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 it 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 it 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 Godfread 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: 11/17/21
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 a group's 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.)*

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)
SalePrc	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		2nd 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]
ClmClDt	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 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 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 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 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 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 (*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 *(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 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 17

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 17

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 documented, created, 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 *(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, *(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, *(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 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 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 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 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 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 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 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 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 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 *(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 though 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 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 *(hyphens removed from up to date)*.

STANDARDS
NETWORK ADEQUACY

Standard 5
The company executes with each participating provider 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 *(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 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 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 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 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 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 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 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 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 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 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

_____ 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.