

Draft: 8/23/21

Market Regulation and Consumer Affairs (D) Committee
Columbus, Ohio
August 16, 2021

The Market Regulation and Consumer Affairs (D) Committee met in Columbus, OH, Aug. 16, 2021. The following Committee members participated: Barbara D. Richardson, Chair (NV); Sharon P. Clark, Vice Chair (KY); Alan McClain (AR); Evan G. Daniels (AZ); Trinidad Navarro (DE); Dana Popish Severinghaus represented by Erica Weyhenmeyer (IL); Chlora Lindley-Myers and Cynthia Amann (MO); Chris Nicolopoulos (NH); Jon Godfread (ND); Carter Lawrence (TN); Jonathan T. Pike (UT); and Michael S. Pieciak (VT). Also participating were: Damion Hughes (CO); Elizabeth Kelleher Dwyer (RI); Mike Kreidler and John Haworth (WA); and Rebecca Rebholz (WI).

1. Adopted its July 27 Minutes

The Committee met July 27 and took the following action: 1) adopted its Spring National Meeting minutes; 2) adopted revised charges for the Antifraud (D) Task Force; 3) adopted the short-term, limited-duration Market Conduct Annual Statement (MCAS) data call and definitions; 4) adopted the Travel Insurance MCAS data call and definitions; 5) adopted digital claims data in the private passenger auto and homeowners data call and definitions; and 6) heard presentations from a state insurance regulator, an NAIC funded consumer representative, and an industry trade representative on the benefits and challenges of collecting market conduct data annually on a transactional level.

Commissioner Clark made a motion, seconded by Commissioner Godfread, to adopt the Committee's July 27 minutes (Attachment One). The motion passed unanimously.

2. Heard a Presentation from the UConn School of Law on Claim Optimization and the Insurance Promise

Peter Kochenburger (UConn School of Law) said the insurance promise includes insurers paying the full value of covered claims without exceeding the policy limits. He noted there are disparities in knowledge and economic power between insurers and most insureds. He said the insurance company cannot use the claim process to rewrite the policy to leverage lower payments than the value of what the claim is worth.

Mr. Kochenburger said artificial intelligence (AI) has provided insurers with the potential to evaluate the willingness of insureds or claimants to accept values less than the fair and equitable amount. He said this would violate the *Unfair Claims Settlement Practices Act* (#900). While Mr. Kochenburger admitted that it is unknown if claim optimization is occurring, he said it is used in other consumer transactions; it has been used in underwriting for price optimization; and the marketing by InsurTech vendors suggests this is being built into InsurTech tools. Mr. Kochenburger encouraged state insurance regulators to determine the extent of use of predictive analytics in claim settlements and require insurers to report on the algorithmic models used in claim handling.

Angela Gleason (American Property Casualty Insurance Association—APCIA) said the term “claim optimization” is leveraging the negative connotations of price optimization to imply consumers are being harmed. She said insurance companies go above and beyond to treat their insureds and claimants fairly. She said consumers are always encouraged to question how claims are valued by the insurance company and always have the recourse to shop for other insurance.

Birny Birnbaum (Center for Economic Justice—CEJ) said shopping for other insurance is not an option after filing a claim. He asked if the implication of claim optimization is that insureds in similar situations are being treated differently according to factors unrelated to the claim. Mr. Kochenburger said that is correct. Mr. Birnbaum also asked if a publicly owned insurance company would be failing its investors if it did not use claim optimization. Mr. Kochenburger said that was the case because the company would be operating illegally if it did do so and that was not in the best interest of investors. Finally, Mr. Birnbaum asked if the collection of more granular data would assist state insurance regulators in monitoring and assessing the use of claim settlement models in claim settlements. Mr. Kochenburger said it would. He noted that it is not easy to evaluate whether a claim is settled fairly and that there are always good faith disputes, so the more granular data that is available, the better.

Erica Eversman (Automotive Education & Policy Institute—AEPI) also said the ability to shop around for other insurance coverage is not an option for a consumer after the claim. She noted that the three major claim evaluation vendors are beholden to the insurance companies.

3. Adopted its Task Force and Working Group Reports

Commissioner Richardson said the Market Information Systems (D) Task Force adopted a proposal for coding changes to the Regulatory Information Retrieval System (RIRS). She said when the Committee votes to approve the Working Group and Task Force reports, it will also be voting to adopt the RIRS coding changes proposal. She also noted that the Market Actions (D) Working Group and the Advisory Organization Examination Oversight (D) Working Group met in regulator-to-regulator session due to the nature of their discussions focusing on specific company practices. She said there are no written or verbal reports for these two working groups.

a. Antifraud (D) Task Force

Commissioner Navarro said the Antifraud (D) Task Force met July 26 and took the following action: 1) heard an update from the Antifraud Education Enhancement (D) Working Group. He said the Working Group held a webinar on Feb. 11 regarding the mobile capabilities CARCO can provide state departments of insurance (DOIs) to assist in fighting insurance fraud. He said the Working Group also conducted an insurance fraud investigator safety course on June 2.

Commissioner Navarro said Task Force also received a report from the Antifraud Technology (D) Working Group. He said the Working Group advised that the adopted revisions to the *Antifraud Plan Guideline* (#1690) was the first step in its charge to create an antifraud plan repository that will be used by insurers to create and store an electronic fraud plan for distribution to states. He said the Working Group formed a subject matter expert (SME) group to create a template for industry to use when creating their antifraud plans. The SME group expects to complete its work by October.

Commissioner Navarro said the Task Force received an update on the NAIC Online Fraud Reporting System (OFRS) redesign. He said beta testing began with a small group of state insurance fraud directors. The beta testing will be opened to additional state insurance regulators and industry representatives to finalize the testing period.

Commissioner Navarro said the Task Force also received reports from the National Insurance Crime Bureau (NICB) and the Coalition Against Insurance Fraud (CAIF).

b. Market Information Systems (D) Task Force

Commissioner Kreidler said the Market Information Systems Task Force met July 28 and took the following action: 1) adopted its Spring National Meeting minutes; and 2) reviewed the status of outstanding User System Enhancement Requests (USER).

Commissioner Kreidler said the Task Force also heard the report of the Market Information Systems Research and Development (D) Working Group. He said the Working Group is researching the potential of incorporating AI into the NAIC Market Information Systems (MIS). The Working Group heard a presentation from NAIC financial regulation staff regarding their testing of the use of AI to construct predictive models of insolvency risk, and it also heard from CEJ regarding how AI can be used in market analysis. Commissioner Kreidler said the Working Group's next step is to form an SME group to develop recommendations for incorporating AI into the MIS.

Commissioner Kreidler said that prior to the Spring National Meeting, the Market Information Systems Research and Development (D) Working Group adopted RIRS coding changes proposal. He said the RIRS coding changes include: 1) a new field to distinguish routine administrative actions from actions that are a result of an infraction or financial impairment; 2) a new field to link related to RIRS records; 3) a new Line of Business field; and 4) revisions to the Origin of Action, Reason for Action, and Disposition for Action codes to create a more logical data structure. Commissioner Kreidler said the Task Force adopted the proposal.

c. Producer Licensing (D) Task Force

Superintendent Dwyer said the Producer Licensing (D) Task Force met Aug. 4 and adopted its March 21 minutes. She also said the Task Force discussed state implementation of online examinations with 40 jurisdictions offering online examinations for producer licensing. She said this is a significant change as only Washington offered online examinations prior to the COVID-19 pandemic. She said states are reporting similar pass rates for online and in-person examinations and that approximately 35% to 40% of examinations are now taken through the online format. Notably, she said Washington reported that 80% of its examinations are administered through the online format. Superintendent Dwyer said the Task Force also discussed security concerns with online examinations and will be obtaining additional information from the examination vendors on what percentage of online examinations had security concerns.

Superintendent Dwyer said the Task Force discussed the pending referral from the Special (EX) Committee on Race and Insurance regarding the elimination of bias in producer licensing examinations. She said examination vendors have been solicited on the processes they follow to eliminate bias in examinations. She said the Task Force is also reaching out to continuing education (CE) providers and will have additional discussions on this topic at its next meeting.

Superintendent Dwyer said the Task Force discussed the review of the NAIC's *Guidelines for State Insurance Regulators to the Violent Crime Control and Law Enforcement Act of 1994* and the need to revise the guidelines to make them more useful in the state's day-to-day review of 1033 waiver requests.

Superintendent Dwyer said the Task Force also heard an update on a new program in Pennsylvania for prospective insurance agents with criminal records and how their specific convictions, history, and background may affect their ability to successfully obtain a producer license. He said the Pennsylvania program allows a person with a criminal conviction to provide this information to the Pennsylvania DOI through an electronic portal. The DOI then reviews the information and provides non-binding feedback to the prospective applicant on how the criminal conviction might affect their ability to obtain an insurance producer license before the applicant spends the time and effort with pre-licensing education and taking a producer licensing exam.

Superintendent Dwyer said the Task Force briefly discussed the draft procedure for amending NAIC Uniform Producer Licensing Applications. He said the procedures are being developed to ensure the consideration of changes to the uniform applications support the NAIC members' goal of providing stable applications and encourage the use of electronic technology for licensing. She said the Task Force is seeking comments on the procedures through Sept. 3.

Finally, Superintendent Dwyer said the Task Force discussed the status of the Producer Licensing Uniformity (D) Working Group and the Uniform Education (D) Working Group. She noted that the chair position for the Producer Licensing Uniformity (D) Working Group remains open and that the leadership for both Working Groups continues to be in a state of flux.

d. Market Conduct Examination Guidelines (D) Working Group

Mr. Hughes said the Market Conduct Examination Guidelines (D) Working Group met June 10 and took the following action: 1) reviewed and discussed its 2021 charges; 2) prioritized potential Working Group tasks; and 3) identified NAIC models acts and model laws adopted in 2020. Mr. Hughes said the Working Group also asked for state insurance regulators to volunteer to review the adopted model laws and model acts to determine whether revisions to the corresponding sections of the NAIC *Market Regulation Handbook* are warranted.

Finally, Mr. Hughes said the Working Group discussed a new title insurance in-force policy standardized data request (SDR) for inclusion in the *Market Regulation Handbook*.

e. Market Analysis Procedures (D) Working Group

Mr. Haworth said the Market Analysis Procedures (D) Working Group met July 1 and took the following action: 1) adopted its Spring National Meeting minutes; and 2) continued its discussion on the training needs for market analysts. He said ideas include: 1) having monthly analysis groups to share techniques and tips; 2) leveraging the materials from the NAIC's Market Analysis Techniques online course and adapt them for new analysts; 3) creating more and better tutorials and help in i-Site+; 4) incorporating Tableau visuals into the Market Analysis Review System (MARS) and other market analysis tools; and 5) providing more training on analyzing financial information and MCAS ratios.

Mr. Haworth said the Working Group also opened discussions on the next line of business to add to the MCAS and is asking for written and verbal suggestions. Additionally, Mr. Haworth said the Working Group began discussions on its members' initial impressions of the current MCAS submissions. He said the conversations are on a high-level aggregated level.

Finally, Mr. Haworth said the Working Group considered whether MCAS submissions should be required to be reported by the residency of the policyholder or by where the policy was issued. He said the current MCAS instructions specify the data should be reported in the same manner as the company reports its financial annual statement. He the Working Group agreed to continue with these instructions without amendment.

f. Market Conduct Annual Statement Blanks (D) Working Group

Ms. Rebholz that since the Spring National Meeting, the Market Conduct Annual Statement Blanks (D) Working Group met five times.

Ms. Rebholz said that during these meetings, the Working Group adopted the travel MCAS data call and definitions and the short-term, limited-duration (STLD) MCAS data call and definitions on May 25—prior to the June 1 deadline. She said the first MCAS due date for the travel MCAS blank will be on April 30, 2023, and the STLD MCAS blank will be June 30, 2023. She said both will cover the 2022 data year.

Ms. Rebholz said the Working Group also adopted the addition of digital claim data to the auto and homeowners (HO) MCAS blanks. She said these were adopted on June 30. The first due date for the data will be April 30, 2024, covering the 2023 data year.

Ms. Rebholz said the Working Group is continuing its development of accelerated underwriting data elements to the life and annuity MCAS blanks. She said the Working Group is monitoring the work of the Accelerated Underwriting (A) Working Group so it can coordinate the MCAS definition of accelerated underwriting with the definition they adopt.

Ms. Rebholz said the Working Group has spent considerable time drafting revisions to the definition of “lawsuit” in the various MCAS blanks. She said this includes adding non-claims-related lawsuits to the auto and HO MCAS blanks and editing the definition to conform to the type of product being reported on. She said that due to the continued discussions, the Working Group postponed collection of non-claims-related lawsuit information to the 2023 data year. Ms. Rebholz also said that due to the complexity of the lawsuit reporting issues, the Working Group formed an SME drafting group to consider options to present to the Working Group. She said the SME group is also tasked with considering the best way to collect vendor information on the digital claims data elements.

Finally, Ms. Rebholz said that because the STLD MCAS blank was adopted by the Committee in July, the Working Group will continue the development of MCAS blanks for other health products not covered in the current health or STLD MCAS data call and definitions.

g. Privacy Protections (D) Working Group

Ms. Amann said that since the Spring National Meeting the Privacy Protections (D) Working Group met July 12, June 14, and May 10.

Ms. Amann said that during its May 10 meeting, the Working Group took the following action: 1) adopted its Spring National Meeting minutes; 2) reviewed the 2021 NAIC strategy for consumer data privacy protections; 3) discussed the verbal gap analysis of consumer issues; 4) discussed the draft of the initial privacy policy statement; and 5) requested comments in the form of parameters and examples on the privacy policy statement.

Ms. Amann said that during its June 14 meeting, the Working Group took the following action: 1) adopted its May 10 minutes; and 2) discussed the comments received from America’s Health Insurance Plans (AHIP), the Blue Cross and Blue Shield Association (BCBSA), and the Coalition of Health Companies on the privacy policy statement.

Ms. Amann said that during its July 12 meeting, the Working Group took the following action: 1) adopted its June 14 minutes; 2) received comments from the American Council of Life Insurers (ACLI) about the six consumer privacy rights identified in the NAIC strategy for consumer data privacy protections; 3) heard a presentation from NAIC funded consumer representatives on the consumer perspective on consumer data privacy rights; 4) requested comments on the private policy statement.

Ms. Amann said the privacy policy statement template located on the Working Group web page is being combined with the received comments into a draft for exposure. She said there will be an accelerated review by the Working Group.

Mr. Birnbaum asked how the Working Group will be addressing the data ownership issue referred to the Working Group by the Innovation and Technology (EX) Task Force. Ms. Amann said the Working Group first needs to receive permission from the Committee before it can act on the referral.

Commissioner Godfreed made a motion, seconded by Commissioner Navarro, to adopt the following reports, including the proposal for coding changes to the RIRS (Attachment Two) adopted by the Market Information Systems (D) Task Force:

1) Antifraud (D) Task Force; 2) Market Information Systems (D) Task Force; 3) Producer Licensing (D) Task Force; 4) Market Conduct Examination Guidelines (D) Working Group (Attachment Three); 5) Market Analysis Procedures (D) Working Group (Attachment Four); 6) Market Conduct Annual Statement Blanks (D) Working Group (Attachment Five); and 8) Privacy Protections (D) Working Group (Attachment Six). The motion passed unanimously.

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

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Draft: 12/1/21

Adopted by the Executive (EX) Committee and Plenary, Dec. XX, 2021

Adopted by the Market Regulation and Consumer Affairs (D) Committee, Dec. XX, 2021

2022 Proposed Charges

MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

The mission of the Market Regulation and Consumer Affairs (D) Committee is to monitor all aspects of the market regulatory process for continuous improvement. This includes market analysis, regulatory interventions with companies, and multi-jurisdictional collaboration. The Committee will also review and make recommendations regarding the underwriting and market practices of insurers and producers, as those practices affect insurance consumers, including the availability and affordability of insurance.

Ongoing Support of NAIC Programs, Products or Services

1. The **Market Regulation and Consumer Affairs (D) Committee** will:
 - A. Monitor the centralized collection and storage of market conduct data, national analysis, and reporting at the NAIC, including issues regarding the public availability of data.
 - B. Monitor and assess the current process for multi-jurisdictional market conduct activities and provide appropriate recommendations for enhancement, as necessary.
 - C. Evaluate all data currently collected in the NAIC Market Information Systems (MIS) and considered confidential to determine what, if any, can be made more widely available.
 - D. Oversee the activities of the Antifraud (D) Task Force.
 - E. Oversee the activities of the Market Information Systems (D) Task Force.
 - F. Oversee the activities of the Producer Licensing (D) Task Force.
 - G. Monitor the underwriting and market practices of insurers and producers, as well as the conditions of insurance marketplaces, including urban markets, to identify specific market conduct issues of importance and concern. Hold public hearings on these issues at the NAIC national meetings, as appropriate.
 - H. In collaboration with other technical working groups, discuss and share best practices through public forums to address broad consumer concerns regarding personal insurance products.
 - I. Coordinate with the International Insurance Relations (G) Committee to develop input and submit comments to the International Association of Insurance Supervisors (IAIS) and/or other related groups on issues regarding market regulation concepts.
 - J. Coordinate with the Health Insurance and Managed Care (B) Committee to provide policy recommendations regarding uniform state enforcement of the federal Affordable Care Act (ACA).
 - K. Review the “Best Practices and Guidelines for Consumer Information Disclosures” (adopted October 2012) and update, as needed.
2. The **Advisory Organization Examination Oversight (D) Working Group** will:
 - A. Revise the protocols, as necessary, for the examination of national or multistate advisory organizations (including rating organizations and statistical agents) to be more comprehensive, efficient, and possibly less frequent than the current system of single-state exams. Solicit input and collaboration from other interested and affected committees and task forces.
 - B. Monitor the data reporting and data collection processes of advisory organizations (including rating organizations and statistical agents) to determine if they are implementing appropriate measures to ensure data quality. Report the results of this ongoing charge, as needed.
 - C. Actively assist with and coordinate multistate examinations of advisory organizations (including rating organizations and statistical agents).
3. The **Market Actions (D) Working Group** will:
 - A. Facilitate interstate communication and coordinate collaborative state regulatory actions.
4. The **Market Analysis Procedures (D) Working Group** will:
 - A. Recommend changes to the market analysis framework based on results over the past five years, including the current set of Level 1 and Level 2 questions.
 - B. Discuss other market data collection issues and make recommendations, as necessary.
 - C. Consider recommendations for new lines of business for the Market Conduct Annual Statement (MCAS).

5. The **Market Conduct Annual Statement Blanks (D) Working Group** will:
 - A. Review the MCAS data elements and the “Data Call and Definitions” for those lines of business that have been in effect for longer than three years and update them, as necessary.
 - B. Develop an MCAS blank to be used for the collection of data for additional lines of business, where appropriate.

6. The **Market Conduct Examination Guidelines (D) Working Group** will:
 - A. Develop market conduct examination standards, as necessary, for inclusion in the *Market Regulation Handbook*.
 - B. Monitor the adoption and revision of NAIC models and develop market conduct examination standards to correspond with adopted NAIC models.
 - C. Develop updated standardized data requests, as necessary, for inclusion in the *Market Regulation Handbook*.
 - D. Develop uniform market conduct procedural guidance (e.g., a library, depository or warehouse with market conduct examination templates, such as an exam call letter, exam exit agenda, etc.) for inclusion in, or for use in conjunction with, the *Market Regulation Handbook*.
 - E. Coordinate with the Innovation, Cybersecurity and Technology (H) Committee to develop market conduct examiner guidance for the oversight of regulated entities’ use of insurance and non-insurance consumer data and models using algorithms and artificial intelligence (AI).
 - F. Discuss the effectiveness of group supervision of market conduct risks and develop examination procedural guidance, as necessary.
 - G. Discuss the role of market conduct examiners in reviewing insurers’ corporate governance as outlined in the NAIC’s *Corporate Governance Annual Disclosure Model Act (#305)* and *Corporate Governance Annual Disclosure Model Regulation (#306)*.

7. The **Market Regulation Certification (D) Working Group** will:
 - A. Develop a formal market regulation certification proposal for consideration by the NAIC membership that provides recommendations for the following: 1) certification standards; 2) a process for the state implementation of the standards; 3) a process to measure the states’ compliance with the standards; 4) a process for future revisions to the standards; and 5) assistance for jurisdictions to achieve certification.

8. The **Privacy Protections (D) Working Group** will:
 - A. 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)*. *(Further direction from NAIC Executive Committee may result in this charge being moved to the new Innovation, Cybersecurity, and Technology (H) Committee.)*

Draft: 10/28/21

Adopted by the Executive (EX) Committee and Plenary, TBD

Adopted by the Market Regulation and Consumer Affairs (D) Committee, TBD

Adopted by the Antifraud (D) Task Force, Oct. 27, 2021

2022 Amended Charges

ANTIFRAUD (D) TASK FORCE

The mission of the Antifraud (D) Task Force is to serve the public interest by assisting the state insurance supervisory officials, individually and collectively, through the detection, monitoring, and appropriate referral for the investigation of insurance crime, both by and against consumers. The Task Force will assist the insurance regulatory community by conducting the following activities: 1) maintaining and improving electronic databases regarding fraudulent insurance activities; 2) disseminating the results of research and analysis of insurance fraud trends, as well as case-specific analysis, to the insurance regulatory community; and 3) providing a liaison function between state insurance regulators, law enforcement (federal, state, local, and international), and other specific antifraud organizations. The Task Force will also serve as a liaison with the NAIC Information Technology Group (ITG) and other NAIC committees, task forces, and/or working groups to develop technological solutions for data collection and information sharing. The Task Force will monitor all aspects of antifraud activities by its working groups on the following charges.

Ongoing Support of NAIC Programs, Products or Services

1. The **Antifraud (D) Task Force** will:
 - A. Work with NAIC committees, task forces, and working groups (e.g., Title Insurance (C) Task Force, etc.) to review issues and concerns related to fraud activities and schemes related to insurance fraud.
 - B. Coordinate efforts to address national concerns related to agent fraud and activities of unauthorized agents related to insurance sales.
 - C. Coordinate the enforcement and investigation efforts of state and federal securities regulators with state insurance fraud bureaus.
 - D. Coordinate with state, federal, and international law enforcement agencies in addressing antifraud issues relating to the insurance industry.
 - E. Review and provide comments to the International Association of Insurance Supervisors (IAIS) on its Insurance Core Principles (ICPs) related to insurance fraud.
 - F. Coordinate activities and information from national antifraud organizations and provide information to state insurance fraud bureaus.
 - G. Coordinate activities and information with state and federal fraud divisions to determine guidelines that will assist with reciprocal involvement concerning antifraud issues resulting from natural disasters and catastrophes.
 - H. Coordinate efforts with the insurance industry to address antifraud issues and concerns.
 - I. Evaluate and recommend methods to track national fraud trends.
2. The **Antifraud Education Enhancement (D) Working Group** will:
 - A. Develop seminars, trainings, and webinars regarding insurance fraud. Provide three webinars by the 2022 Fall National Meeting.
3. The **Antifraud Technology (D) Working Group** will:
 - A. Work with the NAIC to develop an Antifraud Plan Repository to be used by insurers to create and store an electronic fraud plan for distribution among the states/jurisdictions. Complete by 2022 Fall National Meeting.
 - B. Evaluate sources of antifraud data and propose methods for enhancing the utilization and exchange of information among state insurance regulators, fraud investigative divisions, law enforcement officials, insurers, and antifraud organizations. Complete by the 2022 Fall National Meeting.
4. The **Improper Marketing of Health Insurance (D) Working Group** will:
 - A. Coordinate with state insurance regulators, both on a state and federal level, to provide assistance and guidance monitoring the improper marketing of health plans, and coordinate appropriate enforcement actions, as needed, with other NAIC committees, task forces, and working groups.
 - B. Review existing NAIC models and guidelines that address the use of lead generators for sales of health insurance products, and identify models and guidelines that need to be updated or developed to address current marketplace activities.

NAIC Support Staff: Greg Welker/Lois E. Alexander

[https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member meetings/fall 2021/tf/antifraud/2021 charges/2022 draft atf charges-clean.docx](https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member%20meetings/fall%202021/tf/antifraud/2021%20charges/2022%20draft%20atf%20charges-clean.docx)

Draft: 11/24/21

Adopted by the Executive (EX) Committee and Plenary, Dec. __, 2021

Adopted by the Market Regulation and Consumer Affairs (D) Committee, Dec. __, 2021

Adopted by the Market Information Systems (D) Task Force, Dec. 3, 2021

2022 Proposed Charges

MARKET INFORMATION SYSTEMS (D) TASK FORCE

The mission of the Market Information Systems (D) Task Force is to provide business expertise regarding the desired functionality of the NAIC Market Information Systems (MIS) and the prioritization of regulatory requests for the development and enhancements of the MIS.

Ongoing Support of NAIC Programs, Products or Services

1. The **Market Information Systems (D) Task Force** will:
 - A. Ensure that the MIS support the strategic direction set forth by the Market Regulation and Consumer Affairs (D) Committee.
 - B. Develop recommendations for the incorporation of artificial intelligence (AI) abilities in NAIC Market Information Systems for use in market analysis. Complete by the 2022 Summer National Meeting.
 - C. Analyze the data in the MIS. If needed, recommend methods to ensure better data quality. Complete by the 2022 Fall National Meeting.
 - D. Provide guidance on the appropriate use of the MIS and the data entered in them.
 1. Complaints Database System (CDS).
 2. Electronic Forums.
 3. Market Actions Tracking System (MATS).
 4. Market Analysis Profile.
 5. Market Analysis Prioritization Tool (MAPT).
 6. Market Analysis Review System (MARS).
 7. Market Conduct Annual Statement (MCAS).
 8. Regulatory Information Retrieval System (RIRS).
 9. 1033 State Decision Repository (SDR1033) (in conjunction with the Antifraud (D) Task Force).
2. The **Market Information Systems Research and Development (D) Working Group** will:
 - A. Serve as the business partner to review and prioritize submitted Uniform System Enhancement Request (USER) forms to ensure an efficient use of available NAIC staffing and resources.
 - B. Assist the Task Force with tasks as assigned, such as:
 1. Analyze MIS data.
 2. Provide state users with query access to MIS data.
 3. Provide guidance on the appropriate use of the MIS.

NAIC Support Staff: Randy Helder

[MISTF Proposed Charges Adopted 112421 v1.1](#)

Draft: 10/26/21

Adopted by the Executive (EX) Committee and Plenary, XX, 2021

Adopted by the Market Regulation and Consumer Affairs (D) Committee, XX, 2021

Adopted by the Producer Licensing (D) Task Force, Oct. 26, 2021

2022 Proposed Charges

PRODUCER LICENSING (D) TASK FORCE

The mission of the Producer Licensing (D) Task Force is to: 1) develop and implement uniform standards, interpretations, and treatment of producer and adjuster licensees and licensing terminology; 2) monitor and respond to developments related to licensing reciprocity; 3) coordinate with industry and consumer groups regarding priorities for licensing reforms; and 4) provide direction based on NAIC membership initiatives to the National Insurance Producer Registry (NIPR) Board of Directors regarding the development and implementation of uniform producer licensing initiatives, with a primary emphasis on encouraging the use of electronic technology.

Ongoing Support of NAIC Programs, Products or Services

1. The **Producer Licensing (D) Task Force** will:
 - A. Work closely with NIPR to encourage the full utilization of NIPR products and services by all the states and producers, and encourage accurate and timely reporting of state administrative actions to the NAIC's Regulatory Information Retrieval System (RIRS) to ensure that this data is properly reflected in the State Producer Licensing Database (SPLD) and the Producer Database (PDB).
 - B. Facilitate roundtable discussions, as needed, with the state producer licensing directors for the exchange of views, opinions, and ideas on producer licensing activities in the states and at the NAIC.
 - C. Discuss, as necessary, state perspectives regarding the regulation and benefit of the activities of the federal Affordable Care Act (ACA), established enrollment assisters (including navigators and non-navigator assisters and certified application counselors), and the activities of producers in assisting individuals and businesses purchasing in the health insurance marketplaces. Coordinate with the Health Insurance and Managed Care (B) Committee and the Antifraud (D) Task Force, as necessary.
 - D. Monitor the activities of the National Association of Registered Agents and Brokers (NARAB) in the development and enforcement of the NARAB membership rules, including the criteria for successfully passing a background check.
 - E. Coordinate through NAIC staff to provide guidance to NIPR on producer licensing-related electronic initiatives. Hear a report from NIPR at each national meeting.
 - F. Coordinate with the Market Information Systems (D) Task Force and the Antifraud (D) Task Force to evaluate and make recommendations regarding the entry, retention, and use of data in the NAIC's Market Information Systems (MIS).
 - G. Monitor the state implementation of adjuster licensing reciprocity and uniformity; update, as necessary, NAIC adjuster licensing standards.
 - H. Coordinate with the Special (EX) Committee on Race and Insurance on referrals affecting insurance producers.
 - I. Discuss how criminal convictions may affect producer licensing applicants and review the NAIC's *Guidelines for State Insurance Regulators to the Violent Crime Control and Law Enforcement Act of 1994* to create a more simplified and consistent approach in how states review 1033 waiver requests.
2. The **Producer Licensing Uniformity (D) Working Group** will:
 - A. Work closely with state producer licensing directors and exam vendors to ensure that: 1) the states achieve full compliance with the standards in order to achieve greater uniformity; and 2) the exams test the qualifications for an entry-level position as a producer.
 - B. Provide oversight and ongoing updates, as needed, to the *State Licensing Handbook*.
 - C. Monitor and assess the state implementation of the Uniform Licensing Standards (ULS) and update the standards, as needed.
 - D. Review and update, as needed, the NAIC's uniform producer licensing applications and uniform appointment form. Provide any recommended updates to the Producer Licensing (D) Task Force by the NAIC Summer National Meeting.

3. The **Uniform Education (D) Working Group** will:
 - A. Update, as needed, the reciprocity guidelines, the uniform application forms for continuing education (CE) providers, and the process for state review and approval of instructors and courses. Provide any recommended updates to the Producer Licensing (D) Task Force by the 2022 Fall National Meeting.
 - B. Coordinate with NAIC parent committees, task forces, and/or working groups to review and provide recommendations, as necessary, on prelicensing education and CE requirements that are included in NAIC model acts, regulations, and/or standards.

NAIC Support Staff: Tim Mullen/Greg Welker

POLICY IN FORCE STANDARDIZED DATA REQUEST
Title Line of Business

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

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

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

- 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 agent licensure.

Field Name	Start	Length	Type	Decimals	Description
TAgency	1	20	A		Title agency name
TUnder	21	20	A		Underwriting title insurer
CoCode	41	5	A		NAIC company code
PolPre	46	3	A		Policy prefix (Blank if NONE)
PolNo	49	20	A		Policy number
PolSuf	69	3	A		Policy suffix (Blank if NONE)
PolTyp	72	1	A		Type of policy (Presumably an alphabetic character such as O (Owner), M (Mortgagee), L (Lender), S (Simultaneous), H (Hold Open) Please provide a list to explain any codes used)
PolForm	73	10	A		Policy form number as filed with the insurance department
Reissue	83	1	A		Is the policy reissued? (Y/N)
ArbProv	84	1	A		Arbitration provision (Y/N)
ClsFilNo	85	10	A		Closing file number
PropTyp	95	15	A		Property type – residential or non-residential
LiabAsmd	110	10	N	2	Amount of liability assumed
PolAmt	120	10	N	2	Dollar limit of coverage
FileNo	130	10	A		File identifier assigned by agent or company's issuing office (order number)
SalePre	140	10	N	2	Sale/Purchase price of subject property
LoanAmt	150	10	N	2	Loan amount
CommitDt	160	10	D		Date commitment issued [MM/DD/YYYY]
CloseDt	170	10	D		Date transaction closed [MM/DD/YYYY]
EffDt	180	10	D		Effective date of policy [MM/DD/YYYY]
PollssDt	190	10	D		Date policy issued/delivered to insured [MM/DD/YYYY]
DRecDt	200	10	D		Date deed is recorded [MM/DD/YYYY]

Field Name	Start	Length	Type	Decimals	Description
DPrsDt	210	10	D		Date deed was presented for recording [MM/DD/YYYY]
DisbDt	220	10	D		Disbursement date [MM/DD/YYYY]
AgCode	230	6	A		Company internal agent, CSR, or agency identification code Please provide a list to explain any codes used
NPN	236	6	A		National producer number
AgFirst	242	15	A		First name of agent
AgMid	257	15	A		Middle name of agent
AgLast	272	20	A		Last name of agent (or agency name, if applicable)
AgStat	292	15	A		Status of agent, CSR or agency appointment (active, inactive, terminated, etc.)
AgAddr	307	25	A		Agent's, CSR's or agency's street address
AgCity	332	25	A		Agent's, CSR's or agency's city
AgSt	357	2	A		Agent's, CSR's or agency's state abbreviation
PrZip	359	9	A		Agent's, CSR's or agency's ZIP code
BasePrem	368	10	N	2	Base premium charged for the policy per company filed rates as defined by [Insert statutory citation here]
EndorLst	378	20	A		List endorsements attached to the policy Please provide a list to explain any codes used
EndorPrm	398	10	N	2	Endorsement premium
DiscTyp	408	25	A		Type of policy discount (Employee, military, charitable organization, etc.) If codes are used, provide a list of codes along with their meanings
DiscAmt	433	10	N	2	Discount (percentage or amount)
AgRetPrm	443	10	N	2	Amount of premium retained by the agent or agency
RemitPrm	453	10	N	2	Premium remitted by agency to insurer
CPLetter	463	1	A		Closing protection letter (Y/N)
CPFee	464	10	N	2	Closing protection fee
TSChgs	474	10	N	2	Title service charges
ClosChgs	484	10	N	2	Closing charges
RemitDt	494	10	D		Date premium remitted to insurer [MM/DD/YYYY]
LendName	504	50	A		Full name of lender insured by policy (if applicable)
OwnFirst	554	15	A		First name of owner insured by policy (if applicable)
OwnMid	569	15	A		Middle name owner insured by policy (if applicable)
OwnLast	584	20	A		Last name of owner insured by policy (if applicable)
PropAddr	604	25	A		Address of subject property
PropCity	629	20	A		City of subject property
PropSt	649	2	A		State of subject property
PropZip	651	9	A		ZIP code of subject property
PropCty	660	20	A		County of subject property
SellName	680	50	A		Name of seller of subject property

Field Name	Start	Length	Type	Decimals	Description
RealEst	730	50	A		Name of real estate agent involved in transaction
NewConst	780	1	A		Subject property a new construction (Y/N)
Ref	781	1	A		Refinance transaction (Y/N)
Second	782	1	A		2 nd mortgage (Y/N)
EndRec	783	1	A		End of record marker. Please place an asterisk in this field to indicate the end of the record. This must be in the same character position for every record in this table.

CLAIMS STANDARDIZED DATA REQUEST
Title Line of Business

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

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

- Cross-reference to annual statement claims data (amount) to ensure completeness of exam data submitted.

Field Name	Start	Length	Type	Decimals	Description
TAgency	1	20	A		Title agency name
TUnder	21	20	A		Underwriting title insurer
CoCode	41	5	A		NAIC company code
ClmNo	46	20	A		Claim number
ClmPre	66	3	A		Claim number prefix (Blank if NONE)
ClmSuf	69	3	A		Claim number suffix (Blank if NONE)
PolNo	72	20	A		Policy number
PolTyp	92	1	A		Type of policy (Presumably an alphabetic character such as O (Owner), M (Mortgagee), L (Lender), S (Simultaneous), H (Hold Open) Please provide a list to explain any codes used)
ClsFilNo	93	10	A		Closing file number
ClmName	103	50	A		Claimant name
LendName	153	50	A		Full name of lender insured by policy (if applicable)
OwnFirst	203	15	A		First name of owner insured by policy (if applicable)
OwnMid	218	1	A		Middle initial of owner insured by policy (if applicable)
OwnLast	219	20	A		Last name of owner insured by policy (if applicable)
RcvdDt	239	10	D		First notice of loss [MM/DD/YYYY]
ClmOpnDt	249	10	D		Date claim opened [MM/DD/YYYY]
ClmAckDt	259	10	D		Date company or its producer acknowledged the claim [MM/DD/YYYY]
NtcInvDt	269	10	D		Date of written notice to insured/claimant regarding incomplete investigation [MM/DD/YYYY]
ResEstDt	279	10	D		Date reserves established for claim, if applicable [MM/DD/YYYY]
AggResAm	289	10	N	2	Aggregate amount of reserves established for claim
AggClmEx	299	10	N	2	Aggregate amount of claim expenses (litigation, research fees, etc.)
Litig	309	1	A		Claim litigated? (Y/N)

Field Name	Start	Length	Type	Decimals	Description
OutCnsl	310	1	A		Claim referred to outside counsel (Y/N)
RefDt	311	10	D		Date referred for legal counsel [MM/DD/YYYY]
Arbt	321	1	A		Claim arbitrated? (Y/N)
ClmStat	322	1	A		Claim status P = Paid, D = Denied, N = Pending, H = Partial Payment, C = Closed Without Payment, R = Rescinded, T = Title Cleared
ClmPdDt	323	10	D		Claim paid date [MM/DD/YYYY]
ClmAmtPd	333	10	N	2	Claim payment amount
ClmDnyDt	343	10	D		Date claim was denied [MM/DD/YYYY]
ClmCIDt	353	10	D		Date claim closed [MM/DD/YYYY]
EndRec	363	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.

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
- _____ Quality of Care complaints

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.

A. Operations/Management

1. Purpose

The Operations/Management portion of the examination is designed to provide a view of what the entity is and how it operates. Normally, it is not based on sampling techniques; it is more concerned with structure. This review is not intended to duplicate financial examination review, but is important in providing the market conduct examiner with an understanding of the examined entity. Many troubled insurance companies have become so because management has not been structured to recognize and address the problems that can arise in the insurance industry. In addition to the general categories, examiners should also review Section J Provider Credentialing (Medicare Select carriers only) of this chapter.

a. Provider Credentialing

Examiners should determine that a Medicare Select carrier has established ~~written~~-documented verification programs to ensure that participating health care professionals meet minimum specific professional qualifications, both initially and on an ongoing basis.

Additional introductory material is located in Chapter 20—General Examination Standards.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 1

The Medicare Select carrier’s plan of operation complies with applicable statutes, rules and regulations.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Plan of operations

_____ Information to enrollees

_____ Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act
(#651), [Section 10](#)

Review Procedures and Criteria

Ascertain that the plan of operation has been filed with the insurance commissioner.

Review the plan of operation for compliance with applicable statutes, rules and regulations.

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 2

The entity reports to the insurance department on an annual basis, each resident of the state for whom the entity has more than one Medicare supplement policy or certificate in force.

Apply to: All Medicare supplement carriers

Priority: Essential

Documents to be Reviewed

_____ Reporting Medicare supplement policies form

_____ Records of issued Medicare supplement policies/certificates

_____ Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act
(#651), [Section 9.2 and 22](#)

Review Procedures and Criteria

Ascertain that the reporting Medicare supplement policies form has been filed with the insurance commissioner.

Review policy and certificate records to ascertain whether multiple sales of policies or certificates to individual enrollees have been made.

Review the reporting Medicare supplement policies form and compare with multiple sales findings during the examination to ensure that the entity has accurately reported multiple sales.

Verify plans after Jan. 1, 2020 are in compliance with Section 9.2 of Model # 651.

Verify the Benefit Chart of Medicare Supplement Plans Sold on or after Jan. 1, 2020 is correct pursuant to Model #651.

Verify the information provided by the carrier on Plan F or High Deductible F is correct pursuant to Model #651, for plans issued on or after Jan. 1, 2020.

Verify the information provided by the carrier on Plan G or High Deductible G is correct pursuant to Model #651, for plans issued on or after Jan. 1, 2020.

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 4
The entity does not provide producer compensation that encourages replacement sales.

Apply to: All Medicare supplement carriers

Priority: Essential

Documents to be Reviewed

_____ Producer manuals

_____ Producer compensation agreements

_____ Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act
(#651), [Section 16](#)

Review Procedures and Criteria

Review procedures, producer compensation agreements and producer manuals to ascertain whether the entity's standards for producer compensation are in compliance with applicable statutes, rules and regulations concerning replacement sales.

B. Complaint Handling

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

C. Marketing and Sales

1. Purpose

The marketing and sales portion of the examination is designed to evaluate the representations made by the entity about its product(s). Typically, it is not based on sampling techniques, but sampling may be used as a review tool. The areas to be considered in this kind of review include all ~~written~~ documented, verbal and electronic advertising and sales materials. The entity's website that informs about Medicare supplement availability and/or benefits, would be considered advertising and should be reviewed for accuracy.

2. Techniques

This area of review should include all advertising and sales material, including Internet advertising, and all producer sales training materials to determine compliance with applicable statutes, rules and regulations. Information from other jurisdictions may be reviewed, if appropriate. The examiner may contact policyholders, producers and others to verify the accuracy of the information provided or to obtain additional information. The examiner should be familiar with outlines of coverage and replacement regulations. Policyholder records are a good source for detection of multiple issues of Medicare supplement policies. Suitability should be considered in reviewing the entity's sales and marketing practices.

The entity must have procedures in place to establish and at all times maintain a system of control over the content, form and method of dissemination of its advertisements. All advertisements maintained by, or for, and authorized by the entity are the responsibility of the entity.

The same statutes, rules and regulations (such as the *Unfair Trade Practices Act* (#880)) that apply to conventional advertising also apply to Internet advertising. When the examiner is reviewing an entity's Internet advertisements, it is important to also review the safeguards implemented by the entity.

All advertisements are required to be truthful and not misleading in fact or by implication. The form and content of an advertisement of a policy shall be sufficiently clear ~~so as~~ to avoid deception. The advertisement must not have the capacity or tendency to mislead or deceive. Whether an advertisement has the capacity or tendency to mislead or deceive must be determined when reviewing the overall impression that the advertisement reasonably may be expected to create upon a person of average education or intelligence with the segment of the public to which the advertisement is directed.

Ensure that the entity actively offers all ~~of~~ its Medicare supplement products to eligible individuals. The company should not engage in marketing practices such as discriminatory commission levels or references to health conditions that discourage individuals with less favorable risk characteristics from seeking or obtaining coverage.

Determine whether producer training materials require the producer to report all sales of Medicare supplement policies and/or certificates.

Ascertain that the entity has procedures for distributing to producers and other company personnel any bulletins issued by state or federal regulators.

Ensure that the entity prohibits the sale of Medicare supplement policies or certificates to people enrolled in a Medicare ~~+Choice-Advantage~~ or private fee-for-service plans.

Ensure that the entity prohibits the sale of a Medicare supplement policy/certificate to an individual already covered under such a policy, unless the new policy/certificate is a replacement policy/certificate.

Ensure that producer commission schedules do not encourage replacement sales or sales of more than one Medicare supplement policy/certificate to an individual, or discourage eligible individuals with unfavorable risk characteristics.

Ensure that the entity offers to all eligible individuals all the Medicare supplement products it sells.

Determine whether individuals in the state have been eligible for ~~guaranteed-issue~~ guaranteed issue (*was previously hyphenated, changed to guaranteed issue without a hyphen*) because of termination of Medicare business by managed care organizations, and review company practices with respect to eligible individuals.

Determine whether individuals in the state have been eligible for guaranteed issue for other situations as described in NAIC Model References Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 12.

Review entity communications to company personnel, producers and applicants about open enrollment and guaranteed-issue rights.

3. Tests and Standards

The marketing and sales review includes, but is not limited to, the following standards addressing various aspects of the marketing and sales function. The sequence of the standards listed here does not indicate the priority of the standard.

**STANDARDS
MARKETING AND SALES**

Standard 1
Entity rules concerning replacement are in compliance with applicable statutes, rules and regulations.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

- _____ Bulletins, newsletters and memos
- _____ Replacement register
- _____ Underwriting guidelines and files
- _____ Replacement comparison forms (if external replacement)
- _____ Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

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

Review Procedures and Criteria

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

Ensure that the application or other form asks whether the policy or certificate is intended to replace or add to any coverage currently in force.

Ensure that the application or other form asks all the questions required by state law to be asked.

Determine if the entity permits multiple sales of Medicare supplement policies to the same person.

Using a random selection of policyholders, have the entity run a policyholder/certificateholder history to identify the number of policies or certificates sold to those individuals.

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

Ensure that the entity, when determining whether a sale involves replacement, furnishes to the applicant prior to policy/certificate issue, or at the time of issue in the case of a direct response sale, the required notice concerning replacement of Medicare supplement coverage, obtains the signatures required by state law, and maintains one copy of the signed notice on file.

Determine whether marketing materials encourage multiple issues of policies, for example, use of existing policyholder/certificateholder 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 entity has a system to discourage “over-insurance,” as defined in the entity’s underwriting requirements, of policyholders/certificateholders.

Determine whether individuals in the state have been eligible for ~~guaranteed-issue~~guaranteed issue (*was previously hyphenated, changed to guaranteed issue without a hyphen*) because of terminations of Medicare business by managed care organizations, and review entity practices with respect to eligible individuals.

Review entity communications to company personnel, producers and applicants about open enrollment and guaranteed-issue rights.

Determine that the regulated entity, upon replacement, does not impose any waiting periods, elimination periods or probationary periods in their replacement policies unless the replaced individual had not satisfied their ~~six month~~six-month (*six month was previously unhyphenated*), preexisting condition period under their prior coverage.

**STANDARDS
MARKETING AND SALES**

Standard 3

The entity obtains receipts from applicants verifying that the outline of coverage has been received and that it is the outline of the policy for which the applicant has applied.

Apply to: All Medicare supplement carriers

Priority: Essential

Documents to be Reviewed

_____ Application files

_____ Outlines of Coverage

_____ Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act
(#651), Section 17C

Review Procedures and Criteria

Verify through signed receipts that outlines of coverage have been provided to applicants prior to the sale of a policy or certificate.

Verify that the outline of coverage provided reflects the benefits of the policy for which the applicant applied, and, if not, that the applicant has been provided with a copy of the correct outline of coverage and the required disclosure concerning the substitution.

**STANDARDS
MARKETING AND SALES**

Standard 4

The *Guide to Health Insurance for People with Medicare* is provided to the applicant within the time frame required by law and is in compliance with applicable statutes, rules and regulations.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ Application files

_____ Underwriting files

_____ *Guide to Health Insurance for People with Medicare*

_____ Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act
(#651), Section 17A

Review Procedures and Criteria

Verify that the *Guide to Health Insurance for People with Medicare* was received by the applicant, by ensuring that the receipt for the guide contains the signature of the applicant.

Ensure that the applicant was provided with a copy of the guide prior to policy issuance or at the time of issuance, as required by state law.

Ensure that the guide was provided to the applicant within the time frame specified by state law.

Ensure that the guide is provided in the required format.

**STANDARDS
MARKETING AND SALES**

Standard 5

The entity maintains a system of control over the content, form and method of dissemination of all of its Medicare supplement advertisements.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

- _____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials
- _____ Producers' advertising and sales materials
- _____ Guide to Health Insurance for People with Medicare
- _____ Outlines of coverage
- _____ Applicable statutes, rules and regulations

Others Reviewed

- _____
- _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines
(#660)

Review Procedures and Criteria

Ensure that the entity retains responsibility for all advertisements (as the term “advertisement” is defined by state law) regardless of by whom ~~written~~ documented, created, ~~designed~~ designed, *(comma inserted after designed,)* or presented.

**STANDARDS
MARKETING AND SALES**

Standard 8
Advertisements truthfully represent the Medicare supplement coverage being marketed.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ Guide to Health Insurance for People with Medicare

_____ Outlines of coverage

_____ Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines
(#660), Sections 6 and 7

Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Ensure that advertisements do not contain words or phrases such as “all,” “full,” “complete,” “comprehensive,” “unlimited,” “up to,” “as high as,” “this policy pays all that Medicare doesn’t” or similar words or phrases in a manner that exaggerates any benefit beyond the terms of the policy.

Advertisements that are invitations to contract should:

- Disclose exceptions, reductions and limitations affecting the basic provisions of the policy;
- If a preexisting conditions limitation applies, ask a question immediately above the signature line concerning the applicant’s understanding of the limitation; and
- Disclose renewability, modification, cancellability, termination, losses covered and premium changes due to age or other reasons in a manner that does not minimize or obscure the qualifying conditions.

Ensure that if the policy is not ~~guaranteed-issue~~ guaranteed issue (*was previously hyphenated, changed to guaranteed issue without a hyphen*) or if a preexisting conditions limitation applies, the advertisement does not state or imply that health history will not affect the issuance of the policy or payment of a claim under the policy.

Ensure that provisions that are negative in nature, such as a preexisting conditions limitation, are presented in a negative light and that if the advertisement is an invitation to contract, the term “preexisting conditions limitation,” if used, is defined.

Ensure that advertisements do not state or imply that claim settlements are “liberal” or “generous,” or words of similar import, and do not mislead by quoting unusual claims that may have been paid.

**STANDARDS
MARKETING AND SALES**

**Standard 9
Testimonials comply with applicable statutes, rules and regulations.**

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines,
Section 8 (#660)

Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Ensure that testimonials used in advertising are genuine, represent the current opinion of the author, are applicable to the policy advertised, are accurately ~~reproduced~~reproduced, (*comma inserted after reproduced*), and otherwise comply with all provisions of state law concerning the use of testimonials.

Ensure that the use of a spokesperson complies with all provisions of state law concerning disclosure of the interests of the spokesperson.

**STANDARDS
MARKETING AND SALES**

Standard 12

Advertisements do not imply licensing of the entity beyond the jurisdiction in which the entity is licensed or imply a status with any governmental entity.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ Guide to Health Insurance for People with Medicare

_____ Outlines of coverage

_____ Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines
(#660), Section 11
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Ensure that advertisements do not imply that the entity is licensed in jurisdictions other than that in which it is licensed.

| Ensure that advertisements do not imply that the entity's products are approved, ~~endorsed~~endorsed, (*comma inserted after endorsed*.) or accredited, or connected with any governmental entity.

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.

F. Underwriting and Rating

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

G. Claims

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

H. Grievance Procedures

1. Purpose

The grievance procedures portion of the examination is designed to evaluate how well the Medicare Select carrier handles grievances.

A “grievance” means dissatisfaction in writing with the administration, claims practices or provision of services concerning an issuer of a Medicare Select product or network provider.

Note that these definitions may not include all ~~written~~-documented communications that the company tracks as “complaints” under the 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 company should reconcile the company grievance register with a list of grievances from the insurance department. A random sample of grievances and appeals should be selected for review from the company’s grievance register.

The company’s ~~written~~-documented 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 types of grievance. Should the type of grievance noted be cause for unusual concern, specific measures should be instituted to investigate other areas of a company’s operation. This may include modifying the scope of examination to examine specific company behavior.

STANDARDS
GRIEVANCE PROCEDURES

Standard 1

The entity defines as a grievance any dissatisfaction expressed in writing with the administration, claims practices or provision of services concerning an issuer of a Medicare Select product or network.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Sample documents and files, including electronic correspondence

_____ Outlines of coverage

_____ Policies and/or certificates of coverage

_____ Contracts

_____ Grievance procedures

_____ Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act
(#651), [Section 10](#)

Review Procedures and Criteria

Review the contracts, outlines of coverage, grievance procedures, sample grievance files and disclosures to determine if the company is correctly defining “grievance.”

STANDARDS
GRIEVANCE PROCEDURES

Standard 2

The entity develops ~~written~~-documented grievance procedures that comply with applicable statutes, rules and regulations, and provides enrollees with a copy of its grievance procedures.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

- _____ Procedures manuals
- _____ Policies and/or certificates of coverage
- _____ Outlines of coverage
- _____ All forms used to process a grievance
- _____ Applicable statutes, rules and regulations

Others Reviewed

- _____
- _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), [Section 10](#)

Review Procedures and Criteria

Determine if the entity provides grievance registration information to the policyholder at the time of the issuance of a policy or certificate.

Determine if the entity has procedures to ensure that a copy of its grievance procedures is provided to any enrollee or prospective enrollee upon request.

Determine if the entity includes a copy of its grievance procedures in its policies, certificates (if applicable) and outlines of coverage.

Review the disclosure form(s) to determine if a description of the entity's grievances procedures is included.

Review the entity's grievance procedures to ensure that the procedures are aimed at mutual agreement for settlement and that, if applicable, any arbitration procedures are disclosed.

**STANDARDS
GRIEVANCE PROCEDURES**

Standard 3

The entity documents, resolves and records grievances in compliance with applicable statutes, rules and regulations, and their contract language.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Entity’s grievance handling policies and procedures

_____ Sample of grievance files

_____ Outlines of coverage

_____ Policies and/or certificates of coverage

_____ Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act
(#651), [Section 10](#)

Review Procedures and Criteria

The entity maintains a grievance register ~~consisting of written records~~ that documents all grievances received during the calendar year.

The entity reports all grievances to the insurance commissioner annually, with the information and in the format required by law.

The entity complies with its ~~written-documented~~ procedures when receiving and resolving grievances.

The entity considers grievances in a timely manner and transmits grievances to appropriate decision-makers.

The entity takes corrective action promptly on valid grievances.

The entity promptly notifies concerned parties of the results of a grievance review.

**STANDARDS
GRIEVANCE PROCEDURES**

Standard 4

The company provides to any enrollee, who has filed a grievance, detailed information concerning its grievance and appeal procedures, how to use them and how to notify the insurance department, if applicable.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Procedures for processing grievances

_____ Grievance forms and other information provided to an enrollee at the time the enrollee files a grievance

_____ Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), [Section 10](#)

Review Procedures and Criteria

Review the entity's procedures for processing a grievance to determine if the required disclosures are provided.

Review the entity's procedures to determine if, when required by state law, the enrollee is advised of the right to contact the insurance department.

Review the grievance procedures to ensure that a provision is made for grievance registration information to be provided at the time of issue and upon request.

As grievances are detected throughout the entire examination, ensure that they have been handled and recorded properly.

STANDARDS
GRIEVANCE PROCEDURES

Standard 5

The company reports its grievance procedures to the insurance commissioner on an annual basis.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Procedures for processing grievances

_____ Procedures for annually reporting grievances to the insurance commissioner

_____ Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act
(#651), [Section 10](#)

Review Procedures and Criteria

The examiner should determine whether the entity has procedures in place for recording and reporting grievances to the insurance commissioner.

The examiner should ensure that the entity has reported on an annual basis and in the format prescribed by the insurance commissioner, the number of grievances filed in the previous year and a summary of the subject, nature and resolution of such grievances.

I. Network Adequacy

1. Purpose

The network adequacy portion of the examination is designed to ensure that companies offering Medicare Select 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 the company's plan of operation and 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 from the company a statement or map that reasonably describes the service area. Additional items for review include a list and description by specialty of network providers and facilities. The examiner should determine whether the company 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 company arranges for covered services that cannot be provided within the network. Examiners should request the carrier's written-documented selection standards for providers and review the plan of operation. Using the list 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-documented guidelines and contractual requirements established for intermediary contracts. Availability of emergency care facilities and procedures should be evaluated. Examiners should obtain verification that accurate provider directories are provided upon enrollment, are updated and dispersed periodically, and that the company has filed its updated list of network providers with the insurance commissioner on a quarterly basis. 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 company demonstrates, using reasonable criteria, that it maintains a network that is sufficient in number and types of providers to ensure that all services to enrollees will be accessible without unreasonable delay.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Selection criteria

_____ Documents related to physician recruitment

_____ Provider directory

_____ List of providers by specialty

_____ Reports of out-of-network service denials

_____ Company policy for in-network/out-of-network coverage levels

_____ Provider/enrollee location reports by ~~ZIP code~~ geographic location

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

_____ Computer tools used to assess the network's adequacy

_____ Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

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

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

Reasonable criteria include, but are not limited to:

- Ratios of providers (primary care providers and specialty providers) to enrollees;
- Geographic accessibility, as measured by the reasonable proximity of participating providers to the business or personal residence of enrollees;
- Waiting times for appointments;
- Hours of operation; and

- Volume of technological and specialty services available to serve the needs of enrollees requiring technologically advanced or specialty care.

The company develops and complies with ~~written-documented~~ policies and procedures specifying when the company will pay for out-of-area and out-of-network services that are covered by the policy, or as are required by state law. In any case where the company is required to cover services and it has an insufficient number or type of participating providers to provide a covered benefit, the company shall ensure that the enrollee obtains the covered benefit at no greater cost than if the benefit were obtained from participating ~~providers, or providers or~~ *(comma removed after providers)* shall make other arrangements acceptable to the insurance commissioner.

The company establishes and maintains adequate arrangements to ensure reasonable proximity of participating providers to the business or personal residences of enrollees. In determining whether a company has complied with this provision, the insurance commissioner shall give due consideration to the relative availability of health care providers in the enrollees' service area.

The company demonstrates that it monitors, on an ongoing basis, its providers, provider groups and intermediaries with which it contracts to ensure the ability, clinical capacity, financial capability and legal authority, including applicable licensure requirements, to furnish all contracted benefits to enrollees. There are standards pertinent to provider licensing in Section J. Provider Credentialing of this chapter.

The company complies with all applicable provisions of state law not expressly covered by any other of these standards.

**STANDARDS
NETWORK ADEQUACY**

Standard 2

The company has a plan of operation for each plan offered in the state, and files updates whenever it makes a material change to an existing plan.

Apply to: Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Plan of operation

_____ Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), [Section 10](#)

Review Procedures and Criteria

The plan of operation contains evidence of at least the following:

- Covered services are available and accessible through network providers;
- Either the number of network providers in the service area is sufficient to deliver adequately all services, or that the company makes appropriate referrals for provision of such services outside its network;
- There are ~~written~~ documented agreements with network providers describing specific responsibilities;
- Emergency care is available 24 hours per day, 7 days per week;
- The provider agreements prohibit the provider from billing or otherwise seeking reimbursement from enrollees, other than for coinsurance, copayments or supplemental charges;
- A description or map of the service area;
- A description of the company's grievance procedures;
- A description of the quality assurance program, including the formal organizational structure, the criteria for selection, retention and removal of network providers and the procedures for evaluating quality of care and taking corrective action when warranted;
- A list and description of network providers, by specialty; and
- Any other information requested by the insurance commissioner.

STANDARDS
NETWORK ADEQUACY

Standard 3

The company ensures that enrollees have access to emergency services 24 hours per day, 7 days per week within its network and provides coverage for urgently needed services and emergency services outside of the service area.

Apply to: Medicare Select carriers

Priority: Essential

Documents to be Reviewed

- _____ Provider manuals and contracts
- _____ Policy forms
- _____ Plan of operation
- _____ Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), [Section 10](#)

Review Procedures and Criteria

Within the network, the company operates or contracts with facilities to provide enrollees with access to emergency and urgently needed services on a 24 hours per day, 7 day per week basis.

The company covers in full, emergency services or services that are immediately required for an unforeseen illness, injury or condition, when it is not reasonable to obtain services through network providers.

STANDARDS
NETWORK ADEQUACY

Standard 4

The company 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: Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Provider manuals

_____ Sample of provider contracts

_____ Credentialing file

_____ Directory of providers

_____ Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), [Section 10](#).

Review Procedures and Criteria

Determine if the provider contracts and endorsements have been filed (if required by state law).

Review provider contracts to determine if the provider is listed in the directory and to determine if credentialing is ~~up to date~~ up to date (*hyphens removed from up to date*).

**STANDARDS
NETWORK ADEQUACY**

Standard 5

The company executes with each participating provider ~~written~~ documented agreements that are in compliance with applicable statutes, rules and regulations.

Apply to: Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Provider manuals, contracts and intermediary subcontracts

_____ Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10.

Review Procedures and Criteria

Every contract between a Medicare Select carrier and a participating provider or provider group contains a “hold harmless” provision specifying protection for enrollees from being billed by providers for other than coinsurance, copayments or supplemental charges.

The contract provides an extension of benefits beyond the period during which the policy was in ~~force, if~~ force if *(comma removed after in-force)* the enrollee suffers continuous total disability after contract termination.

**STANDARDS
NETWORK ADEQUACY**

Standard 7

The company provides at enrollment a directory of providers participating in its network. It also makes available, on a timely and reasonable basis, updates to its directory and files the directory with the insurance commissioner.

Apply to: Medicare Select carriers

Priority: Essential

Documents to be Reviewed

- _____ Provider directory and updates
- _____ Provider contracts
- _____ Credentialing and re-credentialing documentation
- _____ Internet directory
- _____ Applicable statutes, rules and regulations

Others Reviewed

- _____
- _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), [Section 10](#)

Review Procedures and Criteria

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

Verify that the company is providing directory updates to enrollees and to the insurance commissioner at the frequency required by state law.

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.

[If the provider directory is made available on the carriers’ website, verify that a paper version can be requested, as an option, by the enrollee.](#)

J. Provider Credentialing

1. Purpose

The provider credentialing portion of the examination is designed to ensure that companies offering Medicare Select 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~~-documented 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~~-documented credentialing procedures from the company. Examiners should determine the composition of the carrier'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:

- a. The provider application;
- b. Credentialing verification materials, including materials obtained through primary and secondary sources;
- c. Updates to credentialing information; and
- d. 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 and contracting processes. The sequence of the standards listed here does not indicate priority of the standard.

**STANDARDS
PROVIDER CREDENTIALING**

Standard 1

The company establishes and maintains a program for credentialing and re-credentialing of providers in compliance with applicable statutes, rules and regulations.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

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

Others Reviewed

- _____
- _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70), Section 5

Review Procedures and Criteria

The company establishes ~~written~~-documented policies and procedures for credentialing and re-credentialing of all health care professionals with whom the company contracts and applies those standards consistently.

The company ensures that the carrier's medical director or other designated health care professional has the responsibility for, and participates in, the health care professional credentialing verification process.

The company establishes 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 company makes all application and credentialing verification policies and procedures available for review by the applying health care professional upon written request.

The company keeps confidential all information obtained in the credentialing verification process, except as otherwise provided by state law.

The company retains all records and documents relating to a health care professional's credentialing verification process for at least the number of years required by state law.

The company's policies and procedures for credentialing and re-credentialing of providers are in compliance with state law.

K. Quality Assessment and Improvement

1. Purpose

The quality assessment portion of the examination is designed to ensure that companies offering Medicare Select 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 enrollees. For Medicare Select plans that limit access to health care services 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~~ documented 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 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. Examiners should also determine frequency of quality assessment and improvement meetings. To obtain an accurate assessment of a company'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 carrier 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 company develops and maintains a quality assessment program that is in compliance with state law to evaluate, maintain and improve the quality of health services provided to enrollees.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Quality assessment policies and procedures

_____ Quality assessment plan (if any)

_____ Minutes of the quality assessment committee

_____ Minutes of the board of directors

_____ Evaluations of the quality assessment program

_____ Job descriptions of the chief medical officer or clinical director

_____ Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

Quality Assessment and Improvement Model Act (#71)

Review Procedures and Criteria

The company develops a quality assessment program and procedures to ensure effective corporate oversight of the program.

The company develops and maintains the infrastructure and disclosure systems necessary to measure the quality of health care services provided to enrollees on a regular basis and appropriate to the types of plans offered by the company.

The company establishes a system designed to assess the quality of health care provided to enrollees. The system includes systematic collection, analysis and reporting of relevant data in accordance with statutory and regulatory requirements.

The company communicates findings in a timely manner to applicable regulatory agencies, providers and consumers as provided for by state law.

The company appoints a chief medical officer or clinical director to have primary responsibility for the quality assessment activities carried out by, or on behalf of, the company (*Quality Assessment and Improvement Model Act* (#71), Section 7).

| The chief medical officer or clinical director approves the ~~written~~documented quality assessment program, periodically reviews and revises the program documents and acts to ensure ongoing appropriateness. Not less than semi-annually, the chief medical officer or clinical director reviews reports of quality assessment activities (*Quality Assessment and Improvement Model Act* (#71), Section 7).

| The company has an appropriate ~~written~~documented policy to ensure the confidentiality of an enrollee's health information used in the company's quality assessment programs (*Quality Assessment and Improvement Model Act* (#71), Section 9).

The company complies with all applicable provisions of state law not expressly covered by any other of these standards.

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 2

The company develops and maintains a quality improvement program that is in compliance with applicable statutes, rules and regulations to evaluate, maintain and improve the quality of health services provided to enrollees.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

- _____ Quality improvement policies and procedures
- _____ Quality improvement plan
- _____ Minutes of the quality improvement committee
- _____ Minutes of the board of directors
- _____ Evaluations of the quality improvement program
- _____ Job descriptions of the chief medical officer or clinical director
- _____ Applicable statutes, rules and regulations

Others Reviewed

- _____
- _____

NAIC Model References

Quality Assessment and Improvement Model Act (#71)

Review Procedures and Criteria

The company develops a quality improvement program and procedures to ensure effective corporate oversight of the program (*Quality Assessment and Improvement Model Act (#71)*, Section 7).

The company develops and maintains the infrastructure and disclosure systems necessary to measure, on a regular basis, the quality of health care services provided to covered persons and appropriate to the types of plans offered by the company.

The company establishes a system designed to improve the quality and outcomes of health care provided to enrollees. The system includes systematic collection, analysis and reporting of relevant data in accordance with statutory and regulatory requirements (*Quality Assessment and Improvement Model Act (#71)*, Section 6C).

The company has a ~~written~~-documented quality improvement plan that includes:

- 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 an enrollee or provider gathered from multiple sources and documentation of both the satisfaction and grievances of the enrollee(s);
- A method to compare program findings with past performance and internal goals and external standards;
- Methods for:
 - Measuring the performance of participating providers;
 - Conducting peer review activities to identify practices that do not meet the company's standards;
 - Taking action to correct deficiencies;
 - 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 plan, including a description of good faith efforts to communicate with public health agencies.

The company establishes 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 (*Quality Assessment and Improvement Model Act* (#71), Section 6A).

The company ensures that participating providers have the opportunity to participate in developing, implementing and evaluating the quality improvement system (*Quality Assessment and Improvement Model Act* (#71), Section 6D).

The company provides enrollees with the opportunity to comment on the quality improvement process (*Quality Assessment and Improvement Model Act* (#71), Section 6E).

The company uses 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 enrollees (*Quality Assessment and Improvement Model Act* (#71), Section 6B).

The company appoints 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 (*Quality Assessment and Improvement Model Act* (#71), Section 7).

The chief medical officer or clinical director approves the ~~written~~-documented quality improvement program, periodically reviews and revises the program document and acts to ensure ongoing appropriateness. Not less than semi-annually, the chief medical officer or clinical director reviews reports of quality assessment activities (*Quality Assessment and Improvement Model Act* (#71), Section 7).

The company has an appropriate ~~written~~-documented policy to ensure the confidentiality of an enrollee's health information used in the company's quality improvement programs (*Quality Assessment and Improvement Model Act* (#71), Section 9).

The company complies with all applicable provisions of state law not expressly covered by any other of these standards.

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 3

The company files with the insurance commissioner a ~~written~~-documented description, in the prescribed format, of the quality assessment program, which includes a signed certification by a corporate officer of the company that the filing meets the requirements of applicable statutes, rules and regulations.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ ~~Written~~-Documented description of the quality assessment program

_____ Signed certification by a corporate officer

_____ Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

Quality Assessment and Improvement Model Act (#71), Section 5D

Review Procedures and Criteria

Determine if the forms have been filed.

Date: 12/7/21

Virtual Meeting

(in lieu of meeting at the 2021 Fall National Meeting)

ANTIFRAUD (D) TASK FORCE

Monday, November 12, 2021

Meeting Summary Report

The Antifraud (D) Task Force met Nov. 12, 2021. During this meeting, the Task Force:

1. Adopted its Oct. 27 and Summer National Meeting minutes, which included the following action:
 - A. Adopted its 2022 proposed charges.
2. Received an update from the Antifraud Education Enhancement (D) Working Group. The Working Group has been working with NAIC staff in preparation for the upcoming investigator safety training webinar that will take place in December. The Working Group advised its members to send any suggested training/webinar topics they would like to have provided.
3. Received an update from the Antifraud Technology (D) Working Group. The Working Group formed a subject matter expert (SME) group to create a template for industry to use when creating their Antifraud Plan. The SME group has been meeting since September to finalize this project. The final draft will be exposed to the Working Group for comment. Once adopted by the Working Group, it will be presented to the Task Force for consideration of adoption.
4. Received an update from the Improper Marketing of Health Insurance (D) Working Group. The Working Group has continued to meet monthly in regulator-to-regulator session. The Working Group is holding its first open meeting at the Fall National Meeting.
5. Heard reports on antifraud activity from NAIC staff and the Coalition Against Insurance Fraud (CAIF).

[AFTF Summary](#)

*Virtual Meeting
(in lieu of meeting at the 2021 Fall National Meeting)*

MARKET INFORMATION SYSTEMS (D) TASK FORCE

Tuesday, November 23, 2021

Meeting Summary Report

The Market Information Systems (D) Task Force met Nov. 23, 2021. During this meeting, the Task Force:

1. Adopted its Oct. 29 minutes, which included the following action:
 - A. Adopted its 2022 proposed charges.
2. Adopted its Summer National Meeting minutes.
3. Adopted the report of the Market Information Systems Research and Development (D) Working Group, which met Nov. 5 and Oct. 24 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) and paragraph 6 (consultations with NAIC staff members) of the NAIC Policy Statement on Open Meetings, and took the following action:
 - A. Adopted the artificial intelligence (AI) subject matter expert (SME) group's recommendation, which included:
 - i. Evaluate currently available market analysis data and assess its quality.
 - ii. Adopt a more rigorously statistical approach to identify the predictive power of market scoring systems and integrate data into a single overall analysis.
 - iii. Incorporate promising AI modes of analyses, as well as traditional statistical modeling.
 - iv. Assess ways AI can improve the efficiency of qualitative analysis and facilitate pattern recognition across larger volumes of textual evidence.
 - v. Explore potential data sources suitable for AI techniques.
 - B. Reviewed and prioritized the outstanding Uniform System Enhancement Request (USER) forms.
 - C. Reviewed the 2020 Market Information Systems (MIS) data analysis metric results. The Working Group will continue its analysis of the results and determine recommendations to improve data quality.
4. Considered the Market Information Systems Research and Development (D) Working Group recommendations regarding the incorporation of AI in the NAIC MIS. The Task Force will continue discussion and consideration for adoption at its next meeting

[MISTF Summary for Fall National Meeting.docx](#)

*Virtual Meeting
(in lieu of meeting at the 2021 Fall National Meeting)*

PRODUCER LICENSING (D) TASK FORCE

Monday, November 29, 2021

Meeting Summary Report

The Producer Licensing (D) Task Force met Nov. 29, 2021. During this meeting, the Task Force:

1. Adopted its Oct. 29 and Summer National Meeting minutes, which included the following action:
 - A. Adopted its 2022 proposed charges.
 - B. Heard an update on state implementation of online producer licensing examinations.
 - C. Discussed a referral from the Special (EX) Committee on Race and Insurance regarding the availability of producer licensing examinations in foreign languages, steps examination vendors have taken to mitigate cultural bias in examinations, and the location of insurance producers compared to demographic information for a geographic area.
 - D. Discussed the review of the NAIC's *Guidelines for State Insurance Regulators to the Violent Crime Control and Law Enforcement Act of 1994* to create a more user-friendly resource for states that would lead to better consistency in how states review 1033 waiver requests.
 - E. Discussed procedures for amending the NAIC Uniform Producer Licensing Applications.
 - F. Received reports from the Producer Licensing Uniformity (D) Working Group and the Uniform Education (D) Working Group.
2. Received the report of the Producer Licensing Uniformity (D) Working Group, which provided the Task Force with the results of its survey addressing the appropriate producer licensing standard for the sell, solicitation, and negotiation of pet insurance. Seven states responded to the survey that the current uniform licensing standard for pet insurance is the correct policy direction; seven responded that the major lines of authority of Property/Casualty (P/C) should be required; one state responded that pet insurance should become a core limited line; and one state responded that a license for any major line of authority should be required.
3. Received the report of the Uniform Education (D) Working Group, which is continuing to discuss various state requirements for the approval of continuing education (CE) course instructors.
4. Discussed the draft procedures for amending the NAIC Producer Licensing Applications, which are being developed to ensure that the consideration of changes to the uniform applications support the NAIC members' goal of providing stable, uniform applications and encourage the use of electronic technology for licensing.
5. Received comments from the American Council of Life Insurers (ACLI) on diversity, inclusion, and unnecessary barriers to individuals seeking an insurance producer license. The ACLI referenced the 1033 waiver process and the presence of unnecessary pre-licensing education mandates.
6. Discussed the elimination of cultural bias in producer licensing examinations, which included a review of preliminary feedback from two examination vendors on their internal training and industry standards for examination fairness.



7. Received a report from the National Insurance Producer Registry (NIPR) Board of Directors. October marked the 25th anniversary for NIPR, and NIPR is on track to have its highest transaction volume and review year in 2021. NIPR continues to implement the contact change request application for business entities. NIPR has implemented the application in 28 states and has processed more than 7,300 transactions. NIPR recently implemented a chat feature for customers, and from January to October, the customer service department handled over 162,000 calls, more than 70,000 emails, and 20,000 chats. NIPR is also on track to complete its transition to the cloud before the end of the year.
8. Discussed how states could address errors or misstatements on producer licensing applications, which were completed by third-party authorized submitters.

[ProdLic Mtg Summary](#)



NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Virtual Meeting

MARKET CONDUCT EXAMINATION GUIDELINES (D) WORKING GROUP

November 4, 2021 / October 7, 2021 / September 2, 2021

Summary Report

The Market Conduct Examination Guidelines (D) Working Group met Nov. 4, Oct. 7, and Sept. 2, 2021.

1. During its Nov. 4 meeting, the Working Group:
 - A. Adopted its Oct. 7 minutes.
 - B. Adopted a revised draft Chapter 25—Conducting the Medicare Supplement Examination for inclusion in the *Market Regulation Handbook* (Handbook). The draft was updated to include provisions from the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651).
 - C. Adopted a revised draft Chapter 24—Conducting the Health Examination for inclusion in the Handbook. The draft was updated to include a provision from the *Health Maintenance Organization Model Act* (#430).
 - D. Discussed draft revisions to Chapter 21—Conducting the Property and Casualty Examination for inclusion in the Handbook regarding provisions from the recently adopted *Real Property Lender-Placed Insurance Model Act* (#631).
 - E. Discussed draft revisions to Chapter 20—General Examination Standards for inclusion in the Handbook regarding provisions in the *Insurance Holding Company System Regulatory Act* (#440).
 - F. Received verbal updates from state insurance regulator volunteers reviewing models potentially affecting the Handbook. The models reviewed were the *Suitability in Annuity Transactions Model Regulation* (#275), the *Corporate Governance Annual Disclosure Model Act* (#305), and the *Corporate Governance Annual Disclosure Model Regulation* (#306).
 - G. Received a verbal update from Tim Mullen (NAIC) regarding the Working Group’s group supervision charge to “[d]iscuss the effectiveness of a group’s supervision of market conduct risks and develop examination procedural guidance, as necessary.” Mr. Mullen provided a brief background regarding how and why the charge was developed, and he provided some areas for the Working Group to consider when discussing the charge.

2. During its Oct. 7 meeting, the Working Group:
 - A. Adopted its Sept. 2 minutes.
 - B. Discussed draft revisions to Chapter 25 for inclusion in the Handbook. The draft was updated to include provisions from Model #651.
 - C. Discussed draft revisions to Chapter 24 for inclusion in the Handbook. The draft was updated to include a provision from Model #430.
 - D. Received verbal updates from state insurance regulator volunteers reviewing models potentially affecting the Handbook. The models reviewed were Model #631, Model #440, Model #275, Model #305, and Model #306.

3. During its Sept. 2 meeting, the Working Group:
 - A. Adopted a new title insurance standardized data request (SDR) to address in force policies and a new title insurance SDR to address claims for inclusion in the reference documents of the Handbook.
 - B. Received verbal updates from state insurance regulator volunteers who had reviewed adopted models potentially affecting the content of the Handbook, which included the *Unfair Trade*



NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Practices Act (#880), Model #440, Model #305, Model #306, Model #275, Model #430, and Model #651.

 [MCEG_WG_Interim_Summary.docx](#)

*Virtual Meeting
(in lieu of meeting at the 2021 Fall National Meeting)*

MARKET ANALYSIS PROCEDURES (D) WORKING GROUP

Thursday, November 18, 2021

Meeting Summary Report

The Market Analysis Procedures (D) Working Group met Nov. 18, 2021. During this meeting, the Task Force:

1. Adopted its Summer National Meeting minutes.
2. Discussed market analysis training needs for state insurance regulators.
3. Reviewed the first draft of standard Market Conduct Annual Statement (MCAS) scorecard ratios for the MCAS Travel Insurance and the MCAS Short-Term Limited-Duration (STLD) Insurance Data Call and Definitions. The first collection of data for these new lines of business will be for 2022 data collected in 2023.
4. Discussed market analysis tools that may be eliminated as they are replaced with enhanced tools created as part of the NAIC *State Ahead* project to develop market regulation self-service dashboards.
5. Discussed the definition of “surrender” and “replacement” for the purposes of the Annuity MCAS Data Call and Definitions. A clarification will be drafted for the Frequently Asked Questions (FAQ) document.

[MAPWG Summary for Fall National Meeting.docx](#)



NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Virtual Meeting

MARKET CONDUCT ANNUAL STATEMENT BLANKS (D) WORKING GROUP

Monday, November 22, 2021

Summary Report

The Market Conduct Annual Statement Blanks (D) Working Group met Nov. 22, 2021. During this meeting, the Working Group:

1. Adopted its July 28 minutes which included the following action:
 - A. Adopted its June 30 minutes.
 - B. Received an update on the life Market Conduct Annual Statement (MCAS) draft edits for accelerated underwriting (AU).
 - C. Received an update on the Other Health Drafting Group.
 - D. Discussed the lawsuit definitions and placement of the lawsuit data elements for the homeowners and private passenger auto (PPA) MCAS.
 - E. Requested submission of suggested edits to existing MCAS blanks and data call and definitions.
2. Received an update on the life MCAS draft edits for accelerated underwriting (AU). The Working Group is coordinating its definition with the definition that will be adopted by the Accelerated Underwriting (A) Working Group. The Accelerated Underwriting (A) Working Group will discuss a proposed definition for AU during its Dec. 6 meeting.
3. Received an update from the Other Health Drafting Group. A new chair for the drafting group has been appointed, and it will resume its work on the other health blank.
4. Exposed revisions to the definition of "lawsuit" and the placement of the lawsuit data elements in the homeowners and PPA MCAS blanks. The revisions and structure will allow for the distinction between claims-related lawsuits and non-claims-related lawsuits.
5. Exposed an interrogatory question for capturing information on third-party vendors providing data and algorithms used in the digital claims process.

[MCASWG Summary for Fall National Meeting](#)

*2021 Fall National Meeting
San Diego, California*

PRIVACY PROTECTIONS (D) WORKING GROUP

Saturday, December 11, 2021

1:00 – 2:00 p.m.

Meeting Summary Report

The Privacy Protections (D) Working Group met Dec. 11, 2021. During this meeting, the Working Group:

1. Adopted its Nov. 22, Oct. 25, and Oct. 11 minutes, which included the following action:
 - A. Discussed comments received on the remaining segments of the consumer rights (right to correct information, right to delete information, right of data portability, and right to restrict the use of data) in the draft privacy report.
 - B. Discussed the Nov. 18 final draft of the Privacy Report to the Market Regulation and Consumer Affairs (D) Committee, which the Working Group exposed for a 14-day public comment period ending Dec. 2.
2. Received comments on the final exposure draft of the Privacy Protections (D) Working Group Report on Consumer Data Privacy Protections.
3. Adopted the final exposure draft of the Privacy Protections (D) Working Group Report on Consumer Data Privacy Protections with edits marked in redline in Attachment Four:
 - A. Changed the title of the report in Appendix A by removing “NAIC” and changing “Privacy Policy Statement” to “Privacy Report.”
 - B. Reworded a certain segment to clarify that by “rights,” the Working Group meant “categories” to be discussed further during the revisions to privacy models phase recommended in the Working Group.
 - C. Clarified wording that referenced future concerns to ensure the report met its charges to make recommendations concerning the need for NAIC privacy models to be modernized in 2022.

CMA: combined suggested changes from Consumer Reps, ACLI and Trades/Joint Group

**Privacy Protections (D) Working Group Report on
Consumer Data Privacy Protections**

**Exposure Draft
December 7, 2021**

DRAFT

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I. Introduction

The Privacy Protections (D) Working Group was appointed in 2019 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 NAIC models addressing privacy protection. This work included the review of an insurer's use of data collected from a consumer and data supplied to an insurer by a third-party vendor. Rather than focusing on revisions to NAIC models, the main deliverables for 2021 were to set forth a Report on the minimum consumer privacy protections that are appropriate for the business of insurance, after taking into consideration the consumer privacy protections that already exist under applicable state and federal laws.

The Working Group discussed how best to balance the **need for information by those conducting the business of insurance and the consumer's need for fairness in insurance information practices.** ~~rights of insurers to use data for legitimate business purposes with consumers' rights to control what data is used and how it is used.~~ The following privacy protections for consumers were discussed: (1) the right to opt out of data sharing, (2) the right to limit data sharing unless the consumer opts in, (3) the right to correct information, (4) the right to delete information, (5) the right of data portability, (6) the right to restrict the use of data, (7) the right of data ownership, (8) the right of notice, and (9) the right of nondiscrimination and/or non-retaliation.

As a reminder, opting in is not a way the consumer can protect their privacy – it is a way a consumer can waive a privacy protection. The Working Group intended to consolidate (1) and (2) above as a single “right to restrict data sharing, on either an opt-out or an opt-in basis,” however, since these issues were discussed extensively as separate “rights” that for purposes of this Report the issues are being listed separately.

The Working Group received comments from the ACLI, AHIP, APCIA, BCBSA, the Coalition of Health Insurers, NAMIC, MLPA, and NAIC consumer representatives Birny Birnbaum, Brenda Cude, Karrol Kitt, and Harry Ting.

II. Overview of Issue

Consumer awareness and regulatory concerns about the use of consumer data by a variety of commercial, financial, and technology companies are increasing. This has led to the adoption of the General Data Protection Regulation (GDPR) in the E.U. and the California Consumer Privacy Act (CCPA) and other state data privacy protection laws in the U.S. Though data privacy concerns extend beyond the insurance sector, the increasing use of data and the passage of these new laws is causing the insurance industry and consumer groups alike to **compel** Congress to enact federal privacy legislation.

While federal legislative efforts are currently stalled due to other legislative priorities and differing perspectives from consumers and industry on the best path forward, it is likely that Congress will begin focusing on the issue again soon. The current pause provides state insurance regulators an opportunity to update state privacy protections consistent with the current insurance business environment and potentially forestall or mitigate the impacts of any preemptive federal legislation. State policymakers have also responded to the privacy debate with varying legislative proposals to provide consumers with greater transparency and control over the use of personal information, with California, Virginia, and Colorado being the most recent examples. These comprehensive state data privacy laws each have either entity-level or data-level exemptions for entities subject to or information collected pursuant to the federal Gramm-Leach-Bliley Act (GLBA) and/or the privacy regulations adopted under the Health Insurance Portability and Accountability Act (HIPAA).

III. Summary of Consumer Privacy Protections Provided by NAIC Model Laws

The NAIC has three model laws governing data privacy: *Health Information Privacy Model Act* (Model #55); *NAIC Insurance Information and Privacy Protection Model Act* (#670) and *Privacy of Consumer Financial and Health Information Regulation* (#672), each of which is based upon or influenced by federal privacy laws. The NAIC's Model #670 contains many of the consumer rights found in these comprehensive state laws, which can be traced back to the Fair Credit Reporting Act (FCRA), and Model #672 is based, in large part, on GLBA and the HIPAA regulations. Generally, insurers and other entities licensed by state departments of insurance **have certain exemptions from** ~~are carved out of~~ more comprehensive state laws of general applicability.

Because of these exemptions, insurance regulators must be aware when new protections are added to laws applicable to other businesses, especially when these laws address new technologies and ways consumer information is collected and shared, so that comparable protection can be added, as necessary, to the laws governing the insurance industry. Of note, GLBA and HIPAA each set a federal floor for the entities within their scope, upon which states can build. This is what the NAIC did in drafting the *Health Information Privacy Model Act* (Model #55) and the *Privacy of Consumer Financial and Health Information Regulation* (Model #672). GLBA applies to the entire insurance industry while HIPAA applies to the health insurance sector **and those that collect or use Protected Health Information {PHI}**.

A. NAIC Insurance Information and Privacy Protection Model Act (Model #670)

The NAIC adopted the *NAIC Insurance Information and Privacy Protection Model Act* (#670) in 1980 following federal enactment of the Fair Credit Reporting Act in 1970 and the Federal Privacy Act in 1974. This model act establishes standards for the collection, use and disclosure of information gathered in connection with insurance transactions by insurance companies, insurance producers and insurance support organizations.

A key aspect of this model is that it establishes a regulatory framework for consumers to: (1) ascertain what information is being or has been collected about them in connection with insurance transactions; (2) obtain access to such information for the purpose of verifying or disputing its accuracy; (3) limit the disclosure of information collected in connection with insurance transactions; and (4) obtain the reasons for any adverse underwriting decision.

This regulatory framework is facilitated through a requirement that insurers or agents provide a written notice to all applicants and policyholders regarding the insurer's information practices. The notice must address the following: (1) whether personal information may be collected from persons other than the individual or individuals seeking insurance coverage; (2) the types of personal information that may be collected, the types of sources and investigative techniques that may be used to collect such information; (3) the types of disclosures allowed under the law; (4) a description of the rights established under the law; and (5) notice that information obtained from a report prepared by an insurance support organization may be retained by the insurance support organization and disclosed to other persons.

Of note, the model prohibits disclosure of any personal information about an individual collected or received in connection with an insurance transaction without the individual's written authorization, subject to limited exceptions. However, some categories of information may be disclosed for marketing purposes if the consumer "has been given an opportunity to indicate that he or she does not want personal information disclosed for marketing purposes and has given no indication that he or she does not want the information disclosed." Model #670 also provides consumers with the right to request that an insurer provide access to recorded personal information, disclose the identity of the third parties to whom the insurance company disclosed information (if recorded); disclose the source of collected information (if available); and provide procedures by which the consumer may request correction, amendment, or deletion of recorded personal information.

Seventeen (17) states have adopted Model #670: AZ, CA, CT, GA, HI, IL, KS, MA, ME, MN, MT, NV, NJ, NC, OH, OR, and VA.

B. NAIC Health Information Privacy Model Act (Model #55)

The NAIC adopted the *Health Information Privacy Model Act* (Model #55) following federal adoption of the privacy regulations authorized by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This model sets standards to protect health information from unauthorized collection, use and disclosure by requiring insurance companies to establish procedures for the treatment of all health information by all insurance carriers. The drafters of Model #55 believed it was important that the same rules apply to all lines of insurance, since health insurance carriers are not the only ones that

use health information to transact business. For example, health information is necessary for life insurance underwriting, and often essential to property and casualty insurers in settling workers' compensation claims and personal injury liability claims. Reinsurers also use protected health information write reinsurance.

The model requires carriers to develop and implement written policies, standards, and procedures for the management of health information, including to guard against the unauthorized collection, use or disclosure of protected health information. It provides consumers with the right to access their protected health information and amend any inaccuracies. The model also requires insurers to obtain written authorization ("opt-in") before collecting, using, or disclosing protected health information, except when performing limited activities.

Many of the provisions found in Model #55 were later incorporated into the *Privacy of Consumer Financial and Health Information Regulation* (Model #672).

The following 11 13 jurisdictions have adopted legislation related to Model #55: CA, CO, DE, KY, LA, ME, MO, ND, RI, SD, TX.

C. NAIC Privacy of Consumer Financial and Health Information Regulation (Model #672)

The NAIC adopted the *Privacy of Consumer Financial and Health Information Model Regulation (Model #672)* in 2000. The model regulation was drafted to implement the requirements set forth in Title V of GLBA. GLBA imposed privacy and security standards on financial institutions, defined to include insurers and other insurance licensees, and directed state insurance commissioners to adopt certain data privacy and data security regulations. The provisions governing protection of financial information are based on privacy regulations promulgated by federal banking agencies. This model also contains provisions governing protection of health information that were taken directly from Model #55 and from the HIPAA Privacy Rule promulgated by the U.S. Department of Health and Human Services {HHS}.

The model regulation provides protection for non-public financial and personal health information about consumers held by insurance companies, agents, and other entities engaged in insurance activities. In general, the model regulation requires insurers to: (1) notify consumers about their privacy policies; (2) give consumers the opportunity to opt-out of prohibit the sharing of their protected non-public financial information with non-affiliated third parties; and (3) obtain affirmative consent from consumers before sharing protected non-public personal health information with any other parties, affiliates, and non-affiliates.

The key difference between the treatment of financial information and health information is that insurers must give consumers the right to “opt out” of the disclosure or sharing of their financial information but insurers must obtain explicit authorization from the consumer (“opt-in”) before sharing health information. Every jurisdiction has a version of this model regulation, although nineteen (19) jurisdictions have only adopted the provisions regarding financial information and not the provisions regarding health information **for purposes not within an exemption**. Some jurisdictions that have adopted Model #670 have adopted additional provisions from Model #672 by bulletin rather than regulation.

IV. Summary of Health Insurance Portability and Accountability Act (HIPAA)

In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA), which, among other things, authorized the U.S. HHS ~~Department of Health and Human Services~~ to promulgate regulations governing consumer privacy protections. The HIPAA Privacy Rule was finalized in 2000. The rule applies to health plans and health care providers, restricting the permitted uses and disclosure of protected health information. HIPAA preempts state law only to the extent that a covered entity or business associate would find it impossible to comply with both the state and federal requirements.

HIPAA provides individuals the right to (1) access and amend their protected health information, (2) the right to request the restriction of uses and disclosures of protected health information, and (3) the right to receive an accounting of disclosures made to other entities.

A covered entity must obtain the individual’s written authorization for any use or disclosure of protected health information that is not for treatment, payment or health care operations or otherwise permitted or required by the law. A covered entity is also required to provide notice of its privacy practices.

V. Summary of General Data Protection Regulation (GDPR)

The GDPR became effective in May 2018 and **may apply** ~~applies~~ to U.S. companies **based on whether or not they process the if they collect** data from citizens of the E.U. **or are processing data within the E.U. and provided that they have a sufficient nexus with the E.U. over the internet**. This law requires companies (referred to as data “controllers”) to obtain explicit consent from consumers to collect their data (“opt in”) along with an explanation of how the data will be used. It also contains standards for safeguarding the data collected. Under the GDPR, a consumer has the following rights: (1) to receive information about the processing of personal data; (2) to obtain access to that personal data; (3) to request that incorrect, inaccurate or incomplete personal data be corrected; (4) to request that personal data be erased when it is no longer needed or if processing it is unlawful; (5) to object to the processing of personal data for marketing purposes or on grounds relating to a consumer’s particular situation; (6) to request the restriction of the processing of

personal data in specific cases; (7) to receive personal data in a machine-readable format and the ability to ~~transmit send~~ it to another controller, *if technically feasible* (“data portability”); and (8) to request that decisions based *solely* on automated processing concerning the consumer or significantly affecting the consumer and based on a consumer’s personal data, are made by human beings *or to challenge a decision*.

For further clarification - the GDPR does not, necessarily, apply to a company simply because it collects data from citizens of the EU over the internet. Specifically, the company must actively market its products and services to those in the EU. It is a factual determination. For example, routinely shipping goods to the EU, utilizing the French language on the website (in addition to English) and setting a website up to accept euros would likely result in the GDPR applying to a given company.

VI. Summary of Recently Adopted Consumer Privacy Protection Laws

A. California Consumer Privacy Act (CCPA) and California Privacy Rights Act (CPRA)

In 2018, California became the first U.S. state to adopt a comprehensive privacy law, *applicable beyond the insurance industry*, imposing broad obligations on businesses to provide consumers with transparency and control of their personal data. The California Consumer Privacy Act (CCPA) became effective in 2020. Since it was adopted, it was amended by the California Privacy Rights Act (CPRA), which becomes effective January 1, 2023. Additionally, the California Attorney General promulgated implementing regulations in 2020.

Scope

The CCPA, as amended by the CPRA (California law) applies to companies doing business in California that collect or process consumers’ personal information and meet one of the following thresholds: (1) has annual gross revenue in excess of \$25,000,000 in the preceding calendar year; (2) annually buys, sells, or shares the personal information of 100,000 or more consumers or households; or (3) derives 50% or more of its annual revenue from selling or sharing consumers’ personal information.

Exemptions

The law does not apply to personal information collected, processed, sold, or disclosed pursuant to the federal Gramm-Leach-Bliley Act (GLBA), and its implementing regulations. It also does not apply to protected health information that is governed by the privacy, security, and breach notification rules issued by the U.S. ~~Department of Health and Human Services (HHS)~~. Furthermore, this law contains an entity-level exemption for HIPAA-covered entities or business associates governed by the privacy, security, and breach notification rules issued by HHS.

Consumer Rights

California law provides consumers with the following rights **subject to certain limitations**: (1) to request deletion of any personal information;¹ (2) to correct inaccurate personal information, taking into account the nature of the personal information and the purposes of the processing of the information; (3) to know about and access the personal information being collected by requesting that the business disclose: the categories and specific pieces of personal information collected, the categories of sources the information was collected from, the business purpose for collecting the information, the categories of third parties with whom the information is shared, and the specific pieces of personal information that was shared; (4) to request the personal information provided by the consumer in a format that is easily understandable, and to the extent technically feasible, in a structured, commonly used, machine-readable format that may also be transmitted to another entity at the consumer's request without hindrance; (5) to know what personal information is sold or shared and to whom; (6) to opt out of the sale or sharing of personal information; (7) to limit the use and disclosure of sensitive personal information **aside from permissible enumerated purposes**; and (7) to not be retaliated against for requesting to opt out or exercise other rights under the law.

Business Obligations

The law imposes the following obligations on all covered businesses: (1) prohibits retaining a consumer's personal information for longer than reasonably necessary for the disclosed purpose; (2) requires implementing reasonable security procedures and practices; (3) requires notice of the following: collection of personal information, including sensitive personal information, retention of information, right to opt out of sale and sharing, and financial incentives; (4) prohibits using sensitive personal information **outside of enumerated purposes** when a consumer has requested not to use or disclose such data.

Enforcement

The CPRA amends the CCPA by placing administrative enforcement authority with the California Privacy Protection Agency, a new state agency created by the CPRA. Under the CPRA, the California Attorney General retains authority for seeking injunctions and civil penalties. Additionally, if personal information is breached, the consumer can pursue a private civil action against the company.

¹ And even when information is "deleted," the CCPA right to deletion allows the business to "maintain a confidential record of deletion requests solely for the purpose of preventing the personal information of a consumer who has submitted a deletion request from being sold, for compliance with laws or for other purposes."

B. Colorado Privacy Act (CPA)

Scope

The Colorado Privacy Act (CPA) takes effect on July 1, 2023. **Subject to certain limitations this law** ~~It~~ applies to entities that conduct business in Colorado or produce or deliver commercial products or services intentionally targeted to residents of Colorado and satisfy one of the following thresholds: (1) controls or processes the personal data of 100,000 or more consumers in a year; or (2) derives revenue or receives a discount on the price of goods or services from the sale of personal data and processes or controls the personal data of 25,000 or more consumers. The law defines “controllers” as those that “determine the purposes for and means of processing personal data” and defines “processors” as those that “process data on behalf of a controller.”

Exemptions

The law contains data-based exemptions (rather than entity-level exemptions) for protected health information collected, processed, or stored by HIPAA-covered entities and their business associates, and information and documents created by a HIPAA-covered entity for purposes of complying with HIPAA and its implementing regulations. Additionally, the law contains an exemption for any personal data collected, processed, sold, or disclosed pursuant to the Gramm-Leach-Bliley Act (GLBA), and implementing regulations, if such collection, processing, sale, or disclosure is in compliance with that law.

Consumer Rights

The CPA provides consumers with the following rights: (1) to opt out of targeted advertising, sale of personal data, and profiling; (2) to confirm whether a controller is processing the consumer’s personal data and the right to access such data; (3) to correct inaccuracies in personal data; (4) to delete personal data; and (5) to obtain the personal data in a portable and readily usable format that allows the consumer to transmit the data to another entity.

Business Obligations

The CPA imposes affirmative obligations on controllers, including the following: (1) provide consumers with an accessible, clear, and meaningful privacy notice; (2) specify the express purposes for which personal data are collected and processed; (3) collection of personal data must be adequate, relevant and limited to what is reasonably necessary in relation to the specified purposes; (4) not process personal data for purposes that are not reasonably necessary to or compatible with the specified purposes, without obtaining consent from the consumer; (5) take reasonable measures to secure personal data; (6) not process personal data in violation of any law that prohibits unlawful discrimination; and (7) not process a consumer’s sensitive data without first obtaining the consumer’s consent. Additionally, controllers are required to enter into contracts

with data processors, referencing the responsibilities under the CPA and controllers must conduct a data protection assessment prior to any processing activities that have a heightened risk of harm to consumers.

Enforcement

The CPA does not contain a private right of action but does provide the state attorney general and district attorneys authority to take action against entities for violations.

C. Virginia Consumer Data Protection Act (CDPA)

Scope

The Virginia Consumer Data Protection Act (CDPA) becomes effective January 1, 2023. **Subject to certain limitations, this law** applies to entities that conduct business in Virginia or produce products or services targeted to Virginia residents when they control or process personal data of at least 100,000 consumers or control or process personal data of at least 25,000 consumers and also derive over 50% of gross revenue from the sale of personal data.

Exemptions

The law contains entity-level exemptions for those subject to GLBA and HIPAA. It specifically exempts financial institutions and data subject to GLBA, and covered entities or business associates governed by the privacy, security, and breach notification rules issued by the U.S. **HHS Department of Health and Human Services**. It also exempts protected health information under HIPAA.

Consumer Rights

The CDPA provides consumers with the following rights: (1) to confirm whether or not a controller is processing the consumer's personal data and if so, to provide the right to access such personal data; (2) to correct inaccuracies in the consumer's personal data, taking into account the nature of the personal data and the purposes of processing of the consumer's personal data; (3) to delete personal data provided by or obtained about the consumer; (4) to obtain a copy of the consumer's personal data in a portable and readily usable format that allows the consumer to transmit the data to another controller; and (5) to opt out of the processing of the personal data for purposes of targeted advertising, sale of personal data, and profiling.

Business Obligations

Under the law, controllers have the responsibility to do the following: (1) limit the collection of personal data to what is adequate, relevant, and reasonably necessary in relation to the purposes for which such data is processed; (2) not process personal data without consumer consent for purposes that are neither reasonably necessary to nor compatible with the disclosed purposes for

which such personal data is processed; (3) establish, implement, and maintain reasonable data security practices to protect personal data; (4) not process personal data in violation of any laws that prohibit unlawful discrimination against consumers and not discriminate against consumers exercising their rights under this law; and (5) not process sensitive data concerning a consumer without obtaining the consumer's consent. In addition, controllers must provide consumers with a reasonably accessible, clear, and meaningful privacy notice. Processing activities undertaken by a processor on behalf of a controller must be governed by a data processing agreement. Controllers also must conduct data protection assessments that evaluate the risks associated with processing activities.

Enforcement

Similar to the Colorado law, the Virginia law does not contain a private right of action but does provide the state attorney general authority to pursue action against entities for violations.

VII. Summary of Working Group Discussions of Selected Key Points

The Working Group began discussions December 8, 2019, during the Fall National Meeting with the following minimum consumer privacy protections being considered as appropriate for the business of insurance. These rights were based on the Working Group's proposed 2020 charges and are included in the Working Group's initial 2019 Work Plan:

1. the right to receive notice of an insurer's privacy policies and practices;
2. the right to limit an insurer's disclosure of personal data;
3. the right to have access to personal data used by an insurer;
4. the right to request the correction or amendment of personal data used by an insurer;
5. the right of data ownership; and
6. the right of data portability.

An example of the other types of issues the Working Group will need to discuss includes clarifying the specific circumstances for when a "right" does exist. Is it really a "right to request" as contained in the California law? Or is it merely a right to delete inaccurate information like FCRA? Or is it a right to request deletion of inaccurate information as described in Model #670?

Eventually the Working Group decided on nine (9) categories to study. In addition to the six above, the Working Group added (7) the right of data ownership, (8) the right of notice, and (9) the right of nondiscrimination and/or non-retaliation.

The Work Plan also stated that the Working Group discussions would focus on data privacy (and not data security) and identify areas within existing NAIC models and state requirements where consumer data privacy protections might need to be enhanced due to changes in technology. In her a December 8 presentation, Jennifer McAdam (NAIC) outlined existing privacy provisions in

NAIC models and state insurance laws. She said the difference between data privacy and data security is that data privacy is about how data is being collected and used by businesses; while data security is about how data that a business has already collected, has in its possession, and is stored and protected from unauthorized access. She said the two are often conflated and there are some laws that address both – for example, the GDPR.

Furthermore, as many comments have noted, the two issues overlap because a breach of security often results in a loss of privacy. Ms. McAdam said the CCPA is an example of a data privacy law that governs how businesses collect and use consumer data; the rights consumers have to know how that data is being used; the rights consumers have to challenge the accuracy of the data; and how it is being used. Data privacy laws are focused on legal protections for data and consumer rights: In comparison, data security laws, such as the NAIC's Insurance Data Security Model Act (#668), require operational and technological protections sufficient to ensure that the legal protections are meaningful. Ms. McAdam explained that Model #668 governs how businesses protect the data once it has been collected as well as what businesses need to do if those protections fail as the result of a data breach or other cybersecurity event.

The Working Group operated under these distinctions.

State insurance regulators were concerned about the consumer data that insurers were already presenting in rate filings that had ballooned up to thousands of pages of different data points being gathered by insurers on consumers. Regulators have also seen an increased reliance on third-party risk scores that aggregate consumer information in order to make determinations and conclusions about consumer information. Regulators noted that insurers have a responsibility to ensure that the third parties used are following state laws and complying with the state's standards for accuracy and fairness. In addition to providing disclosure of the third parties used by insurers when consumers request it, insurers are required to report how the information was gathered; where it was drawn from (*e.g.*, web traffic, geolocation data, social media, etc.); and why the company thinks it needs to use those particular data points.

Industry asked the Working Group to consider: 1) workability by allowing for various exemptions for operational and other reasons that acknowledge vital business purposes for insurers to collect, use, and disclose information. For example, Article IV of the NAIC Model #672 was developed to implement the GLBA, and the exceptions embedded into Section 13 of Model #672 are instructive as to the types of operational functions that need to be preserved and facilitated; 2) exclusivity by avoiding dual regulation, so insurers are not simultaneously subject to potentially inconsistent or conflicting interpretations by more than one regulator; 3) clarity by asking that care be taken to consider how best to dovetail new requirements with existing models/laws/regulations; consulting other resources and educating legislators on how privacy bill language impacts the insurance industry, including the legal requirements to retain and use certain data, as well as data

mandates; 4) an effective date that allows advance time (like the two to five years that was afforded under the GDPR) for insurers to be ready for implementation, to avoid having piecemeal revisions like the CCPA and the GDPR, as well as a roll-out period with different dates for different provisions within that time frame as a more measured approach to undertake such a significant endeavor.

Consumer Representatives asked the Working Group to consider that: 1) data vendors are scraping personal consumer information from public sources to produce consumer profiles, scores, and other tools for insurers. The data vendor products, while assembled from public information, raise concerns over consumers' digital rights and privacy; 2) many data vendors and many types of personal consumer information are not subject to FCRA consumer protections. In turn, many of the types of data and algorithms used by insurers are not subject to either FCRA consumer protections (even though they are the functional equivalent of a consumer report) or the NAIC model law/regulation protections; 3) it is unclear whether the NAIC models cover the new types of data being generated by consumers as part of, or related to, insurance transactions. For example, consumers are producing large volumes of data through telematics programs from devices collecting personal consumer data in the vehicle or home or through wearable devices; 4) there are several organizations working on consumer digital rights (such as the Center for Digital Democracy, the Electronic Privacy Information Center, the Electronic Frontier Foundation, the Public Knowledge-Privacy Rights Clearinghouse, the Public Citizen, the U.S. Public Interest Research Group, and the World Privacy Forum) from whom input and presentations at Working Group meetings could be solicited; and 5) if consumer disclosures are to be used, that disclosure should be a compliance or enforcement tool that would be created using consumer focus testing and established best practices for the creation of such consumer disclosures.

The COVID-19 pandemic slowed the Working Group's discussions in 2020, however, discussions continued through seven virtual meetings and two regulator-only meetings of subject matter experts as areas of concentration were being narrowed leading to the Working Group receiving additional guidance from its parent committee.

In April 2021, the Working Group's discussions were redirected to six consumer data privacy rights or types of consumer data privacy protections based on the specific examples identified in item 1.c. of the NAIC Member Adopted Strategy for Consumer Data Privacy Protections received through its parent Committee, the Market Regulation and Consumer Affairs (D) Committee. The Working Group's task was to comment on the following consumer privacy rights concerning consumers' personal information as a basis for a privacy protection framework for the insurance industry (not just health insurance):

1. Right to opt out of data sharing;
2. Right to limit data sharing unless the consumer opts in;

3. Right to correct information;
4. Right to delete information;
5. Right to data portability;
6. Right to restrict the use of data.

Consequently, the Working Group was also tasked with analyzing or determining how insurers were protecting these rights – either to comply with state or federal statutory or regulatory requirements, on their own initiative or through the adoption of voluntary standards. In 2021, the Working Group met ten times and the regulator only subject matter experts met nine times.

Prior to the 2021 Summer National Meeting, the Working Group focused on discussion of, and input on, the following key points from regulators, industry, and consumers for each of the six consumer privacy data rights noted above: definitions; examples; consumer risk/impact; current state and federal laws/rules; insurer/licensee impact; actions necessary/insurer obligations to minimize consumer harm; and recommendations. Suggestions that separate privacy requirements be established for each line of business were discussed, but there was consensus that this did not seem to be feasible, as different consumer data privacy requirements across lines of business would limit both consumer protections and understanding.

It was noted during Working Group discussions that insurers are increasingly utilizing third party vendors as sources of data collection and that such vendors may not be subject to regulation by state insurance departments. Regulators stated that the insurers they regulate bear the responsibility for compliance with state insurance privacy requirements. Insurers felt they could not be held responsible because they did not know how such vendors collected or used consumer data and had no way to control the vendors' business activities. Regulators and consumer representatives expressed different opinions indicating that insurers' contracts with such vendors could and should be written to require vendors and insurers maintain compliance with insurance regulations regarding consumer data privacy.

During the 2021 Summer National Meeting, NAIC members further recommended that the Working Group's discussion be expanded to include the issue of consumer data ownership.

Working Group discussions revealed that state insurance regulators and consumer representatives believe consumers own the data that is collected and used by the insurance industry to market, sell, and issue insurance policies. It was felt that the type of data collected (name, age, date of birth, height, weight, income, physical condition, personal habits, etc.) describes who a person is and distinguishes one person from another by its very nature. When a consumer shares their data with an insurance company, it is with the understanding that the consumer is letting the company borrow it for a time to determine what insurance rates and insurance coverage the consumer needs. The consumer is not giving up their data to an insurer so it can be sold or given to other organizations from whom the consumer is not seeking insurance coverage, or any other product. **Consumer**

representatives indicated that this practice had happened when they did an online search for insurance rates on health plans. As a result, the consumer representative received hundreds of cold calls from companies selling products other than insurance. When the consumer representative asked with whom the insurance company shared his data, the company sent him a list of 1,700 companies – none of which sold insurance. ~~[Trades ask to delete this portion or to make clear that it is opinion and being reported by consumer group but not verified. I do not agree with deleting.]~~

The Report in Appendix A is designed to be the foundation for the minimum consumer data privacy protections that are appropriate for the business of insurance to be applied to the NAIC models as revisions. It is intended to kick start the next step in creating revisions by defining the parameters of the existing consumer data privacy rights; ~~by suggesting definitions and by showing examples of consumer risks~~ **impact**. Further discussion is necessary, however, to clarify consumer data privacy rights that may not be fully protected in federal laws or fully covered under NAIC Model laws, and to decide how to provide appropriate protections.

VIII. Conclusion and Recommendations

Months of detailed discussions with regulator, industry, and consumer stakeholders, and the comments they have submitted, have led the Working Group to determine that the *NAIC Insurance Information and Privacy Protection Model Act (Model #670)* and the *Privacy of Consumer Financial and Health Information Regulation (Model #672)* have in the past provided an effective regulatory framework for consumer privacy protections to oversee and enforce consumer data privacy as required by state and federal statutes and regulation. ~~However, these~~ **These** models were adopted by the NAIC 20 and 40 years ago, respectively; with only 17 jurisdictions adopting Model #670.

However, in consideration of the many business developments and technological improvements that have occurred in recent years, as well as the rate of increase in the use of new technologies (AI, machine learning, accelerated underwriting, rating algorithms, etc.), and big data by insurers, the Working Group recommends **additional considerations of the ways** that Models #55, #670 and #672 **could** be amended to ensure that regulators **and legislators** can continue to **have a robust menu of options to** provide consumer data privacy protections essential to meet the consumer data privacy challenges presented by the public use of technology and data by insurers in today's business environment.

As a reminder, the standards established in these models, while not only being between 20 and 40 years old, are considered to be a 'floor,' they are basic requirements, and these requirements are not to be considered a 'ceiling' that limits future NAIC initiatives. As business practices and technological developments have progressed so too must the consumer, the industry and the regulator.

It is clear that with the proliferation of data and the use of such data by licensed entities, that insurance regulation needs to modernize to protect the consumer of unintended consequences of the use ownership and security of such data. It is the intention of this Working Group to recommend that either the NAIC models be reopened and revised, or a new Model Law be created concerning the 9 categories listed in this Report, including a focus on data ownership, data rights and data protections. The work product going forward can use the GDPR as a possible template, along with other recently enacted state laws, while keeping in mind federal laws that already protect consumers' data. Emphasis will be given to data transparency, customer control, customer access, data accuracy, and data ownership and portability as explained in Appendix A.

Subsequent to systemic and transparent decisions relating to Appendix A discussions and adoption of any model law changes, the Working Group also recommends the NAIC's *Market Regulation Handbook* and the *NAIC's IT Examiners' Handbook* be updated, as necessary, to provide guidance to state insurance regulators so they can verify insurers' compliance with the state's regulatory framework for consumer privacy protections.

Appendix A

National Association of Insurance Commissioners Report on Consumer Data Privacy Protections

By adhering to the same/similar intent behind the drafting of the NAIC's Principles on Artificial Intelligence, this Report also requests that all "... insurance companies and all persons or entities facilitating the business of insurance that play an active role" in the protection of and usage of consumer data ... promote, consider, monitor and uphold the principles as described in this Report.

This Report is intended to be a high-level report of the discussions and research conducted by the Privacy Protections (D) Working Group. The focus of our work was determining the minimum consumer data protections that are appropriate for the business of insurance. Once determinations were made, the Working Group discussed whether or not the current model laws are sufficient in order to continue protecting consumers and providing regulatory oversight, are revisions needed or does the Working Group need to draft a new model. This Report can be viewed as being similar to the Ai Principles in that it provides insight to regulatory expectations and serves as an outline for actions to be discussed ~~taken~~ going forward.

This Report only provides research information ~~guidance~~ to the Regulator and does not carry the weight of law or impose any legal liability. This guidance only ~~can serve~~ serves to inform state insurance departments and insurance companies of intended recommendations designed to address improvements needed for data privacy protections and to highlight issues needing further discussion.

Appendix B contains a list of resources relied upon during the pendency of this Working Group.

Because the business operations of insurance companies are dependent upon the collection and use of personal information and data, state insurance regulators have long understood the need to balance an insurance company's need to collect consumer information and data with the consumer's right to understand ~~limit~~ the collection and use of this data.

The NAIC adopted the *Insurance Information and Privacy Protection Model Act* (Model #670) in 1980 to establish standards for the collection, use and disclosure of information gathered in connection with insurance transactions. A key aspect of this model is that it establishes a regulatory framework for consumers to (1) ascertain what information is being or has been collected about them in connection with insurance transactions; (2) obtain access to such information for the purpose of verifying or disputing its accuracy; (3) limit the disclosure of information collected in connection with insurance transactions; and (4) obtain the reasons for any adverse underwriting decision. This regulatory framework is facilitated through a requirement that insurers or agents provide a written notice to all applicants and policyholders regarding the insurer's information practices.

The NAIC adopted the *Privacy of Consumer Financial and Health Information Model Regulation* (Model #672) in 2000. The model regulation was drafted to implement the requirements set forth in Title V of the federal *Gramm-Leach-Bliley Act* (P.L. 106-102) of 1999 (GLBA). GLBA imposed privacy and security standards on financial institutions and directed state insurance commissioners to adopt certain data privacy and data security regulations. The model also contains provisions governing protection of health information that were taken directly from the ~~Health Insurance Portability and Accountability Act (HIPAA)~~ Privacy Rule promulgated by HHS. The NAIC model regulation requires insurers to: (1) notify consumers about their privacy policies; (2) give consumers the opportunity to ~~prohibit~~ opt-out of the sharing of their ~~protected non-public~~ financial information with non-affiliated third parties; and (3) obtain affirmative consent from consumers before sharing ~~protected non-public personal~~ health information with any other parties, affiliates, and non-affiliates. The key difference between the treatment of financial information and health information is that insurers must give consumers the right (with limited exceptions) to “opt out” of the disclosure or sharing of their ~~non-public~~ financial information ~~to third-parties for the third party’s own business use~~, but insurers must get explicit authorization (“opt in”) before sharing health information ~~absent an applicable exception~~.

This ~~Report~~ addresses consumer data privacy protections of (1) transparency; (2) consumer control; (3) consumer access; (4) data accuracy; and (5) data ownership and portability. The ~~Report~~ intentionally excludes standards for data security and standards for the investigation and notification to an insurance commissioner of a licensed insurance entity’s cybersecurity event, ~~which since these issues~~ are the subject of separate model laws and interpretive guidance.

The following definitions are used for the purposes of this policy statement.

- A. “Adverse Decision” means declination of insurance coverage, termination of insurance coverage, charging a higher rate for insurance coverage, or denying a claim.
- B. “Consumer” means an individual who is seeking to obtain, obtaining, or have obtained a product or service from an insurer. For example, an individual who has submitted an application for insurance is a consumer of the company to which he or she has applied, as is an individual whose policy with the company has expired.
- C. “Customer” means a consumer with whom an insurer has an on-going relationship.
For purposes of this Report, customers are a subset of consumers, so there is no reason to reference “customer or consumer.”
- D. “Licensee” means any insurer, producer, or other person licensed or required to be licensed, or authorized or required to be authorized, or registered or required to be registered pursuant to a state insurance law.
For purposes of this Report, what is defined above in (D) is a “regulated entity,” however, the models have been using the term “licensee” so this Report will continue to use the more

familiar terminology.

- E. “Personal Information” means any individually identifiable information or data gathered in connection with an insurance transaction from which judgments can be made about an individual’s character, habits, avocations, finances, occupation, general reputation, credit, health, or any other personal characteristics. Personal information includes:
1. “Non-Public Personal Information,” which means information that a consumer provides to a licensee to obtain an insurance product or service (like income, credit history, name and address); information about a consumer a licensee has as a result of a transaction involving an insurance product or service (like premium payment history, how much a life insurance policy is worth, and the value of personal property insured); and all other information about a consumer that a licensee uses in connection with providing a product or service to a consumer.
 2. “Non-public personal health information,” which means any information that identifies a consumer in some way, and includes information about a consumer’s health, including past and present physical and mental health, details about health care, and payment for health care.

I. Transparency [Trades have a lot of comments; see ACLI pt 19]

It is recommended that a A licensee ~~should~~ provide a clear and conspicuous notice to consumers that accurately reflects its privacy policies and practices ~~when it first requests personal information about the consumer from the consumer or a third party.~~

It is recommended that a A licensee ~~should also~~ provide a periodic notice of its privacy policies and practices to customers ~~when substantive changes have occurred not less than annually~~ during the continuation of the customer relationship.

If a licensee makes an adverse decision based on information/data that was not supplied by the consumer, it is recommended that the licensee ~~should~~ provide the consumer with the specific reasons for the adverse decision. [Note: this standard is already a requirement – for declinations/nonrenewals the consumer is to be given the reason in such detail as to not require the need for further inquiry. Use Cons Rep example?]

**Going forward the WG types of issues to understand - would ensure all definitions, such as “on-going relationship,” consumer and customer are [copasetic]; company business operations are considered, record retention practices are understood, what happens to personal data/info when a person applies for but decides to not purchase a policy; when they cancel the policy; ensure the findings from the gap analysis have been addressed.

II. Consumer Control [Trades – change to Consumer Preference Default Mechanism]

It is recommended that A licensees ~~should~~, at a minimum, provide consumers the opportunity to ~~prohibit~~ limit the sharing of their non-public personal information with third parties, except for specific purposes required or specifically permitted by law. (Opt-Out)

It is recommended that A licensees ~~should~~ obtain affirmative consent from consumers before sharing non-public personal health information with any other entity, including its affiliates and non-affiliates. (Opt-In)

III. Consumer Access

It is recommended that A any consumer ~~should~~ have the ~~right~~ ability to submit a request to a licensee to obtain access to his/her personal information used by the licensee in its operations. Upon request, ~~within a specified period of time~~, the licensee ~~should within 30 business days~~ provides a copy of the consumer's personal information, an explanation on how the personal information was used (*i.e.*, rating, underwriting, claims), and provides the source of the personal information. If personal information is in coded form, the licensee ~~should would be expected to~~ provide an accurate translation in plain language.

IV. Data Accuracy

It is recommended that ~~W~~within a specified period of time, ~~30 business days~~ after receiving a ~~written~~ request from a consumer to correct, amend, or delete personal information ~~used by the licensee in its operations; within its possession~~ the licensee ~~should will~~ either make the requested correction, amendment, or deletion or notify the consumer of its refusal to do so, the reasons for the refusal, and the consumer's right to file a statement of dispute setting forth what the consumer thinks is the correct information and the reasons for disagreeing with the licensee.

If the licensee corrects, amends, or deletes personal information, the licensee should notify any person or entity that has received the prior personal information ~~within a specified period of time the last 7 years~~. If the licensee does not correct, amend, or delete the disputed personal information, the licensee should notify any person or entity that has received the prior personal information within ~~a specified period of time the last 7 years of the consumer's statement of dispute~~.

V. Data Ownership and Portability

A ~~consumer~~ ~~customer~~ should have the right to request a copy of his/her personal information that he/she has provided to the licensee for use in the licensee's operations. A licensee should provide a ~~consumer~~ ~~customer~~ a copy of his/her personal information ~~within a specified period of time~~ ~~30 business days~~ of the request. Examples of this type of personal information include telematics data and "Internet of Things" ("IoT") data.

[Pull information from minutes pertaining to category of data ownership, post Summer Nat'l Mtg]

Office of Research Integrity {ORI} within the DHHS - Data Ownership. Data ownership refers to both the possession of and responsibility for information. The control of information includes not just the ability to access, create, modify, package, derive benefit from, sell or remove data, but also the right to assign these access privileges to others.

Scofield (1998) suggest replacing the term 'ownership' with 'stewardship', "because it implies a broader responsibility where the user must consider the consequences of making changes over 'his' data."

National Institute of Standards and Technology (NIST) – Information owner – An official with statutory or operational authority for specified information and responsibility for establishing the controls for its generation, collection, processing, dissemination, and disposal.

Data ownership formalizes the role of data owners and establishes accountability, assigning responsibility for managing data from creation to consumption. It puts rules and processes in place to ensure that the right people define usage directives, set quality standards, and consistently resolve data issues.

- Are there other points in the CO, VA, or Calif. laws that we want to include here?

Appendix B – Version 3**National Association of Insurance Commissioners
Resources on Consumer Data Privacy Protections
Reviewed by the Privacy Protections (D) Working Group**

1. California Consumer Privacy Act (CCPA)
2. California Privacy Rights Act (CPRA)
3. Colorado Privacy Act (CPA)
4. General Data Protection Regulation (GDPR)
5. Health Insurance Portability and Accountability Act (HIPAA)
6. Gramm-Leach-Bliley Act (GLBA)
7. Federal Credit Reporting Act (FCRA)
8. NAIC Health Information Privacy Model Act #55
9. NAIC Insurance Data Security Model Act #668
10. NAIC Insurance Information and Privacy Protection Model Act #670
11. NAIC Privacy of Consumer Financial and Health Information Regulation #672
12. Virginia Consumer Data Protection Act (CDPA)
13. Troutman Analysis of Virginia Consumer Data Protection Act
14. Presentation by Dr. Karrol Kitt (The University of Texas at Austin) and Dr. Brenda J. Cude (University of Georgia) on the Additional Insurer Responsibility to Protect Consumer Data due to Consumers' Lack of Knowledge and Understanding of Privacy Risks
15. Presentation by Dr. Harold M. Ting (Consumer Healthcare Advocate) Exploring Results of His Secret Shopper Research and the Effects on the Privacy of Consumer Data
16. Nine Privacy Principles developed by Dr. Harold M. Ting (Consumer Healthcare Advocate)
17. Presentation by Clay McClure (Blue Cross Blue Shield Association) on the Need for Privacy Gap Analysis
18. Presentation by Damon Diedrich (CA) on California's Privacy Legislation (CCPA and CPRA)
19. Presentation by Katie Johnson (VA) on Virginia's Privacy Legislation
20. Abbreviated Data Privacy Legislation Chart 10.8.21 prepared by Jennifer McAdam (NAIC Legal)
21. State Privacy Law Comparison Chart 10.8.21 prepared by Jennifer McAdam (NAIC Legal)

22. Model #670 / CCPA Privacy Comparison prepared by Jennifer McAdam (NAIC Legal)
23. GLBA / HIPAA Privacy Comparison prepared by Jennifer McAdam (NAIC Legal)
24. 2021 NAIC Member Adopted Strategy for Consumer Privacy Protections provided by its parent committee, Market Regulation and Consumer Affairs (D) Committee, April 29, 2021
25. Privacy Briefing 2011.7.19 prepared by Jennifer McAdam and Lois Alexander
26. Final Exposure Draft Report to D Cmte on Privacy 11.18.21
27. First Working Group Exposure Draft of Privacy Policy Statement_082621.pdf
28. Comment Schedule for Draft Exposed 082621.pdf
29. MO670_041520_ExposureDraftTopics_with_042920_CommentsonSec1-9_rev082221.pdf
30. MO672_redline082221.pdf
31. Privacy Policy Statement Draft3 070121
32. Initial Privacy Policy Statement_Draft1_042821
33. **MO670_041520_Exposure Draft Topics**
34. *Uniform Personal Data Protection Act*
35. Baker Donelson Summary of Privacy Laws
36. Article by Barbara Kiviat, Stanford University, “Which Data Fairly Differentiate? American Views on the Use of Personal Data in Two Market Settings.” Sociological Science, published: January 13, 2021,

Summary:

In 2021, this working group had ten open calls between Mar. 29 and Nov. 22, 2021.

The Regulator-Only Subject Matter Experts had eight calls.

The Working Group heard eight presentations as well as Federal and State Legislative Updates at seven meetings in 2021:

1. Karrol Kitt (NAIC Consumer Representative)
2. Brenda Cude (NAIC Consumer Representative)
3. Harry Ting (NAIC Consumer Representative)
4. Clay McClure, BCBSA
5. Damon Diederich (CA)
6. Katie Johnson (VA)
7. Model #670 / CCPA Privacy Comparison by Jennifer McAdam (NAIC)
8. GLBA / HIPAA Privacy Comparison by Jennifer McAdam (NAIC)
9. Federal Legislative Updates at most open meetings by Brooke Stringer (NAIC)
10. State Legislative Updates at most open meetings by Jennifer McAdam (NAIC)
 - a. Abbreviated Data Privacy Legislation Chart
 - b. State Privacy Law Comparison Chart

Four NAIC Models were reviewed:

1. NAIC Health Information Privacy Model Act #55
2. NAIC Insurance Data Security Model Act #668
3. NAIC Insurance Information and Privacy Protection Model Act #670
4. NAIC Privacy of Consumer Financial and Health Information Regulation #672

State Laws reviewed:

1. California Consumer Privacy Act (CCPA)
2. California Privacy Rights Act (CPRA)
3. Colorado Privacy Act (CPA)
4. Virginia Consumer Data Protection Act (CDPA)

Federal Laws reviewed:

1. Health Insurance Portability and Accountability Act (HIPAA)
2. Gramm-Leach-Bliley Act (GLBA)
3. Federal Credit Reporting Act (FCRA)

Reviewed the European Union's General Data Protection Regulation (GDPR)

Drafts (All with Privacy Policy Statement in their titles) were exposed and posted for comment on:

1. April 28, 2021
2. July 1, 2021
3. August 26, 2021

The Final Exposure Draft Report (which included the Privacy Policy Statement as Appendix A) was exposed and posted for comment on November 18, 2021.