to pull out the non-claims-related lawsuits, especially for the larger insurers. Mr. Birnbaum stated the guidelines are set up so that companies have five months to prepare to collect information after approved by the Market Regulation and Consumer Affairs (D) Committee and then start reporting it two years after that approval. He stated the MCAS is a critical part of market analysis and market regulation and that when there are changes, companies should take it just as seriously as changes to the annual financial statement. Ms. Pelta stated her earlier comments regarding timeline concerns were related to the other health MCAS since some of the interrogatories and data elements have not been traditionally collected in other lines of business.

Ms. Weyhenmeyer stated she, Mr. Helder, and Ms. LeDuc gave a presentation at the Insurance Regulatory Examiners Society (IRES) foundation regarding changes to the homeowners and auto MCAS blanks for digital claims. She stated some clarifying questions came up that will be discussed in more detail with the Working Group at a later meeting. Ms. LeDuc asked Ms. Brown to start asking companies what questions they have regarding what constitutes a digital claim versus a hybrid claim so that those questions can be addressed.

Having no further business, the MCAS Blanks (D) Working Group adjourned.

SharePoint/Market Regulation - Home/D Working Groups/MCAS Blanks WG/2022/WG Mtg 0428/MCAS Blanks WG Minutes 0428

Draft Pending Adoption

Attachment Eleven
Market Regulation and Consumer Affairs (D) Committee
8/12/22

Draft: 7/21/22

Market Regulation Certification (D) Working Group
Virtual Meeting (*in lieu of meeting at the 2022 Summer National Meeting*)
July 13, 2022

The Market Regulation Certification (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met July 13, 2022. The following Working Group members participated: Russell Toal, Chair (NM); John Haworth, Vice Chair (WA); Lori K. Wing-Heier represented by Sarah Bailey (AK); Doug Ommen represented by Kim Cross (IA); Erica Weyhenmeyer (IL); Chlora Lindley-Myers represented by Jo LeDuc (MO); Mike Causey represented by Tracy Biehn (NC); Martin Swanson and Robert McCullough (NE); Marlene Caride represented by Ralph Boeckman (NJ); Judith L. French represented by Don Layson (OH); Glen Mulready represented by Shelly Scott (OK); Don Beatty and Katie Johnson (VA); and Kevin Gaffney represented by Mary Block and Nick Marineau (VT). Also participating was: Pam O'Connell (CA).

1. Adopted its June 1 Minutes

Superintendent Toal said the Working Group met June 1. During this meeting, the Working Group took the following action: 1) adopted the Voluntary Market Regulation Certification Program scoring matrix; 2) reviewed the certification program implementation plan; and 3) reviewed the pilot state suggestions to the certification program.

Mr. Haworth made a motion, seconded by Ms. Weyhenmeyer, to adopt the Working Group's June 1 (Attachment Eleven-A) minutes. The motion passed unanimously.

2. Reviewed the Certification Program Implementation Plan

Superintendent Toal said the implementation plan provides for a three-year self-certification period in which any jurisdiction may use the guidelines and checklists to measure its compliance to the certification requirements. He said that during the self-certification period, recommendations for changes and improvements to the requirements would be received and considered.

Superintendent Toal said that after three years, any jurisdiction could choose to continue to self-certify, or it could apply to be fully certified. He said a Market Regulation and Certification Committee would be formed to review each jurisdiction seeking full certification. He said a review team would be formed to review applications and report to the Committee, and re-evaluations would be done every five years.

Superintendent Toal said fully certified jurisdictions may withdraw at any time and continue to self-certify. He said any self-certified jurisdiction would be considered provisionally certified.

Superintendent Toal noted that during the last Working Group meeting on June 1, Mr. Haworth addressed the process for peer review, the timing for moving from self-certification to full certification, and whether the use of contractors in the certification process should be allowed. Superintendent Toal noted that in their comments to the Working Group, two states proposed the Working Group re-evaluate the implementation plan in its entirety and then re-draft a plan for adoption. He said that was a good idea. He said some of what is currently in the original implementation plan can be retained, but the Working Group should draft a plan that it determines is the best way to implement and administer the certification program.

Draft Pending Adoption

Attachment Eleven
Market Regulation and Consumer Affairs (D) Committee
8/12/22

Superintendent Toal asked for comments on the implementation plan to be sent to Randy Helder (NAIC) by July 29.

3. Reviewed Pilot State Suggested Revisions to the Certification Program

Superintendent Toal said the Working Group received three sets of comments. He said all the comments were helpful and will improve the certification program. He said his plan for the certification requirements is to ask a smaller group of state insurance regulators to meet a couple times in between each monthly Working Group meeting to review the recommendations on each requirement and report back to the Working Group on their progress. He said having a small group work on the certification requirements will also allow the Working Group time to work on the implementation plan.

Mr. Beatty said that requirement 2 requires jurisdictions to use the most current version of the NAIC *Market Regulation Handbook*, but there is no checklist question to affirm this. He suggested adding such a question. He said checklist question 3i asks about the staffing policies and procedures, and he said he is unsure how that relates to identifying market conduct issues. Regarding requirement 4, Mr. Beatty asked how a jurisdiction can support a claim that it encourages professional development. He also suggested that checklist item 4d should reference examiners in charge (EICs) to avoid confusion. Finally, Mr. Beatty said requirement 11 should provide the opportunity for a jurisdiction to indicate whether any of the companies chosen in the Market Actions (D) Working Group National Analysis Program wrote business in the jurisdiction since that would affect whether they participated.

Ms. O'Connell said her comments focused on correcting inconsistencies between the adopted scoring matrix and the certification program guidelines and checklist. She said she would be happy to work with the small group to discuss and incorporate appropriate suggestions.

Ms. LeDuc said her comments generally agreed with the comments of Ms. O'Connell. Ms. LeDuc said her comments noted some inconsistencies in the language used through the certification program requirement, guidelines and checklist, and identified areas that needed clarification. Her comments also pointed out some concerns with the requirements such as the blanket statement requiring the use of the most recent version of the NAIC *Market Regulation Handbook* rather than allowing for case-specific usage, especially for the application of standards to exams initiated prior to a new version. Ms. LeDuc volunteered to be on the small group to discuss the suggestions for revisions and make recommendations to the Working Group.

Mr. Swanson said hiring, training, and retaining employees is getting more difficult for departments of insurance (DOIs). He said that as the Working Group moves forward with the certification program, it needs to take into account the staffing difficulties. Superintendent Toal said that was a valid point and that most DOIs are experiencing the same hiring and retention issues. He said the Working Group needs to temper any unrealistic expectations of what a DOI can do and how quickly.

Superintendent Toal asked for volunteers to be on the drafting group for the requirements. Ms. LeDuc, Ms. O'Connell, Ms. Biehn, and Mr. Haworth volunteered.

Having no further business, the Market Regulation Certification (D) Working Group adjourned.

Sharepoint/Member Meetings/D CMTE/2022 Summer National Meeting/MRCWG/0713/0713 MRCWG .docx

Draft: 6/15/22

Market Regulation Certification (D) Working Group
Virtual Meeting
June 1, 2022

The Market Regulation Certification (D) Working Group met June 1, 2022. The following Working Group members participated: Russell Toal, Chair (NM); John Haworth, Vice Chair (WA); Lori K. Wing-Heier represented by Sarah Bailey (AK); Alan McClain represented by Crystal Phelps (AR); Erica Weyhenmeyer (IL); Chlora Lindley-Myers represented by Jo LeDuc (MO); Mike Causey represented by Tracy Biehn (NC); Chris Nicolopoulos represented by Edwin Pugsley (NH); Marlene Caride represented by Ralph Boeckman (NJ); Judith L. French represented by Todd Oberholtzer (OH); Andrew R. Stolfi represented by Brian Fordham (OR); Don Beatty, Katie Johnson, and Andrea Baytop (VA); Kevin Gaffney represented by Mary Block (VT); and Bill Cole (WY).

1. Adopted its March 22 Minutes

The Working Group met March 22 and took the following action: 1) reviewed the progress of the Voluntary Market Regulation Certification Program and discussed the charge to complete the revisions by the Fall National Meeting; and 2) reviewed the scoring matrix for the Market Regulation Certification Program.

Mr. Beatty made a motion, seconded by Mr. Cole, to adopt the Working Group's March 22 minutes (*see NAIC Proceedings – Spring 2022, Market Regulation and Consumer Affairs (D) Committee, Attachment Two*). The motion passed unanimously.

2. Adopted the Certification Program Scoring Matrix

Superintendent Toal said that during the Working Group's Mar. 22 meeting, Mr. Haworth reviewed the draft of a scoring matrix to be used when evaluating whether a jurisdiction would be certified. He noted that the matrix was posted on the Working Group's web page under exposure drafts.

Superintendent Toal said the goal for the Working Group is to deliver a revised Certification Program to the Market Regulation and Consumer Affairs (D) Committee by the Fall National Meeting. That will require the Working Group to adopt three documents: 1) the scoring matrix; 2) the revisions to the Voluntary Market Regulation Certification Program; and 3) the implementation plan. All three documents are attached to the agenda. He said that because the scoring matrix is complete and was discussed in detail during the Working Group's Mar. 22 meeting, it would be considered for adoption during this meeting.

Mr. Haworth reviewed the scoring matrix. He said the Certification Program questions that are coded red must be met for the jurisdiction to be certified. If any of the red questions are not met, the jurisdiction cannot be certified regardless of its responses to the remaining questions. He said the yellow questions are primary goals and are scored according to whether the jurisdiction meets the goal. The green questions are not scored since they request additional information supportive of the yellow primary goals.

Ms. Baytop asked if questions 3d and 3e are answered affirmatively, would a jurisdiction received 25 for both—meaning they use both state examiners and contract examiners. Mr. Haworth noted that the instructions read that if the jurisdiction can answer affirmatively to either having state examiners or using contract examiners, it would satisfy both questions, so the jurisdiction would only receive one score for both questions. Ms. Baytop asked if the same logic applied to questions 6b and 6c. Mr. Haworth said question 6b asks if the jurisdiction notified other jurisdictions of potential collaborative actions, and if they received a positive response, did they make a

referral to the Market Actions (D) Working Group. Mr. Haworth said if the jurisdiction did not have this type of situation arise, it would satisfy the requirement by having a policy in place.

Ms. LeDuc noted that question 6b requires notification by meeting, bulletin board, or other communications. She said there is a retention period for bulletin board posts, and the record of the notification would disappear if done via bulletin board. Randy Helder (NAIC) said the retention period for bulletin board posts is one year, but the recipient of emails from the bulletin board can save them for as long as needed. Ms. LeDuc and Mr. Gendron both said that the bulletin board postings are not always received, and that could affect a jurisdiction's ability to document compliance with question 6b. Superintendent Toal said that was a valid concern and is an operational issue that Mr. Helder will take back to the NAIC.

Mr. Haworth made a motion, seconded by Mr. Beatty, to adopt the Certification Program scoring matrix. The motion passed unanimously.

3. Reviewed the Market Regulation Certification Implementation Plan

Mr. Haworth said the implementation plan was reviewed with an eye towards updating it, putting some state insurance regulator concerns at ease. He noted that during the three-year self-certification period, any jurisdiction could request a peer review of seasoned state insurance regulators. Mr. Haworth suggested it would be good to put together a list of state insurance regulators who have agreed to perform requested peer reviews. He also noted there should be a communication plan between the requesting jurisdiction and the peer group of state insurance regulators. He said the posted implementation has his and Hermoliva Abejar's (NV) comments in the margin and should help to begin the discussion.

Superintendent Toal asked that comments on the implementation plan be sent to Mr. Helder by June 30.

4. Reviewed the Pilot Program Suggested Revisions to the Certification Program

Superintendent Toal said there are two versions of the suggested revisions of the pilot states to the Market Regulation Certification Program posted on the Working Group's web page. One is a portable document format (PDF) version, which is a little difficult to read because in the conversion of the redlined document to PDF, the color is removed. He said Mr. Helder also posted the Word document with the redline in the Exposure Documents of the Working Group.

Superintendent Toal asked all Working Group members, interested state insurance regulators, and interested parties to review the program and suggestions and provide comments to Mr. Helder by June 30.

Having no further business, the Market Regulation Certification (D) Working Group adjourned.

Sharepoint/Teams/Marketregulationteam/Working Groups/MR Certification WG/D WG 2022/0601/

Draft: 8/4/22

Market Conduct Examination Guidelines (D) Working Group
Virtual Meeting
July 14, 2022

The Market Conduct Examination Guidelines (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met July 14, 2022. The following Working Group members participated: Damion Hughes, Chair, Eleanor Coe, and Dennis Newman (CO); Erica Weyhenmeyer, Vice Chair (IL); Chris Erwin, Donna Lambert, Gwen McClendon, and Crystal Phelps (AR); Maria Ailor and Tolanda Coker (AZ); Steve DeAngelis (CT); Susan Jennette and Frank Pyle (DE); Paula Shamburger (GA); Lori Cunningham and Ron Kreiter (KY); Rebecca Butler and Mary Lou Moran (MA); Maybeth Moses (MN); Cynthia Amann, Camille Anderson-Weddle, Jennifer Hopper, Teresa Kroll, Jo LeDuc, and Win Nickens (MO); Tracy Biehn (NC); Maureen Belanger, Sarah Cahn, and Edwin Pugsley (NH); Erin Porter (NJ); Myra L. Morris (NM); Sylvia Lawson and Elvis Soto (NY); Rodney Beetch (OH); Kevin Foor, Rebecca Ross and Shelly Scott (OK); Sandra Emanuel and Ana K. Pace (OR); Penny Callihan, Gary Jones, Lindsi Swartz, and Paul Townsen (PA); Brett Bache and Segun Daramola (RI); Matthew Tarpley (TX); Kelly Christensen, Heidi Clausen, Ryan Jubber, Tracy Klausmeier, and Shelley Wiseman (UT); Julie Fairbanks, Brant Lyons, and Joy Morton (VA); Mary Block, Nick Marineau, Karla Nuissl, and Marcia Violette (VT); Barb Jones, Jeanette Plitt, and Kim Tocco (WA); Barbara Belling, Diane Dambach, Darcy Paskey, Rebecca Rebholz, and Mary Kay Rodriguez (WI); and Desiree Mauler (WV).

1. Adopted its June 9 Minutes

The Working Group met June 9 and took the following action: 1) adopted its April 21 minutes; 2) discussed a new Chapter 24B—Conducting the Mental Health Parity and Addiction Equity Act (MHPAEA) Related Examination of the *Market Regulation Handbook* (Handbook). The chapter was updated to align more closely with federal guidance on compliance analysis requirements for non-quantitative treatment limitations (NQTLs). The Working Group received numerous comments on the draft Chapter 24B from state insurance regulators and interested parties; 3) discussed revisions to Chapter 23—Conducting the Life and Annuity Examination of the Handbook, which correspond with the February 2020 revisions adopted by the NAIC to the *Suitability in Annuity Transactions Model Regulation* (#275); 4) received numerous comments on the draft Chapter 23 from state insurance regulators and interested parties; and 5) discussed revisions to Chapter 20—General Examination Standards of the Handbook regarding the *Insurance Holding Company System Regulatory Act* (#440).

Ms. Plitt made a motion, seconded by Ms Amann, to adopt the Working Group's June 9 minutes (Attachment Twelve-A). The motion passed unanimously.

2. Adopted Revisions to the July 6 Draft Chapter 20 of the Handbook

Mr. Hughes said the draft Chapter 20 was first circulated on Oct. 27, 2021, and the Working Group began discussing the draft at its Nov. 4, 2021, meeting. He said the revisions in the draft, which relate to Model #440, were proposed by Mr. Kreiter. The Working Group continued discussion of the Oct. 27, 2021, draft at its March 10, April 21, and June 9 meetings.

Mr. Hughes said Chapter 20 was revised and distributed on July 6 to the Working Group members, interested state insurance regulators, and interested parties. He said all the revisions in the Oct. 27, 2021, draft chapter were removed, except for in Marketing and Sales Examination Standard 1, where a reference to Model #440 was

retained, and a reference to Section 8G of the model was incorporated there. Mr. Hughes said he had proposed making these revisions at the Working Group's June 9 meeting.

Mr. Kreiter made a motion, seconded by Ms. Phelps, to adopt the July 6 draft Chapter 20 of the Handbook. The motion passed unanimously.

3. Adopted Draft Revisions to the July 6 Draft Chapter 1 of the Handbook

Mr. Hughes said he proposed revisions to Chapter 1—Introduction of the Handbook at the Working Group's June 9 meeting. The draft Chapter 1, which was distributed on July 6 to Working Group members, interested state insurance regulators, and interested parties, contained Mr. Hughes' proposed revisions in the subsection titled Financial Analysis in Section B—Resources within State Insurance Departments, where the following language was added, "Additionally, market regulators are encouraged to coordinate with a company's domestic financial regulator to obtain information related the company's group capital calculations, liquidity stress test results, corporate governance, and Own Risk and Solvency Assessment (ORSA)."

Ms. Plitt said while the language "it is encouraged" is very appropriate to incorporate in the chapter, numerous state departments of insurance (DOIs) already incorporate this type of coordination across various divisions of the DOI. She said she believes this coordination is a requirement of the NAIC financial accreditation program/process.

Joseph E. Zolecki (Blue Cross Blue Shield Association—BCBSA) thanked Mr. Hughes for incorporating the new language into Chapter 1 for the Working Group's consideration. He said the language will result in better coordination among market regulators and financial regulators, which will lead to avoiding redundancies in state insurance regulators' review of regulated entities. Charles Feinen (State Farm) said he agrees with Mr. Zolecki's comments.

Mr. Kreiter made a motion, seconded by Ms. Jennette, to adopt the July 6 draft Chapter 1 of the Handbook. The motion passed unanimously.

4. Adopted an Updated Chapter 24B, July 11 draft, of the Handbook

Ms. Weyhenmeyer, vice chair of the Working Group and chair of the MHPAEA (B) Working Group, said Chapter 24B was updated to be more robust and more consistent with federal guidance on the issue of compliance analysis requirements for NQTLs. She said the draft chapter was first distributed to Working Group members, interested state insurance regulators, and interested parties on April 19, and numerous comments from state insurance regulators and interested parties were received on the draft chapter in late May 2022, which were presented and discussed at the Working Group's June 9 meeting.

Ms. Weyhenmeyer said since the last Working Group meeting on June 9, a subject matter expert (SME) group worked to address the comments presented by state insurance regulators and interested parties at that meeting, and a revised Chapter 24B exposure draft was distributed to the Working Group, interested state insurance regulators, and interested parties on July 11. She said the draft was initially distributed to those individuals on July 6; however, there were some changes she noted that needed to be made to the draft, and the draft chapter was re-distributed to the Working Group, interested state insurance regulators, and interested parties on July 11.

Ms. Weyhenmeyer said the draft was initially discussed and developed in regulator-only meetings of the MHPAEA (B) Working Group prior to exposure at the Market Conduct Examination Guidelines (D) Working Group. Those meetings also included federal representatives of the Tri-Departments.

Ms. Amann said she likes the incorporation of the “Forward” section in the chapter—this Forward section is found in other examination standards chapters of the Handbook as well—as it is a good reminder that Chapter 24B is to outline federal guidance and considerations regarding the MHPAEA, while allowing states to use their state-specific statutes, rules, and regulations regarding the MHPAEA.

Ms. Callihan said upon review of the chapter on the day prior to the July 14 meeting, Pennsylvania noted some additional substantive language changes and suggestions that could be made to the chapter to allow for better consistency with the Consolidated Appropriations Act, and Pennsylvania also noted a correction to a couple of statutory citation errors and a couple of typographical errors in the draft chapter. She said Pennsylvania submitted the comments to the Working Group’s chair/vice chair a half hour prior to the Working Group’s July 14 meeting. Ms. Weyhenmeyer said the correction to the statutory citations and the typographical (spelling) errors can be addressed today because they are editorial (non-substantive) changes, and the substantive changes—i.e., additional language proposed by Pennsylvania—can be incorporated into the chapter later.

Meghan Stringer (America’s Health Insurance Plans—AHIP) said she is appreciative that most of the additional comments AHIP submitted regarding the draft were incorporated into the chapter. She said AHIP still has areas of concern, including: 1) supporting documentation required under the applicable statute should satisfy Examination Standard 5; 2) in Examination Standard 5, AHIP does not agree with the request for all communications listed in that examination standard; and 3) AHIP would still want to review the impact of the scope of review being expanded to contractual arrangement between health carriers and vendors in Examination Standard 7. She said there will be additional federal rulemaking that is scheduled to occur in a few months’ time regarding the MHPAEA, and she suggested that the Working Group postpone the adoption of the draft chapter until such time that federal regulators release the additional guidance. Mr. Zolecki said he agrees with Ms. Stringer’s comments regarding delaying the adoption of Chapter 24B.

Birny Birnbaum (Center for Economic Justice—CEJ) said the issue of delaying adoption of the MHPAEA chapter, while waiting for future federal guidance on MHPAEA, results in no current MHPAEA guidance available to state insurance regulators, which limits their ability to effectively conduct the analysis of NQTLs, which is of concern to insurance consumers.

Pamela Greenberg (Association for Behavioral Health and Wellness—ABHW) said if the Working Group is considering the chapter for adoption at the meeting, the chapter could be updated at a future date to reflect the forthcoming federal guidance to allow for consistency with the guidance.

Tim Clement (American Psychiatric Association—APA) said while forthcoming federal guidance may slightly change or add clarity to MHPAEA statutory requirements, delaying the adoption of the updated MHPAEA chapter currently before the Working Group means the current MHPAEA chapter, which is inconsistent with statutory requirements regarding the MHPAEA, remains in place.

Ms. Rebholz made a motion, seconded by Mr. Kreiter, to adopt the July 11 exposure draft of Chapter 24B of the Handbook, as revised during the meeting, which includes the incorporation of the following editorial corrections: 1) inserting a (3) in the reference citations in the Expected Plan Payments and Plan Payments subsections of the section titled “Classifications of benefits used for applying parity rules” and the correction of spelling errors in that same section. The adopted Chapter 24B will replace the Chapter 24B that is currently in the Handbook. The motion passed unanimously.

5. Discussed Other Matters

Mr. Hughes said an updated exposure draft of a revised Chapter 23 is forthcoming for the Working Group's review and consideration at its next meeting. The revisions to Chapter 23 correspond with the February 2020 revisions adopted by the NAIC to Model #275 and take into consideration some of the comments and changes proposed by state insurance regulators and interested parties at the June 9 meeting. Mr. Hughes said new standardized data requests (SDRs) will also be distributed for consideration at that meeting.

Mr. Hughes said the Working Group will continue to work on its assigned charges, in addition to the current exposure draft before the Working Group. NAIC staff will send out a notice of the next Working Group meeting, which is scheduled for Sept. 8.

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

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Draft: 6/16/22

Market Conduct Examination Guidelines (D) Working Group
Virtual Meeting
June 9, 2022

The Market Conduct Examination Guidelines (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met June 9, 2022. The following Working Group members participated: Damion Hughes, Chair, Eleanor Coe, and Neil A. Derr (CO); Erica Weyhenmeyer, Vice Chair (IL); Chris Erwin and Teri Ann Mecca (AR); Kurt Swan (CT); Susan Jennette (DE); Paula Shamburger (GA); Jared Kirby and Daniel Mathis (IA); Lori Cunningham and Ron Kreiter (KY); Mary Lou Moran (MA); Airic Boyce and Jeff Hayden (MI); Paul Hanson (MN) Cynthia Amann, Jennifer Hopper, Teresa Kroll, and Win Nickens (MO); Teresa Knowles (NC); Sarah Cahn and Edwin Pugsley (NH); Ralph Boeckman and Erin Porter (NJ); Paige Duhamel and Leatrice Geckler (NM); Hermoliva Abejar (NV); Sylvia Lawson (NY); Rodney Beetch (OH); Landon Hubbart (OK); Scott D. Martin and Tashia Sizemore (OR); Paul Towsen (PA); Brett Bache and Matt Gendron (RI); Matthew Tarpley (TX); Andrea Baytop, Julie Fairbanks, Melissa Gerachis, Brant Lyons, and Bryan Wachter (VA); Mary Block and Isabelle Turpin Keiser (VT); Jane Beyer, John Haworth, and Jeanette Plitt (WA); and Barbara Belling, Diane Dambach, Darcy Paskey, Mark Prodoehl, Rebecca Rebholz, Mary Kay Rodriguez, and Jody Ullman (WI).

1. Heard Opening Remarks

Mr. Hughes welcomed Maria Ailor (AZ) and Mr. Hayden to the Working Group.

2. Adopted its April 21 Minutes

The Working Group met April 21 and took the following action: 1) adopted revisions to the April 19 draft Chapter 21—Conducting the Property and Casualty Examination of the *Market Regulation Handbook* (Handbook). The revisions relate to the *Real Property Lender-Placed Insurance Model Act* (#631); 2) discussed revisions to Chapter 24B—Conducting the MHPAEA Related Examination of the Handbook to update the chapter to align more closely with federal guidance on compliance analysis requirements for non-quantitative treatment limits (NQTLs); 3) discussed revisions to Chapter 23—Conducting the Life and Annuity Examination of the Handbook, which correspond with the February 2020 revisions adopted by the NAIC to the *Suitability in Annuity Transactions Model Regulation* (#275); and 4) discussed revisions to Chapter 20—General Examination Standards of the Handbook regarding the *Insurance Holding Company System Regulatory Act* (#440).

Mr. Kreiter made a motion, seconded by Mr. Haworth, to adopt the Working Group's April 21 minutes (Attachment Twelve-A1). The motion passed unanimously.

3. Discussed Draft Revisions to the Oct. 27, 2021, Draft Chapter 20 of the Handbook

Mr. Hughes said the draft Chapter 20—General Examination Standards was first circulated on Oct. 27, 2021, and the Working Group began discussing the draft at its Nov. 4, 2021, meeting. He said the revisions in the draft, which relate to the *Insurance Holding Company System Regulatory Act* (#440) were proposed by Mr. Kreiter. The Working Group discussed the draft at its March 10 and April 21 meetings. Mr. Hughes said no revisions were agreed upon at the April 21 meeting, and the comment due date was subsequently extended. Comments were received from the American Council of Life Insurers (ACLI) on May 18. Mr. Hughes said the ACLI's May 18 comments were very similar to the ACLI's comments of December 17, 2021.

Gabrielle Griffith (ACLI) said the word "determine" in the Review Procedures and Criteria section of Operations/Management Standard 1 is of concern; she suggested that the Working Group change "determine" to

instead read “review or discuss with the domestic should there be an issue with ORSA, LST or GCC-related information.” She also recommended that the references to the group capital calculation (GCC) and liquidity stress test (LST) be removed from Marketing and Sales Standard 1; alternatively, she said the references could instead be made more generic to apply to all prohibited marketing activity for any of the model references listed in Marketing and Sales Standard 1.

Mr. Hughes proposed removing all redlined revisions in the Oct. 27, 2021, exposure draft of Chapter 20, except for the reference to the name of the model in the NAIC Model References section of Marketing and Sales Standard 1. He suggested adding “(Section 8G)” after the model reference since that is the section in Model #440 that sets forth the prohibition of insurers’ use of the GCC and the LST in advertising. He said a revised Chapter 20 containing these changes would be circulated ahead of the next meeting.

Mr. Hughes proposed that language be added to the subsection titled “Financial Analysis” in Section B “Resources Within State Insurance Departments” of Chapter 1—Introduction of the Handbook, stating that the market regulator has the option to review the GCC and the LST. Ms. Amann suggested that wording should be added to that section regarding the need for market regulators to coordinate with the domestic regulator. Mr. Hughes said proposed revisions to Chapter 1 would be distributed prior to the next meeting.

Joe Zolecki (Blue Cross Blue Shield Association—BCBSA) and Ms. Griffith said they would welcome language regarding the coordination of market and financial regulators.

4. Discussed Draft Revisions to the April 19 Draft Chapter 23 of the Handbook

Mr. Hughes said the exposure draft of a revised Chapter 23—Conducting the Life and Annuity Examination was circulated to the Working Group, interested state insurance regulators, and interested parties on April 19. He said Brian Werbeloff (RI), Mr. Swan, Frank Pyle (DE), and other state insurance regulators on their respective teams collaborated to produce the draft for the Working Group’s review and consideration. The revisions to the chapter correspond with the February 2020 revisions adopted by the NAIC to the *Suitability in Annuity Transactions Model Regulation* (#275).

Mr. Hughes said comments were received from Virginia on May 25, Missouri on May 27, and the Insured Retirement Institute (IRI) on May 27.

Ms. Gerachis suggested making changes to the Supplemental Checklists for Marketing and Sales Standards 12, 16, and 17 in the exposure draft:

Supplemental Checklist for Marketing and Sales Standard #12: Change “Ensure the insurer’s and applicable producer’s system of annuity suitability supervision and training include:” to “Ensure the insurer’s and applicable producer’s system of annuity suitability supervision and training include from Model #275:” Also, change the first requirement from “A producer who engages in the sale of annuity products shall complete a one-time four (4) credit training course approved by the department of insurance and provided by the department of insurance-approved education provider” to “A producer who engages in the sale of annuity products shall complete a one-time four (4) credit training course approved by the department of insurance and provided by the department of insurance-approved education provider to comply with Section 7 of this regulation.”

Supplemental Checklist for Marketing and Sales Standard #16: Change the fourth bullet point in the first requirement, “Communicate the basis or basis of the recommendation” to “Communicate the basis or bases of the recommendation.”

Supplemental Checklist for Marketing and Sales Standard #17: To be consistent with Checklist K, change “Ensure the insurer’s and applicable producer’s system of annuity suitability supervision include:” to “Ensure the insurer’s and applicable producer’s system of annuity suitability supervision include from Model #275:” Also, change the first requirement from “The producer has disclosed a description of the scope and terms of the relationship with the consumer and the role of the producer in the transaction.” to “The producer has disclosed to the consumer, on a form substantially similar to Appendix A, a description of the scope and terms of the relationship with the consumer and the role of the producer in the transaction.”

Ms. Hopper presented a high-level overview of some of the comments submitted by Jo LeDuc (MO). Ms. Hopper:

- Asked whether the newly developed checklists will be moved to the end of exposure draft so they appear together with the checklists that are already in Chapter 23.
- Suggested that ambiguity in the Marketing and Sales Standard 10 should be corrected where the words “additional review” are duplicated within the same sentence.
- Requested clarification of the requirement, “shall establish and maintain reasonable procedures to identify and eliminate any sales contests...” in Supplemental Checklist K.
- Requested clarification of the references to “regulation” in Supplemental Checklist L.
- Requested that Marketing and Sales Standard 16 not be phrased in the negative.
- Requested that the word “agency” in Marketing and Sales Standard 16 be changed to “business entity producer.”
- Requested clarification on what requirements are being referenced with, “The requirements apply to the particular annuity...” and “The requirements do not mean...” in Marketing and Sales Standard 16.
- Requested clarification on the references to “Paragraph 1,” “Paragraph 2,” and “Subsection” in Marketing and Sales Standard 16.
- Asked that additional clarification be added to Marketing and Sales Standard 17 regarding what items a producer needs to disclose.

Sarah Wood (IRI) suggested revisions to Marketing and Sales Standards 9 and 10. She suggested that the current Review Procedures and Criteria:

Verify that the insurer has adequate procedures in place for monitoring that sales are made in compliance with Financial Industry Regulatory Authority (FINRA) requirements pertaining to suitability and supervision of annuity transactions. Sales made in compliance with FINRA requirements pertaining to suitability and supervision of annuity transactions shall satisfy the requirements under this regulation. This subsection applies to FINRA broker-dealer sales of variable annuities and fixed annuities if the suitability and supervision is similar to those applied to variable annuity sales. However, nothing in this subsection shall limit the insurance commissioner’s ability to enforce (including investigate) the provisions of this regulation.

Note: Noncompliance with FINRA requirements means that the broker-dealer transaction is subject to compliance with the suitability requirements of the applicable state’s statutes, rules and regulations.

be changed to the following:

Verify that the insurer has adequate procedures in place for monitoring that sales are made in compliance with comparable standards as defined in Section 6(E)(5) of Model #275. Sales made

in compliance with comparable standards shall satisfy the requirements under this regulation. This subsection applies to all recommendations and sales of annuities made by financial professionals in compliance with business rules, controls and procedures that satisfy a comparable standard even if such standard would not otherwise apply to the product or recommendation at issue. However, nothing in this subsection shall limit the insurance commissioner's ability to enforce (including investigate) the provisions of this regulation.

Note: Noncompliance with comparable standards means that the recommendation or sale is subject to compliance with the suitability requirements of the applicable state's statutes, rules and regulations.

Mr. Gendron said he would agree with many of the proposed changes presented by Virginia, Missouri, and the IRI. He said regarding the IRI's reference to "comparable standards," it would be his preference to list the comparable standards so the examiner guidance can be more thoroughly outlined in the chapter. He said he and the other subject matter experts (SMEs) who prepared the initial exposure draft will develop a revised exposure draft of Chapter 23 for discussion at an upcoming Working Group meeting.

Birny Birnbaum (Center for Economic Justice—CEJ) said the Working Group should monitor the Annuity Suitability (A) Working Group's current work on a Safe Harbor Provision Frequently Asked Questions (FAQ) document.

5. Discussed Draft Revisions to the April 19 Draft Chapter 24B of the Handbook

Ms. Weyhenmeyer, vice chair of the Working Group and chair of the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group, said Chapter 24B—Conducting the MHPAEA-Related Examination was updated to more closely align with federal guidance on the issue of compliance analysis requirements for NQTLs. The revised chapter exposure draft was circulated to the Market Conduct Examination Guidelines (D) Working Group, interested state insurance regulators, and interested parties on April 19.

Ms. Weyhenmeyer said the exposure draft was prepared under the guidance of the MHPAEA (B) Working Group since its members have expertise in this area. She said the draft will replace Chapter 24B in the Handbook upon adoption by the Market Conduct Examination Guidelines (D) Working Group, the Market Regulation and Consumer Affairs (D) Committee, and the Executive (EX) Committee and Plenary.

Ms. Weyhenmeyer said comments were received from Wisconsin on May 25, Missouri on May 27, Virginia on May 27, America's Health Insurance Plans (AHIP) on May 27, the Association for Behavioral Health and Wellness (ABHW) on May 27, and the BCBSA on May 27. She asked all parties submitting comments to provide a high-level summary of their comments.

Ms. Belling said the purpose of Wisconsin's comments is to reword the review procedures and criteria sections in the exposure draft to be more consistent with review procedures and criteria sections in other chapters in the Handbook. The Wisconsin proposed changes switch the focus of the review procedures and criteria to what examiners should review, rather than on the requirements for health carriers. Wisconsin also added revisions to the review procedures and criteria sections of the exam standards in the chapter.

Ms. LeDuc submitted comments on the exposure draft, some of which were presented by Ms. Hopper:

- Clarification needs to be added to the chapter that the MHPAEA does not apply to all types of health insurance products.

- There are instances in the chapter where there is a lengthy list of documents to review, which do not necessarily align with the review procedures and criteria, and there is no information provided in the review procedures and criteria to instruct examiners why they need to review the documents.
- To shorten Standard 1 and remove some of the language from the standard itself into the Review Procedures and Criteria section of Standard 1.
- Standard 6 is lengthy and Missouri suggests that it be broken up into four separate examination standards.
- Standards 6 and 7 should cite back to other standards from relevant chapters, such as Chapter 20 Operations/Management Standard 6 and Chapter 24 Utilization Review Standards 1, 2, and 5.

Ms. Fairbanks presented comments submitted by Virginia. She said Virginia comments were essentially similar to those of Wisconsin, and the Virginia comments were addressed by the proposed changes to the exposure draft submitted by Wisconsin.

Meghan Stringer (AHIP) presented the AHIP comments. She said the legal requirements of the new draft are generally consistent with the MHPAEA, with a few exceptions. She said some of the documents that are requested in several of the exam standards fall outside of what is required under federal MHPAEA guidance (e.g., in Standard 5, there is a very large volume of documents requested), which is directly contrary to federal guidance that directs carriers to avoid the production of a large volume of documents without a clear explanation of how each document is relevant to the comparative analysis to which it is attached. She said the submission of the comparative analysis alone should satisfy Standard 5, and she recommended that the additional documents can be flagged as documents that might be needed when additional information is necessary.

Ms. Stringer recommended that the Handbook include allowable sub-classifications to make state insurance regulators aware of them and the parity rules that then apply. Regarding Standard 7, she said it is standard for health carriers to require within their contracts that vendors and third-party service providers be compliant with relevant laws, which makes Standard 7 unnecessary. She said the requirement in Standard 7 to provide all written communication between the health carrier and the third-party service provider would be cumbersome (e.g., thousands of emails and random communications not relevant to the issue of compliance). She suggested that additional language pertaining to resource documentation be incorporated into Standard 7 instead to provide an explanation for how third-party service providers and health carriers can coordinate to achieve MHPAEA compliance.

Pamela Greenberg (ABHW) submitted comments, some of which were presented by Maeghan Gilmore (ABHW). Ms. Gilmore said one of the ABHW's main objectives regarding MHPAEA implementation is to have uniformity among state insurance regulators at both the federal and state level, which benefits consumers, health care providers, employers, health carriers, and state insurance regulators. She said the proposed documents to be submitted for review in the exposure draft go well beyond the current U.S. Department of Labor (DOL) Self-Compliance Tool and Consolidated Appropriations Act (CAA) requirements, and she asked that any unnecessary or contrary items be removed from the exposure draft. She said a proposed rule/report is anticipated to be released later this year by the DOL, the U.S. Department of Health and Human Services (HHS), and the U.S. Department of the Treasury (Treasury Department), collectively known as the Tri-Departments, and she asked that the NAIC wait to finalize the proposed updates to the exposure draft until that time so the reporting template and DOL Self-Compliance Tool can be in complete alignment with federal MHPAEA guidance.

Randi Chapman (BCBSA) presented the BCBSA comments. She said she agrees with AHIP's comments on Standard 7 regarding health carriers and vendors/third-party service providers, as outlined by Ms. Stringer. She said the proposed documents to be submitted in the exposure draft go beyond federal guidance. She suggested that the exposure draft instead be aligned with the federal standards for required documents and any additional documentation be provided at the request of state insurance regulators. She suggested that Standard 5 be

changed to identify a subset of NQTLs so state insurance regulators can have a more targeted approach. She said the Tri-Departments will set forth additional guidance on MHPAEA compliance and a second report to the U.S. Congress (Congress) this year, and she requested that the NAIC delay finalizing this exposure draft until that time so the guidance in the exposure draft can better align with federal MHPAEA guidance.

Ms. Beyer, the vice chair of the MHPAEA (B) Working Group, said the Working Group should not delay implementation of this exposure draft. Ms. Weyhenmeyer said the draft was discussed and developed in regulator-only meetings of the MHPAEA (B) Working Group prior to exposure at the Market Conduct Examination Guidelines (D) Working Group. Those meetings also included federal representatives of the Tri-Departments, and the federal regulators involved did not raise any objections regarding the documentation requested in the exposure draft. Ms. Weyhenmeyer reminded the Working Group that the whole Handbook is a guide, and the intent of this exposure draft of Chapter 24B is to outline federal guidance and considerations regarding the MHPAEA, while allowing states to use their state-specific statutes, rules, and regulations regarding the MHPAEA.

Ms. Weyhenmeyer said a revised Chapter 24B exposure draft will be developed and circulated for discussion at the next Working Group meeting.

6. Discussed Other Matters

The Working Group will continue to work on its assigned charges, in addition to the current exposure drafts before the Working Group. NAIC staff will send out a notice of the next Working Group meeting, which is scheduled for July 14.

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

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Draft: 5/10/22

Market Conduct Examination Guidelines (D) Working Group
Virtual Meeting
April 21, 2022

The Market Conduct Examination Guidelines (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met April 21, 2022. The following Working Group members participated: Damion Hughes, Chair, and Eleanor Coe and Neil A. Derr (CO); Erica Weyhenmeyer, Vice Chair (IL); Chris Erwin, Teri Ann Mecca, and Crystal Phelps (AR); Sarah Borunda (AZ); Kurt Swan (CT); Sharon Shipp (DC); Susan Jennette and Frank Pyle (DE); Elizabeth Nunes and Paula Shamburger (GA); Lori Cunningham and Ron Kreiter (KY); Mary Lou Moran (MA); Jeff Hayden (MI); Cynthia Amann, Jennifer Hopper, Jo LeDuc, and Win Nickens (MO); Tracy Biehn and Teresa Knowles (NC); Maureen Belanger and Edwin Pugsley (NH); Ralph Boeckman and Erin Porter (NJ); Leatrice Geckler (NM); Hermoliva Abejar (NV); Sylvia Lawson (NY); Rodney Beetch (OH); Landon Hubbart (OK); Ana K. Pace (OR); Paul Towsen (PA); Brett Bache, Jack Broccoli, Segun Daramola, Matt Gendron, and Brian Werbeloff (RI); Matthew Tarpley (TX); Kelly Christensen, Tracy Klausmeier, Tanji J. Northrup, and Shelley Wiseman (UT); Andrea Baytop, Julie Fairbanks, Will Felvey, Joy Morton, and Bryan Wachter (VA); Mary Block, Isabelle Turpin Keiser, and Karla Nuisl (VT); Jeanette Plitt (WA); and Barbara Belling, Diane Dambach, Darcy Paskey, Mark Prodoehl, Rebecca Rebholz, and Jody Ullman (WI).

1. Adopted Revisions to the April 19 Draft Chapter 21 of the *Market Regulation Handbook*

Mr. Hughes said the Working Group began discussing the draft Chapter 21—Conducting the Property and Casualty Examination of the *Market Regulation Handbook*, initially circulated on Oct. 27, 2021, at its Nov. 4, 2021, meeting. He said Ms. Shipp reviewed the *Real Property Lender-Placed Insurance Model Act* (#631) and recommended revisions to various areas of the chapter for the Working Group’s consideration. He said since the last Working Group meeting on March 10, the industry trade associations’ edits were incorporated into the April 19 draft, shown in yellow highlight, as Patrice Garnette (DC) had indicated on the March 10 call that all the revisions proposed by the industry trade associations—i.e., comments dated Nov. 11, 2021, and sent to the NAIC on Nov. 23, 2021—were acceptable. Mr. Hughes said Ms. Garnette also revised the language of the examination standard in Marketing and Sales Examination Standard 8 to revert to the language that existed prior to all the District of Columbia’s proposed revisions.

Mr. Gendron made a motion, seconded by Ms. Weyhenmeyer, to adopt the April 19 draft Chapter 21 of the *Market Regulation Handbook*. The motion passed unanimously.

2. Discussed Draft Revisions to the April 19 Draft Chapter 24B of the *Market Regulation Handbook*

Mr. Hughes said Chapter 24B—Conducting the MHPAEA-Related Examination was updated to align with federal guidance more closely on the issue of compliance analysis requirements for non-quantitative treatment limitations (NQTLs). He said he mentioned at the March 10 Working Group meeting that the draft chapter would be forthcoming, to be distributed to the Working Group after the Spring National Meeting. The revised chapter exposure draft was circulated to the Working Group, interested state insurance regulators, and interested parties on April 19.

Ms. Weyhenmeyer, vice chair of the Working Group and chair of the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group, said the Market Conduct Examination Guidelines (D) Working Group had been asked to review and update the chapter. The April 19 exposure draft was developed under the guidance of the MHPAEA (B) Working Group, as that is where the subject matter experts (SMEs) in this area reside. Ms.

Weyhenmeyer said the exposure draft is before the Market Conduct Examination Guidelines (D) Working Group for review and comment, so the guidance therein can be organized and further developed in a market conduct examination-related context. The comment due date on the draft is May 20.

Ms. Dambach said the exposure draft should be modified to contain language as shown in other *Market Regulation Handbook* chapters (e.g., the ACA-related chapter). The exposure draft, as currently written, contains the language, "... the health carrier shall ..." Ms. Dambach said the language should be changed to read, "... the market conduct examiner should verify that ..." She said she will submit comments regarding this language change.

In response to Kris Hathaway's (America's Health Insurance Plans—AHIP) inquiry during the Working Group meeting asking for a redlined version of the draft, Ms. Weyhenmeyer said the exposure draft will completely replace the current Chapter 24B in the *Market Regulation Handbook*; therefore, there is no redlined version of the current Chapter 24B to provide. Mr. Hughes said the initial comment period on the exposure draft is for 30 days; the comment due date on the draft is May 20. Petra Wallace (NAIC) asked state insurance regulators and interested parties to email her a request for a Word version of the chapter for the purpose of providing comments/suggested edits in Microsoft Word track changes format.

3. Discussed Draft Revisions to the April 19 Draft Chapter 23 of the *Market Regulation Handbook*

Mr. Hughes said the exposure draft of a revised Chapter 23—Conducting the Life and Annuity Examination was circulated to the Working Group, interested state insurance regulators and interested parties on April 19. He said Mr. Werbeloff, Mr. Swan, Mr. Pyle, and other state insurance regulators on their respective teams collaborated to produce the draft for the Working Group's review and consideration. The revisions to the chapter correspond with the February 2020 revisions adopted by the NAIC to the *Suitability in Annuity Transactions Model Regulation* (#275).

Mr. Werbeloff said in 2010, the NAIC introduced Model #275, which outlined an insurance producer's responsibilities when recommending an annuity to a client. In 2020, the NAIC updated Model #275 to require an insurance producer to work in his/her client's best interests. The then Nebraska Department of Insurance Director Bruce R. Ramage reviewed the updated Model #275 in early 2020 to determine what changes may need to be made to the *Market Regulation Handbook*, and he created an initial redlined draft of Chapter 23. Mr. Werbeloff said the group of state insurance regulator SMEs previously mentioned expanded upon that draft by reinserting relevant examination standards that were not present in the former Director Ramage's draft. The SMEs also developed additional Marketing and Sales examination standards and accompanying checklists to the chapter.

Additional proposed changes not directly found in Model #275 were added, including: 1) a note that examiners should ensure a company is reviewing all transactions that have been flagged for internal review, rather than just using sampling techniques; and 2) a note that internal suitability reviews should consider all internal transactions for a customer, even if those transactions occur in multiple jurisdictions. Additional minor changes to the chapter include the removal of references to the *Disclosure for Small Face Amount Life Insurance Policies Model Act* (#605), due to only five states having adopted that model, and the removal of the *Suitability of Sales of Life Insurance and Annuities* white paper, due to the white paper not being currently publicly accessible on the NAIC web page.

Mr. Hughes said the comment due date on the draft is May 20. Ms. Wallace asked state insurance regulators and interested parties to email her a request for a Word version of the chapter for the purpose of providing comments/suggested edits in Microsoft Word track changes format.

4. Discussed Draft Revisions to the October 27, 2021, Draft Chapter 20 of the *Market Regulation Handbook*

Mr. Hughes said the draft Chapter 20—General Examination Standards was first circulated on Oct. 27, 2021, and the Working Group began discussing the draft at its Nov. 4, 2021, meeting. He said the draft was provided by Mr. Kreiter for the Working Group’s consideration. Mr. Kreiter reviewed the *Insurance Holding Company System Regulatory Act* (#440) in 2021 and recommended corresponding revisions to the chapter. Since the March 10 Working Group meeting, comments were received on the draft from Nevada on April 14 and AHIP/Blue Cross Blue Shield Association (BCBSA) on April 15. These comments were circulated to the Working Group, interested state insurance regulators, and interested parties on April 19.

Ms. Abejar presented Nevada’s comments dated April 14, and she indicated that she reviewed Operations/Management Standard 1 and Marketing and Sales Standard 1. Her April 14 comments reflected new language shown in pink and deleted language shown in gray. In Operations/Management Standard 1, she recommended deleting the sentence, “Determine if the NAIC liquidity Stress Test Framework needs to be utilized for a specified data year,” and replacing it with, “Determine if there any liquidity issues by reviewing the latest Insurer Profile Summary or Group Profile Summary from the domicile state’s assigned financial analyst.”

Ms. Abejar said the reason for the change is because if there are any liquidity issues present, they would have been identified by a domicile state’s assigned financial analyst, so the change in language is needed to avoid the duplication of effort; i.e., there is no need for a market conduct examiner to re-do what financial examiners or financial analysts have already performed.

In Operations/Management Standard 1, Ms. Abejar recommended deleting the language:

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

She then recommended replacing it with:

Determine if there are any contagion risks that could affect the examined company’s market conduct associated with how the holding company system is set up by reviewing the latest Group Profile Summary issued by assigned financial analyst of the financial lead state and the latest financial examination report and management letter. If a group capital calculation was not initiated or completed by the financial lead state to determine potential risk to policyholders; specially for holding company systems with member companies outside of U.S., consult your state assigned financial analyst if requesting a group capital calculation to the Commissioner of the financial lead state is appropriate.

The reason for the change is because a holding company system is not something that is formally instituted all the time; therefore, the language should be removed. Determining the relationships between the entities within a holding company system, whether the holding company system formally instituted or not, is a more relevant examiner review procedure, but that should form part of a larger mission, which is to determine if there are any contagion risks within the holding company system that could affect the examined company’s market conduct. The group capital calculation (GCC) is intended to provide additional analytical information to the financial lead state for use in assessing group risks and capital adequacy to complement the current holding company analysis in the U.S. It includes information on potential risks to policyholders emanating from outside an insurance company, as well as the location and sources of capital within a group. The calculation of which and determination of when to perform a GCC is part of the responsibilities of an insurance financial regulator, not a market examiner.

In Operations/Management Standard 1, Ms. Abejar also recommended the deletion of:

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

The reason for the change is the group capital ratio and any GCC is to be kept confidential by state insurance regulators. The question as to whether the insurers who own the information can keep this information confidential is a matter of law within the state of domicile or the state the insurer is doing business with. If an insurer is displaying in their marketing materials, on their website, or elsewhere, a false or misleading misrepresentation of its financial condition, that issue is technically covered by financial regulation examiners. In this instance, Ms. Abejar said it is easier for a market examiner to get the opinion of financial examiners regarding this issue, rather than market examiners performing a review procedure that is not part of their designated expertise.

In Marketing and Sales Standard 1, Ms. Abejar recommended the deletion of two review procedures:

For the review of group capital calculation, resulting group capital ratio and liquidity stress test:

Review the making, publishing, disseminating, circulating or placing before the public, or causing directly or indirectly to be made, published, disseminated, circulated or placed before the public in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station or any electronic means of communication available to the public, or in any other way as an advertisement, announcement or statement containing a representation or statement with regard to the group capital calculation, group capital ratio, the liquidity stress test results, or supporting disclosures for the liquidity stress test of any insurer or any insurer group, or of any component derived in the calculation by any insurer, broker, or other person engaged in any manner in the insurance business because it would be misleading and is therefore prohibited; and

Review if any materially false statement with respect to the group capital calculation, resulting group capital ratio, an inappropriate comparison of any amount to an insurer's or insurance group's group capital calculation or resulting group capital ratio, liquidity stress test result, supporting disclosures for the liquidity stress test, or an inappropriate comparison of any amount to an insurer's or insurance group's liquidity stress test result or supporting disclosures is published in any written publication and if the insurer is able to demonstrate to the commissioner with substantial proof the falsity of such statement or the inappropriateness, as the case may be, then the insurer may publish announcements in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

Ms. Abejar recommended replacing the language of the two deleted procedures with:

In reviewing the capital calculation, resulting group capital ratio, and liquidity stress test performed by the assigned financial analyst of the financial lead state, note the risks identified by the assigned financial analyst and determine if the risks are directly or indirectly affecting policyholders and whether risk mitigations in place are also documented by the assigned financial analysts. If they are directly affecting policyholders of a company within the holding company system that is currently under market conduct examination, determine if the risk is imminent. If it is, determine the extent of injury to the policyholders.

If the documented risk mitigations do not resolve the market conduct risks, request additional information from the company being examined.

Note that most financial risks have an equivalent market conduct risk that may or may not be obvious to the assigned financial analyst, therefore, request a copy of the Group Insurer Profile and not just a confirmation from the assigned financial analyst that there are no market conduct risks.

The purpose of the change is to direct the market examiner as to where to look, which document to look for, and whom to contact, since market conduct examiners do not perform the referenced financial calculations, these are performed by financial examiners/analysts.

Joe Zolecki (BCBSA) presented the AHIP/BCBSA comments dated April 15. He said the review of insurer GCCs, the Own Risk and Solvency Assessment (ORSA), etc. is performed by financial regulators as part of the risk focused approach. He said he would agree with the revisions proposed by Ms. Abejar, and he supports financial regulators reaching out at any time to market conduct regulators for information and vice versa. This collaboration between financial and market regulators avoids creating a siloed approach, and the result of this collaboration between financial and market conduct examiners is a more effective and comprehensive regulatory review of insurers.

Mr. Zolecki asked the Working Group to consider including references from various sections (e.g., where noted in the portable document format (PDF) excerpts from the *Financial Analysis Handbook* pages provided in the AHIP/BCBSA April 15 comments), where appropriate, in the *Market Regulation Handbook*, not necessarily in Chapter 20. He said he will submit formal comments containing the specific suggested changes to be incorporated from the *Financial Analysis Handbook* into the *Market Regulation Handbook*.

Ms. LeDuc, Ms. Geckler, Ms. Plitt, and Mr. Swan recommended an extension of the comment due date so the draft can be discussed at the next call along with the additional comments to be received. Mr. Hughes said the comment due date will be extended for that purpose, and he is hopeful that the Chapter 20 exposure draft will be able to be adopted at the next scheduled Working Group meeting.

5. Discussed Other Matters

The Working Group will continue to work on its assigned charges, in addition to the current exposure drafts before the Working Group. NAIC staff will send out a notice of the next scheduled Working Group call, which is tentatively scheduled for June 9.

Having no further business, the Market Conduct Examination Guidelines (D) Working Group adjourned.
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Draft: 4/28/22

Speed to Market (D) Working Group
Virtual Meeting
April 20, 2022

The Speed to Market (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met April 20, 2022. The following Working Group members participated: Rebecca Nichols, Chair (VA); Maureen Motter, Vice Chair (OH); Jimmy Gunn represented by Erick Wright (AL); Jimmy Harris represented by Becky Harrington (AR); Frank Pyle (DE); Julie Rachford (IL); Tammy Lohmann (MN); Camille Anderson-Weddle and Jo LeDuc (MO); Ted Hamby (NC); Cuc Nguyen (OK); Mark Worman (TX); Tanji J. Northrup (UT); and Lichiou Lee (WA). Also participating was: Danie Capps (WY).

1. Adopted its Nov. 16, 2021, Minutes

The Working Group met Nov. 16, 2021, and took the following action: 1) adopted its June 30 and June 29, 2021, minutes; 2) adopted the *Regulatory Review of Predictive Models* white paper edits to the *Product Filing Review Handbook* (Handbook); and 3) discussed the Product Requirements Locator (PRL) contacts.

Ms. Northrup made a motion, seconded by Ms. Motter, to adopt the Working Group's Nov. 16, 2021, minutes (*see NAIC Proceedings – Fall 2021, Executive (EX) Committee and Plenary, Attachment Two*). The motion passed unanimously.

2. Heard an Update on SERFF

Joy E. Morrison (NAIC) stated that there will be a report provided at each Working Group meeting regarding the status of the System for Electronic Rates & Forms Filing (SERFF) Modernization Project. Bridget Kieras (NAIC) discussed the key capabilities that will be delivered with the SERFF Modernization Project. The first capability discussed was user managed customization, which will provide more customization of the system for all users. This improvement will include everything from expanded user preferences to the implementation of state business rules that guide the process of making filings, which should help with compliance. The next two capabilities discussed were: 1) filing preparation and submittal; and 2) consistent and efficient filing review. Ms. Kieras stated that more state business rules will be built up front to ensure the industry filings are very compliant, which should reduce intake objections and post-submission updates. The next capability discussed was communication and collaboration tools. Ms. Kieras stated that tools and functions are being worked on for industry and state users to communicate better with each other. The next capability discussed was Application Programming Interface (API) integration with business partners and NAIC products. Ms. Kieras stated that the existing web services that are used by states, companies, and vendors will be built out, and better integration with NAIC systems is being looked at as well. The last two capabilities discussed were: 1) workload management; and 2) robust search and reporting. Ms. Kieras stated that a lot of tools are being worked on to enhance and improve searches and exports.

Ms. Kieras discussed the business objectives being considered for the SERFF Modernization Project. She stated that the business objectives are to: 1) deliver incremental value; 2) minimize production disruption; 3) ensure preservation of existing data; 4) support integration partners; 5) build staff capabilities; 6) practice good financial stewardship; 7) design for ease of use; and 8) provide a seamless user experience. She explained the timeline and phases of the SERFF Modernization Project. There are seven phases that began in March 2022 and are planned to go through December 2024. Ms. Kieras stated that the work is focused on improving the search capabilities and rebuilding the core platform. The tool will be tested through the Interstate Insurance Product Regulation

Commission (Compact) first since it is the smallest group of users, but there will be outreach to companies and states not involved in the Compact to ensure the system is being built in a way that will work for the Life, Property/Casualty (P/C), Health, and Plan Management modules.

Ms. Kieras stated that some of the things being done right now are building out the infrastructure, as all the new tools need to be installed, and servers and development environments need to be put in place. She stated that the NAIC is also working on login and landing pages, including the implementation of the single sign-on (SSO), as well as putting in instances, companies, and contacts that will be used on filings. She stated that the NAIC is beginning module development for state business rules related to filing fees, and it plans on introducing the calculation of filing fees. The NAIC is also building a module for states to map licensing lines of business to their SERFF type of insurance (TOI) so a more thorough licensing check can be done before filing is submitted. She stated that the NAIC is also rebuilding the filing rules module, which will be vastly streamlined and updated and leverage the product coding matrix (PCM) in a way that will reduce a lot of manual entry and provide better reporting.

Ms. Kieras stated that focus groups would be created to get input on the Portable Document Format (PDF) Pipeline, including when and why it is used. She stated that the NAIC suspects that there are some uses that could be better served by improved tools. She stated that the NAIC will also be seeking input on a synonym list. She stated that the NAIC would like to improve the search feature so when a keyword is entered, the system returns results for a synonym that may be relevant. She provided an example of a drone and an unmanned aircraft.

Ms. Kieras stated that an update on the SERFF Modernization Project will be given at each Working Group meeting, and she invited anyone that is not on the SERFF Product Steering Committee (PSC) to join and attend meetings if they are interested.

3. Received an Update on Edits to the Handbook

Ms. Nichols reminded everyone that reviewing updates of the Handbook is underway, and this is one of the Working Group's charges. She stated that some of the updates are technical edits that are just corrections and only a matter of correcting outdated information, updating current uniform resource locators (URLs), making formatting edits, etc. She stated that these types of technical changes will not need to go through the Working Group for adoption, as they are not content related; however, the areas that need substantive or nontechnical content edits will be considered by the Working Group.

Petra Wallace (NAIC) said that the last publication of the Handbook was in 2016 and she is in the process of reviewing the Handbook for technical (non-substantive) edits. She stated there is an NAIC style guide that needs to be followed and a lot of what she is doing is cleaning up the publication to be compliant with the NAIC style guide and provided examples of this. She stated that once the updates are completed, the Handbook will be republished, with the updated NAIC logo, and the publication will not be available as a hard copy, it will instead be available in an electronic version. Ms. Wallace stated she has reached out to SERFF and the Compact staff to get updated information concerning various areas in the Handbook that contain inaccurate information. Ms. LeDuc asked if a track changes Word version of the technical updates Ms. Wallace is performing will be provided to the Working Group. Ms. Nichols stated since the technical edits are non-substantive, the plan is not to bring those back to the Working Group in a track changes format since adoption is not required for technical edits, however content-related and substantive changes will be brought to the Working Group for review and consideration.

Ms. Nichols asked that Working Group members willing to volunteer to review some of the substantive content in Chapter Two—The Filing Process, Chapter Four—The Basics of Life and Annuity Regulation, Chapter Five—The

Basics of Health Rate Regulation, Chapter Six—The Federal Affordable Care Act (ACA) and Plan Management, and Chapter Seven—Policy Form Filings let Leana Massey (NAIC) know. She stated that these reviews would be done behind the scenes and later brought to the Working Group for discussion and consideration. She stated that the goal for completion of this review is to have it ready to present at the Fall National Meeting in December. Ms. Motter stated that when volunteers worked on Handbook updates in the past, it involved reaching out to peers and staff that were subject matter experts (SMEs) in certain areas, so staff members should be asked if assistance is needed with these efforts.

4. Discussed the Annual Review of the PCM and UTD Suggestions

Ms. Motter stated that now is the time of year when suggestions or changes to the PCM and Uniform Transmittal Document (UTD) are solicited. She stated that an alert regarding this was sent in SERFF, and any suggestions are requested by May 31. The suggestions will then be compiled, and it will be determined how many calls to schedule to discuss and consider the suggestions. Ms. Motter stated that these discussions sometimes lead to suggestions on how to better create a solution with a filing label rather than a new TOI when only one state will use a potential new TOI for example or verbiage is changed where needed. She stated that the Working Group calls to discuss the suggestions will take place in June to allow enough time to present the information at the Fall National Meeting for possible implementation in January 2023.

5. Discussed Other Matters

Ms. Nichols stated that during the Spring National Meeting, the decision was made to move the Working Group from the Innovation, Cybersecurity, and Technology (H) Committee to the Market Regulation and Consumer Affairs (D) Committee. She stated that this would not affect any of the work to be done by the Working Group. She stated that the SERFF Advisory Board was also disbanded during the Spring National Meeting, and the Working Group charges will be updated to reflect this.

Having no further business, the Speed to Market (D) Working Group adjourned.

SharePoint/Market Regulation - Home/D Working Groups/Speed to Market/2022/April 20 Call