

## MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

- Market Regulation and Consumer Affairs (D) Committee Dec. 8, 2020, Minutes
  - 2011 NAIC *Antifraud Plan Guideline* (#1690) (Attachment One)
  - Claims Standardized Data Request LTC (Attachment Two)
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## Draft Pending Adoption

Draft: 12/15/20

Market Regulation and Consumer Affairs (D) Committee  
Virtual 2020 Fall National Meeting  
December 8, 2020

The Market Regulation and Consumer Affairs (D) Committee met Dec. 8, 2020. The following Committee members participated: Barbara D. Richardson, Chair (NV); Sharon P. Clark, Vice Chair (KY); Alan McClain, represented by Crystal Phelps (AR); Trinidad Navarro (DE); Dean L. Cameron (ID); Robert H. Muriel (IL); Anita G. Fox, represented by Michele Riddering (MI); Chlora Lindley-Myers and Cynthia Amann (MO); Mike Causey represented by Michelle Osborne and Tracy Biehn (NC); Russell Toal represented by Robert Doucette (NM); Texas represented by Doug Slape (TX); Michael S. Pieciak represented by Christina Rouleau (VT); and Mark Afable and Rebecca Rebholz (WI). Also participating were: Bruce R. Ramge (NE); Michele Brugh Rafeld (OH); Elizabeth Kelleher Dwyer (RI); and John Haworth (WA).

### 1. Adopted its Summer National Meeting Minutes

Commissioner Richardson said the Committee met Aug. 11 and took the following action: 1) adopted its July 27 minutes; 2) adopted its task force and working group reports; and 3) heard a presentation from Alliance Health Care Sharing Ministries (AHCSM). Commissioner Clark made a motion, seconded by Commissioner Navarro, to adopt the Committee's Aug. 11 minutes (*see NAIC Proceedings – Summer 2020, Market Regulation and Consumer Affairs (D) Committee*). The motion passed unanimously.

### 2. Adopted its 2021 Proposed Charges

Commissioner Richardson said each task force adopted its 2021 proposed charges in October, and the draft charges of the Committee were circulated to the Committee members for review and comment on Nov. 6. She said the charges were posted to the NAIC website the week of Nov. 23.

Commissioner Richardson said the 2021 proposed charges of the Committee are very similar to the 2020 charges except for edits to the charges of the Market Conduct Examination Standards (D) Working Group. For 2021, she said the Working Group has been renamed the Market Conduct Examination Guidelines (D) Working Group. The Working Group will continue to focus on the development of examination standards and data calls to be incorporated into the *Market Regulation Handbook* (Handbook), but it will also focus on developing exam templates, such as a sample exam call letter, for states to reference. Commissioner Richardson said the Working Group will also have a closer tie to the activities of the Innovation and Technology (EX) Task Force's work in developing guidance for the oversight of insurers' use of data and models using artificial intelligence (AI).

Director Lindley-Myers made a motion, seconded by Commissioner Clark, to adopt the Committee's 2021 proposed charges. The motion passed unanimously.

### 3. Adopted Revisions to Guideline #1690

Commissioner Navarro said the Antifraud Technology (D) Working Group has revised the 2011 *Antifraud Plan Guideline* (#1690) (Attachment One). He said the focus was to reorganize the guideline more intuitively, eliminate repetitive requirements, and add suggestions to better meet existing requirements for most states. Commissioner Navarro said the Working Group adopted the revisions and presented the revised guideline to the Antifraud (D) Task Force on Oct. 29. He said the Task Force exposed the revisions for comment until Nov. 12. No comments were received on the revised guideline, and the Task Force adopted the revisions on Nov. 16. Commissioner Navarro said Ms. Rafeld and Armand Glick (UT) were integral to completing the revisions.

Ms. Rafeld said in 2019, the Working Group determined that the guideline would be a great resource for the creation of an electronic antifraud submission or repository system to help streamline the submission of antifraud plans nationwide. She said for more than a year, interested parties, interested state insurance regulators, consumer representatives and industry representatives worked on redesigning the guideline to provide valuable insight on key elements an insurance company should consider when developing an antifraud plan.

Ms. Rafeld said the following revisions were made: 1) the 2011 guideline was not written as a law or rule, so the language was updated to assist jurisdictions in their rule and lawmaking process; 2) the content of the guideline was rearranged so that it is

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more intuitive and will assist insurers in taking a logical and comprehensive approach to developing an antifraud plan; 3) definitions were added to reduce different interpretations; 4) the language was streamlined to eliminate duplication and requirements that were overly burdensome to insurers or were functions not performed by insurer Special Investigation Units (SIUs); 5) all current state requirements were added; and 6) new content was added to address hurdles faced by fraud directors in investigating allegations of agent misconduct and insurance fraud.

Ms. Rafeld said while the development and submission of an antifraud plan is not mandated in all states, most state departments of insurance (DOIs) and fraud fighting agencies believe the development of an antifraud plan is a significant and important best practice for insurers, so the revised guideline provides valuable guidance to insurers looking to have strong antifraud measures in place. She said the Antifraud Technology (D) Working Group and the Antifraud (D) Task Force believe that the revised guideline can tremendously assist state fraud bureaus planning to introduce new antifraud plan legislation or revise existing antifraud plan laws in their jurisdictions.

Ms. Rafeld said the Antifraud (D) Task Force intends to utilize the revised guideline as a basis for developing an antifraud plan submission system. Until a system can be developed, the Task Force believes that the revised guideline is a very important antifraud tool for state insurance regulators and the industry.

Birny Birnbaum (Center for Economic Justice—CEJ) said the guideline drafting group explicitly excluded a requirement for insurers to test antifraud data and algorithms for bias and proxy discrimination against protected classes. He asked why the drafting group did not include that requirement. Ms. Rafeld said the group knew this was an important topic, but there were other working groups and task forces addressing the issue, and it would be premature to include such a requirement in the guideline. She noted that many SIUs do not necessarily deal with those issues. She said the Working Group would consider those issues after the other work has been done by the other working groups.

Commissioner Navarro made a motion, seconded by Mr. Doucette, to adopt the revisions to the 2011 Guideline #1690. The motion passed unanimously.

#### 4. Adopted Revisions to the MCAS

Commissioner Richardson said the Market Conduct Annual Statement (MCAS) Revision Process was developed so insurance companies would have appropriate notice regarding what MCAS data needs to be captured in the coming year for future MCAS filings. She said the Market Conduct Annual Statement Blanks (D) Working Group must adopt substantive revisions, such as the addition of data elements or non-technical changes to definitions, by June 1. The Committee must then adopt the proposed revisions by Aug. 1. Finally, the Executive (EX) Committee and Plenary must adopt the proposed revisions by Dec. 31.

Ms. Rebholz said that earlier in 2020 the Working Group decided to make the MCAS questions regarding lawsuits consistent across all lines of business. As a result, the Working Group voted to add the data element “Lawsuits Closed in Consideration of the Consumer” to the Home and Auto MCAS blanks, and it copied the 2021 “Lawsuit” definition from the Life and Annuity MCAS Data Call and Definitions. She said the Committee approved the revisions on July 27.

Ms. Rebholz said the Working Group later became aware of unintended complications caused by directly using the definitions from the Life and Annuity MCAS Data Call and Definitions. She said the definition of “Lawsuit” in the MCAS Life and Annuity MCAS Data Call and Definitions is specific to those lines of business, and it does not transfer well to the Home and Auto lines of business. She said on Nov. 16, the Working Group voted to revert the 2021 “Lawsuit” definition back to the definition used in 2019 and 2020. She said this means that company MCAS filings for the 2021 data year will use the 2020 data year definition of “Lawsuit”.

Ms. Rebholz said with the reversion to the 2020 “Lawsuit” definition, the definition of “Lawsuits Closed During the Period with Consideration for the Consumer” needs to be clarified. To keep this definition in line with the 2019 and 2020 “Lawsuit” definition currently being used in the Home and Auto blanks, the phrase “applicant, policyholder, or beneficiary” needs to be replaced with “claimant.”

Ms. Rebholz said the Working Group agrees with the proposed solution for the definition of “Lawsuits Closed During the Period with Consideration for the Consumer.” She asked that the Committee approve the Working Group decision to continue using the definition of “Lawsuit” used for the 2019 and 2020 data years and approve the edits to the definition of “Lawsuits Closed During the Period with Consideration for the Consumer”.

Ms. Rebholz said the Working Group believes that these are technical non-substantive changes that comply with the MCAS

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Revision Process. She said the “Lawsuit” definition will be the same as the 2020 definition, and the change to the “Closed with Consideration for the Consumer” data element, which was adopted prior to June 1, is a clarification that the data element applies to lawsuits arising from claims.

Ms. Rebholz said the Working Group will more closely re-visit the Auto and Home definition of “Lawsuit” in Spring 2021 to determine whether it wants to make a change to definition and, if so, the best way to do so.

Commissioner Clark made a motion, seconded by Commissioner Afable, to adopt the revisions to the Auto and Home MCAS definitions of “Lawsuit” and “Lawsuits Closed During the Period with Consideration for the Consumer.”

### 5. Adopted SDRs for LTC and Updates to the *Market Regulation Handbook*

Director Ramage said on Nov. 19, the Market Conduct Examination Standards (D) Working Group adopted a new long-term care (LTC) policy-in-force standardized data request (SDR) (Attachment Two) and a new LTC claims SDR (Attachment Three). He said the Working Group also updated examination standards addressing supplementary and short-term limited-duration (STLD) health insurance plans (Attachment Four). Director Ramage said the LTC SDRs will be incorporated in the Handbook reference documents. Director Ramage said the updated health examination standards are based upon the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170), and they will be included in Chapter 24—Conducting the Health Examination of the Handbook.

Mr. Doucette made a motion, seconded by Commissioner Navarro, to adopt the LTC policy-in-force SDR, the LTC claims SDR, and the updates to Chapter 24 of the Handbook. The motion passed unanimously.

### 6. Adopted its Task Force and Working Group Reports

#### a. Antifraud (D) Task Force

Commissioner Navarro said the Antifraud (D) Task Force met Nov. 16 and adopted its Oct. 30 and Oct. 26 minutes. Commissioner Navarro said the Task Force adopted the revision to Guideline #1690. Commissioner Navarro said the Task Force received updates from the Antifraud Education Enhancement (D) Working Group. He said the Working Group hosted an investigator safety webinar on Sept. 30 for state insurance investigators, which had over 230 attendees from all over the country. He said the Working Group also held an advance training webinar on Nov. 19 concerning ecoATM, which is an outside source assisting fraud investigators with fraudulent claims involved mobile devices. Commissioner Navarro said the Task Force received reports on matters of national interest to the insurance fraud bureaus from the National Insurance Crime Bureau (NICB) and the Coalition Against Insurance Fraud (CAIF).

#### b. Producer Licensing (D) Task Force

Superintendent Dwyer said the Producer Licensing (D) Task Force met Nov. 13 and adopted its Oct. 30 minutes, which included adoption of the Task Force’s 2021 proposed charges.

Superintendent Dwyer said the Task Force discussed state implementation of remote examinations. She said the National Insurance Producer Registry (NIPR) continues to work with the states and testing vendors to track state implementation of online examinations. She said 25 states have implemented online examinations, and two other states are scheduled to implement online examinations during the fourth quarter of 2020. She said in response to a request from the American Council of Life Insurers (ACLI), the Task Force requested that the Producer Licensing Uniformity (D) Working Group review the examination standards in the *State Licensing Handbook* regarding state implementation of remote examinations to avoid disruptions should physical testing become unavailable.

Superintendent Dwyer said the Task Force discussed adjuster licensing uniformity and reciprocity, which included the following issues for future discussion: 1) home state examination requirement only; 2) simplified fingerprinting; 3) using a uniform application; 4) implementing uniform license renewals; 5) implementing uniform and reciprocal continuing education (CE); 6) streamlining the licensing of adjusters after catastrophe losses; 7) eliminating the licensing of adjusters by line of authority; and 8) implementing consistent application of the Designated Home State standard.

Superintendent Dwyer said the Task Force received updates from the Producer Licensing Uniformity (D) Working Group and the Uniform Education (D) Working Group. She said the two working groups have not met this year, but they reported that 37

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jurisdictions have signed the Continuing Education Reciprocity (CER) Agreement, which the NAIC membership adopted earlier this year.

Superintendent Dwyer said the Task Force discussed producer licensing uniformity and reciprocity, which the NAIC last formally reviewed in 2011. She said in 2011, the National Association of Registered Agents and Brokers (NARAB) Working Group recommended to the NAIC membership that 40 jurisdictions be certified as reciprocal for the purposes of Gramm-Leach-Bliley Act (GLBA) producer licensing. She said it is unknown when the NARAB Board might be appointed pursuant to NARAB II, which was signed into law in 2015. She said the Task Force agreed that further review of state compliance with uniform and reciprocal licensing standards should occur.

Superintendent Dwyer said the Task Force discussed draft procedures for amending the NAIC Uniform Applications, which were drafted as a starting point to address the Task Force's charge to "draft procedures for amending the NAIC's uniform producer licensing applications and uniform appointment form to ensure consistency with the NAIC membership's goal of maintaining uniform and stable applications that encourage the efficient use of electronic technology." She said the Task Force will receive comments on the draft procedures until Dec. 14.

Superintendent Dwyer said the Task Force received a report from the NIPR Board of Directors. She said NIPR's assets are \$5.16 million higher than this time last year, and it is scheduled to achieve its budgeted revenue target for 2020. She said the NIPR Board of Directors is developing the 2021 budget and a strategic plan for the next three years. She noted that NIPR continues to be a source of producer licensing-related information for the states and industry through its COVID-19 Information Resource Center on the NIPR website, which centralizes the state specific bulletins relating to producer licensing and exam vendor updates.

Superintendent Dwyer said the Task Force also discussed producer licensing standards for pet insurance in response to the Pet Insurance (C) Working Group's recommendation to remove Section 6 from the draft Pet Insurance Model Act and replace it with a drafting note that reads, "when each state considers adopting this model, they should review the NAIC *State Licensing Handbook* and other guidance adopted by the Task Force with respect to licensing issues." She said the Task Force requested that the Producer Licensing Uniformity (D) Working Group review the uniform licensing standards for pet insurance.

### c. Market Conduct Examination Standards (D) Working Group

Director Rame said the Market Conduct Examination Standards (D) Working Group met Nov. 19 and Oct. 20. Director Rame said on Nov. 19, the Working Group: 1) adopted revisions to the introduction section and the marketing and sales examination standards two and three in the Conducting the Health Examination chapter for inclusion in the Handbook; and 2) adopted a new LTC in-force policy SDR and a new LTC claims SDR for inclusion in the reference documents of the Handbook. Director Rame said on Oct. 20, the Working Group: 1) discussed revisions to the Conducting the Health Examination chapter of the Handbook to address the provisions of the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170); and 2) discussed LTC SDRs addressing in-force policies and LTC claims for inclusion in the reference documents of the Handbook.

### d. Market Analysis Procedures (D) Working Group

Mr. Haworth said the Market Analysis Procedures (D) Working Group met three times since the Summer National Meeting. He said the Working Group met Nov. 12, Oct. 22 and Sept. 10.

Mr. Haworth said the Working Group reviewed the 2020 MCAS filings for the current filing period. He said the Working Group provided all companies with a 60-day extension to file due to the COVID-19 pandemic. However, he said there were many companies filing MCAS filings for the first time, and many of them asked for additional extensions. He said the Working Group is considering requiring companies to report how the COVID-19 pandemic affected their 2020 data.

Mr. Haworth said the Working Group heard updates on the revisions to the *MCAS Best Practices Guide* and the market analysis chapters of the Handbook. He said the *MCAS Best Practices Guide* was first developed about eight years ago and was overdue for updating. He said the revisions are now complete, and the drafting group is going to review other MCAS documents to ensure consistency. He said the market analysis chapters of the Handbook are being reviewed in light of the changing technology available to market analysts. He said the drafting group has completed one out of the six chapters, but it should be finished by the Spring National Meeting.

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Mr. Haworth said during the Nov. 12 meeting, the Working Group discussed an industry request to allow the ability for more than one attestation per NAIC company code. He said companies that file multiple lines of business or in multiple states often have different people who should attest to the data. He said the Working Group plans to consider options for allowing companies to have multiple attestors in the MCAS.

Mr. Haworth said the Working Group began discussions on providing technical market analysis training to state insurance regulators, and it is receiving comments on what training is needed by jurisdictions.

### e. Market Conduct Annual Statement Blanks (D) Working Group

Ms. Rebholz said the Market Conduct Annual Statement Blanks (D) Working Group met Nov. 16. She said in addition to discussing needed edits to the Home and Auto MCAS, the Working Group considered options for the collection of transaction level data.

Ms. Rebholz said the Market Conduct Annual Statement Blanks (D) Working Group is currently working to create MCAS blanks for lines of business approved by the Market Analysis Procedures (D) Working Group. She said the new lines of business are Other Health and Travel Insurance. She said the CEJ submitted proposals for capturing MCAS data for these two new lines of business at the transaction level. She said the Working Group had several questions, and it asked NAIC Information Technology (IT) staff to provide a presentation about transaction level data collection during the Working Group's October meeting. She said this provided the Working Group with a better understanding of transaction level data along with potential technical effects. She said during its November meeting, the proposals for capturing transaction level data for the MCAS were discussed further. She said while the Working Group members are interested in transaction level data, the Working Group determined that the collection of this type of data does not fit into the current structure of MCAS reporting, and review of this type of data at the state level would put a strain on available resources. She said the Working Group does not plan to pursue transaction level data collection at this time. She asked the Committee to advise the Working Group if they desire more work to be done in the direction of transaction level data reporting for the MCAS.

Commissioner Richardson asked the Committee for its thoughts on the collection of MCAS data at the transaction level. Mr. Birnbaum noted that earlier in the meeting, the Committee adopted transaction level reporting for LTC. He said there is no impediment. He said the MCAS does not specify that data must be collected at either a summary or transaction level. He asked what issues the Working Group members have with transactional level reporting. Ms. Rebholz said collecting MCAS data at a transactional level would be a sea change for the MCAS. She also said even though the NAIC could roll up the transactional level data into summary level reports for market analysts, the data still needs to be analyzed at both the summary and transactional levels. She said the Working Group did not think it could make that big of a change without direction from the Committee.

Commissioner Clark made a motion, seconded by Commissioner Afable, to defer discussion on transactional level data collection until a later date. The motion passed unanimously.

### f. Market Regulation Certification (D) Working Group

Mr. Haworth said the Market Regulation Certification (D) Working Group met three times since the Summer National Meeting. He said the Working Group met Nov. 12, Oct. 19, and Sept. 9. Mr. Haworth said the Working Group developed and discussed a scoring matrix for the Voluntary Market Regulation Certification Program. He said the pass and fail scoring matrix divides the checklist questions into three color-coded categories. They are red for mandatory requirements, yellow for non-mandatory requirements, and green for questions that only provide supporting documentation. Mr. Haworth said the mandatory requirements need to be met for a jurisdiction to be certified. He said the non-mandatory requirement scores will be weighted based on their importance to the ideal functioning of a DOI's market regulation division. Mr. Haworth said after receiving general agreement for the scoring matrix, the Working Group is now considering more revisions to the program guideline to match the scoring matrix color-coding scheme.

### g. Privacy Protections (D) Working Group

Ms. Amann said the Privacy Protections (D) Working Group met Nov. 20. She said during the meeting the Working Group adopted its July 30 minutes, which included receiving an update on federal and state privacy legislation and hearing a presentation on comparative analysis.

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Ms. Amann said the Working Group began the initial draft of a gap analysis using the *Privacy of Consumer Financial and Health Information Regulation* (#672) as a baseline. She said the Working discussed the gap analysis of consumers issues related to notification, portability, opt-in/opt-out and disclosures.

Ms. Biehn made a motion, seconded by Commissioner Clark, 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 Five); 5) Market Conduct Annual Statement Blanks (D) Working Group (Attachment Six); 6) Market Conduct Examination Standards (D) Working Group (Attachment Seven); 7) Privacy Protections (D) Working Group (Attachment Eight); 8) Market Regulation Certification (D) Working Group (Attachment Nine); and 9) Market Actions (D) Working Group. The motion passed unanimously.

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

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*Adopted by the Executive (EX) Committee and Plenary, XXXX*

*Adopted by the Market Regulation and Consumer Affairs (D) Committee, Dec. 8, 2020*

*Adopted by Antifraud (D) Task Force, Nov. 16, 2020*

*Adopted by Antifraud Technology (D) Working Group, Oct. 29, 2020*

## **ANTIFRAUD PLAN GUIDELINE**

### **Narrative**

As insurance fraud costs insurers and consumers billions of dollars annually, and no line of insurance is immune to fraud, state departments of insurance (DOIs) believe it's imperative that insurers make the detection, investigation and reporting of suspected fraud a priority in its overall operations. Failure to dedicate resources towards the fight against insurance fraud can tremendously affect an insurer's financial stability, as well as rates charged to consumers. In light of the aforementioned, insurers are encouraged to proactively take measures to minimize the cost of fraud.

To encourage insurers to take a proactive approach to fighting fraud, and minimize organizational risk, many states require the preparation and/or submission of an antifraud plan. Such plans are often audited and inspected for compliance purposes and/or are reviewed in conjunction with market conduct and financial examinations conducted.

While the development and submission of an antifraud plan is currently not mandated in all states, most state DOIs and fraud fighting agencies believe it is a best practice for all insurers, whether state mandated or not, to develop an antifraud plan that which documents the antifraud efforts an insurer has put in place to prevent, detect investigate and report fraud. As such, this guideline is intended to serve as a guide for insurance company special investigation units (SIU) and other interested parties in the preparation of antifraud plans that meet state mandates.

In the spirit of promoting uniformity amongst the states, and providing insurers with added insight regarding key elements that should be considered when developing an antifraud plan, state fraud bureaus are encouraged to utilize this guideline to introduce new antifraud plan legislation or revise existing antifraud plan laws in their states.

To further uniformity in this area, and assist both insurers and state DOIs with compliance efforts, the NAIC Antifraud Task Force intends to utilize this revised guideline as a basis for developing an antifraud plan submission repository / system that will streamline insurer antifraud plan compliance nationwide. Until such a system is developed and implemented, insurers are encouraged to utilize this guideline, and incorporate all information outlined within the document when developing and/or updating company antifraud plans.

Important Note: Unless this guideline is adopted by a state, this guideline does not preempt existing state laws.

**ANTIFRAUD PLAN GUIDELINE****Table of Contents**

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**Section 1. Application**

The purpose of this ~~guideline~~regulation is to establish standards for ~~state fraud bureaus~~, insurance company ~~SIUs~~special investigation units (SIU) and any other interested parties regarding the preparation of an Antifraud Plan that meets the mandated requirements ~~for submitting a plan with a state Department of Insurance. Currently, twenty states require that fraud plans be prepared for inspection by the state Departments of Insurance. The concept of mandating the submission of an insurer fraud plan was developed to encourage those insurers with direct written premiums to fight insurance fraud proactively by drafting a plan to fight fraud. This plan, along with audits, inspections, or in conjunction with a market conduct examinations, ensure the insurer is following its submitted antifraud plan~~of [insert Department of Insurance (DOI) name].

~~These guidelines are primarily intended for state fraud bureaus as a guide in the preparation of new antifraud plan legislation, revision of existing mandated antifraud plans and for insurer SIUs in the preparation of its antifraud plans. The intention of this guideline is to collate the current twenty states' antifraud plan requirements into a guide for those states researching what should go into a plan. Most national fraud fighting agencies believe it is a good practice for all insurers, whether it is state mandated or not, to develop an internal insurance antifraud plan. Flexibility should be allowed for each insurer to develop a plan that meets its individual needs and still meets state compliance standards.~~

~~This guideline does not preempt other state laws. This guideline is not intended to preempt or amend any guidance previously published by the NAIC Antifraud Task Force or in the NAIC Fraud Prevention Law Model Act. This document is intended to provide a road map for state fraud bureaus, insurers' SIUs or contracted SIU vendors for preparation of an antifraud plan.~~

Drafting Note: In lieu of an agency name, states may amend this statement to incorporate a reference to a state law / rule.

**Section 2. Definitions ~~reserved for state specific information~~**

- A. "Insurance" means any of the lines of authority authorized by state law.
- B. "Insurance commissioner" or "commissioner" means the insurance commissioner of this state.
- C. "Insurer" means a company required to be licensed under the laws of this state to provide insurance products.
- D. "Material or substantive change" means any change, modification or alteration of the operations, standards, methods, staffing or outsourcing utilized by the insurer to detect, investigate and report suspected insurance fraud.
- E. "National Association of Insurance Commissioners" (NAIC) means the organization of state insurance regulators from the fifty (50) states, the District of Columbia and all participating U.S. territories.
- F. "Report in a timely manner" means in accordance with all applicable laws and rules of the state.

Drafting Note: States are able to insert a reference to a state law / rule if they feel it is necessary.

- G. "Respond in a reasonable time" means to respond in accordance with all applicable laws and rules of the state.

Drafting Note: States are able to insert a reference to a state law / rule if they feel it is necessary.

- H. "Special Investigation Unit" (SIU) means an insurer's unit or division that is established to investigate suspected

insurance fraud. The SIU may be made up of insurer employees or by contracting with other entities.

- I. "Suspected Insurance Fraud" means any misrepresentation of fact or omission of fact pertaining to a transaction of insurance including claims, premium and application fraud. These facts may include but are not limited to evidence of doctoring, altering or destroying forms, prior history of the claimant, policy holder, applicant or provider, receipts, estimates, explanations of benefits (EOB), medical evaluations or billings, medical provider notes, police and/or investigative reports, relevant discrepancies in written or oral statements and examinations under oath (EUO), unusual policy activity and falsified or untruthful application for insurance. An identifiable pattern in a claim history may also suggest the possibility of suspected fraudulent claims activity. A claim may contain evidence of suspected insurance fraud regardless of the payment status.

Drafting Note: states can insert, modify or delete definitions as needed and/or insert references to state law if necessary

### Section 3. **Antifraud Plan Creation/Submission Requirement**

- A. An insurer, ~~if required by a Department of Insurance,~~ subject to [insert appropriate state code], shall ~~submit to the Commissioner [or Fraud Bureau] a detailed description of the company's~~ create an antifraud plan. ~~All that documents the insurer's~~ antifraud ~~efforts~~ plans submitted shall be subject to review by the Commissioner.
- B. An insurer shall develop a written plan within [insert number of days based upon state law] days after obtaining its license to transact business within this state or within [insert number of days] days after beginning to engage in the business of insurance.
- C. The DOI has the right to review an insurer's antifraud plan in order to determine compliance with appropriate state laws.
- D. An insurer shall submit their antifraud plan in accordance with all state laws, regulations and requirements.

Drafting Note: States are able to insert a reference to a state law / rule if they feel it is necessary.

- E. If an insurer makes a material / substantive change in the manner in which they detect, investigate and/or report suspected insurance fraud, or there is a change in the person(s) responsible for the insurer's antifraud efforts, the insurer will be required to amend [and submit] their antifraud plan within [insert number of days] days of the change(s) being made.

Drafting Note: States without mandatory submission requirements should adjust this section appropriately.

### Section 4. **Antifraud Plan Requirements**

- A. The following information should be included in the submitted An antifraud plan to satisfy this Section. ~~The plan is an acknowledgment that the insurer and its SIU has established criteria that will be used to~~ overview of the insurer's efforts to prevent, detect ~~suspicious or fraudulent~~ investigate and report all aspects of suspected insurance activity relating ~~fraud related~~ to the different types of insurance offered by that insurer. ~~All antifraud plans submitted shall be subject to review by the Commissioner.~~
- B. One ~~SIU~~ antifraud plan may cover several insurer entities if one SIU has the fraud investigation mission for all entities.

~~The plan should include:~~

A. ~~General Requirements~~

- C. (1) ~~The following information should be included in the submitted antifraud plan to satisfy this Section:~~

(1) ~~The insurer's name and NAIC individual and group code numbers;~~

(a) ~~A description of the insurer's approved lines of authority.~~

Drafting Note: Upon exploring the creation of an electronic fraud plan submission system, the working group will explore the possibility of the above noted information auto-populating based upon NAIC carrier data maintained by individual / group codes.

- (12) An acknowledgment that the SIU insurer has established criteria that will be used for the investigation of acts of internal fraud and suspected insurance fraud relating to the different types of insurance offered by that insurer.
- ~~(2) An acknowledgement that the insurer or SIU shall record the date that suspected fraudulent activity is detected, and shall record the date that reports of such suspected insurance fraud were sent directly to the Fraud Bureau/Department within a specific time frame.~~
- ~~(3) A provision stating whether the SIU is an internal unit or an external or third party unit.~~
- (3) A statement as to whether the insurer has implemented an internal and/or external fraud awareness and or outreach program in order to educate employees, applicants, policy holders and/or members of the general public about insurance fraud.
- (a) A description of the insurer's external fraud awareness or outreach program(s) geared towards applicants, policy holders and members of the general public.
- (b) A description of the insurer's internal awareness / antifraud education and training initiatives of any personnel involved in antifraud related efforts. The description shall include:
- (i) An overview of antifraud training provided to new employees.
- (ii) The internal positions the insurer offers regular education and training to, such as underwriters, adjusters, claims representatives, appointed agents, attorneys, etc.
- (iii) A description of training topics covered with employees.
- (iv) The method(s) in which training is provided.
- (v) The frequency and minimum number of training hours provided
- (vi) The method(s) in which employees, policyholders and members of the general public can report suspected fraud.
- (4) 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.
- (a) The insurer shall include a description of their internal fraud reporting policy.
- (b) The insurer shall identify the person and/or position within the organization who is ultimately responsible for the investigation of internal fraud.
- (c) A description of the insurer's standard operating procedures (SOP) for investigating internal fraud.
- (d) The insurer shall include a description of the reporting procedures it 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.).
- ~~(45) If the SIU is an internal unit, provide a description of whether the unit is part of the insurer's claims or underwriting departments, or whether it is separate from such departments. A 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.

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

(b) The criteria used to report suspicious claims of insurance fraud for investigation to an insurer's SIU.

~~(5) A written description or chart outlining the organizational arrangement of the insurer's antifraud positions responsible for the investigation and reporting of possible fraudulent insurance acts.~~

~~(a) If SIU is an internal unit, the insurer shall provide general contact information for the company's SIU.~~

~~(b) If SIU is an external unit, the insurer shall provide (1) the name of the company or companies used; (2) contact information for the company; and (3) a company organizational chart. The insurer shall specify the person or position at the insurer responsible for maintaining contact with the external SIU Company.~~

~~(c) If an external SIU is employed for purposes of surveillance, the insurer shall include a description of the policies and procedures implemented.~~

~~(6) A provision where the insurer provides the NAIC individual and group code numbers;~~

(6) A statement as to whether the insurer has established an internal SIU to investigate suspected insurance fraud.

(a) A description as to whether the unit is part of any other department within the organization.

(b) A description or chart outlining the organizational arrangement of all internal SIU positions/ job titles.

(a) A general overview of each SIU position is required. In lieu of a general overview, insurers can provide a copy of all applicable position descriptions to the DOI.

Drafting Note: Upon exploring the creation of an electronic fraud plan submission system, the working group will explore the possibility insurers having the ability to upload an organization chart / list of SIU employees / position descriptions, etc

(c) General contact information for the company's SIU as well as contact information for the person/position(s) responsible for overseeing the insurer's antifraud efforts.

(d) A description of the insurer's SOPs for investigating suspected insurance fraud.

~~(7) A statement as to whether the insurer has implemented a fraud awareness or outreach program. If insurer has an awareness or outreach program, a brief description of the program shall be included;~~

~~(8) If the SIU is a third party unit, a description of the insurer's policies and procedures for ensuring that the third party unit fulfills its contractual obligations to the insurer and a copy of the contract with the third party vendor.~~

(7) A statement as to whether the insurer utilizes an external/third party as their SIU or in conjunction with their internal SIU.

(a) If an external/third party is used to substantially perform the insurer's SIU function, the insurer shall provide the name of the company(ies) used and contact information for the company(ies).

- (b) The insurance shall specify the internal persons or position responsible for maintaining contact with the external company(ies) which will serve as the insurer's SIU. The insurer shall provide a description how they will monitor and/or gauge the external/third party's compliance with insurer antifraud mandates.

**Drafting Note:** If a state requires the disclosure of specific and/or all vendors for investigative activities conducted, this section can be modified accordingly.

- (8) A description of the method(s) used to document SIU referrals received and investigations conducted.

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

- (b) The manner in which the insurer tracks SIU/investigative information for compliance purposes; i.e., the number of SIU referrals received, the number of investigations opened, the outcome of investigations conducted, etc.

**Drafting Note:** ~~s~~States that do not mandate fraud reporting ~~should revise or remove inapplicable or have other~~ requirements ~~from~~ ~~should revise~~ this section to reflect state requirements.

#### ~~B. — Prevention, Detection and Investigation of Fraud~~

- ~~(1) A description of the insurer's corporate policies for preventing fraudulent insurance acts by its policy holders.~~
- ~~(2) A description of the insurer's established fraud detection procedures (I.E. technology and other detection procedures).~~
- ~~(3) A description of the internal referral criteria used in reporting suspicious claims of insurance fraud for investigation by SIU~~
- ~~(4) A description of SIU investigation program (IE by business line, external form claims adjustment, venter management SOPs)~~
- ~~(5) A description of the insurer's policies and procedures for referring suspicious or fraudulent activity from the claims or underwriting departments to the SIU.~~

#### ~~C. — Reporting of Fraud~~

- ~~(1) A description of the insurer's reporting procedures for the mandatory reporting of possible fraudulent insurance acts to the Commissioner/Bureau/Division pursuant to Section [Insert applicable State code].~~
- ~~(2) A description of the insurer's criteria or threshold for reporting fraud to the Commissioner.~~
- ~~(3) A description of insurer's means of submission of suspected fraud reports to the Commissioner (e.g. NAIC OFRS, NICB, NHCAA, electronic state system, or other)~~
- (9) A description of the procedures the insurer has established to ensure that suspected insurance fraud is timely reported to [agency/division name] pursuant to [insert reference to state law].
  - (a) A statement as to which individual(s) or group, within the organization is responsible for reporting suspected fraud on the insurer's behalf.
    - (i) When composing such a statement, companies may cite specific position descriptions in lieu of employee names.
    - (ii) A description of the insurer's criteria or threshold for reporting fraud to the Commissioner.

(iii) A description of insurer's means of submission of suspected fraud reports to the Commissioner (e.g. Online Fraud Reporting System (OFRS), National Insurance Crime Bureau (NICB), National Health Care Anti-Fraud Association (NHCAA), electronic state system, or other).

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

**Drafting Note:** ~~h~~f a state has a mandatory reporting method, this section should be adjusted to reflect an acknowledgment of the reporting method.

#### ~~D. Education and Training~~

- ~~(1) If applicable, a description of the insurer's plan for antifraud education and training initiatives of any personnel involved in antifraud related efforts. This description shall include:~~
- ~~(a) The internal positions the insurer offers regular education and training, such as underwriters, adjusters, claims representatives, appointment agents, attorneys, etc.~~
  - ~~(b) If the training will be internal and/or external.~~
  - ~~(c) Number of hours expected per year.~~
  - ~~(d) If training includes ethics, false claims or other legal related issues.~~

#### ~~E. Internal Fraud Detection and Prevention~~

- ~~(1) A description of insurer's internal fraud detection policy for employees, consultants or others, such as underwriters, claims representatives, appointed agents, etc.~~
- ~~(2) A description of insurer's internal fraud reporting system.~~

(10) An insurer shall incorporate within its antifraud plan the steps it will take to ensure all information they, or a contracted party possess with regard to a specific claim or incident of suspected insurance fraud is provided in a timely and complete manner when a formal written request from the [insert agency/division name] has been received.

- (a) For the purpose of this section, the timely release of information means by the deadline provided by the DOI.

**Drafting Note:** States who have a specific time period in which carriers must provide information can determine if a reference to a state statute or rule is warranted.

- (b) Unless an insurer is able to cite legal grounds for withholding information, they must not redact or withhold any information that has been requested by the DOI.

(i) If an insurer has a reasonable belief that information cannot legally be provided to the DOI, the insurer will be required to provide, in writing, a description of any information being withheld, and cite the legal grounds for withholding such information.

#### ~~Section 5. 18 USC 1033 & 1034 Compliance~~

~~The insurer shall include a description of its policies and procedures for candidates for employment and existing employees for compliance with 18 USC 1033 & 1034 [insert applicable State code if appropriate].~~

#### ~~Section 65. Regulatory Compliance~~

~~A Department of Insurance has the right to review insurer antifraud plans in order to determine compliance with appropriate state laws. A Department further~~The DOI has the right, in accordance with Section [insert specific state code], to take appropriate administrative action against an insurer if it fails to comply with the mandated requirements and/or state laws.

## **Section ~~7~~6. Confidentiality of Antifraud Plan**

The submission of required information is not intended to constitute a waiver of an insurer's privilege, trade secret, confidentiality or any proprietary interest in its antifraud plan or its antifraud related policies and procedures. The Commissioner shall maintain the antifraud plan as confidential. Submitted plans shall not be subject to the Freedom of Information Act (FOIA) if submitted properly under the state statutes or regulations which would afford protection of these materials [insert applicable state code].

**Drafting Note:** State will need to cite state specific privacy and protection authority.

## **~~Section 8. Required Antifraud Plan Submission~~**

~~An insurer, if required by a Department of Insurance, shall submit its antifraud plan within ninety days of receiving a certificate of authority. Plans shall be submitted every 5 years thereafter. An insurer shall submit revisions to its plans within thirty days of a material change being made.~~

~~**Drafting Note:** states without mandatory submission requirements should adjust this section appropriately.~~

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*Chronological Summary of Action (all references are to the Proceedings of the NAIC)*

*2011 Proc. 1<sup>st</sup> Quarter, Vol. I 101, 114, 117, 472-477 (adopted).*

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**CLAIMS STANDARDIZED DATA REQUEST**  
**Long-Term Care Line of Business**

**Contents:** This file should be downloaded from company system(s) and contain one record for any and all [examination state] claims which were submitted, reviewed or processed during the examination period.

**Uses:** Data will be used to determine if the company follows appropriate procedures with respect to the adjudication of claims by the company during the scope of examination:

- Cross-reference to MCAS claims data (record count) to ensure completeness of exam data submitted.

Field Name	Start	Length	Type	Decimals	Description
CoCode	1	5	A		NAIC company code
ConClmNo	6	15	A		Number assigned by the company to identify an entire episode of care
ClmNo	21	15	A		Number assigned by the company to identify specific claim
PolPre	36	3	A		Policy prefix <b>(Blank if NONE)</b>
PolNo	39	20	A		Policy number
PolSuf	59	3	A		Policy suffix <b>(Blank if NONE)</b>
CertNo	62	10	A		Certificate number, if applicable
GroupNo	72	5	A		Group number, if applicable
PolForm	77	10	A		Policy form number as filed with the insurance department
PlanCode	87	6	A		System plan code <b>Please provide a list of system plan codes and their descriptions</b>
InsFirst	93	15	A		First name of insured
InsMid	108	15	A		Middle name of insured
InsLast	123	20	A		Last name of insured
InsAddr	143	100	A		Insured street address
InsCity	243	20	A		Insured city
InsSt	263	2	A		Insured state
InsZip	265	5	A		Insured ZIP code
InsDOB	270	10	D		Date of birth of insured [MM/DD/YYYY]
InsIDNo	280	10	A		Number assigned to individual insured by the company <b>If more than one insured is covered under the contract, repeat this field as necessary. (Ex: InsIDNo1, InsIDNo2, etc.)</b>
IssSt	290	2	A		State abbreviation where policy was issued
PolEffDt	292	10	D		Policy effective date [MM/DD/YYYY]
PolTermDt	302	10	D		If policy was terminated during the exam period, date of termination [MM/DD/YYYY]

Field Name	Start	Length	Type	Decimals	Description
BenDesCd	312	3	A		Benefit description code assigned to the claim (e.g. HHC, NH, ALF, etc.) <b>Please provide a list of codes used along with their meanings</b>
Dup	315	1	A		Is the current claim a duplicate of a previous claim? (Y/N)
OrClmNo	316	10	A		If this was a duplicate claim, enter the claim number of the original/first submission
ClmSubTp	326	1	A		How was the claim submitted? <b>P=Paper, E=Electronic</b>
CertFDt	327	10	D		Date services are certified "from" [MM/DD/YYYY]
CertTDt	337	10	D		Date services are certified "to" [MM/DD/YYYY]
DxCode	347	15	A		Please provide the ICD-10 codes submitted with the claim <b>If more than one diagnosis code was submitted with the claim, repeat this field as needed</b>
PSCode	362	10	A		Place of service code <b>If an internal system code is used, please provide a list of codes used along with their meanings</b>
ProvNam	363	100	A		Name of provider or facility
ProvID	463	10	A		Number assigned to provider or provider Tax ID
ProvTyp	473	3	A		Type of provider <b>Please provide a list of system codes and their meanings</b>
BegDOS	476	10	D		Beginning date of service on the claim [MM/DD/YYYY]
EndDOS	486	10	D		Ending date of service on the claim [MM/DD/YYYY]
ClmNtDt	496	10	D		Date the company or producer received notification of claim [MM/DD/YYYY]
DateEnt	506	10	D		Date claim was entered into the company's claim payment system [MM/DD/YYYY]
ClmAckDt	516	10	D		Date company or its producer acknowledged the claim [MM/DD/YYYY]
ClmAdjDt	526	10	D		Claim adjudication/process date [MM/DD/YYYY]
ClmPndRn	536	3	A		Reason for claim pending <b>Please provide a list to explain any codes used</b>
DlyRsn	539	3	A		Reason for claim delay <b>Please provide a list to explain any codes used</b>
DlyLtrDt	542	10	D		Date when delay letter was sent [MM/DD/YYYY]
ClmPdDt	552	10	D		Claim paid date [MM/DD/YYYY]
BillAmt	562	10	N	2	Total amount charged for service
AlwdAmt	572	10	N	2	Total amount allowed for service
ClmPdAmt	582	10	N	2	Amount of claim payment
InterestPd	592	10	N	2	Amount of interest applied to the claim payment, if applicable
ClmDenDt	602	10	D		Claim denial date [MM/DD/YYYY]
ClmDnRn	612	3	A		Reason for claim denial <b>Please provide a list to explain any codes used</b>
ElimAcc	615	3	N		Days accrued toward the applicable elimination period
ElimTyp	618	15	A		Type of elimination period for this kind of service

Field Name	Start	Length	Type	Decimals	Description
EndRec	633	1	A		End of record marker. Please place an asterisk in this field to indicate the end of the record. This must be in the same character position for every record in this table.

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**POLICY IN FORCE STANDARDIZED DATA REQUEST  
Long-Term Care Line of Business**

**Contents:** This file should be downloaded from company system(s) and contain one record for each policy or contract that the company issued which provided long-term care insurance coverage to [applicable state] residents at any time during the examination period.

For any fields where there are multiple entries, please repeat field as necessary. If fields are related, denote by adding a number suffix to applicable fields.

**Uses:** Data will be used to determine if the company follows appropriate procedures with respect to the issuance of long-term care policies or contracts in [applicable state] within the scope of the examination.

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

Field Name	Start	Length	Type	Decimals	Description
CoCode	1	5	A		NAIC company code
PolPre	6	3	A		Policy prefix ( <b>Blank if NONE</b> )
PolNo	9	20	A		Policy number
PolSuf	29	3	A		Policy suffix ( <b>Blank if NONE</b> )
CertNo	32	10	A		Certificate number, if applicable
GroupNo	42	5	A		Group number, if applicable
PaySt	47	2	A		State where premium is reported in annual statement, as of the end of the exam period
PolType	49	25	A		Type of policy (i.e. long-term care, limited long-term care, nursing home only, life rider, etc.)
PolSt	74	2	A		State abbreviation of insured as of the end of the exam period
IssSt	76	2	A		State abbreviation where policy was issued
PolForm	78	10	A		Policy form number as filed with the insurance department
ProdName	88	50	A		Company’s product name
PrCode	138	9	A		Company internal producer, CSR, or business entity producer identification code <b>Please provide a list to explain any codes used</b>
NPN	147	6	A		National producer number
PRFirst	153	15	A		First name of producer or CSR
PRMid	168	15	A		Middle name of producer or CSR
PRLast	183	20	A		Last name of producer or CSR or name of business entity producer
Joint	203	1	A		Is this a joint benefit contract? (Y/N)

Field Name	Start	Length	Type	Decimals	Description
InsIDNo	204	10	A		Number assigned to individual insured by the company <b>If more than one insured is covered under the contract, repeat this field as necessary. (Ex: InsIDNo1, INsIDNo2, etc.)</b>
InsFirst	214	15	A		First name of insured
InsMid	229	15	A		Middle name of insured
InsLast	244	20	A		Last name of insured
InsAddr	264	25	A		Insured street address
InsCity	289	20	A		Insured city
InsSt	309	2	A		Insured state
InsZip	311	5	A		Insured ZIP code
InsDOB	316	10	D		Insured date of birth [MM/DD/YYYY]
InsSx	326	1	A		Insured's sex (M/F)
LTCBnAmA	327	10	N	2	Daily benefit applied for
LTCBnAm	337	10	N	2	Daily benefit issued
BenPICd	347	3	A		Benefit plan code or uniform code utilized by the company to identify eligible benefits <b>Please provide a list of plan codes and their descriptions</b>
LTCInf	350	1	A		Does this contract have an inflation protection benefit? (Y/N)
HCElmPer	351	1	A		Is there a homecare elimination period in this contract? (Y/N)
HCLenElm	352	3	N		Length of homecare elimination period
HCTmElm	355	1	A		Is the homecare elimination period a one-time elimination period (Y/N)
FCElmPer	356	1	A		Is there a facility elimination period in this contract? (Y/N)
FCLenElm	357	3	N		Length of facility elimination period
FCTmELm	360	1	A		Is the facility elimination period a one-time elimination period (Y/N)
LTCQlfy	361	1	A		Is this a qualified or non-qualified policy? <b>Q=Qualified N=Nonqualified</b>
AppDt	362	10	D		The individual's original application date [MM/DD/YYYY]
AppRecDt	372	10	D		Date individual's application received [MM/DD/YYYY]
AppProDt	382	10	D		Date individual's application processed [MM/DD/YYYY]
IssDt	392	10	D		Individual's policy or certificate issue date [MM/DD/YYYY]
EffDt	402	10	D		Individual's policy or certificate effective date [MM/DD/YYYY]
Amrden	412	30	A		All applicable amendments, riders, and endorsements added <b>Please provide a list to explain any codes used</b>
AnnPrem	442	10	N	2	Annual policy premium
PrmRtDt	452	10	D		Date of last premium rate change [MM/DD/YYYY]
PaidDt	462	10	D		Date to which the policy is paid [MM/DD/YYYY]
CanReqDt	472	10	D		Date cancellation requested, if applicable [MM/DD/YYYY]

Field Name	Start	Length	Type	Decimals	Description
CanTerRs	482	64	A		Reason for cancellation/termination of coverage Example: Lapse, death, cash surrender, etc. <b>If codes are used, provide a list of all cancellation codes along with their meanings</b>
CanTer	546	1	A		Who cancelled the coverage <b>C=Consumer</b> and <b>I=Insurer</b>
CanTerNt	547	10	D		Date notice (cancellation, nonrenewal, lapse in coverage) was mailed [MM/DD/YYYY]
CanTerDt	557	10	D		Date policy cancelled/terminated [MM/DD/YYYY]
NonFor	567	1	A		Nonforfeiture option applied to policy? (Y/N)
NonType	568	15	A		Type of nonforfeiture <b>If codes are used, provide a list of all nonforfeiture codes along with their meanings</b>
NonFNDt	583	10	D		Date notice offering nonforfeiture option was made [MM/DD/YYYY]
NonRecDt	593	10	D		Date company received request for nonforfeiture action [MM/DD/YYYY]
NonProDt	603	10	D		Date company processed nonforfeiture request or took nonforfeiture action [MM/DD/YYYY]
NonForPr	613	3	N		Reduced benefit period in months after nonforfeiture option was applied
NonFrAm	616	10	N	2	Amount of policy benefits after nonforfeiture option applied
RefAmt	626	10	N	2	Amount of refund, if applicable
RefDt	636	10	D		Date refund mailed, if applicable [MM/DD/YYYY]
RefTo	646	15	A		Person who received refund, if applicable
EndRec	661	1	A		End of record marker. Please place an asterisk in this field to indicate the end of the record. This must be in the same character position for every record in this table.

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## Chapter 24—Conducting the Health Examination

### Introduction

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

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

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

### IMPORTANT NOTE:

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

This chapter provides a format for conducting health insurance company examinations. Procedures for conducting other types of specialized examinations—such as third-party administrators and surplus lines brokers—may be found in separate chapters.

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

- A. Operations/Management
- B. Complaint Handling
- C. Marketing and Sales
- D. Producer Licensing
- E. Policyholder Service
- F. Underwriting and Rating
- G. Claims
- H. Grievance Procedures
- I. Network Adequacy
- J. Provider Credentialing
- K. Quality Assessment and Improvement
- L. Utilization Review

- M. External Review
- N. Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation

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

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

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

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

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

### **Exempt Benefit Plans**

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

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

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

### **HIPAA—Federal Minimum Requirements**

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

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

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

### **Federally Mandated Benefits**

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

Federally mandated benefits include:

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

### **IIPRC-Approved Products**

When conducting an exam that includes products approved by the Interstate Insurance Product Regulation Commission (IIPRC) on behalf of a compacting state, it is important to keep in mind that the uniform standards—and not state-specific statutes, rules and regulations—are applicable to the content and approval of the product. The IIPRC website is [www.insurancecompact.org](http://www.insurancecompact.org) and the uniform standards are located on its rulemaking record. Compacting states have access through the NAIC System for Electronic Rate and Form Filing (SERFF) to product filings submitted to the IIPRC for approval and use in their respective state or jurisdiction and can use the export tool in SERFF to extract relevant information. Each IIPRC-approved product filing has a completed reviewer checklist(s) to document the applicable uniform standards compliance review. The IIPRC office should be included when a compacting state(s) is concerned that an IIPRC-approved product constitutes a violation of the provisions, standards or requirements of the IIPRC (including the uniform standards).

## **A. Operations/Management**

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

## **B. Complaint Handling**

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

## **C. Marketing and Sales**

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

**STANDARDS  
MARKETING AND SALES**

**Standard 1**

**Regulated entity rules on replacement are in compliance with applicable statutes, rules and regulations.**

**Apply to:** Individual accident and health products in jurisdictions where the NAIC *Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act* (#171) has been adopted

**Priority:** Essential

**Documents to be Reviewed**

- \_\_\_\_\_ Applicable statutes, rules and regulations
- \_\_\_\_\_ Replacement register
- \_\_\_\_\_ Underwriting file
- \_\_\_\_\_ Replacement comparison form (if external replacement)

Others Reviewed

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

**NAIC Model References**

*Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act* (#171),  
Sections 9A and 9B

**Review Procedures and Criteria**

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

Determine if the existing insurer has been notified of replacement as required by applicable statutes, rules and regulations.

Review replacement forms for compliance.

Ensure individual health applications include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other accident and sickness insurance presently in force.

Determine that the insurer or its producer provides applicable notices of replacement to applicants upon determining that a sale of individual health insurance will involve replacement.

**STANDARDS  
MARKETING AND SALES**

**Standard 2**  
**Outline of coverages is in compliance with all applicable statutes, rules and regulations.**

**Apply to:** All health products

**Priority:** Essential

**Documents to be Reviewed**

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

\_\_\_\_\_ Actuarial records

\_\_\_\_\_ Underwriting file

Others Reviewed

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

**NAIC Model References**

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

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

[\*Supplementary and Short-Term Health Insurance Minimum Standards Model Act \(#170\)\*](#)

**Review Procedures and Criteria**

Determine if all outlines of coverages used are authorized by the regulated entity.

Look for verification that outlines of coverages used have been approved by appropriate persons within the regulated entity.

Determine that health policy mandated benefits and benefit limitations are completely and accurately described.

Determine that the following information has been disclosed in all solicitation and sales materials:

- The extent to which premium rates for an individual and dependents are established or adjusted based on rating characteristics;
- The carrier's right to change premium rates and the factors, other than claim experience, that affect changes in premium rates;
- The provisions relating to renewability of policies and contracts;
- Any provisions relating to any preexisting condition provision; and
- All individual health benefit plans offered by the carrier, the prices of the plans, if available to the eligible person and the availability of the plans to the individual.

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

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

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

**STANDARDS  
MARKETING AND SALES**

**Standard 3**

**The regulated entity has suitability standards for its products, when required by applicable statutes, rules and regulations.**

**Apply to:** All health products

**Priority:** Recommended

**Documents to be Reviewed**

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

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

\_\_\_\_\_ Training materials

\_\_\_\_\_ Procedure manuals

Others Reviewed

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

**NAIC Model References**

[Supplementary and Short-Term Health Insurance Minimum Standards Model Act \(#170\), Section 4](#)

**Review Procedures and Criteria**

Determine whether the regulated entity makes multiple sales to individuals of the same product. Use random selection of policyholders and have regulated entity run a policyholder history to identify the number of policies sold to those individuals. Particular attention should be given to long-term care and Medicare products.

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

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

Determine if negative enrollment practices are permitted and used.

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

## **D. Producer Licensing**

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

## **E. Policyholder Service**

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

**STANDARDS**  
**POLICYHOLDER SERVICE**

**Standard 1**  
**Reinstatement is applied consistently and in accordance with policy provisions.**

**Apply to:** All health products  
Disability income products

**Priority:** Essential

**Documents to be Reviewed**

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

\_\_\_\_\_ Notice of reinstatement

Others Reviewed

\_\_\_\_\_

\_\_\_\_\_

**NAIC Model References**

**Review Procedures and Criteria**

Determine that notice was sent in a timely manner.

Verify that reinstatement provisions were applied consistently and in a non-discriminatory manner.

Verify that reinstatement was applied per policy provisions.

**STANDARDS  
POLICYHOLDER SERVICE**

**Standard 2**

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

**Apply to:** All health plans

**Priority:** Essential

**Documents to be Reviewed**

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

\_\_\_\_\_ Policy history file

\_\_\_\_\_ Regulated entity procedures manual

Others Reviewed

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

\_\_\_\_\_

\_\_\_\_\_

**NAIC Model References**

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

**Review Procedures and Criteria**

“Creditable coverage” includes most health coverage, including prior coverage under:

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

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

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

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

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

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

Certificates should automatically be issued to:

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

Creditable coverage certificates should include:

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

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

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

Duplicate certificates should be provided free of charge.

## **F. Underwriting and Rating**

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

**STANDARDS  
UNDERWRITING AND RATING**

**Standard 1**  
**Cancellation practices comply with policy provisions, HIPAA and state laws.**

**Apply to:** All health products  
Disability income products

**Priority:** Essential

**Documents to be Reviewed**

- \_\_\_\_\_ Applicable statutes, rules and regulations
- \_\_\_\_\_ Policy contract
- \_\_\_\_\_ Underwriter's file or notes on a system log
- \_\_\_\_\_ Insured's request (if applicable)
- \_\_\_\_\_ Regulated entity cancellation/nonrenewal guidelines

Others Reviewed

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

**NAIC Model References**

*Small Employer and Individual Health Insurance Availability Model Act (#35)*  
*Group Health Insurance Standards Model Act (#100)*

**Review Procedures and Criteria**

For the group and individual markets, nonrenewal or discontinuance is allowed for:

- Nonpayment of premiums;
- Fraud;
- Insured's request;
- The insured moving outside of service area; or
- The insured terminating membership in an association.

Group coverage may also be terminated for violation of applicable participation/contribution rules. Individuals within groups may be required to select another coverage option for certain misconduct and may lose coverage when they become eligible for Medicare.

An insurer may nonrenew if they discontinue coverage, but they must sit out of the market for 5 years. There are exceptions to this general rule. Refer to HIPAA and state statutes, rules and regulations for the examination of specific situations.

Ensure the regulated entity complies with the provisions of COBRA and HIPAA with respect to continuation of coverage, including required notice periods for withdrawing products from the marketplace.

Note: Many states have specific rules for associations that will provide additional protections. HIPAA addresses the issue of bona fide associations in the individual and group markets in a manner that may also provide additional protections to consumers.

**STANDARDS  
UNDERWRITING AND RATING**

**Standard 2**

**Pertinent information on applications that form a part of the policy is complete and accurate.**

**Apply to:** All health products  
Disability income products

**Priority:** Essential

**Documents to be Reviewed**

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

\_\_\_\_\_ All applications

Others Reviewed

\_\_\_\_\_

\_\_\_\_\_

**NAIC Model References**

*Group Health Insurance Standards Model Act (#100)*

**Review Procedures and Criteria**

Determine if the coverage is issued as applied for.

Determine if the regulated entity has a verification process in place to determine the accuracy of application information.

Verify that applicable nonforfeiture options and dividend options are indicated on the application.

Verify that changes to the application and supplements to the application are initialed by the applicant.

Verify that supplemental applications are used, where appropriate.

**STANDARDS  
UNDERWRITING AND RATING**

**Standard 3**

**The regulated entity complies with the provisions of COBRA and/or continuation of benefits procedures contained in policy forms, statutes, rules and regulations.**

**Apply to:** All health products

**Priority:** Essential

**Documents to be Reviewed**

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

\_\_\_\_\_ Policy forms

\_\_\_\_\_ Regulated entity guidelines

\_\_\_\_\_ Regulated entity marketing materials dealing with continuation of benefits

Others Reviewed

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

**NAIC Model References**

*Individual Health Insurance Portability Model Act (#37), Section 10*

*Group Health Insurance Mandatory Conversion Privilege Model Act (#105)*

**Review Procedures and Criteria**

Review the regulated entity's procedures for providing information pertaining to continuation of benefits, for processing applications for continuation of benefits, for notification to insureds of the beginning and the termination of continuation of benefit periods and for premium notices.

Review continuation of benefit files.

Review declinations/cancellations of continuation of benefits insureds.

Review regulated entity procedures for compliance with COBRA, which allows individuals to continue their group coverage for specified periods of time. In accordance with the provisions of HIPAA:

- An individual may have 29 months of coverage under COBRA if they become disabled during the first 60 days of COBRA coverage. The 29-month extension must also apply to non-disabled family members who were entitled to COBRA coverage;
- COBRA continuation coverage generally can be terminated when an individual becomes covered under another group health plan, which could include a state continuation or risk pool program. COBRA cannot be terminated because of other coverage where the plan limits or excludes coverage for any preexisting condition of the individual. HIPAA limits the circumstances under which a plan may impose a preexisting exclusion period on individuals. If a plan is precluded under HIPAA from imposing an exclusion period on any individual (i.e., it must cover the individual's preexisting condition), COBRA continuation coverage may be terminated;

- Children who are born, adopted or placed for adoption are “qualified beneficiaries” and are thus eligible for COBRA. There is no restriction that they be covered prior to the COBRA qualifying event to be considered a “qualified beneficiary”;
- Guaranteed access requirements to individual insurance must be provided when COBRA benefits are exhausted; and
- If an individual declines coverage due to “other coverage,” COBRA benefits may be required to be exhausted before a “special enrollment” period is allowed due to non-coverage. Note that rules on special enrollment are complex.

**STANDARDS  
UNDERWRITING AND RATING**

**Standard 4**

**The regulated entity complies with the Genetic Information Nondiscrimination Act of 2008.**

**Apply to:** All group health products

**Priority:** Essential

**Documents to be Reviewed**

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

\_\_\_\_\_ Underwriting guidelines and producer guidelines related to group health insurance

\_\_\_\_\_ Rating guidelines related to group health insurance

Others Reviewed

Genetic Information Nondiscrimination Act of 2008 (GINA)

**NAIC Model References**

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

**Review Procedures and Criteria**

For group coverage, GINA prohibits group health plans and health insurance issuers offering health coverage in connection with such a plan from:

- Requesting or requiring genetic testing. Plans that incidentally acquire genetic information will not violate the law;
- Increasing group premiums or denying enrollment based on genetic information;
- Requesting, requiring, or purchasing genetic information for underwriting purposes or with respect to any individual prior to enrollment and in connection with enrollment; and
- Using or disclosing genetic information about an individual for underwriting purposes.

**STANDARDS  
UNDERWRITING AND RATING**

**Standard 5**

**The regulated entity complies with proper use and protection of health information in accordance with statutes, rules and regulations.**

**Apply to:** All health products  
Disability income products

**Priority:** Essential

**Documents to be Reviewed**

- \_\_\_\_\_ Applicable statutes, rules and regulations
- \_\_\_\_\_ Written policies, standards and procedures
- \_\_\_\_\_ Regulated entity guidelines
- \_\_\_\_\_ Rights of individual applicant to access and amend health information

Others Reviewed

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

**NAIC Model References**

*Health Information Privacy Model Act (#55)*  
*Health Maintenance Organization Model Act (#430)*

**Review Procedures and Criteria**

- Review the regulated entity's procedures for proper use of protected health information.
- Review medical/lifestyle questions and underwriting guidelines for AIDS.
- Review guidelines for use of notice and consent form for AIDS.

**STANDARDS  
UNDERWRITING AND RATING**

**Standard 6**

**The regulated entity complies with the provisions of HIPAA and state laws regarding limits on the use of preexisting exclusions.**

**Apply to:** All group health products  
Disability income products

**Priority:** Essential

**Documents to be Reviewed**

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

\_\_\_\_\_ Policy forms and endorsements

\_\_\_\_\_ Regulated entity guidelines

\_\_\_\_\_ Regulated entity materials dealing with HIPAA

Others Reviewed

\_\_\_\_\_

\_\_\_\_\_

**NAIC Model References**

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

*Newborn and Adopted Children Coverage Model Act (#155)*

*Group Health Insurance Standards Model Act (#100)*

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

**Review Procedures and Criteria**

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

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

Continuous coverage is required as follows:

- Issuers are not required to count coverage as creditable if it existed before a 63 day break in coverage (NAIC model allows a 90 day break); and
- Creditable coverage must be in effect for 12 months or 18 months for a late enrollee to fully preempt preexisting conditions. (NAIC model allows 6 months or 12 months for late enrollees);
- “Creditable coverage” includes most health coverage, including:
  - Prior coverage under a group health plan (including a governmental or church plan);
  - Health insurance coverage (either group or individual);
  - Medicare;
  - Medicaid;
  - Military-sponsored health care program such as CHAMPUS (Civilian Health and Medical Program of the Uniformed Services);
  - Program of the Indian Health Service or tribal organization;
  - Qualified state health benefits risk pool;
  - Federal Employees Health Benefit Program;
  - Public health plan established or maintained by a state or local government;
  - COBRA (Consolidated Omnibus Budget Reconciliation Act); or
  - Health benefit plan provided for Peace Corps members.

Waiting periods:

- Generally do not count as creditable coverage unless the individual has other coverage during the waiting period;
- Are not taken into account when determining whether a break of 63 days has occurred; and
- Run concurrently with a preexisting condition exclusion period.

If a carrier imposes a preexisting condition period, the carrier must provide notice that a preexisting condition period will be imposed. If an individual provides evidence of creditable coverage and there would still be a preexisting condition exclusion period remaining, the carrier must notify the individual that a preexisting condition exclusion period will be imposed and for what period of time.

#### Individual Market

HIPAA limitations on preexisting condition exclusions only apply to the group market. The NAIC model outlines limitations for the individual market similar to the group market.

**STANDARDS  
UNDERWRITING AND RATING**

**Standard 7**

**The regulated entity does not improperly deny coverage or discriminate based on health status in the group market or against eligible individuals in the individual market in conflict with the requirements of HIPAA or state law.**

**Apply to:** All health products

**Priority:** Essential

**Documents to be Reviewed**

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

\_\_\_\_\_ Underwriting files of denied policies

\_\_\_\_\_ Regulated entity guidelines

Others Reviewed

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

**NAIC Model References**

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

*Nondiscrimination in Health Insurance Coverage in the Group Market Model Regulation (#107)*

*Group Health Insurance Standards Model Act (#100)*

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

**Review Procedures and Criteria**

For group coverage:

- No individual eligibility determination may be made using health status, physical or mental medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability or disability;
- A special enrollment period must be allowed for changes in family status, including a spouse that declined coverage at open enrollment due to “other coverage” and subsequently lost coverage; and
- Similarly situated individuals cannot be charged a higher premium, pay higher contribution amounts or have limitations or restrictions on their benefits or coverage.

For individual coverage:

- No individual may be denied on the basis of health status if they are an “eligible individual;”
- HIPAA does not preclude states from limiting health status denials for individuals that are not eligible; and
- HIPAA does not preclude states from limiting the ability of an insurer to charge a higher rate to individuals in poor health.

“Eligible individual” includes a person that:

- Has portability because of 18 months of previous coverage most recently under a group plan (including ERISA self-funded plans);
- Has exhausted COBRA benefits or a similar state program;
- Is not eligible for Medicare, Medicaid or a group health plan;
- Is not covered under other health insurance;
- Has had no gaps in coverage exceeding 63 days; and
- Has not been terminated for nonpayment of premiums or fraud.

Note: Under HIPAA’s 45 CFR 148.120, it is the carrier’s responsibility in federal fallback states to offer all federally defined eligible individuals a choice of at least two policies that meet certain requirements and to guarantee issue any of those products to all such individuals that apply for coverage. Furthermore, under 45 CFR 148.126, all carriers in the individual market in federal fallback states are responsible for determining whether an applicant for coverage is an eligible individual, as defined in 45 CFR 148.103. Carriers must exercise reasonable diligence in making this determination.

In a HCFA bulletin issued April 15, 1998 in Missouri, this was interpreted to mean that a carrier has an affirmative responsibility to determine whether an individual is a federally defined eligible individual, whether or not the applicant is aware of his or her status. Compliance by a carrier is also not conditioned upon the type of plan for which the applicant applied. Therefore, a carrier that fails to identify all federally defined eligible individuals and treat them accordingly could potentially be subject to penalties.

For association group coverage in the group or individual market, determine:

- Whether the regulated entity has an arm’s-length relationship with the association;
- If the regulated entity or its affiliates have any control over the association;
- If the association had a 100-person membership at the outset, and if the association has a shared or common purpose;
- If the association has been organized and maintained in good faith primarily for purposes other than obtaining insurance;
- If the association has been in active existence for at least one year and has a constitution and by-laws that require the association to hold regular meetings (at least annually);
- How the association solicits dues or contributions from its members;
- If the association allows its members to have voting privileges and representation on the board and committees;
- If the policy provides the applicable coverage to all members of the association;
- How the premium for the policy is paid; and
- How the association obtains new members.

**STANDARDS  
UNDERWRITING AND RATING**

**Standard 8**

**The regulated entity issues coverage that complies with guaranteed-issue requirements of HIPAA and related state laws for groups of 2 to 50.**

**Apply to:** All small group health products

**Priority:** Essential

**Documents to be Reviewed**

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

\_\_\_\_\_ Underwriting files of denied policies

\_\_\_\_\_ Regulated entity guidelines

Others Reviewed

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

**NAIC Model References**

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

**Review Procedures and Criteria**

Small group coverage must be issued on a guaranteed-issue basis for all products, subject to participation and contribution requirements. No eligible employee or dependent can be excluded on the basis of health status or related factors. The NAIC model requires regulated entities to include a basic and standard plan in offerings.

HIPAA defines a small group as 2 to 50, but allows states to add groups of 1 and/or groups of more than 50 employees.

Under the NAIC model, individual coverage must be issued on a guaranteed-issue basis for all products, including basic and standard plans, with exceptions for individuals eligible for other coverages. The alternative version limits guaranteed-issue to annual open enrollment periods.

**STANDARDS  
UNDERWRITING AND RATING**

**Standard 9**

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

**Apply to:** All health products

**Priority:** Essential

**Documents to be Reviewed**

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

\_\_\_\_\_ Underwriting files of denied policies

\_\_\_\_\_ Regulated entity guidelines

Others Reviewed

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

**NAIC Model References**

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

**Review Procedures and Criteria**

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

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

**STANDARDS  
UNDERWRITING AND RATING**

**Standard 10**

**The regulated entity does not administer self-funded benefit plans for entities subject to state regulation (e.g., MEWAs) or provide insurance coverage to entities not entitled to such coverage under state or federal law.**

**Apply to:** All group health plans

**Priority:** Essential

**Documents to be Reviewed—Multiple employer groups NOT claiming exemption from state regulation**

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

\_\_\_\_\_ Listing of multiple employer groups (including associations) provided insurance coverage

\_\_\_\_\_ Organizational documents or such other information, indicating these entities meet state or federal laws to purchase group coverage

\_\_\_\_\_ Forms and endorsements issued to such groups and copy of insurance department approval (if applicable)

\_\_\_\_\_ Rates charged such groups and insurance department approval of same (if applicable)

**Documents to be Reviewed—Multiple employer groups claiming exemption from state regulation**

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

\_\_\_\_\_ Listing of multiple employer groups for whom self-funded benefits are administered

\_\_\_\_\_ Organizational documents or such other information indicating these entities meet state or federal laws to provide self-funded benefits exempt from state regulation

Others Reviewed

\_\_\_\_\_

\_\_\_\_\_

**NAIC Model References**

*Prevention of Illegal Multiple Employer Welfare Arrangements (MEWAs) and Other Illegal Health Insurers Model Regulation (#220)*

*Group Health Insurance Standards Model Act (#100)*

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

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

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

**Review Procedures and Criteria—Multiple Employer entities claiming exemption from state regulation**

Determine if the multiple employer group satisfies appropriate federal law to be qualified as an entity not subject to state regulation.

## **G. Claims**

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

**STANDARDS  
CLAIMS**

**Standard 1**  
**Claim files are handled in accordance with policy provisions, HIPAA and state law.**

**Apply to:** All health products  
Disability income products

**Priority:** Essential

**Documents to be Reviewed**

- \_\_\_\_\_ Applicable statutes, rules and regulations, including the Unfair Trade Practices Acts, Unfair Claims Settlement Practices Act and Unfair Discrimination Act
- \_\_\_\_\_ Company claim procedure manuals
- \_\_\_\_\_ Claim training manuals
- \_\_\_\_\_ Internal company claim audit reports
- \_\_\_\_\_ Claim bulletins, UCR guidelines and procedure manuals
- \_\_\_\_\_ Company claim forms manual
- \_\_\_\_\_ Claim files

**Others Reviewed**

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

**NAIC Model References**

- Accident and Sickness Insurance Minimum Standards Model Act (#170)*
- Consumer Credit Insurance Model Act (#360)*
- Consumer Credit Insurance Model Regulation (#370)*
- Coordination of Benefits Model Regulation (#120)*
- Insurance Fraud Prevention Model Act (#680)*
- Nondiscrimination in Health Insurance Coverage in the Group Market Model Regulation (#107)*
- Off-Label Drug Use Model Act (#148), Section 4*
- Unfair Claims Settlement Practices Act (#900)*
- Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)*
- Health Maintenance Organization Model Act (#430)*

**Review Procedures and Criteria**

Review company procedures, training manuals and claim bulletins to determine if company standards exist and whether such standards comply with state laws.

Determine if company procedures provide for the detection and reporting of fraudulent or potentially fraudulent insurance acts to the commissioner.

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

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

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

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

Determine if claim files are handled according to policy provisions.

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

Determine if claim handling includes proper referral of suspicious claims.

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

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

For disability income insurance claims:

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

- Where applicable, verify that Social Security benefit increases for inflation are not used to adjust the benefit amount. Likewise, if the Social Security benefit decreases, the offset must also decrease where required by ERISA;
- Verify that cash settlement offers are fair, reasonable and documented; and
- Ensure that overpayment recoveries due to workers' compensation lump sum awards are from only the income protection portion, and not from the medical or other expenses portion of the award.

It is an unfair practice to attempt to settle or settle a claim on the basis of an application that was materially altered without the consent of the insured.

For credit insurance, a provision in the individual policy or certificate that sets a maximum limit on total claim payments must apply only to that individual policy or certificate.

**STANDARDS  
CLAIMS**

**Standard 2**

**The company complies with the requirements of the federal Newborns' and Mothers' Health Protection Act of 1996.**

**Apply to:** All health lines offering maternity coverage

**Priority:** Essential

**Documents to be Reviewed**

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

\_\_\_\_\_ Company claim procedure manuals

Others Reviewed

Newborns' and Mothers' Health Protection Act of 1996

**NAIC Model References**

*Unfair Claims Settlement Practices Act (#900)*

*Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)*

*Health Maintenance Organization Model Act (#430)*

**Review Procedures and Criteria**

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

Unless the state has a specific exemption because of an alternative law, HIPAA requires that all group health plans, insurance companies and HMOs offering health coverage for hospital stays in connection with the birth of a child must provide health coverage for a minimum of 48 hours for a normal natural (non-cesarean) delivery and 96 hours for a cesarean section. (Coverage is required for both the mother and the newborn.) Deductibles, coinsurance and other cost-sharing methods may be applied.

Ensure the company does not engage in incentive arrangements to circumvent the requirements of the law. Such incentive requirements could include: making monetary payments or rebates to mothers to encourage them to accept a shorter length of stay; penalizing or reducing or limiting reimbursement of an attending provider because they provided care to an individual for the above minimum time frames; or providing incentives to induce a provider to provide care in a manner inconsistent with the law.

**STANDARDS  
CLAIMS**

**Standard 3**

**The group health plan complies with the requirements of the federal Mental Health Parity Act of 1996 (MHPA) and the revisions made in the Mental Health Parity and Addiction Equity Act of 2008.**

**Apply to:** Certain group health plans offering mental health coverage

**Priority:** Essential

**Documents to be Reviewed**

- \_\_\_\_\_ Applicable statutes, rules and regulations
- \_\_\_\_\_ Company claim procedure manuals
- \_\_\_\_\_ Claim training manuals
- \_\_\_\_\_ Internal company claim audit reports
- \_\_\_\_\_ Claim bulletins, UCR guidelines and procedure manuals
- \_\_\_\_\_ Company claim forms manual
- \_\_\_\_\_ Claim files

**Others Reviewed**

Mental Health Parity Act of 1996

Mental Health Parity and Addiction Equity Act of 2008

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**NAIC Model References**

**Review Procedures and Criteria**

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

Mental Health Parity Act (MHPA) requirements do not apply to 1) small employer groups of two to 50 employees; or 2) any group health plan where the required federal notice has been filed, documenting that actual costs increased two percent or more due to the application of the MHPA requirements during the first year and at least one percent of the actual cost in each subsequent year. The 1996 MHPA does not allow carriers to set annual or lifetime dollar limits on mental health benefits that are lower than any such dollar limits for medical and surgical benefits. The 2008 revisions include substance abuse parity, and the law affects items such as cost-sharing features and utilization restrictions of the substance abuse/mental health benefits when compared to the medical/surgical benefits under the policy.

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

**STANDARDS  
CLAIMS**

**Standard 4**  
**The group health plan complies with the requirements of the federal Women’s Health and Cancer Rights Act of 1998.**

**Apply to:** Certain group health plans offering mastectomy coverage

**Priority:** Essential

**Documents to be Reviewed**

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

\_\_\_\_\_ Company claim procedure manuals

\_\_\_\_\_ Claim training manuals

\_\_\_\_\_ Internal company claim audit reports

\_\_\_\_\_ Claim bulletins and procedure manuals

\_\_\_\_\_ Company claim forms manual

\_\_\_\_\_ Claim files

Others Reviewed

Women’s Health and Cancer Rights Act of 1998

**NAIC Model References**

**Review Procedures and Criteria**

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

The Women’s Health and Cancer Rights Act of 1998 applies to group health plans offering mastectomy coverage. Written notice about the availability of these benefits must be delivered to plan participants upon enrollment and each year afterwards. Deductibles and coinsurance must have parity with other medical/surgical benefits.

Note: The mandate applies to the large and small group marketplace.

**STANDARDS  
CLAIMS**

**Standard 5**  
**The company complies with applicable statutes, rules and regulations for group coverage replacements.**

**Apply to:** Replacement or replaced group health plans

**Priority:** Essential

**Documents to be Reviewed**

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

\_\_\_\_\_ Company claim procedure manuals

\_\_\_\_\_ Claim files

Others Reviewed

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

**NAIC Model References**

*Group Coverage Discontinuance and Replacement Model Regulation (#110)*

**Review Procedures and Criteria**

Ensure the discontinued or replaced group policy provides an extension of benefits to qualified individuals that are totally disabled or confined in a hospital on the date a group contract is discontinued.

Ensure the prior carrier provides a statement of benefits upon a succeeding carrier's request. The statement should include available or pertinent information to permit verification of benefit determinations.

Ensure the succeeding carrier credits deductibles and waiting periods satisfied under the prior carrier's contract, when required.

Ensure the succeeding carrier complies with preexisting condition requirements. The limitation should be the lesser of 1) the benefits of the new plan determined without application of the preexisting condition limitation; or 2) the benefits of the prior plan.

## H. Grievance Procedures

### 1. Purpose

The grievance procedures portion of the examination is designed to evaluate how well the company handles grievances. The NAIC definition of a grievance is a written complaint, or an oral complaint that involves an urgent care request, submitted by or on behalf of a covered person regarding the:

- a. Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;
- b. Claims payment, handling or reimbursement for health care services; or
- c. Matters pertaining to the contractual relationship between a covered person and a health carrier.

Note: This definition may not include all written communications that the company tracks as “complaints” under the NAIC definition of complaint.

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

### 2. Techniques

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

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

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

### 3. Tests and Standards

The grievance handling review includes, but is not limited to, the following standards addressing various aspects of a company’s operations. The sequence of the standards listed here does not indicate priority of the standard.

**STANDARDS  
GRIEVANCE PROCEDURES**

**Standard 1**

**The health carrier treats as a grievance any written complaint, or any oral complaint that involves an urgent care request, submitted by or on behalf of a covered person regarding: 1) the availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; 2) claims payment, handling or reimbursement for health care services; or 3) matters pertaining to the contractual relationship between a covered person and the health carrier.**

**Apply to:** All health carriers offering a health benefit plan

**Priority:** Essential

**Documents to Be Reviewed**

- \_\_\_\_\_ Applicable statutes, rules and regulations
- \_\_\_\_\_ Sample documents and files (including electronic correspondence)
- \_\_\_\_\_ Member evidence of coverage

**Others Reviewed**

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

**NAIC Model References**

*Health Carrier Grievance Procedure Model Act (#72), Section 3R*

**Review Procedures and Criteria**

As grievances are detected during the examination, verify they have been properly handled and recorded.

**STANDARDS  
GRIEVANCE PROCEDURES**

**Standard 2**

**The health carrier documents, maintains and reports grievances and establishes and maintains grievance procedures in compliance with applicable statutes, rules and regulations.**

**Apply to:** All health carriers offering a health benefit plan

**Priority:** Essential

**Documents to Be Reviewed**

- \_\_\_\_\_ Applicable statutes, rules and regulations
- \_\_\_\_\_ Company's grievance handling policies and procedures
- \_\_\_\_\_ Sample of grievances
- \_\_\_\_\_ Member evidence of coverage
- \_\_\_\_\_ Company's grievance register
- \_\_\_\_\_ Company's annual grievance report to the insurance department

**Others Reviewed**

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

**NAIC Model References**

*Health Carrier Grievance Procedure Model Act (#72), Section 5*

**Review Procedures and Criteria**

Verify that the health carrier maintains a grievance register consisting of written records to document all grievances received during a calendar year (the register).

Verify that the health carrier includes requests for first level review of grievances involving an adverse determination in the grievance register.

Verify that the health carrier includes requests for additional voluntary review of grievances involving an adverse determination in the grievance register.

Verify that the health carrier's grievance register contains, at a minimum, the following information:

- A general description of the reason for the grievance;
- The date the grievance was received;
- The date of each review or, if applicable, review meeting;
- The resolution at each level of the grievance, if applicable;
- The date of resolution at each level, if applicable; and
- The name of the covered person for whom the grievance was filed.

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

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

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

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

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

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

**STANDARDS  
GRIEVANCE PROCEDURES**

**Standard 3**

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

**Apply to:** All health carriers offering a health benefit plan

**Priority:** Essential

**Documents to Be Reviewed**

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

\_\_\_\_\_ Grievance procedures

\_\_\_\_\_ All forms used to process a grievance

\_\_\_\_\_ Company approval register

\_\_\_\_\_ Grievance procedure filings filed with the insurance department

\_\_\_\_\_ Certificates of compliance filed with the insurance department

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

**Others Reviewed**

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

**NAIC Model References**

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

**Review Procedures and Criteria**

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

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

Verify that the health carrier files annually with the insurance commissioner, as part of its annual grievance report required by applicable state statutes, rules and regulations, a certificate of compliance stating that the health carrier has established and maintains, for each of its health benefit plans, grievance procedures that fully comply with applicable state statutes, rules and regulations.

Verify that the health carrier includes a description of its grievance procedures in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage provided to covered persons, or, if applicable, the covered person's authorized representative.

Verify that the health carrier's grievance procedure documents include a statement of a covered person's, or, if applicable, the covered person's authorized representative's, right to contact the insurance commissioner's office for assistance at any time. Verify that the statement includes the telephone number and address of the insurance commissioner's office.

**STANDARDS  
GRIEVANCE PROCEDURES**

**Standard 4**

**The health carrier has procedures for and conducts first level reviews of grievances involving an adverse determination in compliance with applicable statutes, rules and regulations.**

**Apply to:** All health carriers offering a health benefit plan

**Priority:** Essential

**Documents to Be Reviewed**

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

\_\_\_\_\_ Sample of first level reviews of grievances involving an adverse determination

Others Reviewed

\_\_\_\_\_

\_\_\_\_\_

**NAIC Model References**

*Health Carrier Grievance Procedure Model Act (#72), Section 7*

**Review Procedures and Criteria**

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

In the case of an adverse determination involving utilization review, verify that the health carrier designates an appropriate clinical peer or peers of the same or similar specialty as would typically manage the case being reviewed to review the adverse determination. Verify that the clinical peer appointed by the health carrier was not involved in the initial adverse determination.

Verify that the health carrier, in designating an appropriate clinical peer or peers ensures that, if more than one clinical peer is involved in the review, a majority of the individuals reviewing the adverse determination are health care professionals who have appropriate expertise.

Verify that the reviewer or reviewers appointed by the health carrier, in conducting a review of an adverse determination involving utilization review, take into consideration all comments, documents, records, and other information regarding the request for services submitted by the covered person, or, if applicable, the covered person's authorized representative, without regard to whether the information was submitted or considered in making the initial adverse determination.

Verify that the health carrier, within three working days of the date of receipt of a first level grievance, informs the covered person, or if applicable, the covered person's authorized representative, of his or her right to submit written comments, documents, records and other material relating to the request for benefits for reviewer consideration when conducting the review.

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

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

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

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

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

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

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

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

- For a first level review decision that upholds the grievance:
  - The specific reason or reasons for the final adverse determination;
  - The reference to the specific plan provisions on which the determination is based;
  - A statement that the covered person, or, if applicable, the covered person's authorized representative, is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant, as the term "relevant" is defined in applicable state statutes, rules and regulations, to the covered person's, or, if applicable, the covered person's authorized representative's, benefit request;
  - If the health carrier relied upon an internal rule, guideline, protocol or other similar criterion to make the final adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the final adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person, or, if applicable, the covered person's authorized representative, upon request;
  - If the final adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances, or a statement that an explanation will be provided to the covered person, or, if applicable, the covered person's authorized representative, free of charge upon request; and
  - If applicable, instructions for requesting:
    - A copy of the rule, guideline, protocol or other similar criterion relied upon in making the final adverse determination, as set forth in applicable state statutes, rules and regulations; and
    - The written statement of the scientific or clinical rationale for the determination, as set forth in applicable state statutes, rules and regulations;
- If applicable, a statement indicating:
  - A description of the process to obtain an additional voluntary review of the first level review decision, if the covered person, or, if applicable, the covered person's authorized representative, wishes to request a voluntary review;
  - The written procedures governing the voluntary review, including any required time frame for the review;
  - A description of the procedures for obtaining an independent external review of the final adverse determination pursuant to applicable state statutes, rules and regulations equivalent to the *Uniform Health Carrier External Review Model Act (#75)* if the covered person, or, if applicable, the covered person's authorized representative, decides not to file for an additional voluntary review of the first level review decision involving an adverse determination; and
  - The covered person's, or, if applicable, the covered person's authorized representative's, right to bring a civil action in a court of competent jurisdiction;
- If applicable, the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your state Insurance Commissioner"; and
- Notice of the covered person's, or, if applicable, the covered person's authorized representative's, right to contact the insurance commissioner's office for assistance at any time, including the telephone number and address of the insurance commissioner's office.

**STANDARDS  
GRIEVANCE PROCEDURES**

**Standard 5**

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

**Apply to:** All health carriers offering a health benefit plan

**Priority:** Essential

**Documents to Be Reviewed**

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

\_\_\_\_\_ Sample of grievances

Others Reviewed

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

**NAIC Model References**

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

**Review Procedures and Criteria**

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

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

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

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

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

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

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

If circumstances beyond the health carrier's control prevent the health carrier from making a decision and notifying the covered person, or, if applicable, the covered person's authorized representative, of that decision within 20 working days, verify that the health carrier takes no longer than an additional 10 working days to issue a written decision, provided that the health carrier provides written notice to the covered person, or, if applicable, the covered person's authorized representative, of the extension and the reasons for the delay on or before the 20th working day after the request for standard review of the grievance.

Verify that the health carrier's written decision issued pursuant to a standard review of a grievance not involving an adverse determination contains all of the following:

- The titles and qualifying credentials of the person or persons participating in the standard review process (the reviewers);
- A statement of the reviewers' understanding of the covered person's grievance;
- The reviewers' decision in clear terms, and the contract basis in sufficient detail for the covered person, or, if applicable, the covered person's authorized representative, to respond further to the health carrier's position;
- A reference to the evidence or documentation used as the basis for the decision;
- If applicable, a statement containing:
  - A description of the process to obtain an additional review of the standard review decision if the covered person, or, if applicable, the covered person's authorized representative, wishes to request a voluntary review pursuant to applicable state statutes, rules and regulations; and
  - The written procedures governing the voluntary review, including any required time frame for the review; and
- Notice of the covered person's, or, if applicable, the covered person's authorized representative's, right, at any time, to contact the insurance commissioner's office, including the telephone number and address of the insurance commissioner's office.

**STANDARDS  
GRIEVANCE PROCEDURES**

**Standard 6**

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

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

**Priority:** Essential

**Documents to Be Reviewed**

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

\_\_\_\_\_ Sample of voluntary review grievances

Others Reviewed

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

**NAIC Model References**

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

**Review Procedures and Criteria**

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

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

Verify that a health carrier required by applicable state statutes, rules and regulations to establish a voluntary review process provides covered persons, or, if applicable, the covered person's authorized representatives, with notice, pursuant to applicable state statutes, rules and regulations, of the option to file a request with the health carrier for an additional voluntary review of a first level review decision or a standard review decision.

Verify that, upon receipt of a request for an additional voluntary review, the health carrier sends notice to the covered person, or, if applicable, the covered person's authorized representative, of the covered person's right to:

- Request, within the time frame set forth in applicable state statutes, rules and regulations, the opportunity to appear in person before a review panel of designated representatives of the health carrier;
- Receive from the health carrier, upon request, copies of all documents, records and other information that is not confidential or privileged relevant to the covered person's, or, if applicable, the covered person's authorized representative's, request for benefits;
- Present the covered person's case to the review panel;
- Submit written comments, documents, records and other material relating to the request for benefits for the review panel to consider when conducting the review both before and, if applicable, at the review meeting;
- If applicable, ask questions of any representative of the health carrier on the review panel; and
- Be assisted or represented by an individual of the covered person's choice.

Verify that the health carrier has procedures in place to ensure that a covered person's, or, if applicable, the covered person's authorized representative's, right to a fair review is not made conditional on the covered person's, or, if applicable, the covered person's authorized representative's, appearance at the review.

Verify that the health carrier appoints a review panel to review requests for voluntary review of a first level review decision involving an adverse determination.

Verify that the review panel appointed by the health carrier takes into consideration all comments, documents, records and other information regarding the request for benefits submitted by the covered person, or, if applicable, the covered person's authorized representative, without regard to whether the information was submitted or considered in reaching the first level review decision.

Verify that the health carrier review panel has the legal authority to bind the health carrier to the panel's decision.

Verify that a majority of the health carrier's review panel is composed of individuals who were not involved in the first level review decision. This provision does not apply to an individual involved with the first level review decision who may be a member of the panel or who may appear before the panel to present information or answer questions.

Verify that the health carrier ensures that a majority of the individuals conducting the additional voluntary review of the first level review decision involving an adverse determination are health care professionals who have appropriate expertise.

Except, when such a reviewing health care professional is not reasonably available, in cases where there has been a denial of a health care service, verify that the health carrier has procedures in place to ensure that the reviewing health care professional:

- Is not a provider in the covered person's health benefit plan; and
- Does not have a financial interest in the outcome of the review.

Verify that the health carrier appoints a review panel to review requests for voluntary review of a standard review decision.

Verify that the health carrier review panel has the legal authority to bind the health carrier to the panel's decision.

Verify that a majority of the health carrier's review panel is composed of employees or representatives of the health carrier who were not involved in the standard review decision. This provision does not apply to an employee or representative of the health carrier who was involved with the standard review decision, who may be a member of the panel or who may appear before the panel to present information or answer questions.

Whenever a covered person, or, if applicable, the covered person's authorized representative, requests, within the time frame specified in applicable state statutes, rules and regulations, the opportunity to appear in person before an appointed review panel, verify that the health carrier's procedures for conducting the review include the provisions set forth in applicable state statutes, rules and regulations.

Verify that the health carrier review panel schedules and holds a review meeting within 45 working days after the date of receipt of the request.

Verify that the health carrier notifies the covered person, or, if applicable, the covered person's authorized representative, in writing at least 15 working days in advance of the date of the review meeting.

Verify that the health carrier does not unreasonably deny a request for postponement of the review made by the covered person, or, if applicable, the covered person's authorized representative.

Verify that the health carrier holds review meetings during regular business hours at a location reasonably accessible to the covered person, or, if applicable, the covered person's authorized representative.

In cases where a face-to-face meeting is not practical for geographic reasons, verify that the health carrier offers the covered person, or, if applicable, the covered person's authorized representative, the opportunity to communicate with the review panel, at the health carrier's expense, by conference call, video conferencing, or other appropriate technology.

If the health carrier desires to have an attorney present to represent the interests of the health carrier, verify that the health carrier notifies the covered person, or, if applicable, the covered person's authorized representative, at least 15 working days in advance of the date of the review meeting that an attorney will be present and that the covered person, or, if applicable, the covered person's authorized representative, may wish to obtain legal representation of his or her own.

Verify that the health carrier review panel issues a written decision to the covered person, or, if applicable, the covered person's authorized representative, within five working days of completing the review meeting.

Whenever the covered person, or, if applicable, the covered person's authorized representative, does not request the opportunity to appear in person before the review panel within the specified time frame set forth in applicable state statutes, rules and regulations, verify that the health carrier review panel issues a decision and notifies the covered person, or, if applicable, the covered person's authorized representative, of the decision, in writing or electronically, within 45 working days after the earlier of:

- The date the covered person, or, the covered person's authorized representative, notifies the health carrier of the covered person's, or, if applicable, the covered person's authorized representative's, decision not to request the opportunity to appear in person before the review panel; or
- The date on which the covered person's, or, if applicable, the covered person's authorized representative's, opportunity to request to appear in person before the review panel expires pursuant to applicable state statutes, rules and regulations.

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

Verify that the health carrier's written decision contains all of the following:

- The titles and qualifying credentials of the members of the review panel;
- A statement of the review panel's understanding of the nature of the grievance and all pertinent facts;
- The rationale for the review panel's decision;
- A reference to evidence or documentation considered by the review panel in making that decision;
- In cases concerning a grievance involving an adverse determination:
  - The instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination; and
  - If applicable, a statement describing the procedures for obtaining an independent external review of the adverse determination pursuant to applicable state statutes, rules and regulations equivalent to the *Uniform Health Carrier External Review Model Act* (#75);
- Notice of the covered person's, or, if applicable, the covered person's authorized representative's, right to contact the insurance commissioner's office for assistance at any time, including the telephone number and address of the insurance commissioner's office.

**STANDARDS  
GRIEVANCE PROCEDURES**

**Standard 7**

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

**Apply to:** All health carriers offering a health benefit plan

**Priority:** Essential

**Documents to Be Reviewed**

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

\_\_\_\_\_ Sample of expedited appeals

Others Reviewed

\_\_\_\_\_

\_\_\_\_\_

**NAIC Model References**

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

**Review Procedures and Criteria**

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

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

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

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

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

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

In an expedited review, verify that the health carrier makes a decision and notifies the covered person, or, if applicable, the covered person's authorized representative, of the decision in accordance with applicable state statutes, rules and regulations as expeditiously as the covered person's medical condition requires, but in no event more than 72 hours after the receipt of the request for the expedited review.

If the expedited review is of a grievance involving an adverse determination with respect to a concurrent review urgent care request, verify that the health carrier continues service without liability to the covered person until the covered person, or, if applicable, the covered person's authorized representative, has been notified of the determination.

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

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

- The titles and qualifying credentials of each reviewer participating in the expedited review process (the reviewers);
- A statement of the reviewers' understanding of the covered person's, or, if applicable, the covered person's authorized representative's, grievance;
- The reviewers' decision in clear terms, and the contract basis or medical rationale in sufficient detail for the covered person, or, if applicable, the covered person's authorized representative, to respond further to the health carrier's position;
- A reference to the evidence or documentation used as the basis for the decision; and
- If the decision involves a final adverse determination, the notice shall provide:
  - The specific reason or reasons for the final adverse determination
  - Reference to the specific plan provisions on which the determination is based;
  - A description of any additional materials or information necessary for the covered person, or, if applicable, the covered person's authorized representative, to complete the request, including an explanation of why the material or information is necessary to complete the request;
  - If the health carrier relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion, or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person, or, if applicable, the covered person's authorized representative, upon request;
  - If the final adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person, or, if applicable, the covered person's authorized representative, free of charge upon request;
  - If applicable, instructions for requesting:
    - A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; or
    - The written statement of the scientific or clinical rationale for the adverse determination;
  - A statement describing the procedures for obtaining an independent external review of the adverse determination pursuant to applicable state statutes, rules and regulations equivalent to the *Uniform Health Carrier External Review Model Act* (#75);

- A statement indicating the covered person's, or, if applicable, the covered person's authorized representative's, right to bring a civil action in a court of competent jurisdiction;
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your state insurance commissioner"; and
- A notice of the covered person's, or, if applicable, the covered person's authorized representative's, right to contact the insurance commissioner's office for assistance at any time, including the telephone number and address of the insurance commissioner's office.

Verify that the health carrier provides the notice orally, in writing or electronically.

If notice of the adverse determination is provided orally, verify that the health carrier provides written or electronic notice of the adverse determination within three days following the oral notification.

## **I. Network Adequacy**

### **1. Purpose**

The network adequacy portion of the examination is designed to ensure that companies offering network plans maintain service networks that are sufficient to ensure that all services are accessible without unreasonable delay. The standards require companies to ensure the adequacy, accessibility and quality of health care services offered through their service networks.

The areas to be considered in this kind of review include company access plans and other measures used by the company to analyze network sufficiency, contracts with participating providers and intermediaries, and ongoing oversight and assessment of access issues.

### **2. Techniques**

To evaluate network adequacy standards, it is necessary for examiners to request a statement or map from the insurer that reasonably describes the service area. Additional items for review should include a roster of network providers and facilities. The examiner should determine whether the plan has conducted studies to measure waiting times for appointments and other studies that measure the sufficiency and adequacy of the network. The examiner should also determine how the health plan arranges for covered services that cannot be provided within the network. Examiners should request the health plan's written selection standards for providers. Access plans, where required, should also be obtained. Using the roster of providers and facilities, examiners should request a sample of specific provider contracts. The review of provider contracts should include an evaluation of compliance with filing requirements and adherence to patient protection requirements. In addition to direct contracts with providers and facilities, examiners should review the written guidelines and contractual requirements established for intermediary contracts. Availability of emergency care facilities and procedures should be evaluated. Also, examiners should obtain verification that accurate provider directories are provided upon enrollment and are updated and dispersed periodically. Another area for review includes grievances related to provider access issues.

### **3. Tests and Standards**

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

**STANDARDS  
NETWORK ADEQUACY**

**Standard 1**

**The health carrier demonstrates, using reasonable criteria, that it maintains a network that is sufficient in number and types of providers to ensure that all services to covered persons will be accessible without unreasonable delay.**

**Apply to:** Health carriers with network plans

**Priority:** Essential

**Documents to Be Reviewed**

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

\_\_\_\_\_ Selection criteria

\_\_\_\_\_ Documents related to physician recruitment

\_\_\_\_\_ Provider directory

\_\_\_\_\_ Reports of out-of-network service denials

\_\_\_\_\_ Company policy for in-network/out-of-network coverage levels

\_\_\_\_\_ Provider/member location reports (e.g., by ZIP code)

\_\_\_\_\_ List of providers by specialty

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

\_\_\_\_\_ Computer tools used to assess the network's adequacy; e.g., GeoAccess<sup>®</sup>

Others Reviewed

\_\_\_\_\_

\_\_\_\_\_

**NAIC Model References**

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

**Review Procedures and Criteria**

Reasonable criteria include, but are not limited to:

- Ratios of providers, both primary care providers and specialty providers, to covered persons;
- Geographic accessibility, as measured by the reasonable proximity of participating providers to the business or personal residence of covered persons;
- Waiting times for appointments;

- Hours of operation; and
- Volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.

The health carrier shall develop and comply with written policies and procedures specifying when the carrier shall pay for out-of-area and out-of-network services that are required by a covered person and are covered by the network plan pursuant to the covered person's health benefit plan or as required by state laws. In any case where the health carrier is required to cover services, but it has an insufficient number or type of participating providers to provide the covered benefit, the health carrier shall 1) ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers; or 2) make other arrangements acceptable to the insurance commissioner.

The health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to the business or personal residence of covered persons. In determining whether a health carrier has complied with this provision, the commissioner shall give due consideration to the relative availability of health care providers in the service area under consideration.

A health carrier shall demonstrate that it monitors its providers, provider groups and intermediaries with which it contracts on an ongoing basis to ensure their ability, clinical capacity, financial capability and legal authority, including applicable licensure requirements, to furnish all contracted benefits to covered persons. There are standards pertinent to provider licensing in Section J Provider Credentialing in this chapter.

The health carrier shall comply with all applicable state provisions equivalent to the *Health Benefit Plan Network Access and Adequacy Model Act* (#74) and accompanying regulations not expressly covered by any other of these standards.

**STANDARDS  
NETWORK ADEQUACY**

**Standard 2**

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

**Apply to:** Health carriers with network plans

**Priority:** Essential

**Documents to Be Reviewed**

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

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

\_\_\_\_\_ Member materials referencing access plans

\_\_\_\_\_ Provider manual

\_\_\_\_\_ Provider contract

Others Reviewed

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

**NAIC Model References**

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

**Review Procedures and Criteria**

The access plan shall describe or contain the following:

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

- The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination, or the health carrier's insolvency or other cessation of operations, and transferred to other providers in a timely manner.

**STANDARDS**  
**NETWORK ADEQUACY**

**Standard 3**

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

**Apply to:** Health carriers with network plans

**Priority:** Essential

**Documents to Be Reviewed**

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

\_\_\_\_\_ Sample of provider contracts

\_\_\_\_\_ Credentialing file

\_\_\_\_\_ Directory of providers

Others Reviewed

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

**NAIC Model References**

*Health Benefit Plan Network Access and Adequacy Model Act (#74), Section 11*  
*Health Maintenance Organization Model Act (#430)*

**Review Procedures and Criteria**

Determine if the forms and endorsements have been filed.

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

**STANDARDS**  
**NETWORK ADEQUACY**

**Standard 4**

**The health carrier ensures covered persons have access to emergency services 24 hours per day, 7 days per week within its network and provides coverage for emergency services outside of its network, pursuant to the appropriate section of state law that corresponds to the *Utilization Review and Benefit Determination Model Act* (#73) and/or the *Health Benefit Plan Network Access and Adequacy Model Act* (#74).**

**Apply to:** Health carriers with network plans

**Priority:** Essential

**Documents to Be Reviewed**

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

\_\_\_\_\_ Provider manual

\_\_\_\_\_ Provider contracts

Others Reviewed

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

**NAIC Model References**

*Health Benefit Plan Network Access and Network Adequacy Model Act* (#74), Section 5

*Utilization Review and Benefit Determination Model Act* (#73)

*Health Maintenance Organization Model Act* (#430)

**Review Procedures and Criteria**

Within the network, the health carrier shall operate or contract with facilities to provide covered persons with access to emergency services.

The health carrier shall cover emergency services necessary to screen and stabilize a covered person and shall not require prior authorization of such services, if a prudent lay person acting reasonably would have believed that an emergency medical condition existed.

If care is obtained from a non-contracting provider within the service area of the network plan, the health carrier shall cover emergency services necessary to screen and stabilize a covered person and shall not require prior authorization of such services, if a prudent lay person acting reasonably would have believed that the use of a contracting provider would result in a delay that would worsen the emergency, or if a provision of federal, state or local law requires the use of a specific provider.

**STANDARDS  
NETWORK ADEQUACY**

**Standard 5**

**The health carrier executes written agreements with each participating provider that are in compliance with applicable statutes, rules and regulations.**

**Apply to:** Health carriers with network plans

**Priority:** Essential

**Documents to Be Reviewed**

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

\_\_\_\_\_ Provider contracts

Others Reviewed

\_\_\_\_\_

\_\_\_\_\_

**NAIC Model References**

*Health Benefit Plan Network Access and Network Adequacy Model Act (#74), Sections 6B and 6C*

*Health Maintenance Organization Model Act (#430)*

**Review Procedures and Criteria**

Every contract between a health carrier and a participating provider or provider group shall contain a “hold harmless” provision specifying protection for covered persons from being billed by providers. The language of the “hold harmless” provision shall be substantially similar to the language of the *Health Benefit Plan Network Access and Network Adequacy Model Act (#74)*.

Every contract between a health carrier and a participating provider shall contain provisions ensuring that, in the event of the insolvency of the health carrier or an intermediary, covered services to covered persons will continue through the period for which a premium has been paid or until the covered person’s discharge from an inpatient facility, whichever is greater. The language of the contract’s provisions shall satisfy the requirements of state provisions equivalent to the *Health Benefit Plan Network Access and Network Adequacy Model Act (#74)*.

**STANDARDS  
NETWORK ADEQUACY**

**Standard 6**  
**The health carrier's contracts with intermediaries are in compliance with applicable statutes, rules and regulations.**

**Apply to:** Health carriers with network plans

**Priority:** Essential

**Documents to Be Reviewed**

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

\_\_\_\_\_ Intermediary contracts

Others Reviewed

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

**NAIC Model References**

*Health Benefit Plan Network Access and Network Adequacy Model Act (#74), Section 10*  
*Health Maintenance Organization Model Act (#430)*

**Review Procedures and Criteria**

The contract between a health carrier and intermediary shall satisfy the following:

- Intermediaries and participating providers with whom they contract shall comply with all applicable requirements for health carriers and participating providers, as indicated in state provisions equivalent to the *Health Benefit Plan Network Access and Network Adequacy Model Act (#74)* and accompanying regulations;
- A health carrier's statutory responsibility to monitor the offering of covered benefits to covered persons shall not be delegated or assigned to the intermediary;
- A health carrier shall have the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering covered benefits to the carrier's covered persons;
- A health carrier shall maintain copies of all intermediary health care subcontracts at its principal place of business in the state, or ensure that it has access to all intermediary subcontracts, including the right to make copies to facilitate regulatory review, upon 20 days' prior written notice from the health carrier;
- If applicable, an intermediary shall transmit utilization documentation and claims paid documentation to the health carrier. The carrier shall monitor the timeliness and appropriateness of payments made to providers and health care services received by covered persons;
- If applicable, an intermediary shall maintain the books, records, financial information and documentation of services provided to covered persons at its principal place of business in the state and preserve them according to applicable statutory duration, in a manner that facilitates regulatory review;
- An intermediary shall allow the insurance commissioner access to the intermediary's books, records, financial information and any documentation of services provided to covered persons, as necessary to determine compliance; and

- A health carrier shall have the right, in the event of the intermediary's insolvency, to require the assignment to the health carrier of the provisions of a provider's contract addressing the provider's obligation to furnish covered services.

**STANDARDS  
NETWORK ADEQUACY**

**Standard 7**

**The health carrier's arrangements with participating providers comply with applicable statutes, rules and regulations.**

**Apply to:** Health carriers with network plans

**Priority:** Essential

**Documents to Be Reviewed**

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

\_\_\_\_\_ Provider contracts

\_\_\_\_\_ Provider manuals

\_\_\_\_\_ Complaints made by providers

Others Reviewed

\_\_\_\_\_  
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**NAIC Model References**

*Health Benefit Plan Network Access and Network Adequacy Model Act (#74), Section 6*  
*Health Maintenance Organization Model Act (#430)*

**Review Procedures and Criteria**

The health carrier shall establish a mechanism by which the participating provider will be notified on an ongoing basis of the specific covered health services for which the provider will be responsible, including any limitations or conditions on services.

The health carrier shall develop selection standards for primary care professionals and each health care professional specialty in accordance with applicable state provisions equivalent to Section 6F of the *Health Benefit Plan Network Access and Network Adequacy Model Act (#74)*. The standards shall be used in determining the selection of health care professionals by the health carrier, its intermediaries and any provider networks with which it contracts.

The health carrier shall make its selection standards for participating providers available for review by the insurance commissioner.

The health carrier shall notify participating providers of the provider's responsibilities with respect to the health carrier's applicable administrative policies and programs, including, but not limited to, payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements and any applicable federal or state programs.

The health carrier shall not offer an inducement under the network plan to a provider to provide less than medically necessary services to a covered person.

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

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

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

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

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

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

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

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

**STANDARDS  
NETWORK ADEQUACY**

**Standard 8**

**The health carrier provides at enrollment a provider directory that lists all providers who participate in its network. It also makes available, on a timely and reasonable basis, updates to its directory.**

**Apply to:** Health carriers with network plans

**Priority:** Essential

**Documents to Be Reviewed**

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

\_\_\_\_\_ Provider directory and updates

\_\_\_\_\_ Provider contracts

\_\_\_\_\_ Credentialing documentation

\_\_\_\_\_ Internet directory

Others Reviewed

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

**NAIC Model References**

*Health Benefit Plan Network Access and Network Adequacy Model Act (#74), Section 9*  
*Health Maintenance Organization Model Act (#430)*

**Review Procedures and Criteria**

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

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

## **J. Provider Credentialing**

### **1. Purpose**

The provider credentialing portion of the examination is designed to ensure that companies offering managed care plans have verification programs to ensure that participating health care professionals meet minimum specific standards of professional qualification.

The areas to be considered in this kind of review include the company's written credentialing and re-credentialing policies and procedures, the scope and timeliness of verifications, the role of health professionals in ensuring accuracy and the oversight of any delegated verification functions.

### **2. Techniques**

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

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

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

### **3. Tests and Standards**

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

**STANDARDS  
PROVIDER CREDENTIALING**

**Standard 1**

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

**Apply to:** All health carriers with managed care plans

**Priority:** Essential

**Documents to Be Reviewed**

- \_\_\_\_\_ Applicable statutes, rules and regulations
- \_\_\_\_\_ Credentialing policies and procedures
- \_\_\_\_\_ Credentialing plan
- \_\_\_\_\_ Minutes of the credentialing committee
- \_\_\_\_\_ Credentialing plan evaluation reports (if any)

**Others Reviewed**

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

**NAIC Model References**

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

**Review Procedures and Criteria**

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

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

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

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

The health carrier shall keep confidential all information obtained in the credentialing verification process, except as otherwise provided by law.

The health carrier shall retain all records and documents relating to a health care professional's credentialing verification process for a designated period of time, as determined by the applicable state record retention requirements.

The health carrier shall comply with all applicable state provisions equivalent to the *Health Care Professional Credentialing Verification Model Act* (#70) and accompanying regulations not expressly covered by any other of these standards.

**STANDARDS  
PROVIDER CREDENTIALING**

**Standard 2**

**The health carrier verifies the credentials of a health care professional before entering into a contract with that health care professional.**

**Apply to:** All health carriers with managed care plans

**Priority:** Essential

**Documents to Be Reviewed**

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

\_\_\_\_\_ Provider directory

\_\_\_\_\_ Provider credentialing files

Others Reviewed

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

**NAIC Model References**

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

**Review Procedures and Criteria**

Ensure providers are properly credentialed prior to appearing in the provider directory.

**STANDARDS  
PROVIDER CREDENTIALING**

**Standard 3**

**The health carrier obtains primary verification of the information required by applicable state provisions equivalent to the *Health Care Professional Credentialing Verification Model Act (#70)* and accompanying regulations.**

**Apply to:** All health carriers with managed care plans

**Priority:** Essential

**Documents to Be Reviewed**

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

\_\_\_\_\_ Checklist for credentialing

\_\_\_\_\_ Checklist and forms for site visits (if any)

\_\_\_\_\_ Reports made from site visits (if any)

\_\_\_\_\_ Sample of credentialing files

Others Reviewed

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

**NAIC Model References**

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

**Review Procedures and Criteria**

- Current [license, certificate of authority or registration] to practice [health care profession] in [insert state] and history of licensure;
- Current level of professional liability coverage (if applicable);
- Status of hospital privileges (if applicable);
- Specialty board certification status (if applicable);
- Current Drug Enforcement Agency (DEA) registration certificate (if applicable);
- Graduation from [health care professional] school; and
- Completion of postgraduate training (if applicable).

**STANDARDS  
PROVIDER CREDENTIALING**

**Standard 4**

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

**Apply to:** All health carriers with managed care plans

**Priority:** Essential

**Documents to Be Reviewed**

- \_\_\_\_\_ Applicable statutes, rules and regulations
- \_\_\_\_\_ Checklist for credentialing
- \_\_\_\_\_ Checklist and forms for site visits (if any)
- \_\_\_\_\_ Reports made from site visits (if any)
- \_\_\_\_\_ Sample of credentialing files

**Others Reviewed**

\_\_\_\_\_

\_\_\_\_\_

**NAIC Model References**

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

**Review Procedures and Criteria**

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

**STANDARDS  
PROVIDER CREDENTIALING**

**Standard 5**

**The health carrier obtains, at least every 3 years, primary verification of the information required by applicable state provisions equivalent to the *Health Care Professional Credentialing Verification Model Act (#70)* and accompanying regulations.**

**Apply to:** All health carriers with managed care plans

**Priority:** Essential

**Documents to Be Reviewed**

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

\_\_\_\_\_ Checklist for credentialing

\_\_\_\_\_ Checklist and forms for site visits (if any)

\_\_\_\_\_ Reports made from site visits (if any)

\_\_\_\_\_ Sample of credentialing files

Others Reviewed

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

**NAIC Model References**

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

**Review Procedures and Criteria**

- Current [license, certificate of authority or registration] to practice [health care profession] in [insert state];
- Current level of professional liability coverage (if applicable);
- Status of hospital privileges (if applicable);
- Current Drug Enforcement Agency (DEA) registration certificate (if applicable); and
- Specialty board certification status (if applicable).

**STANDARDS  
PROVIDER CREDENTIALING**

**Standard 6**

**The health carrier requires all participating providers to notify the health carrier’s designated individual of changes in the status of any information that is required to be verified by the health carrier.**

**Apply to:** All health carriers with managed care plans

**Priority:** Essential

**Documents to Be Reviewed**

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

\_\_\_\_\_ Credentialing policies and procedures

\_\_\_\_\_ Provider contracts

\_\_\_\_\_ Credentialing files

Others Reviewed

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

**NAIC Model References**

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

**Review Procedures and Criteria**

The health carrier shall identify for participating providers the individual to whom they should report changes in the status of information required to be verified by the health carrier.

**STANDARDS  
PROVIDER CREDENTIALING**

**Standard 7**

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

**Apply to:** All health carriers with managed care plans

**Priority:** Essential

**Documents to Be Reviewed**

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

\_\_\_\_\_ Credentialing policies and procedures

\_\_\_\_\_ Provider manual

\_\_\_\_\_ Listing of providers (active and terminated)

Others Reviewed

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

**NAIC Model References**

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

**Review Procedures and Criteria**

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

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

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

**STANDARDS  
PROVIDER CREDENTIALING**

**Standard 8**

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

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

**Priority:** Essential

**Documents to Be Reviewed**

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

\_\_\_\_\_ Credentialing policies and procedures

\_\_\_\_\_ Intermediary contracts

\_\_\_\_\_ Periodic reports from intermediaries

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

\_\_\_\_\_ Minutes of the health carrier's credentialing committee

\_\_\_\_\_ Minutes of the health carrier's board of directors

**Others Reviewed**

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

**NAIC Model References**

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

**Review Procedures and Criteria**

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

## **K. Quality Assessment and Improvement**

### **1. Purpose**

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

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

### **2. Techniques**

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

### **3. Tests and Standards**

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

**STANDARDS**  
**QUALITY ASSESSMENT AND IMPROVEMENT**

**Standard 1**

**The health carrier develops and maintains a quality assessment program in compliance with applicable statutes, rules and regulations.**

**Apply to:** All health carriers with managed care plans

**Priority:** Essential

**Documents to Be Reviewed**

- \_\_\_\_\_ Applicable statutes, rules and regulations
- \_\_\_\_\_ Quality assessment policies and procedures
- \_\_\_\_\_ Quality assessment plan (if any)
- \_\_\_\_\_ Minutes of the health carrier's quality assessment committee
- \_\_\_\_\_ Minutes of the health carrier's board of directors
- \_\_\_\_\_ Evaluations of the quality assessment program
- \_\_\_\_\_ Job descriptions for the chief medical officer or clinical director

Others Reviewed

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

**NAIC Model References**

*Quality Assessment and Improvement Model Act (#71), Sections 5 and 7*  
*Health Maintenance Organization Model Act (#430)*

**Review Procedures and Criteria**

The health carrier shall develop a quality assessment program and procedures to ensure effective corporate oversight of this program.

The health carrier shall develop and maintain the infrastructure and disclosure systems necessary to measure the quality of health care services provided to covered persons on a regular basis and appropriate to the types of plans offered by the health carrier.

The health carrier shall establish a system designed to assess the quality of health care provided to covered persons. The system shall include systematic collection, analysis and reporting of relevant data, in accordance with statutory and regulatory requirements.

The health carrier shall communicate findings in a timely manner to applicable regulatory agencies, providers and consumers, as provided by applicable statutes, rules and regulations.

The health carrier shall appoint a chief medical officer or clinical director to have primary responsibility for the quality assessment activities carried out by, or on behalf of, the health carrier.

The chief medical officer or clinical director shall approve the written quality assessment program and shall periodically review and revise the program document and act to ensure ongoing appropriateness. Not less than semi-annually, the chief medical officer or clinical director shall review reports of quality assessment activities.

The health carrier shall have an appropriate written policy to ensure the confidentiality of a covered person's health information used in the carrier's quality assessment programs.

The health carrier shall comply with all applicable state provisions equivalent to the *Quality Assessment and Improvement Model Act* (#71) and accompanying regulations not expressly covered by any other of these standards.

**STANDARDS**  
**QUALITY ASSESSMENT AND IMPROVEMENT**

**Standard 2**

**The health carrier files a written description of the quality assessment program with the insurance commissioner in the prescribed format, which shall include a signed certification by a corporate officer of the health carrier that the filing meets applicable statutes, rules and regulations.**

**Apply to:** All health carriers with managed care plans

**Priority:** Essential

**Documents to Be Reviewed**

- \_\_\_\_\_ Applicable statutes, rules and regulations
- \_\_\_\_\_ Written description of the quality assessment program
- \_\_\_\_\_ Signed certification by a corporate officer

Others Reviewed

\_\_\_\_\_

\_\_\_\_\_

**NAIC Model References**

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

**Review Procedures and Criteria**

Determine if the forms have been filed.

**STANDARDS**  
**QUALITY ASSESSMENT AND IMPROVEMENT**

**Standard 3**

**The health carrier develops and maintains a quality improvement program, in compliance with applicable statutes, rules and regulations.**

**Apply to:** All health carriers with closed plans or a combination plan with a closed component

**Priority:** Essential

**Documents to Be Reviewed**

- \_\_\_\_\_ Applicable statutes, rules and regulations
- \_\_\_\_\_ Quality improvement policies and procedures
- \_\_\_\_\_ Quality improvement plan
- \_\_\_\_\_ Minutes of the health carrier's quality improvement committee
- \_\_\_\_\_ Minutes of the health carrier's board of directors
- \_\_\_\_\_ Evaluations of the quality improvement program
- \_\_\_\_\_ Job descriptions for the chief medical officer or clinical director

Others Reviewed

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

**NAIC Model References**

*Quality Assessment and Improvement Model Act (#71), Sections 6 and 7*  
*Health Maintenance Organization Model Act (#430)*

**Review Procedures and Criteria**

The health carrier shall develop a quality improvement program and procedures to ensure effective corporate oversight of this program.

The health carrier shall develop and maintain an organizational program for designing, measuring, assessing and improving the processes and outcomes of health care as identified in the health carrier's quality improvement program, in accordance with applicable state provisions equivalent to the *Quality Assessment and Improvement Model Act (#71)* and accompanying regulations.

The health carrier shall develop a written quality improvement plan. The written plan should include:

- A statement of the objectives, lines of authority and accountability, evaluation tools, data collection responsibilities, performance improvement activities and annual effectiveness review of the program;
- Intent to analyze processes and outcomes of care to discern the causes of variation;
- Identification of the targeted diagnoses and treatments to be reviewed each year;

- Methods to analyze quality, including collection and analysis of information on:
  - Over- or under-utilization of services;
  - Evaluation of courses of treatment and outcome of care; and
  - Collection and analysis of information specific to a covered person(s) or provider(s) gathered from multiple sources, and documentation of both the satisfaction and grievances of the covered person(s);
- A method to compare program findings with past performance, internal goals and external standards;
- Methods for:
  - Measuring the performance of participating providers and conducting peer review activities to identify practices that do not meet health carrier's standards, and taking action to correct deficiencies; and
  - Monitoring participating providers to determine whether they have implemented corrective action, and taking appropriate action when they have not;
- A plan to utilize treatment protocols and practice parameters developed with clinical input and using evaluations described above or acquired treatment protocols and providing participating providers with sufficient information about the protocols to meet the standards; and
- Evaluating access to care for covered persons according to the state's standards and a strategy for integrating public health goals with services offered under the managed care plans, including a description of good faith efforts to communicate with public health agencies.

The health carrier shall establish an internal system to identify practices that result in improved health care outcomes, identify problematic utilization patterns, identify those providers that may be responsible for either exemplary or problematic patterns and foster an environment of continuous quality improvement.

The health carrier shall ensure that participating providers have the opportunity to participate in developing, implementing and evaluating the quality improvement system.

The health carrier shall provide covered persons the opportunity to comment on the quality improvement process.

The health carrier shall use the findings generated by the system to work on a continuing basis with participating providers and other staff to improve the health care delivered to covered persons.

The health carrier shall appoint a chief medical officer or clinical director to have primary responsibility for the quality improvement activities carried out by, or on behalf of, the health carrier.

The chief medical officer or clinical director shall approve the written quality improvement program, periodically review and revise the program document and act to ensure ongoing appropriateness. Not less than semi-annually, the chief medical officer or clinical director shall review reports of quality assessment activities.

The health carrier shall have an appropriate written policy to ensure the confidentiality of a covered person's health information used in the health carrier's quality improvement programs.

The health carrier shall comply with all applicable state provisions equivalent to the *Quality Assessment and Improvement Model Act* (#71) and accompanying regulations not expressly covered by any other of these standards.

**STANDARDS**  
**QUALITY ASSESSMENT AND IMPROVEMENT**

**Standard 4**

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

**Apply to:** All health carriers with managed care plans

**Priority:** Essential

**Documents to Be Reviewed**

- \_\_\_\_\_ Applicable statutes, rules and regulations
- \_\_\_\_\_ Quality assessment and improvement policies and procedures
- \_\_\_\_\_ Reports made to the licensing authority
- \_\_\_\_\_ Terminated and suspended provider contract files

Others Reviewed

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

**NAIC Model References**

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

**Review Procedures and Criteria**

Determine that policies and procedures address reporting requirements.

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

**STANDARDS**  
**QUALITY ASSESSMENT AND IMPROVEMENT**

**Standard 5**  
**The health carrier documents and communicates information about its quality assessment program and its quality improvement program to covered persons and providers.**

**Apply to:** All health carriers with managed care plans

**Priority:** Essential

**Documents to Be Reviewed**

- \_\_\_\_\_ Applicable statutes, rules and regulations
- \_\_\_\_\_ Quality assessment and improvement policies and procedures
- \_\_\_\_\_ Member materials (e.g., member newsletters, advertisements, etc.)

Others Reviewed

\_\_\_\_\_

\_\_\_\_\_

**NAIC Model References**

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

**Review Procedures and Criteria**

The health carrier shall include a summary of its quality assessment and quality improvement programs in marketing materials.

The health carrier shall include a description of its quality assessment and quality improvement programs and a statement of patient rights and responsibilities with respect to those programs in the certificate of coverage or handbook provided to newly enrolled covered persons.

The health carrier shall make available annually to providers and covered persons findings from its quality assessment and quality improvement programs and information about its progress in meeting internal goals and external standards, where available. The reports shall include a description of the methods used to assess each specific area and an explanation of how any assumptions may have affected the findings.

**STANDARDS**  
**QUALITY ASSESSMENT AND IMPROVEMENT**

**Standard 6**

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

**Apply to:** All health carriers with managed care plans

**Priority:** Essential

**Documents to Be Reviewed**

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

\_\_\_\_\_ Certification filings

Others Reviewed

\_\_\_\_\_

\_\_\_\_\_

**NAIC Model References**

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

**Review Procedures and Criteria**

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

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

**STANDARDS**  
**QUALITY ASSESSMENT AND IMPROVEMENT**

**Standard 7**

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

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

**Priority:** Essential

**Documents to Be Reviewed**

- \_\_\_\_\_ Applicable statutes, rules and regulations
- \_\_\_\_\_ Quality assessment and improvement policies and procedures
- \_\_\_\_\_ Contracts with entities
- \_\_\_\_\_ Reports of entity reviews and audits (if any) by health carrier
- \_\_\_\_\_ Periodic reports from the entity
- \_\_\_\_\_ Minutes from the health carrier’s board of directors
- \_\_\_\_\_ Minutes from the health carrier’s quality assessment committee and quality improvement committee

**Others Reviewed**

\_\_\_\_\_

\_\_\_\_\_

**NAIC Model References**

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

**Review Procedures and Criteria**

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

## L. Utilization Review

### 1. Purpose

The utilization review portion of the examination is designed to verify that companies and their designees that provide or perform utilization review services comply with standards and criteria for the structure and operation of utilization review processes. In the *Utilization Review and Benefit Determination Model Act* (#73), the NAIC defines utilization review as a set of formal techniques designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.

The areas to be considered in this kind of review include the company's written utilization review policies and procedures, annual summary reports, timeliness in making utilization review decisions and handling appeals, communications with members about the program and oversight of delegated utilization review functions.

### 2. Techniques

The review of utilization review activities should include an overview of the health plan's written utilization review policies, procedures and scripts, in addition to an overview of how utilization review activities are applied to individual cases. Utilization review issues may also surface during the examiners' review of claims, complaints and grievance procedures.

- a. Examiners should request a written overview of the insurer's utilization review program. The overview should include the names and positions of individuals responsible for overseeing the program, along with the qualifications of the utilization review director and staff. Examiners may request an interview of appropriate personnel, to supplement information obtained in the written overview. During this process, examiners should also determine how the insurer maintains corporate oversight of the utilization review process. Where applicable, the examiner should obtain copies of any required utilization review licenses or certifications. Review the scope of the utilization review program. Utilization review functions for some specialized services are occasionally delegated to other entities. Examiners should request copies of applicable reports required for regulatory purposes.
- b. Examiners should also obtain the program materials and scripts to ascertain the source of guidelines used, how frequently the materials are updated and whether they are supported by reliable sources of data and medical protocol. In addition, obtain standards used by applicable accreditation entities, if any. A review of the time guidelines for responding to utilization review and reconsideration requests should be conducted. An evaluation of the methods used to communicate utilization review decisions to medical providers, subscribers and other applicable divisions within the company should be completed.
- c. Evaluate the availability of, and access to, the utilization review program to plan members or subscribers. Review adequacy of staffing and hours of operation.
- d. Ascertain whether utilization review requirements are consistent with and supported by language in the policy, certificate of coverage and marketing materials.
- e. Obtain listings of utilization review approvals or certifications, denials and requests for reconsideration. Use sampling techniques to review specific cases. Evaluate handling for adherence to written guidelines and standards.

### **3. Tests and Standards**

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

**STANDARDS  
UTILIZATION REVIEW**

**Standard 1**

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

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

**Priority:** Essential

**Documents to Be Reviewed**

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

\_\_\_\_\_ Utilization review policies and procedures

\_\_\_\_\_ Utilization review program or plan documentation

\_\_\_\_\_ Medical criteria used to make utilization review determinations

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

\_\_\_\_\_ Minutes of the health carrier's board of directors

\_\_\_\_\_ Minutes of the health carrier's utilization review committee

\_\_\_\_\_ Documentation of clinical staff credentialing maintenance and education requirements

\_\_\_\_\_ Program assessment reports

Others Reviewed

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

**NAIC Model References**

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

**Review Procedures and Criteria**

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

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

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

Verify that the health carrier's written utilization review program document describes all of the following:

- Procedures to evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services;
- Data sources and clinical review criteria used in decision-making;
- Mechanisms to ensure consistent application of clinical review criteria and compatible decisions;
- Data collection processes and analytical methods used in assessing utilization of health care services;
- Provisions for ensuring confidentiality of clinical and proprietary information;
- The organizational structure (e.g., utilization review committee, quality assurance or other committee) that periodically assesses utilization review activities and reports to the health carrier's governing body; and
- The staff position functionally responsible for day-to-day program management.

Verify that the health carrier ensures that appropriate personnel have operational responsibility for conducting the carrier's utilization review program.

The health carrier shall annually certify in writing to the commissioner that the utilization review program of the health carrier complies with all applicable state and federal laws establishing confidentiality and reporting requirements.

The health carrier shall comply with all applicable state provisions equivalent to the *Utilization Review and Benefit Determination Model Act* (#73) and accompanying regulations not expressly covered by any other of these standards.

**STANDARDS  
UTILIZATION REVIEW**

**Standard 2**  
**The health carrier operates its utilization review program in accordance with applicable state statutes, rules and regulations.**

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

**Priority:** Essential

**Documents to Be Reviewed**

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

\_\_\_\_\_ Utilization review policies and procedures

\_\_\_\_\_ Form letters

\_\_\_\_\_ Activity reports

\_\_\_\_\_ Provider manual

\_\_\_\_\_ Files with utilization review requests (Verify that all levels of authorized, appealed and disapproved requests are reviewed)

Others Reviewed

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

**NAIC Model References**

*Utilization Review and Benefit Determination Model Act (#73), Section 8*

**Review Procedures and Criteria**

Verify that the health carrier's utilization review program uses documented clinical review criteria that are based on sound clinical evidence and evaluated periodically to assure ongoing efficacy.

Note: The health carrier may develop its own clinical review criteria or may purchase or license clinical review criteria from qualified vendors.

Verify that the health carrier makes its clinical review criteria available upon request to authorized government agencies.

Verify that the health carrier ensures that qualified health care professionals administer the utilization review program and oversee review decisions. Verify that the health carrier has appointed clinical peers to evaluate the clinical appropriateness of adverse determinations.

Verify that the health carrier issues utilization review decisions and benefit determinations in a timely and efficient manner pursuant to the requirements set forth in applicable state statutes, rules and regulations.

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

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

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

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

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

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

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

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

**STANDARDS  
UTILIZATION REVIEW**

**Standard 3**

**The health carrier discloses information about its utilization review and benefit determination procedures to covered persons, or, if applicable, the covered person's authorized representative, in compliance with applicable statutes, rules and regulations.**

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

**Priority:** Essential

**Documents to Be Reviewed**

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

\_\_\_\_\_ Member materials

Others Reviewed

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

**NAIC Model References**

*Utilization Review and Benefit Determination Model Act (#73), Section 13*

**Review Procedures and Criteria**

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

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

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

**STANDARDS  
UTILIZATION REVIEW**

**Standard 4**

**The health carrier makes standard utilization review and benefit determinations in a timely manner and as required by applicable state statutes, rules and regulations, as well as the provisions of HIPAA.**

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

**Priority:** Essential

**Documents to Be Reviewed**

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

\_\_\_\_\_ Utilization review policies and procedures

\_\_\_\_\_ Form letters

\_\_\_\_\_ Activity reports

\_\_\_\_\_ Provider manual

\_\_\_\_\_ Files with utilization review requests (Verify that all levels of authorized, appealed and disapproved requests are reviewed)

**Others Reviewed**

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

**NAIC Model References**

*Utilization Review and Benefit Determination Model Act (#73), Section 9*

**Review Procedures and Criteria**

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

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

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

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

- Determined that the extension was necessary due to matters beyond the health carrier's control; and
- Notified the covered person, or, if applicable, the covered person's authorized representative, prior to the expiration of the initial 15-day time period, of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.

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

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

Whenever the health carrier receives a prospective review request from a covered person, or, if applicable, the covered person's authorized representative, that fails to meet the health carrier's filing procedures, verify that the health carrier notifies the covered person, or, if applicable, the covered person's authorized representative, of this failure and provides in the notice information on the proper procedures to be followed for filing a request.

Verify that the notice referenced in the previous paragraph is provided by the health carrier as soon as possible, but in no event later than five days following the date of the failure.

Verify that the health carrier provides the notice orally or, if requested by the covered person, or, if applicable, the covered person's authorized representative, in writing.

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

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

For concurrent review determinations, if a health carrier has certified an ongoing course of treatment to be provided over a period of time or number of treatments, examiners need to be aware that:

- Any reduction or termination by the health carrier during the course of treatment before the end of the period or number of treatments, other than by health benefit plan amendment or termination of the health benefit plan, constitutes an adverse determination; and
- The health carrier shall notify the covered person, or, applicable, the covered person's authorized representative, of the adverse determination in accordance with applicable state statutes, rules and regulations regarding procedures for standard utilization review and benefit determination at a time sufficiently in advance of the reduction or termination to allow the covered person, or, if applicable, the covered person's authorized representative, to file a grievance to:
  - Request a review of the adverse determination pursuant to state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72); and
  - Obtain a determination with respect to that review of the adverse determination before the benefit is reduced or terminated.

Verify that the health care service or treatment that is the subject of the adverse determination is continued by the health carrier without liability to the covered person with respect to the internal review request made pursuant to state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72).

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

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

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

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

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

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

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

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

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

Unless the state has a specific exemption because of an alternative law, HIPAA requires that all group health plans, insurance companies and HMOs offering health coverage for hospital stays in connection with the birth of a child must provide health coverage for a minimum of 48 hours for a normal natural (non-cesarean) delivery and 96 hours for a cesarean section. (Coverage is required for both the mother and the newborn.) Deductibles, coinsurance and other cost-sharing methods may be applied.

Verify that the company does not engage in incentive arrangements to circumvent the requirements of the law. Such incentive requirements could include: making monetary payments or rebates to mothers to encourage them to accept a shorter length of stay; penalizing or reducing or limiting reimbursement of an attending provider because they provided care to an individual for the above minimum time frames; or providing incentives to induce a provider to provide care in a manner inconsistent with the law.

**STANDARDS  
UTILIZATION REVIEW**

**Standard 5**

**The health carrier provides written notice of an adverse determination of standard utilization review and benefit determinations in compliance with applicable statutes, rules and regulations.**

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

**Priority:** Essential

**Documents to Be Reviewed**

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

\_\_\_\_\_ Utilization review policies and procedures

\_\_\_\_\_ Form letters

\_\_\_\_\_ Utilization review files

Others Reviewed

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

**NAIC Model References**

*Utilization Review and Benefit Determination Model Act (#73), Section 9F*

**Review Procedures and Criteria**

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

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

- A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination;
- The written statement of the scientific or clinical rationale for the adverse determination; and
- A statement explaining the availability of and the right of the covered person, or, if applicable, the covered person's authorized representative, as appropriate, to contact the insurance commissioner's office at any time for assistance or, upon completion of the health carrier's grievance procedure process as provided under state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72), to file a civil suit in a court of competent jurisdiction. The statement shall include contact information for the insurance commissioner's office.

Verify that the health carrier provides the notice in writing or electronically.

**STANDARDS  
UTILIZATION REVIEW**

**Standard 6**

**The health carrier conducts expedited utilization review and benefit determinations in a timely manner and in compliance with applicable statutes, rules and regulations.**

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

**Priority:** Essential

**Documents to Be Reviewed**

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

\_\_\_\_\_ Utilization review policies and procedures

\_\_\_\_\_ Form letters

\_\_\_\_\_ Utilization review files

Others Reviewed

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

**NAIC Model References**

*Utilization Review and Benefit Determination Model Act (#73), Section 10*

**Review Procedures and Criteria**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Verify that the health carrier's notification of an adverse determination pursuant to an expedited utilization review and benefit determination is set forth in a manner calculated to be understood by the covered person, or, if applicable, the covered person's authorized representative, to include all of the following:

- The specific reason or reasons for the adverse determination;
- Reference to the specific plan provisions on which the determination is based;
- A description of any additional material or information necessary for the covered person, or, if applicable, the covered person's authorized representative, to complete the request, including an explanation of why the material or information is necessary to complete the request;
- A description of the health carrier's internal review procedures established pursuant to applicable state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72), including any time limits applicable to those procedures;
- A description of the health carrier's expedited review procedures established pursuant to applicable state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72);
- If the health carrier relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion, or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person, or, if applicable, the covered person's authorized representative upon request;
- If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person, or, if applicable, the covered person's authorized representative, free of charge upon request;
- If applicable, instructions for requesting:
  - A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination, as set forth in applicable state statutes, rules and regulations; or
  - The written statement of the scientific or clinical rationale for the adverse determination, as set forth in applicable state statutes, rules and regulations; and
- A statement explaining the availability of and the right of the covered person, or, if applicable, the covered person's authorized representative, as appropriate, to contact the insurance commissioner's office at any time for assistance or, upon completion of the health carrier's grievance procedure process as provided under applicable state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72), to file a civil suit in a court of competent jurisdiction. The statement shall include contact information for the insurance commissioner's office.

Verify that the health carrier provides the notice orally, in writing or electronically.

If the health carrier provides the notice of adverse determination orally, verify that the health carrier also provides written or electronic notice of the adverse determination within three days following the oral notification.

**STANDARDS  
UTILIZATION REVIEW**

**Standard 7**

**The health carrier monitors the activities of the utilization review organization or entity with which the carrier contracts and ensures that the contracting organization complies with applicable state provisions equivalent to the *Utilization Review and Benefit Determination Model Act (#73)* and accompanying regulations.**

**Apply to:** Health carriers offering a health benefit plan contracting out utilization review services

**Priority:** Essential

**Documents to Be Reviewed**

- \_\_\_\_\_ Applicable statutes, rules and regulations
- \_\_\_\_\_ Utilization review policies and procedures
- \_\_\_\_\_ Contracts with organizations or entities
- \_\_\_\_\_ Reports of entity reviews and audits (if any) by health carrier
- \_\_\_\_\_ Periodic reports from the organization or entity
- \_\_\_\_\_ Minutes of the health carrier's board of directors
- \_\_\_\_\_ Minutes of the health carrier's utilization review committee
- \_\_\_\_\_ Policies and procedures for oversight

**Others Reviewed**

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

**NAIC Model References**

*Utilization Review and Benefit Determination Model Act (#73)*, Sections 6 & 12

**Review Procedures and Criteria**

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

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

The health carrier shall annually certify in writing to the commissioner that the utilization review program of its designee complies with all applicable state and federal laws establishing confidentiality and reporting requirements.

## **M. External Review**

Use the standards set forth below.

**STANDARDS  
EXTERNAL REVIEW**

**Standard 1**

**Companies covered under the *Health Carrier External Review Model Act (#75)* will be in compliance with the following procedures and criteria, as well as with other applicable statutes, rules and regulations.**

**Apply to:** Health insurance carriers under the *Health Carrier External Review Model Act (#75)*

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Certificates, policies and company procedures

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

\_\_\_\_\_ Reports on external review requests

Others Reviewed

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

**NAIC Model References**

*Health Carrier External Review Model Act (#75)*, Section 4

*Health Maintenance Organization Model Act (#430)*

*Issues Involving External Review Procedures White Paper*

**Review Procedures and Criteria**

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

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

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

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

The health carrier shall include a description of the external review procedures in or attached to the policy, certificate, membership booklet, an outline of coverage or other evidence of coverage it provides to covered persons.

The health carrier shall maintain written records in the aggregate and for each type of health benefit plan offered by the health carrier on all requests for external review. This information must be submitted to the insurance commissioner, at least annually, via a report in a format specified by the insurance commissioner.

**STANDARDS  
EXTERNAL REVIEW**

**Standard 2**

**In jurisdictions that choose Option 1 or Option 2 under the *Health Carrier External Review Model Act* (#75) for providing an external review process, companies will be in compliance with the following requirements, whether the request for the review is for a standard, expedited or experimental/investigational review.**

**Apply to:** Health insurance carriers in jurisdictions where the *Health Carrier External Review Model Act* (#75) has been adopted

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Certificates, policies and company procedures

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

\_\_\_\_\_ Reports on external review requests

Others Reviewed

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

**NAIC Model References**

*Health Carrier External Review Model Act* (#75), Section 4  
*Health Maintenance Organization Model Act* (#430)  
*Issues Involving External Review Procedures* White Paper

**Review Procedures and Criteria (Option 1, Option 2)**

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

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

#### External Review Process, Option 1

The external review process resides in the office of the insurance commissioner and requires that covered persons file all requests for external review with the commissioner. This option also provides that the commissioner will conduct a preliminary review of the request for external review to ensure that it meets all of the requirements to be eligible for external review. If the request for external review is determined to be eligible for external review, the commissioner is required to assign an independent review organization to conduct the external review. This option requires the assigned independent review organization to provide the commissioner with a written recommendation on whether to uphold or reverse the adverse determination or final adverse determination. After reviewing the recommendation, the commissioner is required to notify the covered person, if applicable, the covered person's authorized representative and the health carrier of the external review decision.

#### External Review Process, Option 2

This alternative is the same as Option 1, except the independent review organization assigned to conduct the review makes the determination, if the company's decision is to be reversed.

#### Standard Review Procedures

Provide within 7 days the documents and any information considered in making the adverse determination or the final adverse determination to the assigned independent review organization.

Notify the covered person, if applicable, the covered person's authorized representative, the assigned independent review organization and the commissioner in writing of its decision upon making the decision to reverse its adverse determination or final adverse determination.

Approve the coverage that was the subject of the adverse determination or final adverse determination upon receipt of a notice of a decision reversing the adverse determination or final adverse determination.

#### Expedited External Review Procedures

Provide in an expeditious manner all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization upon receipt of notice that the case has been accepted for an expedited external review.

Approve the coverage that was the subject of the adverse determination or final adverse determination upon receipt of the notice of a decision reversing the original determination.

#### Experimental or Investigational Treatment Procedures

Provide or transmit in an expeditious manner all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization.

Provide within 7 days the documents and any information considered in making the adverse determination or the final adverse determination to the assigned independent review organization.

Approve the coverage that was the subject of the adverse determination or final adverse determination upon receipt of the notice of a decision reversing the original determination.

**STANDARDS  
EXTERNAL REVIEW**

**Standard 3**

**In states that choose Option 3 under the *Health Carrier External Review Model Act* (#75) for providing an external review process, companies will be in compliance with the following requirements, whether the request for the review is a standard, expedited or experimental/investigational review.**

**Apply to:** Health insurance carriers in jurisdictions where the *Health Carrier External Review Model Act* (#75) has been adopted

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Certificates, policies and company procedures

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

\_\_\_\_\_ Reports on external review requests

Others Reviewed

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

**NAIC Model References**

*Health Carrier External Review Model Act* (#75)  
*Health Maintenance Organization Model Act* (#430)  
*Issues Involving External Review Procedures* White Paper

**Review Procedures and Criteria**

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

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

### External Review Process, Option 3

This option makes it the responsibility of the health carrier to provide for an external review process and requires that covered persons file requests for external review with the health carrier. The health carrier must also assign an independent review organization, from the list of approved independent review organizations compiled by the insurance commissioner, to conduct a preliminary review of the request and conduct an external review of the request, if the request has satisfied specified requirements to be eligible for external review.

### Standard Review Procedures

Send a copy of the request for an external review to the insurance commissioner.

Assign an independent review organization, upon receiving a request for an expedited external review, from the list compiled and maintained pursuant to Section 13 of this Act, to determine whether the request meets the reviewability requirements set forth in Section 8B of this Act and conduct the external review, if the request meets the reviewability requirements of Section 8B of this Act.

Provide within 7 days the documents considered in making the adverse determination or the final adverse determination to the assigned independent review organization.

Notify the covered person, if applicable, the covered person's authorized representative, the assigned independent review organization and the commissioner in writing of its decision upon making the decision to reverse its adverse determination or final adverse determination before a determination by the independent review organization.

Approve the coverage that was the subject of original adverse determination or final adverse determination upon receipt of a notice of a decision reversing the original determination.

### Expedited External Review

Assign an independent review organization, from the list compiled and maintained pursuant to Section 13 of the Act, to determine whether the request meets the reviewability requirements set forth in the Act and conduct the external review if the request meets the reviewability requirements of the Act; and send a copy of the request to the commissioner.

Send a copy of the request for an external review to the commissioner.

Provide or transmit in an expeditious manner all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization.

Approve the coverage that was the subject of original adverse determination or final adverse determination upon receipt of a notice of a decision reversing the original determination.

### Expedited Experimental or Investigational Review

Assign an independent review organization from the list of approved independent review organizations to determine whether the request meets the reviewability requirements and, if the request meets those requirements, conduct the review.

Provide or transmit in an expeditious manner all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization.

### Standard Experimental or Investigational Review

Send a copy of the request for an external review to the commissioner.

Assign an independent review organization, from the list of approved independent review organizations compiled and maintained by the insurance commissioner pursuant to the Act, to conduct a preliminary review of the request to determine whether:

Note: The independent review organization can deny the request for an external review.

Not choose or control the choice of the physicians or other health care professionals to be selected to conduct the external review.

Approve the coverage that was the subject of original adverse determination or final adverse determination upon receipt of a notice of a decision reversing the original determination.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Draft: 11/19/20

Market Analysis Procedures (D) Working Group  
Virtual Meeting  
November 12, 2020

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Nov. 12, 2020. The following Working Group members participated: John Haworth, Chair (WA); Rebecca Rebholz, Vice Chair (WI); Crystal Phelps (AR); Sarah Borunda (AZ); Don McKinley (CA); Damion Hughes (CO); Kurt Swan (CT); Scott Woods and Pamela Lovell (FL); Erica Weyhenmeyer (IL); Tate Flott and Shannon Lloyd (KS); Russell Hamblen (KY); Jeff Zewe (LA); Mary Lou Moran (MA); Dawna Kokosinski (MD); Timothy Schott (ME); Jill Huisken (MI); Cynthia Amann and Teresa Kroll (MO); Jeannie Keller (MT); Reva Vandevoorde (NE); Karen McAllister (NH); Peggy Willard-Ross (NV); Larry Wertel (NY); Guy Self (OH); Landon Hubbart (OK); Jeffrey Arnold (PA); Segun Daramola (RI); Michael Bailes (SC); Tracy Klausmeier (UT); Mel Gerachis (VA); Christina Rouleau and Isabelle Turpin Keiser (VT); and Theresa Miller (WV).

1. Adopted its Oct. 22 Minutes

Mr. Haworth said the Working Group met Oct. 22 and took the following action: 1) adopted its Sept. 10 minutes; 2) discussed the most recent Market Conduct Annual Statement (MCAS) filings; and 3) discussed new lines of business for the MCAS.

Ms. Amann made a motion, seconded by Ms. Weyhenmeyer, to adopt the Working Group's Oct. 22 minutes (Attachment Five-A). The motion passed unanimously.

2. Discussed Revisions to the MCAS Best Practices Guide

Mr. Rebholz said the revisions to the *MCAS Best Practices Guide* are almost complete. She said the final changes are currently being made and will be ready to be considered by the Working Group during its next meeting. She said the drafting group will meet again to review other MCAS documents to be sure all the MCAS documents are consistent. The other documents to be reviewed are the frequently asked questions (FAQ) document, the *MCAS Industry User Guide*, the data call letter and MCAS training videos.

3. Discussed the Market Analysis Framework

Mr. Haworth said the drafting group has finished Chapter 6 of the NAIC *Market Regulation Handbook*. He said the goal is to bring the market analysis chapters up-to-date and to reference current tools and processes.

4. Discussed MCAS Attestation

Joe Zolecki (Blue Cross and Blue Shield of America—BCBSA) thanked the Working Group for the extension to file due to COVID-19. He said the filings went smoothly for companies this year. He said, however, that the attestation process in the MCAS has created some issues for companies. He said many companies file for multiple lines of business in multiple states, but the MCAS attestation only allows for one attestation per CoCode. He said that results in some lines of businesses and state filings are attested to by a person not responsible for that line of business or state. Mr. Zolecki noted that whenever a new attestor is entered into the attestation section of the MCAS, the previous attestor information is overwritten. He said just putting the attestor's name in the comments would not address the accuracy of the attestation section. He said the carriers would support the ability to have multiple attestations to allow the right individuals to attest to each line of business and/or state.

Birny Birnbaum (Center for Economic Justice—CEJ) said he agrees with Mr. Zolecki that the right person should be attesting to the data and questioned why the MCAS attestation was at the CoCode level and not the reporting level.

Mr. Haworth asked NAIC support staff to consider possible solutions.

5. Discussed Market Analysis Training

Mr. Haworth said it would be a good idea for the Working Group to consider the types of training needed by market analysts. He said that while updating the market analysis chapters, it became apparent there are new tools, new MCAS data and possibly new processes for doing market analysis. He said it would be useful to do more technical training on completing baseline and

Market Analysis Review System (MARS) Level 1 and Level 2 reviews, and how to use some of the new tools like Tableau and the new data.

Ms. Phelps said more training is a fabulous idea especially for new market analysts. Ms. Amann said this is also good for experienced analysts who need to learn about the new tools like Tableau and Python. Ms. Klausmeier said Utah welcomes all training. Tressa Smith (NAIC) said the Tableau training done at the Insurance Summit is available in the i-Site+ tutorials.

Mr. Haworth asked state insurance regulators to consider the topics on which they would like training and to send their thoughts and suggestions to Randy Helder (NAIC) by Dec. 11.

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

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## Draft Pending Adoption

Attachment Five-A  
Market Regulation and Consumer Affairs (D) Committee  
12/8/20

Draft: 11/5/20

### Market Analysis Procedures (D) Working Group Virtual Meeting October 22, 2020

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Oct. 22, 2020. The following Working Group members participated: John Haworth, Chair (WA); Crystal Phelps (AR); Sarah Borunda (AZ); Don McKinley (CA); Damion Hughes (CO); Kurt Swan (CT); Scott Woods and Pamela Lovell (FL); Erica Weyhenmeyer (IL); Shannon Lloyd (KS); Russell Hamblen (KY); Nathan Strebeck (LA); Mary Lou Moran (MA); Dawna Kokosinski (MD); Timothy Schott (ME); Jill Huisken (MI); Paul Hanson (MN); Teresa Kroll (MO); Jeannie Keller (MT); Reva Vandevoorde (NE); Ralph Boeckman (NJ); Peggy Willard-Ross (NV); Larry Wertel (NY); Guy Self (OH); Landon Hubbard (OK); Michael Bailes (SC); Laura Klanian (VA); Isabelle Turpin Keiser (VT); Theresa Miller (WV). Also participating was: Mary Kay Rodriguez (WI).

#### 1. Adopted its Sept. 10 Minutes

Mr. Haworth said the Working Group met Sept. 10 and took the following action: 1) adopted its July 20 minutes; and 2) discussed the most recent Market Conduct Annual Statement (MCAS) filings.

Mr. Hanson made a motion, seconded by Mr. Schott, to adopt the Working Group's Sept. 10 minutes (Attachment Five-A1). The motion passed unanimously.

#### 2. Discussed Revisions to the MCAS Best Practices Guide

Mr. Haworth said the *MCAS Best Practices Guide* was originally adopted in 2014. Since that time, additional lines have been added, and some analysis tools have been replaced. He said concerns were also raised about the consistency of how waiver and extension requests are handled, especially for companies that make frequent requests. He said the drafting group for the revisions to the *MCAS Best Practices Guide* met Oct. 20 and continued its work.

#### 3. Discussed the Market Analysis Framework

Mr. Haworth said the NAIC *Market Regulation Handbook* is updated annually. He said it has been some time since the market analysis sections have been updated. The small drafting group is reviewing chapters 6 through 11. He said multiple revisions have been made. The drafting group last met Oct. 15.

#### 4. Discussed MCAS Filings for the Current Filing Period

Mr. Haworth said the Working Group would continue its discussion from the last meeting. He said in Washington, 18–19% of companies had to re-file their Private Passenger Auto MCAS filings. He said the trend was noticed in other lines of business also. He noted that this makes it difficult to do baseline analysis because an analyst does not know if the latest data is being used. He also said he is still receiving waiver requests for the Disability MCAS. He said companies who are not required to file will ask for an extension request first. He said that results in having to have NAIC staff delete the extension request so that a waiver request can be submitted by the company. Ms. Rodriguez said she had four companies submit extension requests even though they did not have to file. She said it takes time to have to have NAIC staff delete the extension requests. Ms. Lovell said she had the same issues. She said she believed it was because Disability MCAS is a new line of business. Ms. Kroll and Ms. Miller also encountered the same issues with Disability MCAS filers. Mr. Haworth suggested that there might need to be additional training, more information included in the data call letter, or outreach to companies.

Lisa Brown (American Property Casualty Insurers Association—APCIA) said first time MCAS filers will tend to be cautious and ask for an extension until they determine whether they must file. She acknowledged that there may be some bad actors that routinely request extensions, but on the newer lines of business, it is most likely confusion.

Birny Birnbaum (Center for Economic Justice—CEJ) suggested asking the NAIC financial reporting staff how often they encounter these same issues when they introduce a new reporting requirement on the financial annual statement (FAS). He said if they do not, then the reason may not be confusion so much as a failure to take the MCAS seriously. Ms. Huisken said FAS

## Draft Pending Adoption

Attachment Five-A  
Market Regulation and Consumer Affairs (D) Committee  
12/8/20

reporting and MCAS reporting are too different to make that comparison. Companies filing their FAS only work with their domestic state when asking for extensions and waivers. Companies filing MCAS must make their requests to every state that they have to file an MCAS. She suggested putting additional information in the MCAS call letter concerning how to address issues and questions.

Mr. Haworth asked if there is anyone looking at the interrogatories to see about how the COVID-19 crisis may have affected how the company underwrote policies or adjusted claims. Ms. Brown noted that there may not be any comments regarding COVID-19 until next year since the current filing is for the 2019 data year. She suggested using the call letter to ask companies to identify in the interrogatories how COVID-19 has affected their data for the 2020 data year.

Mr. Birnbaum suggested asking companies whether they provided premium relief and whether the relief was accounted as a premium reduction or an underwriting expense.

Tanya V. Sherman (INS Regulatory Insurance Services—INSRIS) asked if there is a way to incorporate company comments in the MCAS Market Analysis Prioritization Tool (MAPT) for baseline analysis. Currently, an analysis must manually retrieve the comments. Tressa Smith (NAIC) said the Tableau dashboard that will replace the MCAS MAPT, and it incorporates the company comments. She said any suggestions for the dashboard can be sent to NAIC market regulation staff.

### 5. Discussed New Lines of Business for the MCAS

Mr. Haworth said the Market Conduct Annual Statement Blanks (D) Working Group has completed revisions to current line of business blanks, and it is working on the Other Health and Travel MCAS Blanks. He asked if there are suggestions for a new line of business. Mr. Haworth suggested cybersecurity.

Mr. Birnbaum said the commercial multiperil may be a good candidate for the next line of business. He said this encompasses the Business Owners Policy (BOP). He said it is a line that generates \$40 billion in premium and includes millions of policyholders and small businesses. Mr. Haworth said some states have de-regulated commercial lines.

### 6. Discussed Other Matters

Mr. Haworth said the Market Conduct Annual Statement Blanks (D) Working Group meeting next week will feature a presentation by NAIC Information Technology Group (ITG) staff about the resources available for collecting transactional level data in the MCAS.

Richard L. Bates (State Farm) asked what authority states would use to collect transactional level data in the MCAS. Mr. Haworth said the collection transactional data is already happening on market conduct exams. Mr. Birnbaum said states use their examination authority for the collection of the MCAS, and this would also include transactional level data. He said that is why MCAS data is not considered public. Mr. Bates disagreed. He said there are many procedural and substantive guidelines under the state examination authority when transactional data is collected that would not be present if collected in the MCAS. Mr. Haworth said state insurance regulators need to look at the least intrusive way to collect the data that is needed for analysis, and they need to see if the resources are available. He said he understands that there could be data from third-party administrators (TPAs) that a company may not have. He said, for now, state insurance regulators are doing the discovery they need to do to determine if this is the direction they want to take. Mr. Bates said Mr. Birnbaum's answer is not sufficient. He said there must be some authority that every participating MCAS state is comfortable requiring transactional level data on an annual basis, as opposed to a specific, one-time market conduct examination. Mr. Birnbaum said there is no distinction in the state's examination authority between summary level and transactional level data. If there were, state insurance regulators would have to ask how much summary data is too much whenever they consider new data in the MCAS. Mr. Birnbaum said State Farm has the obligation to show how the examination authority is insufficient.

Ms. Brown said she does not question state insurance regulators' authority to collect transactional level data, but she does question the appropriateness of transactional data for baseline analysis to determine if next steps are necessary with a company. Mr. Hamblen agreed, and he said the MCAS is intended to be a tool for baseline analysis. States clearly have the authority to collect transactional data under their examination authority. Mr. Hamblen said the real question is whether transactional data is helpful and who will store the data.

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

## Draft Pending Adoption

Attachment Five-A1  
Market Regulation and Consumer Affairs (D) Committee  
12/8/20

Draft: 9/14/20

### Market Analysis Procedures (D) Working Group Conference Call September 10, 2020

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Sept. 10, 2020. The following Working Group members participated: John Haworth, Chair (WA); Rebecca Rebholz, Vice Chair (WI); Crystal Phelps (AR); Maria Ailor (AZ); Don McKinley (CA); Damion Hughes (CO); Kurt Swan (CT); Erica Weyhenmeyer (IL); Tate Flott (KS); Russell Hamblen (KY); Nathan Strebeck (LA); Dawna Kokosinski (MD); Timothy Schott (ME); Jill Huisken (MI); Paul Hanson (MN); Teresa Kroll (MO); Jeannie Keller (MT); Reva Vandevoorde (NE); Edwin Pugsley (NH); Ralph Boeckman (NJ); Hermoliva Abejar and Peggy Willard-Ross (NV); Larry Wertel (NY); Todd Oberholtzer (OH); Landon Hubbart (OK); Jeffrey Arnold (PA); Segun Daramola (RI); Rachel Moore and Michael Bailes (SC); Julie Fairbanks (VA); and Christopher Antoine, Isabelle Keiser and Marcia Violette (VT). Also participating were: Stacie Parker (TX); and Ned Gaines (WA).

#### 1. Adopted its July 30 Minutes

Mr. Haworth said the Working Group met July 30 and took the following action: 1) adopted the Market Conduct Annual Statement (MCAS) ratios for the private flood MCAS blank; and 2) discussed industry concerns about the MCAS attestation not distinguishing between different lines of business.

Ms. Rebholz made a motion, seconded by Ms. Keller, to adopt the Working Group's July 30 minutes (*see NAIC Proceedings – Summer 2020, Market Regulation and Consumer Affairs (D) Committee, Attachment Two*). The motion passed unanimously.

#### 2. Discussed Revisions to the MCAS Best Practices Guide

Ms. Rebholz said the drafting group for the revisions to the *MCAS Best Practices Guide* plans to meet on Oct. 20. She said she expects just a few more meetings before the drafting group completes its work.

#### 3. Discussed the Market Analysis Framework

Mr. Haworth said others still have a chance to volunteer before the group's first meeting. He encouraged comments or suggestions from anyone who has an interest, but it may not have the time to volunteer.

#### 4. Discussed MCAS Filings for the Current Filing Period

Mr. Haworth said all companies were provided with 60-day extensions in 2020. All lines of business except disability insurance and health insurance were due on June 30. The disability insurance and health MCAS filings were due on Aug. 31. He noted that for the state of Washington, 18 disability insurance writers that were required to file had not yet filed. He said one company requested an extension on the due date, but that was not approved. He also said one company filing in Washington said the premium reported on the company's financial annual statement (FAS) Schedule T was incorrectly reported.

Ms. Parker said one of the companies considered disability insurance as credit insurance and did not file. She said there may be more. Mr. Gaines said he is familiar with the company Ms. Parker referenced. He said the company is a health company. He spoke with them, and it was using the health MCAS Data Call and Definitions (DCD) instead of the disability MCAS DCD. Mr. Gaines and Ms. Parker both denied the waiver request from the company.

Mr. Haworth asked if some companies were unaware of the requirement to file or the due date. Mr. Flott said some companies claimed to not have received the call letter. He said he is aware of one company that still has not filed and not requested an extension, but the company continues to tell the Kansas Department of Insurance (DOI) that it is working on the filing. Mr. Haworth said the Washington DOI has issued consent orders in those types of instances.

## Draft Pending Adoption

Attachment Five-A1  
Market Regulation and Consumer Affairs (D) Committee  
12/8/20

Ms. Ailor asked if it is possible to receive a nationwide report of all the waiver and extension requests. Teresa Cooper (NAIC) said the MCAS jurisdiction can see all waivers and extensions but only state-by-state. She said she could create a report that provides national data on disability insurance MCAS extension and waiver requests.

### 5. Discussed New Lines of Business for MCAS

Mr. Haworth said it is time to consider the next line of business for MCAS. He said the Working Group could monitor model laws for lines of business not previously defined. He said the Pet Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee is drafting a model law for pet insurance and when completed, the model law could be used as the basis for an MCAS line of business. He said he would like the Working Group to begin thinking about the next line of business.

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

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Draft: 11/24/20

Market Conduct Annual Statement Blanks (D) Working Group  
Virtual Meeting  
(in lieu of meeting at the 2020 Fall National Meeting)  
November 16, 2020

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Nov. 16, 2020. The following Working Group members participated: Rebecca Rebholz, Chair (WI); October Nickel, Vice Chair (ID); Cheryl Hawley (AZ); Kurt Swan (CT); Sheryl Parker (FL); Erica Weyhenmeyer (IL); Todd Oberholtzer and Guy Self (OH); Katie Dzurec (PA); Michael Bailes (SC); Ned Gaines and John Haworth (WA); and Letha Tate (WV).

1. Adopted its Oct. 28 Minutes

The Working Group met Oct. 28 and took the following action: 1) adopted its Sept. 30 minutes; and 2) heard and discussed a presentation on transactional level detail data collection.

Mr. Gaines made a motion, seconded by Mr. Swan, to adopt the Working Group's Sept. 30 minutes (Attachment Six-A). The motion passed unanimously.

2. Discussed Options for Collection Transaction Level Data

Ms. Rebholz noted that during its Oct. 28 meeting, the Working Group heard a presentation from NAIC information technology (IT) staff, which helped with understanding transaction level data along with potential technical impacts. She asked for comments regarding support or lack of support for collection of transactional level data.

Ms. Dzurec noted that she is not against collecting transaction level data. However, she stated she does not believe the MCAS blanks is the right place and that now is the right time to collect it. She stated from her perspective and the perspective of the Other Health blanks development and the short-term limited-duration (STLD) blanks development, the Working Group will continue with summary level data. Ms. Nickel noted she feels the same way. She believes transaction level data collection for MCAS should be considered after any issues on the IT side of things are vetted. Ms. Ailor noted that the previous blanks have been treated the same way, collecting aggregate-related data because that is the way it has always been done. She noted that for some lines of insurance, such as STLD, because of the way some products are marketed and sold through various associations or trusts, etc., collecting summarized data in an aggregate format will present additional challenges. Ms. Ailor said she believes each blank should be treated on its own merit, and that if starting with a transaction level data pilot would be helpful to better understand it, then that flexibility should be considered.

Ms. Dzurec advised that for STLD, she believes transaction level data would give them more of the information they need, but stated the data provided appears to look less like the Market Conduct Annual Statement (MCAS) and more like a market conduct investigation. She advised her hesitation is not that it has always been done that way. Instead, she said she believes that if the shift to transaction level data is made, the shift should be done thoughtfully and carefully in a manner supported by IT and the different staffing models of the departments of insurance (DOIs). She said she does not believe current structures support the transition to collecting transaction level data. Mr. Self stated he agrees with Ms. Dzurec and prefers summary level data collection at this time. Mr. Swan stated he agrees with Ms. Dzurec and Mr. Self. He stated that now is not the time to collect transaction level data, but developing a plan is appropriate for the future.

Ms. Rebholz noted that what she is understanding is that the Working Group is open to transaction level data collection in the future but that now is not the time, and that even doing a pilot right now is not of interest. She noted she can include and share this concept in a report to the Market Regulation and Consumer Affairs (D) Committee during the Fall National Meeting and let it know a pilot is not being pursued at this time but that the Working Group is open to it in the future. Ms. Dzurec asked if it would be worthwhile to put together a high-level strategy for consideration at the committee level for how transaction level data could be included in the MCAS. She noted that considering what has been learned about transaction level data—how the data would come in, how it would look, what it would take to review and checking the data coming in— it is important to be clear with insurance commissioners so they understand how collecting transaction level data could affect staffing so they have an opportunity to provide input.

Birny Birnbaum (Center for Economic Justice—CEJ) noted that during the presentation during the Working Group’s Oct. 28 meeting, the NAIC IT staff said they are prepared for the volume of transaction level data and that their systems are currently capable of collecting that data. He noted that the reporting of transaction level data provides greater abilities for data analysis and data quality and that they could provide the data, metrics and ratios to state insurance regulators in the same format as currently done. He stated that since 2005, when the MCAS began, the insurance industry has undergone a revolution in terms of data they process and utilize for analytics. In contrast, he said he believes the MCAS has remained stagnant. He stated there have been no substantive changes in the granularity or the frequency of the data reporting for the MCAS. He said he believes it is more efficient and less costly for insurers to collect transaction level data as there would be less back and forth between state insurance regulators and insurers over data quality issues and that the focus would be more on insurers who produce bad outcomes. He also stated he has asked the Market Regulation and Consumer Affairs (D) Committee to make a presentation on this topic at the Fall National Meeting.

Ms. Rebholz suggested she provide this information in a report to the Market Regulation and Consumer Affairs (D) Committee at the Fall National Meeting. She stated she can ask for Committee guidance on what it would like to see from this Working Group, such as what type of proposal, feedback or information it may want pulled together if it has further questions or is interested in looking into transactional data collection any further.

Tanya Sherman (The INS Companies) stated she went through all of the types of reports and while there is a lot of functionality, she wanted to point out that the comment made about data being available in the same format as Market Analysis Prioritization Tools (MAPT) is not accurate. She noted the data is not available in the exact format as the MAPT currently, but that Snowflake and some of the other tools that are in process and other upgrades may change that. She said she believes transaction level data is a great thought and would help on the analysis side, but implementing transaction level data now is premature as processes and functionality are being looked at before a line of business has even been decided on. She said she does not believe STLD plans are the best option for transaction level data because of the way the products are marketed and sold and that she agrees that a plan to execute transaction level data is important since it is not a matter of if but when it will happen. J.P. Wieske (Horizon Government Affairs—HGA) noted that one of the things that would be important for the Committee to understand when the report is presented is that this is not a one-size-fits-all for insurers. He stated not every insurance company is deeply embedded in big data and that the IT capabilities of small insurers are not the same as some of the larger carriers, which needs to be considered. Ms. Rebholz stated she would include these considerations in her report at the Committee level requesting feedback and guidance if the Committee would like a more detailed proposal as to the vision of how transaction level data will be utilized in the future on a specific line or otherwise.

### 3. Considered Clarifications to the Home and Auto MCAS Lawsuits Definitions

Ms. Rebholz noted that the recently adopted home and auto MCAS definitions of “lawsuits” and “lawsuits closed with consideration for the consumer” needed to be discussed. She noted that the new definitions contain language that is more specific to life and annuity business, and the lawsuit data elements for home and auto are found within the claims reporting section of the MCAS blank. She noted that moving the location of these data elements was previously discussed, but that was not something that the Working Group agreed on, so they remain in the claims reporting section.

Ms. Rebholz stated that the new definition has the potential to cause confusion for property/casualty (P/C) companies in preparing to capture data for the 2021 data year. She explained the definitions have already been approved by the Working Group and by the Market Regulation and Consumer Affairs (D) Committee and that the timeline for approving edits to the MCAS for the 2021 data year has passed. However, she said the Working Group can approve a fix and request that the Committee approve it, to accommodate proper reporting for the 2021 data year. Ms. Rebholz stated she would like feedback and said she believes the simplest way to resolve this issue would be to revert to the previously used definition of “suit.” In addition to the definition rollback, she stated the Working Group could adjust the definition of “lawsuits closed with consideration for the consumer” to read as shown in the redline attachment provided for the meeting. This adjustment would mean replacing the words “applicant, policyholder or beneficiary” with “claimant” in the definition.

Mr. Birnbaum noted the CEJ opposes the proposed change for three reasons. The first is that the definition of “lawsuit” includes only lawsuits brought by an applicant, policyholder or beneficiary as opposed to the data element for consideration for the consumer. He noted that consequently, the definition clearly envisions reporting of lawsuits for other than claim settlement, as there would be no need to include an applicant if that were not the case. The second reason is there is no rationale for the limiting reporting of lawsuits to include claims-related issues when lawsuits can be brought for any number of reasons other than claims, such as unfair or deceptive sales practices or unfair trading practices. He noted that in the incidence of lawsuits and lawsuits closed with consideration for the consumer for reasons other than claim settlement, it provides relevant and useful information for market analysis in the same way that lawsuit information for claims provides relevant and useful information

The third reason the CEJ opposes this is that the proposed change is a substantive change to a reporting requirement approved by the Market Regulation and Consumer Affairs (D) Committee and that industry had the opportunity to comment on the substantive change during the original consideration. Mr. Birnbaum suggested the appropriate remedy to the term “beneficiary” is to replace it with “claimant” in the two places it shows up, which is in the first sentence of the definition of “lawsuit” and in the definition of “consideration for the consumer.” He noted that would be a technical change and that the proposed change would significantly change the scope of reporting and would not be technical but substantive.

Lisa Brown (American Property Casualty Insurance Association—APCIA) noted that Mr. Birnbaum’s suggestion is fine for a long-term fix. She noted that this potential issue was brought to her attention by NAIC staff shortly after the Market Regulation and Consumer Affairs (D) Committee adopted the definition. She noted that after looking at it more closely, it did not appear appropriate for P&C data reporting, including homeowners and private passenger auto. She stated that subsequently, she was advised to tell her members to hold off and that it would likely revert back to the old definition and not to move forward with any programming changes because the definition was not settled and was going to be changed in some way. She stated a combination of Ms. Rebholz’s suggestion of a fix for 2021 reporting would be appropriate and then to use Mr. Birnbaum’s suggestion for 2022. Ms. Brown noted that her concern is that companies have lost three months of programming to make the change to the definition of lawsuits to the new lawsuits wording. She noted that she stands by her request that lawsuits closed with consideration for the consumer be postponed for a year as companies have not been able to program. Ms. Rebholz summarized for clarification that Ms. Brown’s proposal is to revert to the earlier definition of “suit” while continuing to use the term “lawsuit,” and adjust the definition of lawsuits closed with consideration for the consumer to read as shown in the redlined attachment as a fix for the 2021 data year. Then the Working Group could consider implementing Mr. Birnbaum’s suggestion for 2022 data collection. Ms. Brown confirmed that was correct.

Mr. Birnbaum stated he found it troubling that insurers relied on an informal, non-public communication to hold off on programming for changes that were approved. He noted the proposal is a substantive change and that there is no authority for the Working Group to do it. He said he believes it violates the MCAS procedures as the Market Regulation and Consumer Affairs (D) Committee already approved it and that this is not a technical change, but a significant substantive change. Ms. Rebholz noted that if the Working Group agrees to approve the fix as outlined by rolling back the definition, approval would be sought from the Market Regulation and Consumer Affairs (D) Committee. Mr. Birnbaum responded that even the Committee does not have the authority to make these retroactive changes. He noted that the MCAS procedures are explicit. He said that changes must be complete by June 1 and that the Committee must complete its tasks by Aug. 1.

Ms. Rebholz explained this is an issue the Working Group must resolve and that an adequate fix will need to be agreed upon as there has been some confusion on this new definition and that it was more designed for life and annuity and is not as applicable for homeowners and auto. She asked Teresa Cooper (NAIC) if the Working Group can revert the definition and if she could verify with the NAIC whether it is a violation of the MCAS procedures. She suggested if it is not a violation that it be brought up as a proposal for the Working Group during its next meeting. Ms. Cooper asked Randy Helder (NAIC) if he could provide any recommendations. Mr. Helder noted the procedures are put in place primarily to give companies time to adjust their systems so they can collect the data that is being requested. He noted that reverting to the old definition would not cause companies issues as they were already reporting the data that way, which is why he considers this more of a fix. Ms. Rebholz asked that if the Working Group would like to revert the definition for the 2021 data year and then consider implementing Mr. Birnbaum’s suggested changes for 2022, would that be permissible. Mr. Helder answered “yes.”

Ms. Nickel made a motion, seconded by Mr. Swan, to revert the definition of lawsuit to the one used in the 2019 data year. The motion passed unanimously. Ms. Rebholz noted that hearing no opposition, the definition would be reverted and that the Working Group would review this topic in the future and be sure to allow ample time and notice to the industry.

Mr. Birnbaum noted that he only heard three ayes. He said he believes that would be helpful information to note in the Committee report that will be given. He also said he believes there is a misunderstanding among NAIC staff on some of the procedures regarding this issue. Ms. Brown noted she was participating in all the meetings where these definitions were discussed. She stated that regarding the adoption of the new definition to change from “suit” to “lawsuit,” the only explanation or discussion that was had during those meetings was centered on creating consistency among the various lines of business and data elements. She noted there was not a discussion on changing the definition so that it collects more than claims-related suit information; it was about making the definition consistent with all of the other lines of business it was changed for. Ms. Nickel stated she agrees with Ms. Brown’s statement. Mr. Birnbaum stated he disagrees because if the intent was just making the “lawsuit” definition consistent across all lines, everyone had the definitions in front of them, and those definitions included “applicant, policyholder or beneficiary,” which indicates it would include more than claims. Ms. Brown responded that she understands it would include more than claims, but the adoption of the definition was made under the assumption that it was simply to align definitions and that there was no discussion outside of that. She stated that once she sent out information to

their members after fully reading the definition, she noted it was altering the current definition, which was limited to suits resulting from a claim. She noted that because it was written as “applicant, policyholder or beneficiary,” it was narrowing the population of people who could bring a first-party suit rather than any third-party claim, but was expanding the causes of action, whereas the existing “suit” definition that has been used in previous years could be for a first- or third-party claimant bringing suit against a company, but only a suit that results out of a claim. She noted she understands that the definition as it was adopted would have expanded to suits for any reason, but would have been limited to first-party suits as one had to be a policyholder or applicant, and P/C policies do not have beneficiaries.

Ms. Rebholz offered to take a count on the motion to see who abstained from the vote in response to Mr. Birnbaum’s concern. Ms. Cooper took count, and the following states responded with a “yes” response for the motion to revert the definition of lawsuit to the one used in the 2019 data year: Arkansas, Arizona, Connecticut, Florida, Idaho, Ohio, Pennsylvania, South Carolina, Washington, West Virginia and Wisconsin.

#### 4. Discussed Disability Income MCAS Required to File Criteria

Ms. Cooper noted that the Working Group needed to discuss a fix to current documentation for the disability income MCAS. She stated that when the disability income MCAS reporting threshold was approved, the Working Group agreed to a \$50,000 premium threshold and that no further specification was given in the adoption of the threshold. When the threshold was added to the *Disability Income Data Call and Definitions* document, it was added as \$50,000 of earned premium. The data reference for determining if a company is required to submit disability income data for a state is taken from Schedule T, Part 2. An attachment was provided showing that in Attachment 3, Schedule T, Part 2 shows premiums written. Ms. Rebholz suggested approving a fix to the 2021 *Disability Income Data Call and Definitions* document so that the threshold refers to premiums written. This would make the threshold match the reporting of Schedule T, Part 2.

Ms. Nickel made a motion, seconded by Mr. Haworth, to specify \$50,000 in premiums written as the threshold in the 2021 *Disability Income Data Call and Definitions* document. The motion passed unanimously.

#### 5. Discussed Other Matters Brought Before the Working Group

Ms. Brown noted that she wants to discuss the new data element for suits closed during the period with consideration for the consumer. She asked how reverting back to the former definition of “suit” affects this new data element. Mr. Helder asked if the earlier vote altered this definition, and Ms. Cooper advised her understanding is that the motion in the third agenda item was just to revert to the former definition of “lawsuit” and did not take into account the definition for “lawsuits closed during the period with consideration for the consumer.” Mr. Helder stated in that case, this definition would need to match up with the definition of “lawsuit.” Ms. Brown requested that if allowed by the MCAS procedures, that the motion be to delay the collection of this data element for one year as it appears data collection for 2022 will include causes of action for suits/lawsuits more broad than claims filed. She stated the programming needed to pull this subset of data for one year’s collection of data that is not comparable to subsequent years does not seem appropriate.

Mr. Birnbaum stated he opposes limiting the wording in the definition to “claimant” from “applicant, policyholder or beneficiary,” but he stated if that is to be done, the obvious solution would be to replace the terms “applicant, policyholder or beneficiary” with “claimant” in both of the current and approved definitions. He noted the way to do that would be to say: “For the purposes of 2021 reporting, the terms ‘applicant, policyholder, or beneficiary’ should be understood to mean only ‘claimant.’” Ms. Brown recommended reverting to the previous definition of “suit” for 2021 data and postponing the collection of the new data element of lawsuits closed during the period with consideration for the consumer for one year. Ms. Rebholz noted that she wants to confirm with the NAIC that any proposed fix is an option. Mr. Helder noted in reverting to the previous “lawsuit” definition, which is basically only claims-related lawsuits, he sees no reason that the new data element for lawsuits closed during the period with consideration for the consumer could not be collected, since it includes the term “lawsuit,” which is defined, and if it were just changed to “claimant” from “applicant, policyholder or beneficiary,” it matches up with the current definition of “lawsuit” that was just adopted. Ms. Rebholz noted that in that case, a motion would be needed to change the wording in the definition for “lawsuits closed during the period with consideration for the consumer” from “applicant, policyholder or beneficiary” to “claimant.” She asked Mr. Helder if the Working Group could make that motion, pass it and not be violating any procedures. Mr. Helder noted that he thinks so as he sees this as a fix for a data element already adopted and does not see this as a substantive change.

Mr. Gaines noted that he is concerned with the lack of certainty about whether the Working Group is doing anything in violation of procedures. Mr. Helder noted that he would discuss this with the NAIC Legal Division for feedback. He asked Ms. Brown if industry understood that the new definition of “lawsuit” was to include policyholders in addition to claimants.

She noted that is what she conveyed until NAIC staff advised her that the definition may be reverted to the existing definition. She stated that she told them while it was increasing the causes of action, it would be a change for P/C writers because the new definition for policyholders, applicants and beneficiaries was limited to first-party claims. She noted that it could be an underwriting dispute or a coverage issue, but it would be limited to a first-party claimant. Her original request, regardless of what happens with this definition, is to postpone the collection of the new data element because programming time has been lost. Ms. Brown noted that industry is not suggesting that the new data element for lawsuits closed during the period with consideration for the consumer not be collected. They are just requesting that the collection be postponed for one year until a more settled definition of that data element is determined so there is not one outlier year of data that ends up being thrown out the next year.

Ms. Rebholz asked for feedback from the Working Group on whether lawsuits closed during the period for consideration for the consumer should be the broader definition, which would include third-party claimants, or stay limited to applicant, policyholder, or beneficiary. She noted that considering the definition for “lawsuit” is being reverted to the 2019–2020 definition, she is wondering if the Working Group needs more time to consider that definition and compare it to the definition for lawsuits closed during the period for consideration for the consumer and make sure the terms match, and that correct procedures are being followed to match the terms. Ms. Cooper confirmed with Mr. Helder that the Working Group can meet before the end of this year, after the Fall National Meeting. Mr. Haworth agreed with Ms. Rebholz that it would be appropriate for the Working Group to take some time to consider this topic, as well as to get feedback from the NAIC Legal Division regarding proper procedures and time frames surrounding this.

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

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Draft: 11/10/20

Market Conduct Annual Statement Blanks (D) Working Group  
Virtual Meeting  
October 28, 2020

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Oct. 28, 2020. The following Working Group members participated: Rebecca Rebholz, Chair (WI); October Nickel, Vice Chair (ID); Maria Ailor and Sarah Borunda (AZ); Crystal Phelps (AR); Sheryl Parker (FL); Erica Weyhenmeyer (IL); Lori Cunningham (KY); Phil Vigliaturo (MN); Cynthia Amann (MO); Todd Oberholtzer and Guy Self (OH); Katie Dzurec (PA); Michael Bailes (SC); Ned Gaines and John Haworth (WA); and Letha Tate (WV).

1. Adopted its Sept. 30 Minutes

The Working Group met Sept. 30 and took the following action: 1) adopted its Aug. 26 minutes; 2) discussed the suggestion to conduct a pilot to collect transactional level detail on a single Market Conduct Annual Statement (MCAS) line of business; 3) received an updated on the travel MCAS; 4) discussed questions regarding the life MCAS definition of “lawsuits closed during the period with consideration for the customer”; 5) adopted the motion to add National Producer Number (NPN) reporting for third-party administrators (TPAs) within the home, auto, life and annuity MCAS and NPN reporting for managing general agents (MGAs) within the home and auto MCAS; 6) adopted the motion to move forward with reviewing the proposed definitions and data elements with the intent to implement reporting of accelerated underwriting to the life MCAS; and 7) adopted the motion to move forward with reviewing the proposed definition and data elements with the intent to implement reporting for digital claims settlements in the home and auto MCAS.

Mr. Gaines made a motion, seconded by Ms. Weyhenmeyer, to adopt the Working Group’s Sept. 30 minutes (Attachment Six-A1). The motion passed unanimously.

2. Heard a Presentation on Transactional Level Detail Data Collection

Ms. Rebholz noted that since the Working Group is in the process of having discussions regarding a possible pilot for collecting transactional level data, it would be helpful to receive some input from Ginny Ewing (NAIC), who provides NAIC information technology (IT) leadership for the NAIC applications that support market regulation. She noted that the presentation is intended to provide some understanding of what transaction level data is, methods that could be used for collecting this type of data and what resources would be required from the NAIC in order to implement a transactional level data collection pilot. In addition to Ms. Ewing, Ms. Rebholz noted Scott Morris (NAIC), Chief Technology Officer, was in attendance, and that Jason Hughes (NAIC), enterprise data architect, would be presenting information during the presentation related to the Data Platform project. Ms. Rebholz stated to keep in mind that this discussion originated with a proposal from the Center for Economic Justice (CEJ), for the other health and travel MCAS blanks that have been approved for creation, and that no proposal has been provided to the Market Regulation and Consumer Affairs (D) Committee for its approval yet for a transaction data collection pilot. She also noted that at this time, the subject matter expert (SME) groups working to draft the other health and travel MCAS blanks will continue with drafting summary-level data reporting.

Ms. Rebholz noted that after hearing this presentation, the primary options to consider are: 1) the Working Group could refer the issue to the Market Analysis Procedures (D) Working Group for its consideration of a pilot data call separate from the MCAS data collection process; 2) the Working Group could decide to make a proposal or recommendation to the Market Regulation and Consumer Affairs (D) Committee for an MCAS pilot of transaction-level data collection for one of the approved MCAS lines of business, which could include one of the new lines of other health or travel; or 3) it could be determined that the Working Group members are not interested in pursuing transaction-level data collection at this time. If this is the case, Ms. Rebholz recommends the Working Group communicate this to the Market Analysis Procedures (D) Working Group because it could suggest a pilot separate from the MCAS data collection process if it chooses. This presentation is to simply gather information and answer questions related to what it would mean to have transaction-level data collection. Ms. Rebholz advised if questions taken at the end of this presentation do not allow for time to discuss the other agenda items, they would carry forward to the next Working Group meeting. She also stated that any questions on this presentation could be sent to Teresa Cooper (NAIC).

Ms. Ewing began by reviewing the definition of transaction-level data. She noted that most of the data collected at the NAIC is summary data, which is data reported on financial statements like total bonds, claims and premiums. She said all of those are derived from transaction-level data that today is stored at the company. Transaction-level data is much more granular than the

summary data. It describes an event like a policy issued or terminated or perhaps a claim that was made or closed. It would include all the details around that event. For example, it would include a policy number, or the type of product included in the transaction. For claim data, it could include the date the claim occurred or was reported, so it is the granular data associated with a particular event. She noted that working with this more granular data lends itself to a lot of advantages around determining accuracy and completeness. It makes it easier to identify incomplete or inaccurate data that is reported. It also provides the ability to reconcile data with other data sources and have different kinds of validations. The data can be aggregated in different ways, and particular products can be evaluated. High-level summaries can be obtained, and then any areas of interest can be explored further. For the most part, transaction-level data can be rolled up and summarized; summary-level data cannot generally be made more granular. Starting with more granular data provides more flexibility.

Ms. Ewing discussed the Regulatory Data Collection (RDC) application, which is a product that was rolled out to production in May 2017. The RDC has been used for several data collections to date. It was designed with the need for secure and spur of the moment data accessibility in mind. The RDC was built with the technology and methods capable of loading large data sets. One of the initial applications for this was the principle-based reserving (PBR) mortality experience data collected. This involved millions of records, so one of the considerations was making sure the application could support that and that it was scalable for when needs change. The RDC automates the manual processes associated with submitting, accepting, validating, aggregating, and transforming the data, and it improves data quality by identifying potential issues early on. When the RDC was used to collect mortality experience data for the PBR VM-51, Experience Reporting Formats, it was for data at a policy level and was very granular. It started with an observation year for 2015, which included a couple of pilots with that data. The first year, there were seven companies involved, and there were almost 6 million records submitted and loaded, which totaled to more than 270 million data elements. For 2016, more companies were added, and data was collected for 2018, resulting in billions of data elements. Expansion was supposed to take place this year, but with COVID-19, that has been delayed to 2021, and approximately 130 participating companies are anticipated. Based on this experience, Ms. Ewing noted that some things to consider when collecting transaction level data, includes establishing in advance the file format, as well as naming conventions, and to clarify and level set expectations with the companies that will be submitting data on what will be received.

The next project Ms. Ewing discussed was Enhanced RDC. This project started a couple of months ago. The goal is to extend the functionality, improve it, make it a self-serve data collection tool where all parameters associated with the needed data collection can be set, and the data can then be collected very quickly. To do that, the administration portal needs to be built out. A need that has come up is forms. For example, in PBR, there would not be someone entering data into a form, but rather a file is uploaded that contains those millions of records. However, there are smaller data sets where there is a need for a user entry data screen, so the ability to define a form is being worked on to build into the RDC. Ms. Ewing advised that while there is still some work to be done on the RDC, it is positioned well to address the data collection needs of state insurance regulators, and it is being used for data collection. She advised that collecting data is the first step but being able to use the data once received is where the Enterprise Data Platform program is addressing those needs.

Mr. Hughes discussed the Enterprise Data Platform and explained that once the RDC collects data, the Enterprise Data Platform is where users will go to do the analytical work. He explained data will initially come into a raw data layer from the source and is then moved to a lightly curated data layer. That layer is where data quality rules will be applied and enforced. This is also referred to as the exploration layer, where staff can look through the data and find value in it and then move the data to the business data layer. The business layer is where the data can be accessed through different dashboards such as Tableau and Snowflake. Application Programming Interface (API) access would also be available at the business data layer. Mr. Hughes advised the big benefit for a system and project like this is to centralize all data elements into one location for analytics. This project is in the early stages, and the first data set is being moved through right now. Future data sets are being evaluated for early next year.

Ms. Ewing advised some pilot considerations to think about are selecting a representative, but non-time sensitive data collection since delays can happen. She advised the data needs to be defined such as what the transaction is, are unique records coming in each time or will existing records be updated, what kind of validations are appropriate, how often does data need to come in, what kind of tools make sense for using the data, and what kind of business intelligence or artificial intelligence (AI) should be considered. Other considerations are NAIC staff availability for setting up data collection, working with participating states and companies and their availability, making sure the right people submit the data and that they can be authenticated and have the needed credentials, and how the data will be consumed and presented. She advised that there is a good foundation and tools and capabilities in place to be able to work with members and business partners to meet their needs.

Mr. Haworth asked if the data would be downloadable into an Access or Structured Query Language (SQL) database and if so, would it be at the state insurance regulator level or would it be at the NAIC, where it is partitioned off where queries could be made from that database. Mr. Hughes advised the business data layer of the Enterprise Data Platform will be comprised of

different tools. The foundation is Amazon S3, but one of the other technologies being looked at is Snowflake, which is a data warehousing system. It has a rich data sharing process and is being piloted in a few states right now. Users would be able to log in to Snowflake using their single sign-on (SSO) credentials like when users log into iSite. Based on the roles assigned to the user, they would have access to the data in a read-only state after logging in. From there, users can ingest the data into their own database systems and would also have the flexibility to connect their own tools into it. Mr. Haworth advised he uses Quick Link and links multiple tables and then does queries and extracts. He asked if Snowflake would have that same functionality. Mr. Hughes advised it would and that that is one of the things being tested with pilot states right now as they are heavy Quick Link users as well. Adjusting Quick Link to read against Snowflake was one of the first things addressed, and it has been very successful. Mr. Hughes advised Microsoft Access tools would work as well. Mr. Haworth asked if Python script would also be available, and Mr. Hughes confirmed it would.

Ms. Ailor asked if the data could be obtained in a comma-separated value (CSV) file or a Market Analysis Prioritization Tool (MAPT) format. Mr. Hughes advised he believes so and that Snowflake is a Software as a Service (SaaS), offering so its main interface is a web console. Users can go to the URL and log in, and if there is a query or a table of interest that the user wants to pull down into a CSV, this can be done inside Snowflake. It can also be set up to pull records down from Snowflake to local machines.

Mr. Vigliaturo asked for clarification on exactly what is meant by transaction-level data. He stated he was thinking if a policy is written and canceled mid-term, or if another driver is added on an automobile policy or some type of policy change, his understanding is that the concept of transaction data would mean collecting a record for each one of those types of transactions. He noted it gets even more complicated when the loss record is linked to the policy record and when a claim is first reported, and then additional information comes in as the claim develops and gets settled. He stated he would like to know what is meant by transaction data. Ms. Ewing noted that from a technical perspective, it can be any of those things and that it comes down to what the specific business needs are, so once the business needs were established, that data could be collected.

Birny Birnbaum (CEJ) asked if the NAIC has the capability to collect and process an additional 100 million records representing approximately 100 gigabytes of data. Ms. Ewing answered “yes” and noted that the data would need to be defined. Mr. Birnbaum asked if the NAIC collected transaction data, could the NAIC provide the same reports that are currently provided for MCAS by summarizing the transaction data into the current summary buckets. Ms. Ewing answered “yes,” from a technical perspective working with internal and regulator business partners. Mr. Birnbaum asked if there are differences in data protection for summary data versus transaction data in terms of data confidentiality, and Ms. Ewing answered “no.” She noted that data is data and whether it is summary or transaction-level, it is protected the same way. Mr. Birnbaum asked for examples of improved data quality review that might be possible under transaction reporting that is not possible under summary reporting. Ms. Ewing stated none came to mind right away, but that in general with summary data, by not having the details, it can be unclear what is missing. She explained when looking at an individual record, you can see where a premium may be missing and be able to tie that back to other data to ensure that it is of good quality. Mr. Birnbaum advised PBR VM-51 is considered transaction reporting but asked if his understanding is correct that each record is an individual claim or individual sale. Ms. Ewing answered “yes” and noted that it is at the policy level. Mr. Birnbaum explained his understanding is that while a company may have a number of transactions associated with a particular sale or a number of transactions associated with a particular claim, for PBR reporting, it is summarized as all of the sales transactions into one sales record and all of the claims transactions into one claims record; he asked if that was correct. Ms. Ewing answered that she believes that is correct.

J.P. Wieske (Health Benefits Institute) stated that regarding the PBR data being collected, his understanding is that there are size limitations that attach to the life insurers in a lot of states, and that there is an ability to exempt smaller life insurers from the transactions, at least initially. He asked if the NAIC is prepared to work directly with small companies on specific data to make sure the data set works, as this seems different from a sophistication standpoint. Ms. Ewing advised collaboration would take place with business partners and said details would be worked through with the insurance companies as well. Ms. Cooper answered that assistance would be provided to companies on any needs they had. Mr. Wieske asked if the Working Group approved moving forward today, how quickly would the transaction-level data be available to state insurance regulators to review. Ms. Ewing noted that if this were the No. 1 priority and the data collections were clearly defined and laid out, it could happen in a matter of weeks or months as the technology and foundation are in place.

Ms. Birnbaum asked if the NAIC currently works with the smaller companies on summary reporting for MCAS. Ms. Cooper answered “yes” and noted that there is a team of analysts that takes questions from companies and assists them on how to report. Mr. Birnbaum asked if data were reported in April or May 2022 and the data elements were fixed by August 2021, would that provide enough lead time to get systems in place. Mr. Hughes answered “yes.”

Tom Keepers (Consumer Credit Industry Association—CCIA) asked if there is a sense for what the current unmet needs are with the MCAS environment at the group summary level and how transaction-level data will address those unmet needs. Ms. Dzurec advised that with respect to the short-term, limited-duration (STLD) and other health products, because of the questions being asked, the transaction-level data would be more useful to address the issues that were laid out in 2018. She noted that the unmet need is about data availability and how the data is analyzed to address specific issues, which is less of an IT concern and more of a regulatory analytical concern. Ms. Dzurec said she believes it is not an unmet need on the technology side, but an unmet need on the actual information collected on a large scale in thinking about market analysis generally. She said she believes transaction-level data applies to and could easily get worked in to STLD and other health and may not be necessary in other places.

Lisa Brown (American Property Casualty Insurance Association—APCIA) noted if there are specific lines where transactional data is the only way to do base level market analysis, then perhaps MCAS is not the vehicle. She noted if the pilot is successful for one line, it would only be a matter of time before transaction-level data would be applied to other lines. Ms. Brown stated if it is not needed for other lines, then she does not understand why this would be explored. Ms. Dzurec stated that if the pilot is successful and a transaction-level data path is followed, there are quality controls and raw data details that state insurance regulators can review on the summary level that they are currently not able to review at the summary level. Ms. Dzurec noted that if transaction-level data is determined to be the most useful, then it will be further explored, and business rules will be created to get to the summary data. She advised transaction-level data allows for more analysis and noted there is still a lot to learn, test and discuss. Ms. Dzurec agreed that collecting unnecessary data is not of interest but noted that state insurance regulators do not have access to things they probably should, and that transaction-level data might provide them that information. Ms. Brown noted she appreciates knowing that this is the beginning of discussions on this topic and that there are still things to be worked out, as her members would not currently agree with a decision by this Working Group that fundamentally changed the nature of MCAS data collection.

Mr. Wieske noted he understands the idea that transaction-level data is infinitely more accurate than summary-level data, but he expressed concern that the expectation is too high. He stated there would be issues to work through related to data being misreported related to misunderstanding of the definitions, differing control of the internal data sources and data being filled in incorrectly at a claims level. Ms. Ewing advised that data needs to be defined, validations need to be in place, and it needs to be clear to everyone involved on exactly what is being collected. She stated there is always the potential of submitting data that does not meet the expectation, which can happen at the transaction or summary level. She advised that is why expectations and the definitions of the data are so critical and need to be well-defined. Mr. Birnbaum noted that regardless of the form of data reporting, there is an opportunity for reporting errors. The relevant aspect of transaction reporting is that there is a greater ability to identify errors than with summary data reporting. He stated if the concern is data quality, then transaction data reporting provides more tools and opportunity to identify those errors and relay that information back to the company.

Will Malofchik (National Council of Insurance Legislators—NCOIL) noted that some of NCOIL's members expressed concern about MCAS being significantly expanded beyond the current practices. He stated NCOIL is particularly concerned that it seems driven at a staff level rather than by commissioners. Ms. Rebholz advised this is not a decision being made by this Working Group and explained this is about gathering information at this time. She noted any recommendation made by this Working Group, if any, would not be decided at this level but at the Market Regulation and Consumer Affairs (D) Committee level. Other agenda matters will be discussed during the next Working Group meeting.

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

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Draft: 10/19/20

Market Conduct Annual Statement Blanks (D) Working Group  
WebEx Conference Call  
September 30, 2020

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via WebEx conference call Sept. 30, 2020. The following Working Group members participated: Rebecca Rebholz, Chair (WI); October Nickel, Vice Chair (ID); Maria Ailor represented by Sarah Borunda (AZ); Kurt Swan represented by Steve DeAngelis (CT); Scott Woods (FL); Lori Cunningham (KY); Teresa Kroll (MO); Todd Oberholtzer and Guy Self (OH); Jeffrey Arnold (PA); Michael Bailes represented by Rachel Moore (SC); John Haworth (WA); and Letha Tate (WV). Also participating was: Sarah Crittenden (GA).

1. Adopted its Aug. 26 Minutes

The Working Group met Aug. 26 and took the following action: 1) adopted its July 31 minutes; 2) discussed the creation of the Travel Insurance Market Conduct Annual Statement (MCAS) blanks and data call and definitions; 3) adopted a clarification in the Homeowners MCAS data call and definitions related to the reporting of policies in-force by type of policy within the underwriting section; 4) considered the addition of National Producer Number (NPN) reporting within the Home, Auto, Life and Annuity MCAS and NPN reporting for managing general agents (MGAs) within the Home and Auto MCAS; 5) discussed possible placement changes for the lawsuit and complaint data elements within the Home and Auto MCAS; 6) discussed the addition of accelerated underwriting definition and data elements to the Life MCAS; and 7) discussed the addition of digital claims settlement reporting in the Home and Auto MCAS.

Mr. Haworth made a motion, seconded by Mr. Oberholtzer, to adopt the Working Group's Aug. 26 minutes (Attachment Six-A1a). The motion passed unanimously.

2. Discussed the Suggestion to Conduct a Pilot to Collect Transactional Level Detail on a Single MCAS Line of Business

Ms. Rebholz noted that consumer representatives have raised the idea of a transactional level pilot for a single MCAS line of business, possible short-term limited-duration (STLD) insurance. This suggestion was met with some favorable responses from state insurance regulators on the Other Health drafting group. The same proposal was also received from consumer representatives for the Travel insurance line of business. Ms. Rebholz recommended that the Working Group consider whether it wants to conduct that type of pilot with a more familiar line of business, such as Auto or Homeowners. There could be a launch of a transactional level data collection pilot on one of those lines of business. Before a decision is made on what line the Working Group would like to try a pilot on, it needs to be determined if the Working Group members support such a pilot. The Market Regulation and Consumer Affairs (D) Committee would then need to approve a transactional level pilot for an MCAS line of business.

Ms. Rebholz noted that she asked Ginny Ewing (NAIC) to join the call, in case the Working Group had any questions regarding the information technology (IT) resources that are available to do this or what resources would be needed. Ms. Rebholz asked if there is any interest in moving forward with a pilot or thoughts about this. There were no comments from Working Group members.

Birny Birnbaum (Center for Economic Justice—CEJ) recommended that if a pilot is done, it makes sense to start with a line that has fewer insurers reporting. He noted that starting with a line like Homeowners that has hundreds of insurers reporting could make a pilot more difficult. In conversations he has had with NAIC IT staff, it seemed that they welcome the market regulators moving towards more granular data collection. He noted that the feeling he got is that they want to be providing information to state insurance regulators that they need. He believes the Other Health line may be a good place to start.

Lisa Brown (American Property Casualty Insurance Association—APCIA) noted that given that no state insurance regulators are expressing thoughts on this matter, she does not know how that could translate as sharing a state insurance regulator need with NAIC IT staff. She believes there needs to be some state insurance regulator interest for the need to collect transactional data before moving forward with this suggestion. Ms. Rebholz noted that any comments and/or questions should be sent to Teresa Cooper (NAIC) no later than Oct. 23.

3. Received an Update on the Travel MCAS

Ms. Rebholz noted that the MCAS subject matter expert (SME) group will meet for the first time Oct. 21. Following today's meeting, a travel meeting invitation will be sent out to those that have indicated interest in participating in the SME group. Those that have not yet volunteered and would like to, were advised to contact Ms. Cooper to be added to the list.

Mr. Birnbaum has provided a proposal for the SME group to review, and another proposal from the industry will also be submitted.

4. Discussed Questions Regarding the Life MCAS Definition of "Lawsuits Closed During the Period with Consideration for the Customer"

Ms. Rebholz noted that the definitions used for this new data element already exist in the private flood, disability, lender-placed and long-term care (LTC) MCAS. Shelli Isiminger (TN) submitted some questions regarding the data element for "Lawsuits Closed During the Period with Consideration for the Customer," which was added to the Life MCAS for the 2021 data year. She asked how companies should report an interpleader, which is a process for a person to initiate a lawsuit, but it is not an actual lawsuit. The definition would not appear to require the reporting of interpleaders here. Ms. Isiminger also asked about the use of the term "consumer" since with a life policy, the insured (consumer) is deceased, and the interested party is the beneficiary. The MCAS definition of lawsuit states that companies should include only lawsuits brought by an applicant for insurance, a policyholder, or a beneficiary as a plaintiff against the reporting insurer or its agent as a defendant. The term consumer here can be understood to mean applicant, policyholder, or beneficiary. The last question asked was about the use of the term consideration. Per the definition, "a lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the applicant, policyholder, or beneficiary in an amount greater than offered by the reporting company before the lawsuit was brought.", but consideration here is referring to the payment, benefit, or other thing of value that is given to the claimant as a result of the lawsuit. It is not referring to a policy term or feature. Ms. Isiminger did not have additional comments to add here.

Ms. Rebholz noted that since this is a new topic, time will be allowed for comments and questions to be submitted for review and discussion to occur during the next Working Group call. Any comments should be sent to Ms. Cooper no later than Oct. 23.

Concerns were also raised regarding the definition of lawsuits that was approved for the reporting of "lawsuits closed during the period with consideration for the consumer" within the Home and Auto MCAS. This discussion will also take place during the next Working Group meeting. Ms. Brown was told that she would have a chance to present her concerns at that time. She added that she will also request that the collection of lawsuits closed with consideration for the consumer for private passenger auto (PPA) and homeowners be delayed a year, as there is currently not a working definition of suit or lawsuit to collect the underlying lawsuit information, let alone to try to carve out a subset for another data element. Ms. Rebholz noted that the comments to be discussed will be posted on the Working Group's web page.

5. Considered the Addition of NPN Reporting for TPAs within the Home, Auto, Life and Annuity MCAS and NPN Reporting for MGAs within the Home and Auto MCAS

Ms. Rebholz noted that the Working Group previously approved the suggestions to require the identification of third-party administrators (TPAs) and their functions within the Life and Annuity MCAS and the identification of TPAs and MGAs within the Home and Auto MCAS. The current discussion is whether reporting should also include the TPA and MGA NPN. During the August Working Group meeting, it was established that not all TPAs and MGAs will have an NPN; however, some Working Group members felt that it would be useful to have the NPN to verify if the TPA or MGA is licensed and to be able to better identify the entities if they are using a "doing business as" (DBA) name. Ms. Rebholz noted that one option would be to require the reporting of NPNs when available and allow the insurer to indicate "not applicable" if there is no NPN assigned to the entity. No additional comments were received on this matter since that last discussion.

Ms. Crittenden believes this is a great idea, and she noted that the more information available to identify a TPA or MGA in cases where names are similar, or a DBA is being used is welcome.

Mr. Haworth made a motion, seconded by Ms. Kroll, that TPAs and MGAs be required to report their NPN when available and indicate "not applicable" if no NPN is assigned to the entity. The motion passed unanimously.

6. Discussed the Addition of "Accelerated Underwriting" Definition and Data Elements to the Life MCAS

Ms. Rebholz noted that the reporting suggestion from the CEJ is included in the meeting materials. The suggestion was discussed during the past few meetings, and there has been interest in this reporting, but there are also questions about the timing and the appropriateness of currently proposed definitions. If the Working Group approves the reporting of accelerated underwriting data elements, they would be in effect for the 2022 data year at the earliest. Ms. Rebholz asked if there was a motion from the Working Group to move forward with reviewing the proposed definition and data elements with the intent to implement reporting.

Mr. Haworth made a motion, seconded by Ms. Nickel, to move forward with reviewing the proposed definitions with the intent to implement reporting. The motion passed unanimously. Any comments and suggestions regarding the CEJ proposed definition and data elements are to be sent to Ms. Cooper.

#### 7. Discussed the Addition of Digital Claims Settlement Reporting in the Homeowners and PPA MCAS

Ms. Rebholz noted that the proposal for the addition of digital claims settlement reporting in the Homeowners and PPA MCAS is in the meeting materials. There was good discussion on this topic during the last Working Group meeting. Ms. Rebholz asked if Working Group members had time to think about this topic and whether separating out claims settled using a digital process from those settled using the traditional process would be useful for market analysis.

Mr. Haworth noted that he sees merit to this, especially since it appears that claim adjusting may be going more in this direction. Ms. Nickel noted that she believes this is a very good idea as well, and she believes moving forward with collecting this data is inevitable.

Mr. Birnbaum noted that if the Working Group wants to proceed on this, he welcomes it and is interested in collaborating with industry representatives to clear up any concerns they have with definitions and data elements.

Richard L. Bates (State Farm Insurance) noted that he is not clear on how the method of claim settlement relates to the issue of a claim being settled in a timely manner. He believes this data may be nice to have, but it does not seem necessary. Ms. Nickel noted that the framework of an unfair claims practice is not just based on timing. It is also based on whether those claims were paid appropriately, whether the damage was assessed correctly, and whether everything was taken into consideration. Ms. Nickel noted that market regulation seeks to ensure that that the consumer is made whole again. She noted that it is important to determine that any platform that a carrier uses is resulting in appropriate claim settlements and communications. Mr. Bates noted that he does not know if carriers have an ability to differentiate these different types of claims settlements, and he expressed how he does not believe collecting this data is necessary.

Mr. Birnbaum noted that the purpose of the MCAS is not just to ask if carriers comply with fair trade practices or the *Unfair Claims Settlement Practices Act* (#900). The reason for MCAS breakouts is to enable state insurance regulators to identify differences based on how a product is sold, what the differences in the products are, or how the claims are handled. Mr. Birnbaum noted that the issue here is that a digital only claim settlement is qualitatively different than claims that have human interaction, and if you look at the proposed definition, it explicitly says only a digital interaction. If there is any human interaction, it is no longer identified as a digital claim settlement. Mr. Birnbaum noted that some consumer issues have been raised from digital claim settlements, particularly with auto insurance. Mr. Bates responded that he thinks more discussion on this topic is needed. Ms. Nickel agreed that further discussion should occur. Ms. Rebholz noted that today the decision that needs to be made is just whether the addition of digital claims settlement reporting in the Homeowners and PPA MCAS is of interest and if it would be valuable to state insurance regulators, not necessarily the details of what exactly it will look like. The details and how it would look would take place in a later discussion.

Ms. Nickel made a motion, seconded by Mr. Haworth, to move forward with reviewing the CEJ proposed definition and data elements with the intent to implement reporting. The motion passed unanimously. Any comments and suggestions regarding the CEJ proposed definition and data elements are to be sent to Ms. Cooper.

#### 8. Discussed Other Matters

Ms. Rebholz noted that the Other Health SME group will meet Oct. 8.

Ms. Rebholz also noted that the approved reporting for claims closed without payment because the claim amount was below the deductible for the Auto MCAS will be in effect in the 2021 data year, to be reported in 2022. This reporting was approved through the Market Regulation and Consumer Affairs (D) Committee, and it is now part of the MCAS blank. Mr. Rebholz

noted that Mr. Bates provided comments on this matter during the Summer National Meeting, and comments were also received from the National Association of Mutual Insurance Companies (NAMIC) and the APCA noting their concerns that the data may not be uniformly captured by insurers.

Ms. Brown noted that many companies have a genuine concern that this is not information they capture. It is not just a question of a programming change within their system, but an entire process change, because companies do not always know why a consumer files a claim and do not follow through and drop the claim. Ms. Brown would like more clarification on how companies are expected to capture this information. Ms. Rebholz asked if companies can compare the policy deductible amount with the claim amount and whether the claim goes into claim closed without payment if the amount claimed is less than the deductible when the claim is closed. Ms. Brown noted that she believes it would be challenging because when a claim is opened, sometimes the insured realizes they will not meet the deductible and then does not provide a claim amount for comparison, and the claim is closed as a claim closed without payment.

Ms. Nickel asked if there was any differentiating by companies between a claim that was just not pursued by the insured and one that had a claimed amount that fell below the deductible, so the claim is manually closed as a result. She noted that there must be some way to differentiate these types of claims that makes the information meaningful, such as a letter to the insured that is sent alerting them that the claim is being closed because the claim is below the deductible, or some kind of similar trigger. Ms. Brown noted that she would go to the APCA's members and see how various companies handle that, as she does not know if there is a single answer to that.

Mr. Birnbaum noted that if clarification is provided, he does not see any difficulty in reporting this. He noted that it seems straightforward to say the amount offered by the company is less than the deductible and therefore the claim was closed without payment, and this is something companies should be able to program.

Mr. Bates noted that one of State Farm's main concerns is that there may be instances where they can report claims closed because the claimed amount is below the deductible, but it will not include everything because they do not track this information. Mr. Birnbaum noted that MCAS data collection is a forward-thinking tool, and the reason companies get a year and a half to prepare for this is in case companies need to make changes to start collecting certain data. Ms. Brown noted that there is a year and a half between the adoption of a data element and the reporting of that data element, but not a year and a half from when the data collection must start. She noted that companies essentially only have four months to re-program their system. She noted that when it is a complete processing change, this can take companies more than four months to prepare. After further discussion on this matter, Ms. Rebholz noted that a frequently asked questions (FAQ) document can be created, and the definition of a claim closed without payment because the claim amount was below the deductible can also be modified to address some of the concerns raised.

David Leifer (American Council of Life Insurers—ACLI) asked if the details regarding the accelerated underwriting collection would be worked out in a future call. Ms. Rebholz noted that it would be discussed on another call, and it may also be discussed further in an SME group and then brought back to the Working Group. She noted that input on this subject is welcome, and any comments and suggestions arising from topics discussed on this call should be submitted to Ms. Cooper by Oct. 23 in time for the next Working Group call. The next Working Group meeting will be held Oct. 28.

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

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Draft: 9/10/20

Market Conduct Annual Statement Blanks (D) Working Group  
Conference Call  
August 26, 2020

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Aug. 26, 2020. The following Working Group members participated: Rebecca Rebolz, Chair (WI); Crystal Phelps (AR); Kurt Swan represented by Steve DeAngelis (CT); Scott Woods (FL); Lori Cunningham (KY); Teresa Kroll (MO); Todd Oberholtzer represented by Guy Self (OH); Katie Dzurec (PA); Michael Bailes (SC); Ned Gaines and John Haworth (WA); and Letha Tate (WV). Also participating were: Pam O’Connell (CA); Laura Arp (NE); and Matt Gendron (RI).

1. Adopted its July 31 Minutes

The Working Group met July 31 and took the following action: 1) adopted its June 24 minutes; 2) discussed clarifications for recently adopted Market Conduct Annual Statement (MCAS) updates; and 3) discussed possible MCAS updates previously tabled.

Mr. Haworth made a motion, seconded by Ms. Phelps, to adopt the Working Group’s July 31 minutes (*see NAIC Proceedings – Summer 2020, Market Regulation and Consumer Affairs (D) Committee, Attachment Three*). The motion passed unanimously.

2. Discussed the Creation of the Travel Insurance MCAS Blanks and Data Call and Definitions

Ms. Rebolz noted that the travel insurance MCAS has now been fully approved by the NAIC membership, and the Working Group is tasked with creating the travel blank and data call and definitions. Those interested in being a part of the focus group that drafts the data call and definitions were advised to contact Teresa Cooper (NAIC). The Travel MCAS discussions will begin soon to ensure that the data call and definitions are ready for adoption next spring, prior to the June 1 deadline.

3. Considered a Draft Homeowner MCAS Clarification

Ms. Rebolz noted that clarification is needed for the Homeowner MCAS in relation to the reporting of policies in-force by type of policy within the underwriting section. During the national meeting, the proposed language that could be added to the data call and definitions to ensure correct reporting was discussed. This draft language was included in the meeting materials.

Birny Birnbaum (Center for Economic Justice—CEJ) suggested that the wording of the last sentence of line 3-48, which states, “If your company only writes policies that fall into the forms specified for questions 3-45, 3-46 and 3-47, this number may be 0,” be changed to say, “If your company only writes policies that fall into the forms specified for questions 3-45, 3-46 and 3-47, this number will be 0” or “this number should be 0.” Mr. Haworth noted that he agrees the end of that sentence should state “this number will be 0.”

Mr. Haworth made a motion, seconded by Ms. Kroll, to adopt the wording change in the last part of the sentence for line 3-48 from “this number may be 0” to “this number will be 0.” The motion passed unanimously.

4. Considered the Addition of NPN Reporting for TPAs within the Home, Auto, Life and Annuity MCAS and NPN Reporting for MGAs within the Home and Auto MCAS

Ms. Rebolz noted that the Working Group has already approved the suggestions to require the identification of third-party administrators (TPAs) and their functions within the Life and Annuity MCAS and require the identification of TPAs and managing general agents (MGAs) within the Home and Auto MCAS. Now the Working Group needs to determine if it is appropriate to also request that the TPA and MGA National Producer Number (NPN) be included in the reporting. Comments on this topic were received from David Leifer (American Council of Life Insurers—ACLI). He did not have anything additional to add about the issue of whether the NPN should be included.

Mr. Gaines asked what exactly is gained from gathering the NPN, and he questioned if collecting the NPN was necessary. Mr. Gendron noted that requiring the NPN could give a “double check” for the state to verify if the company is using a licensed company. Mr. Birnbaum noted that this would be useful, as companies often use trade names or “doing business as” (DBA) names that differ from the names used on their license; and by including the NPN, even if a DBA name was used, by having

the NPN, it could more easily identify the correct licensee. He noted that he knows MGAs have an NPN, and he asked if TPAs all have NPNs, as that may change the reporting required. Mr. Gaines noted that TPAs only have NPNs if acting in a producer capacity, so if a TPA is only doing billing for example, they would not necessarily have an NPN. Ms. Rebholz noted that an explanation could be added for the blank for TPAs indicating that the NPN is being requested if it exists, and the answer could be “not applicable” if it does not exist. No motion was made to make this change at this time. Ms. Rebholz noted that if anyone has additional comments on this matter to send them to Ms. Cooper.

5. Discussed Possible Placement Changes for the Lawsuit and Complaint Data Elements within the Home and Auto MCAS

Ms. Rebholz noted that no comments were received regarding the placement of lawsuit and complaints data elements within the Home and Auto MCAS.

Mr. Birnbaum noted that in prior calls, concerns were raised that because lawsuit and complaints data elements were in the claim category, some companies understood that to mean only lawsuits and complaints related to claims were being requested. He suggested finding out if that is in fact the problem and if companies are really interpreting the request for complaints and lawsuits that way. Lisa Brown (American Property Casualty Insurance Association—APCIA) noted that she had not heard of any concerns from members having any MCAS blanks questioned or returned to them by the various states because of a gross under-capturing of the complaints and lawsuit data due to where it is placed in the blanks. She noted that companies are very diligent about reading the data call and definitions document to have a good understanding of how to report these data elements. She noted that that does not mean there are not companies misinterpreting these data elements and not advising her of issues, but she was not aware of this being an issue. No motion was made to make changes here, but if it is brought up to the Working Group’s attention again, it will be readdressed.

6. Discussed the Addition of Accelerated Underwriting Definition and Data Elements to the Life MCAS

Ms. Rebholz noted that the original suggestion from the CEJ to add data elements related to accelerated underwriting was included in the meeting materials. During the national meeting, there seemed to be some interest in the addition of data elements in this area. Comments were received on this topic from the ACLI, the CEJ and October Nickel (ID).

Mr. Leifer noted that the ACLI does not think the MCAS is the right place to gather data for accelerated underwriting or data related to it, at least right now. He is not sure how accelerated underwriting fits in to what the MCAS is for, as he understands it to be a benchmark for consumer complaints and litigation. Some of the sources that are used in accelerated underwriting are sources that have been around for decades. Mr. Leifer noted that there are lots of workstreams at the NAIC on the issue of accelerated underwriting that will be announced soon, and he thinks this topic can be tabled until some of that work proceeds and some of the definitions are settled upon. He asked that this suggestion be put on hold for the time being.

Ms. Arp noted that she spoke with her actuary, and they believe these definitions and what is being collected here needs more attention based on what they are learning in other workstreams. She asked if the definitions as written are overbroad and if there is a better way to capture something unique for the market concern focused on here.

Ms. O’Connell noted that she does feel insurers’ use of accelerated underwriting practices are a growing area, and as a market regulator, she has interest in this data. She believes it would be helpful to gather information on the MCAS that highlights companies who use accelerated underwriting, what the processes are, and what the impact is in terms of policies issued under that methodology versus traditional underwriting and things of that nature. She noted that she does not know if the way the suggestion is laid out is precisely what they would want, but she thinks this is an important area and that market regulators would find value in collecting this data via the MCAS.

Mr. Birnbaum noted that this is extremely relevant data, and some life insurers started using accelerated underwriting as far back as 2008. The practice has been growing exponentially with the pandemic due to less human to human interactions. Accelerated underwriting is using algorithms and third-party non-medical data to replicate the traditional results of traditional underwriting. Mr. Birnbaum noted that this has profound implications on both sales and consumer outcomes. Being able to look at the difference in consumer outcomes between traditional underwriting practices and accelerated underwriting is meaningful to state insurance regulators to understand the cause of these differences. Mr. Birnbaum noted that monitoring accelerated underwriting is also important because a change in an algorithm can affect tens of thousands of applicants virtually instantaneously, whereas doing things on a human to human interaction basis has a much slower impact on consumers. The CEJ suggests that the concept of accelerated underwriting be adopted and the CEJ proposal be exposed for comments because there has not been much engagement from industry to date as far as what they would suggest in the way of definitions. Industry representatives can then provide feedback, and changes can be made. Mr. Birnbaum noted that there are interrogatories, as well

as data elements. Suggested questions mentioned were: 1) does the company use accelerated underwriting; 2) if so, for what product categories; and 3) what are the data sources and vendors supplying the data or the algorithms. He noted that understanding what companies are using accelerated underwriting for is important, especially if the data reveals that certain types of questionable data or data that is known to have a racial bias is being used. He noted that this is something of interest to market regulators and to the broader public policy makers at large. He addressed the concern raised by the ACLI that some of this information is a trade secret. He noted that whether it is a trade secret, it is currently confidential, and there is no public access to it; but this raises the concern that if this is subject to the Fair Credit Reporting Act (FCRA), companies have to disclose the use of the data to consumers and provide adverse action notices if an adverse action occurs. He then addressed the concern raised by the ACLI that this would be duplicative of reporting under the principal-based reserving (PBR) reporting for life insurance, but he noted that the ACLI did not identify any overlap. He noted that if current PBR were changed significantly, then it might be able to be used for market regulation. He also addressed the concern raised by the ACLI that collecting accelerated underwriting data is premature. He stated that if the Working Group decides to move forward, these new data elements would be for 2022 experience, reported in 2023; and given that companies have been using accelerated underwriting for over a decade, it does not seem premature. For these reasons, he asked that the CEJ proposal be exposed for comments with the intention to move forward with the proposal or some revised version based on the comments received.

Mr. Haworth noted that one of the things he is looking at is the vendors supplying data or algorithms. He noted that a possible question to consider is how often the algorithm is updated or changed. He believes there is merit in collecting accelerated underwriting data. He also noted that PBR falls to the domestic state, and he does not know if the other states that would be seeing how those products are marketed would be able to easily find out how the algorithms work.

Peter Kochenburger (University of Connecticut School of Law) noted that it would be useful to collect this data, not only for the states individually, but also for state insurance regulators to see and understand what is happening on a national level.

Ms. Rebholz noted that the addition of accelerated underwriting definitions and data elements to the Life MCAS will be considered further during the next Working Group meeting. Call participants were advised to be prepared to review the definitions and data elements in detail during the next call and to submit any additional comments and suggestions on this matter to Ms. Cooper.

#### 7. Discussed the Addition of Digital Claims Settlement Reporting in the Home and Auto MCAS

Ms. Rebholz noted that no additional comments were received regarding the reporting of digital claims settlements data for the Home and Auto MCAS. The original CEJ suggestion was included in the call materials.

Mr. Birnbaum noted that there is a growth in digital only types of claims settlements where a third-party claimant or policyholder takes pictures and sends them through an application for the insurer after an accident. The insurance company then offers a settlement without inspecting the vehicle and without the use of a human assessor. This is a fairly new approach to claims settlement based on an algorithm that reviews the photos. Some issues have been identified based on these types of claims settlements, including lawsuits claiming that they do not assess structural or underlying damages, including damage associated with the safety devices that are now built into vehicles. It seems that there are likely to be significant differences in claims settlement outcomes for consumers who only utilize digital claims settlement versus the consumers who engage or ask for human appraisal of their vehicle. Based on the rapid growth of technology and the role of algorithms in that technology, the CEJ suggested that some of the data elements in Auto and Home MCAS be broken out between digital claims settlements and other than digital claims settlements. He discussed the definitions offered for these categories and explained that if at any time a human assessor was involved, it would not be reported as digital claims settlement, but it would be reported as other than digital claims settlement.

Mr. Gaines noted that he believes most of the issues surrounding this would be resolved through the claims supplement process. His understanding is that once vehicles are later inspected by the shop, if the shop finds structural damage or damage that was not visible by the pictures provided, additional payments can be made. Mr. Birnbaum noted that that would then be reported as other than digital claims settlement. He noted that he thinks it would be useful to see information related to when a customer takes the offer and never gets the vehicle inspected or repaired. He noted that if there was an interest in seeing how often a digital claims settlement results in multiple supplemental claims, different data elements would be needed. Mr. Gaines noted that this is more on the consumer than the carrier, as in these instances, it is the consumer making the decision not to repair the vehicle or follow up with a shop.

Mr. Self noted that consumers have a right to recover the full value of the damages and are not obliged to have repairs completed. He believes the digital claims settlement adjustment method is more prone to miss damages than a real inspection. Mr. Gaines agreed and again stated that the consumer can still have it inspected by a shop if they disagree with the assessment.

He noted that in most states, the consumer has the duty to prove their damages. He further explained that even an in-person inspection can be low, because if the vehicle is not at a shop and torn down, the carrier cannot write an estimate based on what they do not see, which is not an indication that the carrier is doing anything wrong. He noted that knowing carriers are utilizing digital claims settlements could be the first phase of this data collection, and he asked if knowing how many digital claims settlements were contested to get a better idea of what the dynamics are would be helpful. Mr. Birnbaum noted that that would be a useful metric but knowing how that compares to non-digital claims settlements would be required, as well having a good understanding.

Ms. Brown noted that companies are maximizing digital adjusting tools, and she believes this issue needs more discussion. She noted that once a claim is contested, a human inspection of some kind would normally take place. By saying when there is a physical look at the vehicle, it would no longer fall into the digital claims settlement category and there would be no contested digital claims with the current proposed definition.

Ms. Rebholz asked that state insurance regulators think about what would be helpful for them to see in this area and how that information can be identified. The Working Group will consider the addition of digital claims settlement reporting in the Home and Auto MCAS during the next meeting. Call participants were advised to be prepared to review this suggestion in detail during the next call and submit any additional comments to Ms. Cooper.

#### 8. Discussed Other Matters

Ms. Rebholz noted that comments were received regarding newly approved reporting for claims closed without payment because the amount claimed is below the deductible. These comments will be discussed on the next Working Group call.

Any comments and suggestions arising from topics discussed on this call should be submitted to Ms. Cooper by Sept. 25 in time for the next Working Group call, which will take place on Sept. 30.

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

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Draft: 11/30/20

Market Conduct Examination Standards (D) Working Group  
Virtual Meeting  
November 19, 2020

The Market Conduct Examination Standards (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Nov. 19, 2020. The following Working Group members participated: Bruce R. Ramge, Chair, and Reva Vandevoorde (NE); Russell Hamblen, Vice Chair (KY), Crystal Phelps (AR); Damion Hughes (CO); Steve DeAngelis (CT); Robin David (DE); Lindsay Bates (IA); Erica Weyhenmeyer (IL); Mary Lou Moran (MA); Jill Huisken (MI); Cynthia Amann, Jennifer Hopper and Stewart Freilich (MO); Tracy Biehn and Bill George (NC); Ingrid Marsh (NH); Ralph Boeckman (NJ); Sylvia Lawson (NY); Rodney Beetch, Rick Campbell and Jana Jarrett (OH); Landon Hubbard (OK); Joseph Barrett and Nicole McClain (PA); Christina Rouleau (VT); and Darcy Paskey, Rebecca Rebholz and Mary Kay Rodriguez (WI).

1. Adopted its Oct. 20 Minutes

The Working Group met Oct. 20 and took the following action: 1) discussed updated examination standards in Chapter 24—Conducting the Health Examination of the *Market Regulation Handbook* (Handbook) corresponding to recent amendments to the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170); and 2) discussed a new long-term care insurance (LTCI) in-force policy standardized data request (SDR) and a new LTCI claims SDR for inclusion in the reference documents of the Handbook.

Mr. Hamblen made a motion, seconded by Ms. Rebholz, to adopt the Working Group's Oct. 20 minutes (Attachment Seven-A). The motion passed unanimously.

2. Adopted Revisions to Chapter 24 of the Handbook

Director Ramge said Jeanette Plitt (WA) and Sarah Crittenden (GA) reviewed the recently adopted amendments to Model #170 to ascertain whether there were any necessary changes to be made to Chapter 24 of the Handbook. Ms. Crittenden and Ms. Plitt recommended changes to the Introduction, to Marketing and Sales Standard 2 and to Marketing and Sales Standard 3.

Director Ramge said the draft of proposed changes was distributed to the Working Group Oct. 14.

Mr. Hamblen made a motion, seconded by Ms. Phelps, to adopt the proposed revisions to Chapter 24 of the Handbook. The motion passed unanimously.

3. Adopted New LTCI SDRs for Inclusion in the Reference Documents of the Handbook

Director Ramge said draft LTCI SDRs were developed by state insurance regulator subject-matter experts (SMEs) for the Working Group's review, discussion and consideration of adoption for inclusion as new SDRs in the reference documents of the Handbook.

Mr. Hamblen said the SMEs had developed the LTCI SDRs under the leadership of Ms. Hopper.

Director Ramge said the draft LTCI SDRs were distributed to the Working Group Oct. 14 and were discussed during the Working Group's Oct. 20 meeting.

Mr. Hamblen made a motion, seconded by Ms. Rebholz, to adopt the LTCI SDRs for inclusion in the reference documents of the Handbook. The motion passed unanimously.

4. Discussed Other Matters

Director Ramge said the following are Working Groups and subject areas that he has been following in 2020 for future inclusion in the Handbook:

- The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup’s recent adoption on Oct. 29 of the *[State] Pharmacy Benefit Manager Licensure and Regulation Model Act*, which is a proposed new model to address certain marketplace activities of pharmacy benefit managers (PBMs).
- The Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group’s 2020 charge to “provide supplemental resources to support documentation and reporting in Chapter 24B—Conducting the Mental Health Parity Examination of the Handbook.”
- Amendments to the *Unfair Trade Practices Act* (#880) regarding rebating practices currently being considered by the Innovation and Technology (EX) Task Force.

Director Ramge said the Working Group would likely not meet in December. He said the Working Group will reconvene in 2021 when the Working Group is reappointed by the Market Regulation and Consumer Affairs (D) Committee.

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

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Draft: 11/3/20

Market Conduct Examination Standards (D) Working Group  
Virtual Meeting  
October 20, 2020

The Market Conduct Examination Standards (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Oct. 20, 2020. The following Working Group members participated: Bruce R. Ramage, Chair, Martin Swanson and Reva Vandevoorde (NE); Russell Hamblen, Vice Chair, and DJ Wasson (KY); Jimmy Harris, Mel Heaps and Crystal Phelps (AR); Sarah Borunda (AZ); Eleanor Coe, Damion Hughes and Dennis Newman (CO); Kurt Swan (CT); Sarah Crittenden (GA); Lindsay Bates (IA); Michelle Baldock and Erica Weyhenmeyer (IL); Jill Huisken (MI); Paul Hanson (MN); Cynthia Amann, Jennifer Hopper, Win Nickens and Jessica Schrimpf, (MO); Tracy Biehn and Suling Wang (NC); Maureen Belanger and Ingrid Marsh (NH); Erin Porter (NJ); Laura Baca and Leatrice Geckler (NM); Dai How Bih (NY); Hermoliva Abejar and Peggy Willard-Ross (NV); Rodney Beetch, Rick Campbell and Todd Oberholtzer (OH); Kevin Foor (OK); Brian Fordham and Scott Martin (OR); Katie Dzurec and Christopher Monahan (PA); Julie Fairbanks and Joy Morton (VA); Christina Rouleau (VT); John Haworth and Jeanette Plitt (WA); and Barbara Belling, Diane Dambach, Darcy Paskey, Rebecca Rebholz and Mary Kay Rodriguez (WI).

1. Discussed Draft Revisions to Chapter 24—Conducting the Health Examination of the Handbook

Director Ramage said that Ms. Plitt and Ms. Crittenden reviewed the recently adopted *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170) to ascertain whether there are any necessary changes to be made to Chapter 24—Conducting the Health Examination of the *Market Regulation Handbook* (Handbook). Ms. Crittenden said the following are recommended changes and the reason for each proposed change:

- In the Introduction paragraph to the chapter, add the following sentence to provide context and to provide examiners with a heads-up regarding Model #170: “The health insurance market is always evolving, and new products, such as supplemental, short-term, limited duration insurance, may not fall completely under Chapter 24 or Chapter 24A.”
- In Marketing and Sales, Exam Standard 2, add a reference to Model #170 under the NAIC Model References section.
- In Marketing and Sales, Exam Standard 3, add a reference to Model #170 under the NAIC Model References section.

Ms. Crittenden said that she and Ms. Plitt do not recommend any changes at this time to Chapter 20—General Examination Standards or Chapter 24A—Conducting the ACA-Related Examination relating to the provisions of Model #170. Director Ramage said that the draft Chapter 24 was exposed Oct. 14 and the comments due date on the chapter is Nov. 13.

2. Discussed Draft LTC SDRs for Inclusion in the Reference Documents of the Handbook

Director Ramage said that the draft long-term care (LTC) standardized data requests (SDRs) were developed by state insurance regulator subject matter experts (SMEs) for the Working Group’s review, discussion and consideration of adoption for inclusion as new SDRs in the Reference Documents of the Handbook. Mr. Hamblen said that the SMEs recently developed the LTC SDRs under the leadership of Ms. Hopper. Director Ramage said the draft SDRs were exposed Oct. 14 for a public comment period ending Nov. 13.

3. Discussed Other Matters

Director Ramage said that the following are Working Groups and subject areas that he is following for future inclusion in the Handbook:

- The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup’s development of a new model to address certain marketplace activities of pharmacy benefit managers.
- The Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group’s 2020 charge to “provide supplemental resources to support documentation and reporting in Chapter 24B—Conducting the Mental Health Parity Examination of the Handbook.”
- Amendments to the *Unfair Trade Practices Act* (#880) regarding rebating practices currently being considered by the Innovation and Technology (EX) Task Force.
- Annuity suitability revisions to Chapter 23—Conducting the Life and Annuity Examination chapter of the Handbook to correspond with the February 2020 adopted revisions to the *Suitability in Annuity Transactions Model Regulation* (#275).

Director Ramage said NAIC staff will provide advance email notice of the next Working Group meeting, which is anticipated to occur in November.

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

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Draft: 12/1/20

Privacy Protections (D) Working Group  
Virtual Meeting (*in lieu of meeting at the 2020 Fall National Meeting*)  
November 20, 2020

The Privacy Protections (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Nov. 20, 2020. The following Working Group members participated: Cynthia Amann, Chair, and Marjorie Thompson (MO); Ron Kreiter, Vice Chair (OK); Damon Diederich (CA); Erica Weyhenmeyer (IL); LeAnn Crow (KS); T.J. Patton (MN); Raven Collins (OR); Gary Jones (PA); and Katie C. Johnson (VA). Also participating were Vanessa Darrah (AZ); Scott Woods (FL); and John Haworth (WA).

1. Adopted its July 30 Minutes

Ms. Amann said the Working Group met July 30 and took the following action: 1) adopted its May 5 minutes; 2) heard a presentation that included a comparative analysis and comments received July 24 by the Blue Cross Blue Shield Association (BCBSA) and the Health Coalition; and 3) made plans to begin a gap analysis discussion by Working Group members, interested state insurance regulators, and interested parties using the *Privacy of Consumer Financial and Health Information Regulation* (#672) as a baseline model.

Mr. Kreiter made a motion, seconded by Ms. Weyhenmeyer, to adopt the Working Group's July 30 minutes (*see NAIC Proceedings – Summer 2020, Market Regulation and Consumer Affairs (D) Committee, Attachment Five*). The motion passed unanimously.

2. Discussed Initial Draft Gap Analysis of Consumer Issues

Ms. Amann said the next item on the agenda is to discuss the initial draft gap analysis of consumer issues, and she asked Lois E. Alexander (NAIC) to provide a reminder of what brought the Working Group to this point.

Ms. Alexander said the Working Group kicked off its task during the 2019 Fall National Meeting in Austin, TX by providing a draft discussion document in the form of a workplan that included a privacy briefing. She said this workplan also provided a schedule and overviews of the *NAIC Insurance Information and Privacy Protection Model Act* (#670), Model #672, the General Data Protection Regulation (GDPR), the California Consumer Privacy Act (CCPA), and State Data Privacy Legislation. She said the Working Group met in February to discuss next steps and receive updates from Brooke Stringer (NAIC) on federal legislation and Jennifer McAdam (NAIC) on state legislation, including privacy charts comparing the Gramm-Leach-Bliley Act (GLBA) and the Health Insurance Portability and Accessibility Act of 1996 (HIPAA), the CCPA and Model #670, and detailed and abbreviated data privacy charts of state legislation. Progress by the Working Group continued during the pandemic, but at a slower pace than was anticipated in the schedule. Ms. Alexander said next steps include a draft revision of Model #670 from the subject matter expert (SME) state insurance regulator group that was exposed for comment in April, with comments being discussed during the May meeting. Comments presented at the May meeting indicated that revisions to Model #670 would not be the best approach going forward. Ms. Alexander said the July meeting began with a presentation that included a comparative analysis using Model #672 by the BCBSA and Arbor Strategies LLC on behalf of the Health Coalition, and it ended with the Working Group reviewing plans to begin a gap analysis discussion using Model #672 as a baseline model.

Ms. Amann said as a reminder, the Working Group's 2020 charges are to:

Review state insurance privacy protections regarding the collection, use and disclosure of information gathered in connection with insurance transactions, and make recommended changes, as needed, to certain NAIC models, such as the *NAIC Insurance Information and Privacy Protection Model Act* (#670) and the *Privacy of Consumer Financial and Health Information Regulation* (#672), by the 2020 Summer National Meeting.

Ms. Amann said during the Working Group's last meeting, it determined that it would separate its gap analysis discussions into three parts: Consumer Issues, Industry Obligations and Regulatory Enforcement. She said it was also determined that, where appropriate, the NAIC Data Guiding Principles would be applied and definitions would be updated to align with those already discussed and adopted by other NAIC groups working on similar issues, such as the Artificial Intelligence (EX) Working Group, the Big Data (EX) Working Group, the Accelerated Underwriting (A) Working Group, etc. However, she said today's focus will be on the following consumer issues: notifications, portability, opt-ins/opt-outs and disclosures.

Ms. Amann said the first issue is consumer notifications. She said using the workplan from last fall, the Working Group will compare the consumer notification requirements in Section V—State Privacy Legislation to the consumer notification requirements in Section II—Model #672. She said State Privacy Legislation requires privacy notice to consumers. She said Article II—Privacy and Opt Out Notices for Financial Information of Model #672, which begins on page 672-15, has detailed requirements for insurers to follow regarding the type, method and timing of initial, annual and revised privacy notices to consumers about its privacy policies and practices; so at first review, it appears there is no gap. However, the Working Group would like to discuss the following questions: 1) how consumer notifications are handled currently; 2) whether this method is still effective or there are gaps that require revision; and 3) what areas revisions are needed and why if there are gaps.

Chris Petersen (Arbor Strategies LLC) said the consumer notification and disclosure requirements in the GLBA and HIPAA are very comprehensive and based on set timeframes at initial point of sale and annually thereafter. As a result, he said consumers believe that they get too many notices causing consumers to ignore or toss the notices without being read, so this type of requirement is ineffective. He said federal laws might get in the way of this Working Group taking action that could help consumers, like triggering notices on occurrences rather than on timing. He said encouraging consumers to opt-in to electronic versions would also be very productive. He said the sample provisions in the GLBA are prescribed by law.

Ms. Johnson said when Virginia added the elements of the GLBA to its code, the required notices for insurance were removed from the combined notices and put into security under the *Insurance Data Security Model Law* (#668). She said the General Assembly would not mandate the use of electronic notices because many consumers do not have computer access, so opt-in is required instead. She said companies wanted to post rather than mail the notices. She said Virginia allows posting of the notices, but it also requires companies to provide paper copies to consumers free of charge. Ms. Amann said she receives paper notices from several companies that she throws away without reading. She said her preference is a notice on her billing statement of a web notice via link because it is so easy. Ms. Johnson asked if the GLBA has any restrictions to prevent states and companies from doing this type of notice. Ms. Johnson said the abbreviated notice provided by the federal government in 2015 requires states and companies to follow it exactly or risk the federal government taking this responsibility from state jurisdiction. Ms. Darrah said Arizona requires that a script and recording be available online for the hearing impaired. Mr. Petersen said it could not be required, but it could be offered as an option. Mr. Haworth said accessibility standards require the ability to listen as well as read. Ms. Amann said the assignment going forward is to receive comments prior to the next meeting and consider any option submitted if it helps to streamline and get notices into a consumer's hands.

Ms. Amann said the second issue is consumer portability. In Section V of the workplan, she said State Privacy Legislation includes a consumer right of a portable data format; and in Section II of the workplan, Article II and Article V—Rules for Health Information of Model #672, which begins on page 672-30, provide methods for individuals to prevent a licensee from disclosing that information; i.e., “opt out” for financial info and “opt in” for health information, so it appears there is no gap. However, the Working Group would like to discuss the following questions: 1) how consumer notifications are handled currently; 2) whether this method is still effective or there are gaps that require revision; and 3) what areas revisions are needed and why if there are gaps. Ms. Amann asked for comments to be submitted about portability as well.

Ms. Amann said the third issue is consumer opt-ins versus opt-outs. She said in the workplan, Section V. State Privacy Legislation requires a consumer opt-in or opt-out standard. However, in Article II of Model #672 provides “opt out” for financial info, and Article V of Model #672 provides “opt in” for health information. Ms. Amann said in this case, it appears that there is a gap that will need to be addressed with these and other questions: 1) how consumer notifications are handled currently; 2) whether this method is still effective or there are gaps that require revision; and 3) what areas revisions are needed and why if there are gaps. She said at issue here is whether the consumer fully understands what their choice to opt-in or opt-out really means about control over their data within the insurance industry. Ms. Johnson said Virginia kept the whole list of opt-ins and opt-outs from the GLBA in its legislation that would have to be untangled if Virginia was to pursue a different option at this point. Ms. Amann said any other options would have to work within the GDPR and the CCPA as well. She said the question is really if any provision is still needed that could help to improve business practices and consumer protections. Mr. Petersen asked that the Working Group be mindful that anything it does be for all businesses, not just for the insurance industry, so as not to disadvantage the insurance industry or any other business concern. Ms. Amann agreed and said this issue needs more discussion.

Ms. Amann said the fourth issue is consumer disclosures. She said in the workplan, Section V. State Privacy Legislation includes: 1) a requirement to disclose information collected; 2) a requirement to disclose shared information; 3) a requirement to disclose sources of information; 4) a requirement to disclosure business purpose; and 5) a requirement to disclosure third party involvement. However, she said in Article III—Limits on Disclosures of Financial Information, which begins on page 672-15, and Article V of Model #672 describe the conditions under which a licensee may disclose nonpublic personal health information and nonpublic personal financial information about individuals to affiliates and nonaffiliated third parties. Ms.

Amann said Model #672 appears to cover this requirement in general, but not specifically, so there may be a gap. For each of these requirements, she said the Working Group would like to address the following questions: 1) how consumer notifications are handled currently; 2) whether this method is still effective or there are gaps that require revision; and 3) what areas revisions are needed and why if there are gaps. Ms. Amann said artificial intelligence (AI), accelerated underwriting, and other big data advancements are being developed faster than consumers can tell what is happening. She said the Accelerated Underwriting (A) Working Group is in discussions now. She said third party involvement needs to be addressed, as well as when and how consumers can become involved. She said in this regard, Model #672 needs to be updated. Mr. Haworth asked how the data from driving a car would be used if a consumer uses their cell phone to buy the car, but they are not the person who will be driving the car. He also asked how the consumer would know who, how and why the data on driving that car is being used. Birny Birnbaum (Center for Economic Justice—CEJ) said one cannot separate disclosure from consent. He asked how a consumer knows to what uses their consent is being given. He said general consent should not be allowed because it does not tell consumers any real information about where or for what their consent is being used. He also said it does not tell consumers what data they have control over—i.e., driving record— or who owns the data—i.e., the insurance company, the car dealership, or the consumer. He said this also relates to portability, as a consumer cannot control the sending of data to another carrier or affiliate. Ms. Amann said keeping track of and keeping up with new technology cannot control what consumers read and know either. She said there is a need to review the content of the notices and a consumer's understanding over who has control over their data. Mr. Petersen said the Working Group should proceed with caution because it is hard to separate consumers from business and regulation. He said in the end, it would be necessary to see how all four issues are interconnected and what interplay there is between them.

Ms. Amann said the Working Group will collect comments about consumer issues for the next few weeks and the Working Group will have a series of regulator-only calls during this time in order to provide a completed outline of the insurance functions of Model #672 before Christmas with an email in early January 2020 exposing it for comments. Mr. Kreiter asked that comments be included for all three areas, not just for consumer issues.

Having no further business, the Privacy Protections (D) Working Group adjourned.

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Draft: 11/19/2020

Market Regulation Certification (D) Working Group  
Virtual Meeting  
November 12, 2020

The Market Regulation Certification (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Nov. 12, 2020. The following Working Group members participated: John Haworth, Chair (WA); Bill Cole, Vice Chair (WY); Sarah Bailey (AK); Crystal Phelps (AR); Lindsay Bates (IA); Erica Weyhenmeyer (IL); Mary Lou Moran (MA); Jason Decker (MD); Stewart Freilich and Cynthia Amann (MO); Tracy Biehn (NC); Reva Vandevoorde (NE); Edwin Pugsley (NH); Don Layson (OH); Landon Hubbard (OK); Crystal Welsh (PA); Michael Bailes (SC); Christina Rouleau (VT); and Theresa Miller (WV). Also participating were: Pam O'Connell (CA); and Russell Hamblen (KY).

1. Adopted its Oct. 19 Minutes

Mr. Haworth said the Working Group met Oct. 19 to discuss the pass and fail metrics for the Voluntary Market Regulation Certification Program (Program).

Ms. Amann made a motion, seconded by Mr. Pugsley, to adopt the Working Group's Oct. 19 minutes (Attachment Nine-A). The motion passed unanimously.

2. Discussed Pass and Fail Metrics

Mr. Cole reviewed the red, yellow and green coding scheme for the scoring matrix of the Program. He said the next step to consider is how much weight each of the yellow-coded questions should be given. He noted that participation in the Market Conduct Annual Statement (MCAS) might be weighted lower than some of the staffing requirements. Mr. Haworth asked for thoughts and comments regarding the scoring of the yellow-coded questions.

3. Discussed Comments Concerning Certification Pilot Volunteers' Suggestions

Mr. Haworth said it has been six months since the Working Group met, and he encouraged everyone to review the comments submitted by California, Idaho, Maryland, the American Property Casualty Insurance Association (APCIA) and the American Council of Life Insurers (ACLI). He asked Ms. O'Connell if she would review her comments again since it has been a while since the Working Group had reviewed them.

Ms. O'Connell said some of the questions in the Program checklist can be answered with "not applicable." She said that makes scoring these questions problematic. Mr. Cole said he would review those questions with the scoring drafting group to see how they should be handled. Ms. O'Connell said all the requirements and checklist questions should be reworded to match the red/yellow/green scheme. Red-coded questions should use the word "must"; yellow-coded questions should use words like "should." For Requirement 1, Ms. O'Connell noted that it is coded red, but there are no questions that relate to model laws specified in the guidelines for the requirement. Mr. Hamblen agreed with Ms. O'Connell and suggested the checklist questions should be used as a guide to re-draft the guidelines.

Ms. Amann said the guidelines could be streamlined to provide more direction and be less broad. Mr. Haworth said the goal of the Program is to be inclusive. He said that at some point, consideration can be given to raising the bar.

Mr. Cole said rewording the guidelines and checklist questions may answer some of the questions the drafting group had on the scoring matrix.

Mr. Haworth said the drafting group will meet again to review the guidelines in light of the scoring matrix and will have a draft for the next Working Group meeting.

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

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Draft: 11/2/2020

Market Regulation Certification (D) Working Group  
Virtual Meeting  
October 19, 2020

The Market Regulation Certification (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Oct. 19, 2020. The following Working Group members participated: John Haworth, Chair (WA); Bill Cole, Vice Chair (WY); Crystal Phelps (AR); Erica Weyhenmeyer (IL); Holly Lambert (IN); Jason Decker (MD); Chlora Lindley-Myers (MO); Tracy Biehn (NC); Edwin Pugsley (NH); Don Layson (OH); Shelly Scott (OK); Brian Fordham (OR); Gary Jones (PA); Michael Bailes (SC); Julie Fairbanks (VA); and Christina Rouleau (VT). Also participating were: Pam O'Connell (CA); and Jill Huisken (MI).

1. Adopted its Sept. 9 Minutes

The Working Group met Sept. 9 to discuss a proposed scoring matrix for the Voluntary Market Regulation Certification Program (Program).

Mr. Pugsley made a motion, seconded by Mr. Fordham, to adopt the Working Group's Sept. 9 minutes (Attachment Nine-A1). The motion passed unanimously.

2. Discussed Pass and Fail Metrics

Mr. Cole said the metrics scoresheet assigned each requirement question a color. Each requirement coded as red is mandatory. A Department of Insurance (DOI) will not pass unless it meets every mandatory requirement. Questions coded as yellow are not mandatory, and a DOI would be scored on these requirements. Requirements coded as green are not scored. The green-coded questions only support responses given to the questions coded as red and yellow.

Mr. Cole reviewed the metrics scoresheet and identified the mandatory questions as:

- 1(a) Does the department have the general authority to collect and analyze information whenever it is deemed necessary?
- 2(a) Does the department have authority by statute, rule or other authority to utilize the *Market Regulation Handbook* or its predecessor/successor?
- 3(d) and 3(e) Does the department have examiners on staff whose responsibility is (utilize contract examiners) to examine and/or conduct continuum actions of insurance companies as indicated by the department's market analysis or as prescribed by state laws?
- 4(c) Does the department determine the composition of members of an examination team?
- 5(a) Does the jurisdiction have laws, regulations or case law that specify how the confidentiality of market conduct examination workpapers is to be handled?
- 5(b) Has the jurisdiction entered into the Multi-State Information Sharing Agreement with other jurisdictions and the NAIC?
- 5(c) Does the jurisdiction have written policies and procedures and has communicated such policies and procedures to employees relating to the protection of confidential information, which includes personally identifiable information (PII) and protected health information (PHI), handling of public records requests, and requirements for confidentiality agreements, when it becomes necessary to share confidential information with other federal and international regulatory or law enforcement agencies, not otherwise covered by the multi-state agreement?
- 6(a) Has the department adopted the *Market Regulation Handbook* and the Market Actions (D) Working Group Policies and Procedures, or are the department's policies and procedures consistent with those in the *Market Regulation Handbook* and the Market Actions (D) Working Group policies and procedures?
- 8(a) Does the department enter or transmit data at least quarterly into the Complaints Database System (CDS)?
- 10 (a) Has the department appointed a collaborative action designee (CAD)?
- 10 (c) Does the CAD and/or CAD alternate attend at least 50% of all meetings and conference calls of the Market Actions (D) Working Group?

Mr. Cole said 38 of the questions were coded yellow and would be assigned point values. A DOI could still be certified even without meeting a yellow-coded question if it scored high enough on the other yellow-coded questions and met all the

mandatory requirements. He said there were 19 green-coded questions, which only asked for supporting information for the yellow-coded and red-coded questions.

Mr. Haworth said some of the questions were not identified as red because of the impact that might have on smaller DOIs and on jurisdictions that must comply with union requirements. He noted that some of the questions coded as yellow could later become mandatory.

Ms. O'Connell asked what percentage of the yellow-coded questions would have to be met in addition to the mandatory requirements for a DOI to gain certification. Mr. Haworth said that was not determined yet. He said he thinks 70% to 75% could be the target, but it needs to be discussed.

Ms. Weyenmeyer suggested the addition of definitions to better understand the intent of each of the questions.

Ms. Huisken asked what the consequences were for a jurisdiction that did not meet certification. Mr. Haworth said the Market Regulation Certification Program is voluntary. He said there were no consequences for states that do not participate or do not meet certification. He said the goal for now is just to get participation in the program.

Mr. Haworth asked for comments to be sent to Randy Helder (NAIC) by Nov. 6.

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

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Draft: 9/14/2020

Market Regulation Certification (D) Working Group  
Conference Call  
September 9, 2020

The Market Regulation Certification (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Sept. 9, 2020. The following Working Group members participated: John Haworth, Chair (WA); Bill Cole, Vice Chair (WY); Jimmy Harris (AR); Erica Weyhenmeyer (IL); Jason Decker (MD); Cynthia Amann (MO); Teresa Knowles (NC); Reva Vandevoorde (NE); Edwin Pugsley (NH); Russell Toal (NM); Don Layson (OH); Landon Hubbard (OK); Scott Martin (OR); Christopher Monahan and Crystal Welsh (PA); Michael Bailes (SC); Julie Fairbanks (VA); Christina Rouleau (VT); and Theresa Miller (WV). Also participating were: Pam O'Connell (CA); Jill Huisken (MI); and Matt Gendron (RI).

1. Adopted its Feb. 20 Minutes

The Working Group met Feb. 20 to discuss comments regarding suggested revisions to the Voluntary Market Regulation Certification Program (Program).

Ms. Rouleau made a motion, seconded by Ms. Weyhenmeyer, to adopt the Working Group's Feb. 20 minutes (*see NAIC Proceedings – Summer 2020, Market Regulation and Consumer Affairs (D) Committee, Attachment Six*). The motion passed unanimously.

2. Discussed Comments Concerning Certification Pilot Volunteers' Suggestions

Mr. Haworth said it has been six months since the Working Group met and encouraged everyone to review the comments submitted by California, Idaho, Maryland, the American Property Casualty Insurance Association (APCIA) and the American Council of Life Insurers (ACLI). He said they are posted on the Working Group's web page. The comments are regarding the October 2019 redlined version of the Program that is also posted on the web page.

3. Discussed Pass and Fail Metrics

Mr. Haworth said that during the Working Group's Feb. 20 meeting, there was considerable discussion regarding how a jurisdiction would be scored in a certification audit using the Program checklist and guidelines. He said that Mr. Cole prepared a draft version of a pass/fail metrics chart.

Mr. Cole said the metrics divided each checklist question into mandatory and provisional measures. If a question is a mandatory item, it was valued at 50 points. If it was a provisional measure, it was valued at 25 points. He said three scenarios are provided in the metrics chart. The first scenario assumed that each mandatory question was answered with a "yes" and that each provisional question was answered with a "no." In this scenario, 850 points out of 1,725 possible was achieved. That yields a score of 49.28%, which would not pass. Mr. Cole said the second scenario that assumed all mandatory questions were answered with a "yes" and that 15 of the provisional questions were answered with a "yes." This yielded a score of 71.01%, which just passes. The third scenario measured assumed that all the provisionals were answered "yes" and that only half of the mandatory questions were answered "yes." That also yielded a passing score of 71.01%. Mr. Haworth said the 70% threshold was used as a starting point. He said it could be raised in later years, but he also did not want to set the bar too low at the beginning.

Superintendent Toal noted that New Mexico had some concerns in February but is pleased with the scoring document. He said it is a valuable self-assessment tool. He said he likes the structure and format.

Ms. Vandevoorde said this is a good beginning of a scoring document. She suggested allowing for partial scores on each question. Mr. Cole said that was a good idea since some questions have multiple elements; for example, a question may require policies and procedures that may be in place, but the adherence to the policies and procedures may not be happening. He said this would allow the jurisdiction to improve on that requirement and score higher on the next audit. He suggested a bare minimum should be established in order to achieve any score for any particular question. Ms. Vandevoorde said this would add flexibility to the scoring. Mr. Cole said he would be happy to work with a group to come up with how to include partial scoring in the chart. Ms. Rouleau and Ms. Amann volunteered.

Ms. Amann asked if any questions must be met for a jurisdiction to pass regardless of the point total achieved. Mr. Haworth noted that every state has its examination authority, so he asked if that question needs to have a partial score. He said he does not want to start out with a document that is too inflexible. Mr. Morgan said a core set of requirements should be identified. Superintendent Toal said a total aggregate score is not going to work since some requirements are critical and should, perhaps, be separated out. Ms. Nickel suggested that the core requirements could be 50% of the score. The other requirements would then have to bring the jurisdiction to 70%. Ms. Welsh suggested the mandatory requirements could be separated and not scored and be considered minimum requirements for certification.

Mr. Morgan asked if definitions of “mandatory” and “provisional” could be added. Mr. Haworth said they could.

Ms. Rouleau said some requirements mention having policies and procedures for certain activities. She asked whether having a statute in place could meet the requirement for having policies and procedures in place. She noted that Vermont has a small department, and everyone knows the ground rules laid out by statute. Mr. Haworth said many jurisdictions have employees attest to their knowledge of what is in the policies and procedures. That type of attestation of their knowledge of what they can and cannot do per statute might be a way to meet the requirement. He said this problem is like states that cannot require certain designations because of union contracts. Those states need a way to show that their employees and contractors are qualified based on experience and years of service.

Ms. Rouleau said an annual attestation usually applies to everyone in the department. She asked if the Requirements apply to everyone in the department. Mr. Haworth said the Program applies to anyone performing market conduct in the state. He said many people in departments do multiple tasks, including market conduct tasks. They would apply to market conduct activities. Ms. Rouleau asked for clarifications in the documents of what employees and staff fall under the requirements.

Mr. Haworth said the drafting group for the scoring document will: 1) define mandatory and provisional questions; 2) define employees and staff; 3) determine how to incorporate partial scoring; and 4) identify the requirements that are mandatory and how to score them.

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

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