

6/3/22

Virtual Meeting

MARKET CONDUCT EXAMINATION GUIDELINES (D) WORKING GROUP

Thursday, June 9, 2022

12:00 – 1:00 p.m. ET / 11:00 a.m. – 12:00 p.m. CT / 10:00 – 11:00 a.m. MT / 9:00 – 10:00 a.m. PT

ROLL CALL

Damion Hughes, Chair	Colorado	Leatrice Geckler	New Mexico
Erica Weyhenmeyer, Vice Chair	Illinois	Sylvia Lawson	New York
Maria Ailor	Arizona	Teresa Knowles	North Carolina
Crystal Phelps/Teri Ann Mecca	Arkansas	Todd Oberholtzer	Ohio
Kurt Swan	Connecticut	Landon Hubbard	Oklahoma
Frank Pyle	Delaware	Brian Fordham/ Tashia Sizemore	Oregon
Sharon Shipp	District of Columbia	Gary Jones/ Paul Townsen	Pennsylvania
Elizabeth Nunes/ Paula Shamburger	Georgia	Matt Gendron/ Brett Bache	Rhode Island
Doug Ommen	Iowa	Matthew Tarpley	Texas
Ron Kreiter	Kentucky	Tanji J. Northrup/ Shelley Wiseman	Utah
Mary Lou Moran	Massachusetts	Karla Nuisl	Vermont
Jeff Hayden	Michigan	Julie Fairbanks	Virginia
Paul Hanson	Minnesota	Jeanette Plitt	Washington
Win Nickens/Jo LeDuc	Missouri	Desiree Mauller	West Virginia
Peggy Willard-Ross/ Hermoliva Abejar	Nevada	Rebecca Rebholz/ Diane Dambach	Wisconsin
Maureen Belanger/ Edwin Pugsley	New Hampshire		
Ralph Boeckman	New Jersey		

NAIC Support Staff: Petra Wallace/Lois E. Alexander

AGENDA

1. Consider Adoption of its April 21 Minutes—*Damion Hughes (CO)* Attachment 1
2. Review and Discuss Revisions to Chapter 20—General Examination Standards of the *Market Regulation Handbook*, Oct. 27, 2021, Draft—*Ron Kreiter (KY)* Attachment 2
 - A. ACLI May 18 Comments
3. Review and Discuss Revisions to Chapter 23—Conducting the Life and Annuity Examination of the *Market Regulation Handbook*, April 19 Draft—*Brian Werbeloff (RI)* Attachment 3
 - A. Virginia May 25 Comments
 - B. Missouri May 27 Comments

- C. Insured Retirement Institute (IRI) May 27 Comments

- 4. Review and Discuss Revisions to Chapter 24B—Conducting the Mental Health Parity and Addiction Equity Act (MHPAEA)-Related Examination of the *Market Regulation Handbook*, April 19 Draft—*Erica Weyhenmeyer (IL)* Attachment 4
 - A. Wisconsin May 25 Comments
 - B. Missouri May 27 Comments
 - C. Virginia May 27 Comments
 - D. America’s Health Insurance Plans (AHIP) May 27 Comments
 - E. Association for Behavioral Health and Wellness (ABHW) May 27 Comments
 - F. Blue Cross Blue Shield Association (BCBSA) May 27 Comments

- 5. Discuss Any Other Matters Brought Before the Working Group
—*Damion Hughes (CO)*

- 6. Adjournment

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

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

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

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

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

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

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

Ms. Weyhenmeyer, vice chair of the Working Group and chair of the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group, said the Market Conduct Examination Guidelines (D) Working Group had been asked to review and update the chapter. The April 19 exposure draft was developed under the guidance of the MHPAEA (B) Working Group, as that is where the subject matter experts (SMEs) in this area reside. Ms. Weyhenmeyer said the exposure draft is before the Market Conduct Examination Guidelines (D) Working Group for review and comment, so the guidance therein can be organized and further developed in a market conduct examination-related context. The comment due date on the draft is May 20.

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

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

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

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

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

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

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

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

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

Shield Association (BCBSA) on April 15. These comments were circulated to the Working Group, interested state insurance regulators, and interested parties on April 19.

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

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

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

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

She then recommended replacing it with:

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

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

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

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

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

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

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

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

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

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

In reviewing the capital calculation, resulting group capital ratio, and liquidity stress test performed by the assigned financial analyst of the financial lead state, note the risks identified by the assigned financial analyst and determine if the risks are directly or indirectly affecting policyholders and whether risk mitigations in place are also documented by the assigned financial analysts. If they are directly affecting policyholders of a company within the holding company system that is currently under market conduct examination, determine if the risk is imminent. If it is, determine the extent of injury to the policyholders. If the documented risk mitigations do not resolve the market conduct risks, request additional information from the company being examined.

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

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

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

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

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

5. Discussed Other Matters

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

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

Chapter 20—General Examination Standards

The examination of the insurance operations of a regulated entity may involve reviewing one or more of the following business areas:

- A. Operations/Management
- B. Complaint Handling
- C. Marketing and Sales
- D. Producer Licensing
- E. Policyholder Service
- F. Underwriting and Rating
- G. Claims

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

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

This chapter contains examination standards that are relevant to nearly all types of examinations. Chapters 21 through 32 contain standards that are specific to various product lines and specialized entities.

A. Operations/Management

1. Purpose

The Operations/Management portion of the examination is designed to provide a view of what the regulated entity is and how it operates. It is not based on sampling techniques; it is more concerned with structure. This review is not intended to duplicate a financial examination review, but is important in providing the market conduct examiner with an understanding of the examinee. Many troubled companies have become so because management has not been structured to recognize and address the problems that can arise in the insurance industry. The areas to be considered in this kind of review include:

- a. History;
- b. Profile;
- c. Subcontractor oversight;
- d. Internal audits;
- e. Antifraud initiatives;
- f. Certificates of authority;
- g. Disaster recovery plan;
- h. Computer systems;
- i. Minutes from all meetings attended by the board of directors; and
- j. Privacy.

2. Techniques

Typically, the items to be reviewed here can be prepared by the regulated entity and provided at the pre-examination conference. Supplemental information, including history and profile may be available in the insurance department files. Other items suggest an active review of regulated entity files relating to managing general agent (MGA) or subcontractor oversight, internal audits, procedure manuals, record management, computer systems controls and antifraud plans. The latter category of items should have substantial supporting documentation.

The absence of subcontractor oversight, internal audit functions, written procedures or an antifraud plan should be specifically noted when preparing the examination report.

a. History

The examiner should prepare for the examination report a very brief history of the regulated entity, including its formation; its type; its structure, including the parent corporation and other members of the group; and any major changes that are relevant to the current examination.

b. Profile

The profile includes an overview of the regulated entity's operations, including management structure, type of carrier, states where the regulated entity is licensed and the entity's major line(s) of business. A total change in the management team may generate the need to review the regulated entity on an abbreviated time cycle.

The examiner should review Market Action Tracking System (MATS) findings from prior examinations, Regulatory Information Retrieval System (RIRS) results, complaint index reports and reports from other NAIC applications and databases to determine if other regulators have expressed concerns that may require additional attention during the examination. RIRS and MATS information should not be included in the examination report.

The total written premiums for the major lines of business should be compared to the total writing in a given state to determine the market share. The loss, expense and combined ratios can be obtained from the expense exhibit attached to the annual statement or the NAIC Financial Analyst Workbench (FAW) system and may be calculated for the specific jurisdiction. Review IRIS ratios, which can be an indicator of market conduct problems. The surplus ratio should also be examined and noted for the period under review. Substantial shifts in the geographical area of operation and kinds of business written and volume should be noted, questioned and described.

c. Subcontractor Oversight

The jurisdiction's statutes on MGAs and other subcontractors are sources of tests for this oversight. The aim is to ensure that a regulated entity using subcontractors engages in a realistic level of oversight. Contracts should be reviewed to ensure compliance with the MGA statutes governing contract content and oversight features. The focus is on the oversight impacting records and actions considered in a market conduct examination such as, but not limited to, trade practices, claims practices, policy selection and issuance, rating, complaint handling, etc. Examiners should pay particular attention to a subcontractor's dealings with policyholders and claimants.

d. Internal Audits

A regulated entity that has no internal audit function lacks the ready means to detect structural problems until after problems have occurred. Any questionable findings about the internal audit function should be referred to the Examiner-in-Charge.

e. Antifraud Plans

The regulated entity should have antifraud plans which are reasonably calculated to detect, prosecute and prevent fraudulent insurance acts. Written procedural manuals or guides and antifraud plans should provide sufficient detail to enable employees to perform their functions in accordance with the goals and direction of management. In addition, insurers may be required by law to establish antifraud plans, and examiners should be aware of any state-specific legal requirements pertaining to antifraud measures.

The guidelines set forth in the *Antifraud Plan Guideline* (#1690), adopted by the NAIC in March 2011, are intended to provide a road map for state fraud bureaus, insurers' Special Investigative Units (SIU)s or contracted SIU vendors for preparation of an antifraud plan.

Flexibility should be allowed for each insurer to develop a plan that meets its individual needs and still meet state compliance standards. The *Antifraud Plan Guideline* does not preempt other state laws or preempt or amend any guidance previously published by the NAIC Antifraud (D) Task Force or in the *Fraud Prevention Model Act* (#680).

f. Certificates of Authority

The examiner should determine if the regulated entity's operations conform with the regulated entity's certificates of authority.

g. Disaster Recovery Plan

It is essential that the regulated entity has a formalized disaster recovery plan that will detail procedures for continuing operations in the event of any type of disaster. The examiners should determine if the regulated entity maintains separate backups of all records and facilities to continue operations.

h. Computer Systems

The examiners should determine the types of controls, safeguards and procedures for protecting the integrity of the computer information. The focus in this case is on those records subject to a market conduct examination that are maintained in electronic format, such as, but not limited to, underwriting files, claim files, rate and form filings, complaint files, statistical data used to support rates, etc.

The regulated entity should identify the location(s) of all websites maintained by or for and authorized by the regulated entity and all approved producer sites.

In addition, an Internet search using the regulated entity's name should be conducted using a search engine such as Yahoo, Google or a metasearch (aggregator) search engine such as WebCrawler. If any additional sites are located that the regulated entity did not identify, it should be specifically noted when preparing the examination report. The examiner should be mindful that some searches may produce a large volume of "hits." In such a situation, the examiner should employ sampling techniques to determine the regulated entity's general practices on the Internet.

i. Minutes from All Meetings Attended by the Board of Directors

A review of the minutes of meetings with the board of directors should be conducted to ensure the board has proper oversight of the company's operations and activities. Note: When a credit company is the subject of an examination, examiners should be aware that there may be statutes, rules, and regulations with specific requirements regarding the organization and structure of credit organizations.

j. Privacy

The NAIC has adopted several sets of privacy requirements, and examiners will need to determine which requirement(s) the state imposes to conduct an examination. The first is the *NAIC Insurance Information and Privacy Protection Model Act* (#670) (hereinafter, the 1982 Model Act). The second NAIC approach was the *Health Information Privacy Model Act* (#55), which, according to NAIC records, as of April 2015 had not been adopted by any state, although a few states have related laws.

The NAIC then adopted a model titled *Privacy of Consumer Financial and Health Information Regulation* (#672) (hereinafter, the 2000 Model Privacy Regulation) to assist states with promulgation of regulations to comply with certain requirements of Title V of the federal Gramm-Leach-Bliley Act (GLBA) (PL 102-106), enacted by Congress in 1999. And, in 2002, the *Standards for Safeguarding Customer Information Model Regulation* (#673) (hereinafter, the 2002 Model Information Security Regulation) was adopted to assist states in establishing standards for development and implementation of safeguards by insurers to protect customer information, also required by Title V of GLBA.

In some cases, a state may have one or more of these measures, or a combination thereof, in force. NAIC records indicate that as of April 2015, 39 states plus the District of Columbia and Puerto Rico have enacted regulations/laws based on the 2000 Model Privacy Regulation.

1982 Model Act (#670)

The 1982 Model Act is focused primarily on the insurance application process, underwriting, policy issuance and related transactions. It requires various disclosures to applicants regarding the insurer's practices (e.g., that an investigative consumer report may be obtained and that information may be disclosed to insurance support organizations which, in turn, may retain and later re-disclose the information to others) and the applicant's rights (e.g., that the applicant has a right to obtain a copy of any investigative consumer report and that the applicant has the rights of access to and correction of information about him/her).

Notices providing these disclosures may be required at application and whenever there is a "change of status"—e.g., at renewal or reinstatement—if new or additional information is to be collected from a source other than the applicant. There is no requirement for annual notices. If an insurer intends to disclose information for the marketing of a product or service, the customer must be given an opportunity to opt out. Operations/Management Examination Standards #10 and #11 in this chapter are applicable only for those states that have enacted the 1982 Model Act or substantially similar privacy requirements.

2000 Model Privacy Regulation (#672)

The 2000 Model Privacy Regulation was adopted to implement certain privacy provisions of the Gramm-Leach-Bliley Act. Title V of GLBA addressed the confidentiality of information about customers of "financial institutions," a term that includes insurance companies, banks and depository institutions, broker-dealers, investment companies, registered investment advisors and a variety of other kinds of businesses. Title V, as further implemented by the 2000 Model Privacy Regulation, requires that financial institutions establish and implement a privacy policy and

provide notices to customers describing such policies and the customer's rights to opt out of disclosures other than those allowed by the exceptions in Sections 14 through 16 (Section 17B of the 2000 Model Privacy Regulation sets forth exceptions for the customer authorization requirement for certain health information disclosures). The adoption of regulations and guidelines was delegated to the functional regulators of the various financial institutions.

The federal functional regulators (including, among others, the Securities and Exchange Commission, the Office of the Comptroller of Currency and the Federal Trade Commission) and the NAIC have taken substantially similar positions in their regulations regarding the disclosure of customer personal information and notices. The federal regulations are nearly identical to each other, with very minor differences to reflect the different financial products and services involved and related business practices. The 2000 Model Privacy Regulation is very similar to the federal regulations with respect to the treatment of financial information, with appropriate changes for insurance products and services, as well as established business practices and relationships.

The notices required by the 2000 Model Privacy Regulation include initial, revised and annual privacy notices, which must reflect the privacy policy, including financial information disclosure practices, of the insurance regulated entity or other licensee. It should be noted that privacy policies differ from insurer to insurer, from insurer to other licensee, etc. There is no set format required for privacy notices, although they must be "clear and conspicuous" as that term is defined in the regulation. The regulation does, however, list the topics that the privacy notice must address. Since a privacy notice reflects a specific insurer's or other licensee's own particular financial information privacy practices, notices will legitimately differ.

The 2000 Model Privacy Regulation differs from the federal agency regulations in that the model includes protections for certain health information. In general, a licensee must get an individual's approval (opt-in) prior to disclosing nonpublic personal health information, unless the disclosure falls under an exception listed in Subsection 17B or the licensee is in compliance with the health privacy regulation promulgated by the U.S. Department of Health and Human Services (HHS) pursuant to the federal Health Information Portability and Accountability Act (HIPAA). Even if the licensee is not subject to HIPAA, the 2000 Model Privacy Regulation allows the option of complying with the HHS standards as an alternative to the NAIC standards.

Operations/Management Examination Standards #12, #13, #14, #15 and #16 in this chapter are applicable for examination of compliance with the 2000 Model Privacy Regulation regarding the disclosure of customer information.

2002 Model Information Security Regulation (#673)

The 2002 Model Information Security Regulation was adopted to establish standards regarding safeguarding of customer information, also required by Title V of GLBA. It should be noted that the 2002 Model Information Security Regulation requires that a licensee establish an information security program "appropriate to the size and complexity of the licensee," as well as appropriate to the "nature and scope of (the licensee's) activities." The regulation provides illustrative examples of various factors that a licensee may consider when developing its information security program. Operations/Management Examination Standard #17 in this chapter is applicable for examination of compliance with the 2002 Model Information Security Regulation for security standards.

Insurance Data Security Model Law (#668)

Operations/Management Examination Standard #17 in this chapter is also applicable for examination of compliance with the *Insurance Data Security Model Law* (#668). Note: When reviewing a regulated entity's information security program for compliance with applicable state statutes, rules or regulations relating to Model #668, in the absence of a "Cybersecurity Event," as defined in applicable state statutes, rules or regulations, please refer to the Insurance Data

Security Pre-Breach Checklist found in the Reference Documents of the *Market Regulation Handbook*. Regulators may access Reference Documents on StateNet at the link Market Regulation Handbook, Handbook Updates and Reference Documents. Non-regulators may access Reference Documents via their login credentials on NAIC Account Manager at https://www.naic.org/account_manager.htm.

When reviewing a regulated entity’s information security program and response to a “Cybersecurity Event” for compliance with applicable state statutes, rules or regulations relating to the *Insurance Data Security Model Law* (Model #668), after a Cybersecurity Event has occurred, as defined in applicable state statutes, rules or regulations, please refer to the Insurance Data Security Post-Breach Checklist provided as Addendum A to Operations/Management Examination Standard 17 in this chapter.

3. Tests and Standards

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

DRAFT

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 1

The regulated entity has an up-to-date, valid internal or external audit program.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Audit plan and regulated entities' procedural manuals
- _____ Audit reports and results

Others Reviewed

- _____
- _____

NAIC Model References

Consumer Credit Insurance Model Regulation (#370), Section 12
Model Regulation to Require Reporting of Statistical Data by Property and Casualty Insurance Companies
(#751), Section 11
Best Practices Organizations White Paper
[*Insurance Holding Company System Regulatory Model Act \(#440\)*](#)

Review Procedures and Criteria

Review audit reports to determine if the function is providing meaningful information to management. If external, obtain an explanation.

Determine how management is using the reports.

Determine if the regulated entity responds to internal audit recommendations to correct, modify and implement procedures.

Determine if accuracy of internal statistical data and information systems is periodically tested by the regulated entity's audit program.

Determine if the regulated entity conducts periodic reviews of creditors with respect to their credit insurance business with such creditors.

Determine if the regulated entity has adopted edit and audit procedures to screen and check data submitted by the regulated entity's statistical agent.

[Determine if the NAIC Liquidity Stress Test Framework needs to be utilized for a specified data year.](#)

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

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

Note: The examiner should be mindful of the proprietary nature of internal audit reports. Administrative action should not be recommended by the examiner based on results of internal audit findings for which the regulated entity has taken appropriate corrective action.

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**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 2

The regulated entity has appropriate controls, safeguards and procedures for protecting the integrity of computer information.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Electronic records control, recovery/backup plan and regulated entity's procedural manuals; whether the records are electronic

_____ Negotiated contracts

Others Reviewed

NAIC Model References

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

Health Information Privacy Model Act (#55)

Standards for Safeguarding Consumer Information Model Regulation (#673)

Review Procedures and Criteria

Review regulated entity records, central recovery and backup procedures. The plan and procedures should be valid and up-to-date.

Review computer security procedures.

If the regulated entity permits changes to be made to policies either electronically or verbally, check what security procedures the regulated entity has established to permit these changes. These may include who has authority to make those changes, and what verification is done by the regulated entity with the insured after changes are made.

Ensure there is adequate security of applicant/insured data during the electronic transference of information. Identify any areas where the applicant's/insured's privacy is not properly protected.

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 3

The regulated entity has antifraud initiatives in place that are reasonably calculated to detect, prosecute and prevent fraudulent insurance acts.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity antifraud plan and procedural manuals

Others Reviewed

NAIC Model References

Insurance Fraud Prevention Model Act (#680)

Antifraud Plan Guideline (#1690)

Stranger-Originated Annuity Transactions (STOA) NAIC Sample Bulletin

Review Procedures and Criteria

Review the regulated entity's antifraud initiatives in conjunction with applicable statutory requirements. Antifraud initiatives may include fraud investigators, who may be insurer employees or independent contractors, and an antifraud plan.

Verify that the insurer, if required by applicable state statutes, rules and regulations, submits its antifraud plan to the insurance commissioner:

- Within ninety days of receiving a certificate of authority;
- Every five years thereafter; and
- Within thirty days of a material change made to the antifraud plan.

Determine if the plan is adequate, up-to-date and in compliance with statutes, rules and regulations.

Review the regulated entity's implementation (staffing, support, etc.) of its plan and, if necessary, discuss with management.

Note: An SIU antifraud plan may cover several insurer entities within a regulated entity, if one SIU has the fraud investigation mission for all entities.

Verify that the insurer's antifraud plan includes the following five sections:

1. General Requirements

- An acknowledgment that the SIU has established criteria that will be used for the investigation of acts of suspected insurance fraud relating to the different types of insurance offered by that insurer;
- An acknowledgement that the insurer or SIU shall record the date that suspected fraudulent activity is detected, and shall record the date that reports of such suspected insurance fraud were sent directly to the insurance department or other applicable state regulatory agency within a specific time frame;
- A provision stating whether the SIU is an internal unit or an external or third-party unit;
- If the SIU is an internal unit, provide a description of whether the unit is part of the insurer's claims or underwriting departments, or whether it is separate from such departments;
- A written description or chart outlining the organizational arrangement of the insurer's antifraud positions responsible for the investigation and reporting of possible fraudulent insurance acts:
 - If the SIU is an internal unit, the insurer shall provide general contact information for the company's SIU;
 - If the SIU is an external unit, the insurer shall provide (1) the name of the company or companies used; (2) contact information for the company; and (3) a company organizational chart. The insurer shall specify the person or position at the insurer responsible for maintaining contact with the external SIU company; and
 - If an external SIU is employed for purposes of surveillance, the insurer shall include a description of the policies and procedures implemented;
- A provision where the insurer provides the appropriate NAIC individual and group code numbers;
- A statement as to whether the insurer has implemented a fraud awareness or outreach program. If the insurer has an awareness or outreach program, a brief description of the program shall be included; and
- If the SIU is a third-party unit, a description of the insurer's policies and procedures for ensuring that the third-party unit fulfills its contractual obligations to the insurer and a copy of the contract with the third-party vendor.

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

2. Prevention, Detection and Investigation of Fraud

- A description of the insurer's corporate policies for preventing fraudulent insurance acts by its policyholders;
- A description of the insurer's established fraud detection procedures (i.e. technology and other detection procedures);
- A description of the internal referral criteria used in reporting suspicious claims of insurance fraud for investigation by the SIU;
- A description of the SIU investigation program (i.e. by business line, external form claims adjustment, vendor management Statement of Positions (SOPs); and
- A description of the insurer's policies and procedures for referring suspicious or fraudulent activity from its claims or underwriting departments to the SIU.

3. Reporting of Fraud

- A description of the insurer's reporting procedures for the mandatory reporting of possible fraudulent insurance acts to the insurance commissioner or applicable state regulatory agency pursuant to applicable state statutes, rules and regulations;

- A description of the insurer's criteria or threshold for reporting fraud to the insurance commissioner; and
- A description of the insurer's means of submission of suspected fraud reports to the insurance commissioner (e.g., the NAIC Online Fraud Reporting System (OFRS), National Insurance Crime Bureau (NICB), National Health Care Anti-Fraud Association (NHCAA), electronic state system or other).

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

Note: The examiner should be aware of any applicable state statutes, rules and regulations regarding state antifraud mandatory reporting methods.

4. Education and Training

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

5. Internal Fraud Detection and Prevention

- A description of insurer's internal fraud detection policy for employees, consultants or others, such as underwriters, claims representatives, appointed agents, etc.; and
- A description of the insurer's internal fraud reporting system.

Determine if the regulated entity has procedures in place to prevent persons convicted of a felony involving dishonesty or breach of trust from participating in the business of insurance.

Determine if the regulated entity has procedures in place to provide information regarding fraudulent insurance acts to the insurance commissioner and in a manner prescribed by the insurance commissioner.

Examiners may wish to remind insurers that sell annuities of the existence of the *Stranger-Originated Annuity Transactions (STOA) NAIC Sample Bulletin* because sales of stranger-originated annuities may be an indicator of potentially fraudulent transactions.

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 4
The regulated entity has a valid disaster recovery plan.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Description of the regulated entity’s disaster recovery plan, procedural manuals and controls
- _____ Description of protective devices for various hazards and procedures/controls for protection from those hazards
- _____ Negotiated contracts

Others Reviewed

- _____
- _____

NAIC Model References

Market Conduct Record Retention and Production Model Regulation (#910)

Review Procedures and Criteria

Determine that the regulated entity’s database(s) are protected from various hazards, including environmental hazards.

Review the regulated entity’s documents. Any additional areas or lack of information should be discussed with the regulated entity’s management. The disaster recovery plan should be valid, specific and operational, with procedures for implementation and should also be current. Failure of the regulated entity to adequately plan for the future means the standard was not met.

Failure of the regulated entity to adequately (on an ongoing basis) provide for off-site backup, failure of the regulated entity to provide adequate controls and, in the case of a catastrophe, failure to provide for recovery, means the standard was not met.

Operations/Management Examination Standard #2 in this chapter also addresses disaster recovery issues.

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 5

Contracts between the regulated entity and entities assuming a business function or acting on behalf of the regulated entity, such as, but not limited to, managing general agents (MGAs), general agents (GAs), third-party administrators (TPAs) and management agreements, must comply with applicable licensing requirements, statutes, rules and regulations.

Apply to All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Contracts

Others Reviewed

NAIC Model References

Service Contracts Model Act (#685)

Managing General Agents Act (#225)

Registration and Regulation of Third-Party Administrators, An NAIC Guideline (#1090)

Third Party Administrator Statute (#90)

Review Procedures and Criteria

Review the contract to determine compliance with state statutes and rules.

The contract should specify the responsibilities of the subcontractor regarding recordkeeping and responsibilities of the regulated entity for conducting audits.

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 6

The regulated entity is adequately monitoring the activities of any entity that contractually assumes a business function or is acting on behalf of the regulated entity.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Contracts

_____ Audit reports

Others Reviewed

NAIC Model References

Managing General Agents Act (#225), Section 5
Registration and Regulation of Third-Party Administrators, An NAIC Guideline (#1090)
Third Party Administrator Statute (#90), Section 6
Consumer Credit Insurance Model Regulation (#370), Section 12
Variable Life Insurance Model Regulation (#270)

Review Procedures and Criteria

Entities can include an MGA, GA or TPA. Suppliers of consulting, investment, administrative, sales, marketing, custodial or other services with respect to variable life insurance operations are also considered entities (*Variable Life Insurance Model Regulation (#270), Section 3E*).

Review entity contracts to determine compliance with statutes, rules and regulations. The contract should specify the responsibilities of the MGA, GA and TPA concerning recordkeeping and responsibilities of the regulated entity for conducting audits.

Review audit reports to determine whether the regulated entity is adequately monitoring the activities of the contracted entity.

Review activities of entities to ensure compliance with applicable statutes and rules.

For credit insurance, each insurer is responsible for conducting a thorough periodic review of creditors with respect to their credit insurance business. The review should ensure compliance with statutes, rules and regulations. Written records of the reviews must be maintained by the insurer.

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 7

Records are adequate, accessible, consistent and orderly and comply with state record retention requirements.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ All records, files and documents

Others Reviewed

NAIC Model References

Model Regulation for Complaint Records to be Maintained Pursuant to the NAIC Unfair Trade Practices Act (#884)

Market Conduct Record Retention and Production Model Regulation (#910)

Unfair Claims Settlement Practices Act (#900)

Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)

Model Law on Examinations (#390), Section 4

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

The Use of Social Media in Insurance White Paper

Review Procedures and Criteria

Evaluate the orderly organization, legibility and structure of files.

Review state record retention requirements to determine regulated entity compliance.

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 8

The regulated entity is licensed for the lines of business that are being written.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Certificate of authority or other similar documents
- _____ Access NAIC financial system
- _____ Regulated entity system

Others Reviewed

NAIC Model References

- Service Contracts Model Act (#685)*
- Nonadmitted Insurance Model Act (#870)*
- Unauthorized Transaction of Insurance Criminal Model Act (#890)*

Review Procedures and Criteria

Review certificates of authority; compare writings with authorized lines.

Review financial annual statement submitted to the NAIC; compare writings with authorized states.

Obtain explanation of any discrepancies.

Access regulated entity system to verify that writings are in line with written premium reported in the financial annual statement.

Automation Tip:

The Financial Applications section of NAIC iSite+ contains the annual statement financial information for insurance companies that report to the NAIC. The most useful for market conduct examiners would be the annual statement Pick-a-Page. The State Page Exhibit displays the direct written premiums in any particular state for any particular year.

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 9

The regulated entity cooperates on a timely basis with examiners performing the examinations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations, especially insurance examination law

_____ All records, files and documents

Others Reviewed

NAIC Model References

Model Law on Examinations (#390)

Review Procedures and Criteria

Monitor regulated entity's cooperation during the course of the examination; this may be noted in the examination report.

Automation Tip:

Requests for information or "crits" can be monitored using either a database or spreadsheet. The information that should be captured includes: area of review, type of request, contact person, date given, date due and date received. Databases and spreadsheets contain functions that will calculate the number of days between two dates. The information can be easily sorted and reviewed to see what is still outstanding and if the regulated entity is responding in a timely fashion.

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 10

The regulated entity has procedures for the collection, use and disclosure of information gathered in connection with insurance transactions so as to minimize any improper intrusion into the privacy of applicants and policyholders.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Written procedures of regulated entity for maintaining personal information and privileged information of applicants and policyholders
- _____ The “Notice of Information Practices” required to be provided to applicants and policyholders
- _____ Disclosure authorization forms
- _____ Written procedures for the correction, amendment or deletion of recorded personal information

Others Reviewed

- _____
- _____

NAIC Model References

- NAIC Insurance Information and Privacy Protection Model Act (#670)*
- Health Information Privacy Model Act (#55)*
- Unfair Discrimination Against Subjects of Abuse in Property and Casualty Insurance Model Act (#898)*
- Unfair Discrimination Against Subjects of Abuse in Life Insurance Model Act (#896)*
- Unfair Discrimination Against Subjects of Abuse in Health Benefit Plans Model Act (#895)*
- The Use of Social Media in Insurance White Paper*

Review Procedures and Criteria

Determine if the regulated entity appropriately provides a “notice of information practices” that contains the required information.

Determine if the content of disclosure authorization forms meet content standards.

Determine if the regulated entity properly handles the use of investigative consumer reports.

Determine if the regulated entity’s procedures appropriately limit access to personal information.

Determine if the regulated entity provides specific and accurate reasons for adverse underwriting decisions.

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 11

The regulated entity has developed and implemented written policies, standards and procedures for the management of insurance information.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity procedure manual

_____ Regulated entity training manual

_____ Internal regulated entity claim audit procedures

_____ Regulated entity bulletins regarding insurance information

_____ Contractual arrangements between the carrier and a person other than the covered person

Others Reviewed

NAIC Model References

Health Information Privacy Model Act (#55), Section 5

NAIC Insurance Information and Privacy Protection Model Act (#670), Sections 4-9

Review Procedures and Criteria

Review regulated entity procedures, training manuals and claim bulletins to determine if regulated entity standards exist and whether standards comply with state law.

Review contractual arrangements between the regulated entity and other persons to determine if the contracts address privacy procedures and standards for the person with whom the regulated entity is contracting.

Review the regulated entity's methods for handling, disclosing, storing and disposing of insurance information. The examiners should determine whether there are procedures in place to ensure proper authorization is obtained prior to disclosure of insurance information.

Review the regulated entity's training manual to determine whether the regulated entity's employees are properly trained on the handling of insurance information.

Verify that the regulated entity provides a "Notice of Information Practices" to all applicants or policyholders or has procedures in place for the producer to deliver the notice. The examiner should determine whether the notice contains all provisions required by applicable state law.

Verify that the regulated entity specifies those questions designed to obtain information solely for marketing or research purposes.

Verify that the regulated entity has implemented reasonable procedures to address investigative consumer reports and personal interviews.

Verify that the regulated entity has established procedures to address access to, correction, amendment or deletion of recorded personal information.

DRAFT

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 12

The regulated entity has policies and procedures to protect the privacy of nonpublic personal information relating to its customers, former customers and consumers that are not customers.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity privacy policies and procedures
- _____ Other regulated entity manuals/instruction books
- _____ Communication provided by the regulated entity to employees and producers subject to the regulated entity’s privacy policies
- _____ Prior to conducting an examination, the examiner should review the state’s definition of “customer” and “consumer” to determine appropriate usage of the terms. The examiner should also review the various exceptions and exclusions contained in the state’s privacy act/regulation.

Others Reviewed

- _____ _____
- _____ _____

NAIC Model References

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

Review Procedures and Criteria

Review the regulated entity’s policies, practices and procedures regarding protection and disclosure of nonpublic personal information of customers, former customers and consumers who are not customers, to verify that they comply with applicable state laws regarding privacy.

Review employee procedures regarding the treatment of nonpublic personal information to verify that they comply with the regulated entity’s privacy policies, practices and procedures and with applicable state laws regarding privacy.

As applicable, verify that the regulated entity/licensee has provided a copy of its privacy notice to its producers.

Determine that the regulated entity does not unfairly discriminate against customers and consumers who are not customers who (1) have opted out from the disclosure of nonpublic personal financial information to nonaffiliated third parties; and (2) have not authorized disclosure of nonpublic personal health information, if applicable.

Review all privacy-related consumer complaints and inquiries.

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 13

The regulated entity provides privacy notices to its customers and, if applicable, to its consumers who are not customers regarding treatment of nonpublic personal financial information.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity privacy policies and procedures

_____ Sample notices to customers: initial, annual, revised and simplified, if applicable

_____ Sample notices to consumers that are not customers, if applicable: initial (standard and short-form) notices and revised notice

_____ Prior to conducting an examination, the examiner should review the state’s definition of “customer” and “consumer” to determine appropriate usage of the terms. The examiner should also review the various exceptions and exclusions contained in the state’s privacy act/regulation.

Others Reviewed

NAIC Model References

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

Review Procedures and Criteria

Review the content of the regulated entity’s initial, annual and revised notices.

Verify that these notices are clear and conspicuous and accurately reflect privacy policies and practices.

Notices should include the following:

- Identification of the regulated entity, if applicable;
- The categories of nonpublic personal financial information that the regulated entity collects;
- The categories of nonpublic personal financial information that the regulated entity discloses, if applicable;
- The categories of affiliates and nonaffiliated third parties to whom the regulated entity discloses nonpublic personal financial information, other than disclosures permitted under Sections 15 and 16 of Model #672, if applicable;
- The categories of nonpublic personal financial information about the regulated entity’s former customers that the regulated entity discloses and the categories of affiliates and nonaffiliated third parties to whom the regulated entity discloses nonpublic personal financial information about the regulated entity’s former customers, other than disclosures permitted under Sections 15 and 16 of Model #672, if applicable;

- If a regulated entity discloses nonpublic personal financial information to a nonaffiliated third party under Section 14 of Model #672, a separate description of the categories of information the regulated entity discloses and the categories of third parties with whom the regulated entity has contracted;
- An explanation of the consumer's right to opt out of the disclosure of nonpublic personal financial information to nonaffiliated third parties, including the methods by which the consumer may exercise that right, if applicable;
- Any disclosures that the regulated entity may make under Section 603(d)(2)(A)(iii) of the federal Fair Credit Reporting Act (15 USC Section 1681a(d)(2)(A)(iii) (i.e., notices regarding the ability to opt out of disclosures of information among affiliates, other than transaction and experience information);
- The regulated entity's policies and practices with respect to protecting the confidentiality and security of nonpublic personal information; and
- If a regulated entity only discloses nonpublic personal financial information as authorized under Sections 15 and 16 of Model #672, a statement that indicates the regulated entity makes disclosures to other affiliated or nonaffiliated third parties, as applicable, as permitted by law.

Review the content of the regulated entity's simplified notice, if applicable, which shall include:

- Identification of the regulated entity and affiliates or subsidiaries, if applicable;
- The categories of nonpublic personal financial information that the regulated entity collects;
- The regulated entity's policies and practices with respect to protecting the confidentiality and security of nonpublic personal information; and
- That the regulated entity only discloses nonpublic personal financial information to affiliates and nonaffiliated third parties, as applicable, as authorized under Sections 15 and 16 of Model #672.

Review the content of the regulated entity's short-form notice for consumers who are not customers, if applicable, which shall state that the regulated entity's privacy notice is available upon request and provide a reasonable means by which the consumer may obtain a full notice.

Verify that the regulated entity's process for delivery of notices includes:

- Initial notice, if applicable, to consumers who are not customers;
- Initial notice to all customers, as required;
- Annual notice to all customers, as required;
- Revised notice to customers and consumers who are not customers entitled to notice, if applicable;
- Where applicable, simplified notices to customers, if the regulated entity only discloses nonpublic personal financial information about customers and former customers to affiliates and nonaffiliated third parties as authorized under Sections 15 and 16 of Model #672 (or the applicable sections under state law regarding privacy); and
- Short-form notices to consumers who are not customers, in lieu of initial notices, if applicable.

Verify that a notice is delivered to the regulated entity's customers at or prior to the time the regulated entity establishes a customer relationship (initial notice), and at least once in any period of 12 consecutive months or once in each calendar year thereafter (annual notice) during the continuation of the customer relationship, if appropriate. If initial notice was provided to customers after the customer relationship was established, verify that the notice was delivered within a reasonable time after the customer relationship was established and (1) establishing the customer relationship was not at the customer's election; or (2) providing notice at or prior to the establishment of the relationship would have substantially delayed the customer's transaction and the customer agreed to receive the notice at a later time.

Verify that if the regulated entity discloses any consumer's nonpublic personal financial information to any nonaffiliated third party, other than as authorized under Section 15 or 16 of Model #672 (or the applicable sections under state laws regarding privacy), the regulated entity delivers a notice before disclosing the information.

Verify that individuals deemed consumers under applicable law are provided with an initial notice where applicable (such as where a licensee discloses a claimant's nonpublic personal financial information outside Sections 14 through 16 of Model #672 or its equivalent under state laws regarding privacy).

Verify that a notice was delivered to the regulated entity's customers and, if applicable, to consumers who are not customers in a manner that can reasonably be expected to provide actual notice.

Verify that a notice was provided to the regulated entity's customers and, if applicable, to consumers who are not customers, in writing, or, if the licensee provides and if the consumer has agreed, electronically.

Verify that the regulated entity has provided customers with clear and conspicuous initial, annual and revised notices in a manner that allows the customer to retain the notices or obtain them later in writing or, if the customer has agreed, electronically.

If the regulated entity is an excess lines insurer and does not disclose nonpublic personal financial information to nonaffiliated third parties, except as authorized under Sections 15 and 16 of Model #672, verify that the notice set forth in Section 4Q(3)(ii) of Model #672 has been delivered to all customers at the time the regulated entity established ongoing relationships with the customers. If the regulated entity makes disclosures other than as authorized under Sections 15 and 16 of Model #672, the regulated entity is required to comply with applicable initial, annual and revised notice requirements and the opt-out requirements.

Review the regulated entity's notice content and notice delivery procedures to verify that the regulated entity complies with applicable statutes, rules and regulations regarding privacy.

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**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 14

If the regulated entity discloses information subject to an opt-out right, the regulated entity has policies and procedures in place so that nonpublic personal financial information will not be disclosed when a consumer who is not a customer has opted out, and the regulated entity provides opt-out notices to its customers and other affected consumers.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity privacy policies and procedures
- _____ Sample notices to customers: initial, annual and, if applicable, revised
- _____ Sample notices to consumers who are not customers, if applicable
- _____ Sample opt-out notice, if applicable
- _____ Regulated entity records of consumers and other customers who have opted out, if applicable
- _____ Communication of customers' and consumers who are not customers' opt-out elections to producers of record
- _____ Prior to conducting an examination, the examiner should review the state's definition of "customer" and "consumer" to determine appropriate usage of the terms. The examiner should also review the various exceptions and exclusions contained in the state's privacy act/regulation.

Others Reviewed

NAIC Model References

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

Review Procedures and Criteria

Determine whether the regulated entity discloses nonpublic personal information relating to customers or consumers who are not customers beyond the scope permitted under Sections 14, 15 and 16 of Model #672.

- Verify that consumers who may be affected by such disclosures have been offered the opportunity to opt out before the disclosures are made. Continue with Steps 1 through 5 below.
- If not, verify that any communications the regulated entity makes regarding opt-out rights are accurate and are in compliance with applicable law.
 1. If applicable, verify that the regulated entity has policies and procedures in place so that customers and other affected consumers may opt out of the disclosure of their nonpublic personal

financial information to nonaffiliated third parties, except to the extent such disclosure is permitted under Sections 14, 15 and 16 of Model #672.

2. If applicable, review the regulated entity's policies and procedures to verify that the regulated entity has the capability to keep nonpublic personal financial information from being unlawfully disclosed to nonaffiliated third parties when a consumer has opted out.
3. If applicable, verify that the regulated entity does not disclose, directly or through any affiliate, unless authorized or permitted by applicable federal and/or state law or regulations, nonpublic personal financial information about a consumer or to a nonaffiliated third party except when:
 - The regulated entity has provided a notice to the consumer;
 - The regulated entity has provided an opt-out notice to the consumer;
 - The regulated entity has given the consumer a reasonable opportunity to opt out of the disclosure before the regulated entity discloses the consumer's nonpublic personal financial information to a nonaffiliated third party; and
 - The consumer does not opt out.
4. As applicable, determine that the regulated entity's initial, annual, revised and short-form notices accurately explain the consumer's right to opt-out, including the methods by which the consumer may exercise that right at any time, in accordance with applicable law and the regulated entity's policies and procedures.
5. If applicable, review the content of the regulated entity's opt-out notice to determine if it is clear and conspicuous and includes, either on the form or on the initial privacy notice:
 - A statement that the regulated entity discloses or reserves the right to disclose nonpublic personal financial information about its consumer to a nonaffiliated third party;
 - A statement that the consumer has the right to opt out of that disclosure; and
 - A reasonable means by which the consumer may exercise the opt-out right.

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 15

The regulated entity’s collection, use and disclosure of nonpublic personal financial information are in compliance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity privacy policies and procedures
- _____ Joint marketing agreements, if any
- _____ Sample service agreements, if any, with nonaffiliated third parties involved in the regulated entity’s marketing activities
- _____ Prior to conducting an examination, the examiner should review the state’s definition of “customer” and “consumer” to determine appropriate usage of the terms. The examiner should also review the various exceptions and exclusions contained in the state’s privacy act/regulation.

Others Reviewed

- _____
- _____

NAIC Model References

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

Review Procedures and Criteria

If the regulated entity discloses nonpublic personal financial information of its customers or consumers who are not customers to nonaffiliated third parties for joint marketing purposes, verify that all such disclosures are in compliance with Model #672:

- Verify that the regulated entity has provided initial notices to its customers and other affected consumers that include the required information regarding the regulated entity’s joint marketing and servicing activities; and
- Review joint marketing agreements, where applicable, to verify that they prohibit the nonaffiliated third party from disclosing or using the nonpublic personal financial information received from the regulated entity other than to carry out the purposes for which the regulated entity disclosed the information, including use under an exception in Sections 15 or 16 of Model #672.

Verify that the regulated entity does not disclose nonpublic personal financial information that it receives from a nonaffiliated financial institution, except in compliance with Model #672.

Review sample service agreements under which a third party markets a licensee’s own products and services, if any, to verify inclusion of non-disclosure requirements.

Verify that the regulated entity prohibits disclosure of policy numbers or similar forms of access numbers or access codes for a consumer's policy or transaction account to any nonaffiliated third party, except as permitted by applicable law or regulation regarding privacy.

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**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 16

In states promulgating the health information provisions of the *Privacy of Consumer Financial and Health Information Model Regulation* (#672), or providing equivalent protection through other substantially similar laws under the jurisdiction of the insurance department, the regulated entity has policies and procedures in place so that nonpublic personal health information will not be disclosed, except as permitted by law, unless a customer or a consumer who is not a customer has authorized the disclosure.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity privacy policies and procedures
- _____ Sample authorizations used by the regulated entity to permit disclosure of nonpublic personal health information, if applicable
- _____ Regulated entity records of customer and other consumer authorizations
- _____ Prior to conducting an examination, the examiner should review the state’s definition of “customer” and “consumer” to determine appropriate usage of the terms. The examiner should also review the various exceptions and exclusions contained in the state’s privacy act/regulation.

Others Reviewed

- _____
- _____

NAIC Model References

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

Review Procedures and Criteria

If applicable, verify that the regulated entity has policies and procedures in place to secure authorizations from its customers and consumers who are not customers before disclosing their nonpublic personal health information to nonaffiliated third parties, except to the extent such disclosure is permitted under Subsection 17B of Model #672.

If applicable, verify that the regulated entity has obtained valid authorizations from customers and consumers who are not customers before disclosing their nonpublic personal health information, except to the extent such disclosures are permitted under Subsection 17B of Model #672. A valid authorization shall include:

- The identity of the consumer who is the subject of the nonpublic personal health information;
- A general description of the types of nonpublic personal health information to be disclosed;
- A general description of the parties to whom the licensee discloses nonpublic personal health information;
- A general description of the purpose of the disclosure of the nonpublic personal health information;
- A general explanation of how the nonpublic personal health information will be used;

- The signature of the consumer who is the subject of the nonpublic personal health information or the individual who is legally empowered to grant disclosure authority and the date signed;
- A notice of the length of time for which the authorization is valid; and
- A notice that the consumer may revoke the authorization at any time, and an explanation of the procedure for making a revocation.

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**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 17

Each licensee shall implement a comprehensive written information security program for the protection of nonpublic customer information.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity written materials describing its information security program
- _____ Regulated entity policies, procedures and other materials it uses to implement its information security program
- _____ Prior to conducting an examination, the examiner should review the state’s definition of “customer” and “consumer” to determine appropriate usage of the terms. The examiner should also review the various exceptions and exclusions contained in the state’s privacy act/regulation.

Others Reviewed

- _____
- _____

NAIC Model References

Standards for Safeguarding Customer Information Model Regulation (#673)
Insurance Data Security Model Law (#668)

Review Procedures and Criteria

Note: When reviewing a regulated entity’s information security program for compliance with applicable state statutes, rules or regulations relating to the *Insurance Data Security Model Law* (Model #668), in the absence of a Cybersecurity Event, as defined in applicable state statutes, rules or regulations, please refer to the Insurance Data Security Pre-Breach Checklist found in the Reference Documents of the *Market Regulation Handbook*. Regulators may access Reference Documents on StateNet at the link Market Regulation Handbook, Handbook Updates and Reference Documents. Non-regulators may access Reference Documents via NAIC Account Manager at https://www.naic.org/account_manager.htm.

Note: When reviewing a regulated entity’s information security program and response to a Cybersecurity Event for compliance with applicable state statutes, rules or regulations relating to the *Insurance Data Security Model Law* (Model #668), after a Cybersecurity Event has occurred, as defined in applicable state statutes, rules or regulations, please refer to the Insurance Data Security Post-Breach Checklist provided as Addendum A to Operations/Management Examination Standard 17 in Chapter 20—General Examination Standards.

Review the regulated entity’s written information security program to determine whether the security program includes administrative, technical and physical safeguards.

Determine whether, when developing safeguards, the regulated entity took into consideration the:

- Size and complexity of the regulated entity; and
- Nature and scope of regulated entity's activities.

In making the assessment above, consider factors such as: (1) the products and services offered by the regulated entity; (2) the methods of distribution for the products and services; (3) the types of information maintained by the regulated entity; (4) the size of the regulated entity (which may include the number of employees and the volume of business, etc.); (5) the marketing arrangements; and (6) the extent to which, or methods by which, the regulated entity communicates electronically with customers, producers and other third parties.

Evaluate whether the regulated entity's information security program is designed to:

- Ensure the security and confidentiality of customer information;
- Protect against any anticipated threats or hazards to the security or integrity of the information; and
- Protect against unauthorized access to or use of the information that could result in substantial harm or inconvenience to any customer.

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**ADDENDUM A TO OPERATIONS/MANAGEMENT STANDARD 17
CHAPTER 20—GENERAL EXAMINATION STANDARDS
MARKET REGULATION HANDBOOK
INSURANCE DATA SECURITY POST-BREACH CHECKLIST**

**Supplemental Incident Response Plan Investigation (Post-Breach) and Notification Cybersecurity Event Checklist for Operations/Management Standard #17
Model #668, Sections 5 and 6**

Company Name	
Period of Examination	
Examination Field Date	
Prepared By	
Date	

GUIDANCE

Insurance Data Security Model Law (#668)

The guidance that follows should only be used in states that have enacted the *Insurance Data Security Model Law* (#668) or legislation, which is substantially similar to Model #668. Moreover, in performing work during an exam in relation to Model #668, it is important that the examiners first obtain an understanding and leverage the work performed by other units in the department, including but not limited to, financial examination-related work.

OVERVIEW

The purpose and intent of Model #668 is to establish standards for data security and standards for the investigation of and notification to the Commissioner or Director of Insurance of a Cybersecurity Event affecting Licensees.

REVIEW GUIDELINES AND INSTRUCTIONS

When reviewing a Licensee’s Information Security Program (ISP) for compliance with Model #668 for the prevention of a Cybersecurity Event, as defined in Model #668, please refer to the pre-breach examination checklist in the Reference Documents of the *Market Regulation Handbook* . Regulators can access the pre-breach examination checklist on the Market Regulation Handbook Reference Documents web page on StateNet. Non-regulators may access the pre-breach examination checklist at https://www.naic.org/account_manager.htm.

When reviewing a Licensee’s ISP and response to a Cybersecurity Event for compliance with Model #668 subsequent to a suspected and/or known Cybersecurity Event, as defined in Model #668, please refer to both the pre-breach examination checklist and the post-breach examination checklist.

When considering whether to underake such a review, refer to Section 9 of Model #668, which provides certain exceptions to compliance for licensees with fewer than 10 employees; licensees subject to the Health Insurance Portability and Accountability Act (HIPAA) (Pub.L. 104–191, 110 Stat. 1936, enacted Aug. 21, 1996); and certain employees, agents, representatives, or designees of licensees who are in themselves licensees.

**ADDENDUM A TO OPERATIONS/MANAGEMENT STANDARD 17
CHAPTER 20—GENERAL EXAMINATION STANDARDS
MARKET REGULATION HANDBOOK
INSURANCE DATA SECURITY POST-BREACH CHECKLIST, CONT'D**

**Supplemental Incident Response Plan Investigation (Post-Breach) and Notification Cybersecurity Event Checklist for Operations/Management Standard #17
Model #668, Sections 5 and 6**

Company Name	
Period of Examination	
Examination Field Date	
Prepared By	
Date	

POST-EVENT INVESTIGATION BY LICENSEE (Section 5)

REVIEW CRITERIA	NOTES (YES, NO, NOT APPLICABLE, OTHER)
1. Did the Licensee conduct a prompt investigation of the Cybersecurity Event? (Section 5A)	
2. Did the Licensee appropriately determine the nature and scope of the Cybersecurity Event? (Section 5B)	

NOTICE TO COMMISSIONER/DIRECTOR OF INSURANCE (Section 6)

REVIEW CRITERIA	NOTES (YES, NO, NOT APPLICABLE, OTHER)
3. Did the Licensee provide timely notice (no later than 72 hours) to the Commissioner or Director of Insurance following the Cybersecurity Event? (Section 6A)	
4. Did the notification to the Commissioner or Director of Insurance include the following information, to the extent reasonably available? (Section 6B)	
4a. The date of the Cybersecurity Event, or the date upon which it was discovered?	
4b. A description of how the Nonpublic Information was exposed, lost, stolen or breached, including the specific roles and responsibilities of Third-Party Service Providers, if any?	
4c. How the Cybersecurity Event was discovered?	
4d. Whether any lost, stolen or breached Nonpublic Information has been recovered, and if so, how this was done?	
4e. The identity of the source of the Cybersecurity Event?	
4f. Whether the Licensee has filed a police report or has notified any regulatory, government or law enforcement agencies? (If YES, did the Licensee provide the date(s) of such notification(s)?)	
4g. A description of the specific types of Nonpublic Information acquired without authorization?	
4h. The period during which the Information System was compromised by the Cybersecurity Event?	
4i. A best estimate of the number of total Consumers in this state and globally affected by the Cybersecurity Event?	
4j. The results of any internal review of automated controls and internal procedures and whether or not such controls and procedures were followed?	

**ADDENDUM A TO OPERATIONS/MANAGEMENT STANDARD 17
CHAPTER 20—GENERAL EXAMINATION STANDARDS
MARKET REGULATION HANDBOOK
INSURANCE DATA SECURITY POST-BREACH CHECKLIST, CONT'D**

**Supplemental Incident Response Plan Investigation (Post-Breach) and Notification Cybersecurity Event Checklist for Operations/Management Standard #17
Model #668, Sections 5 and 6**

Company Name	
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Examination Field Date	
Prepared By	
Date	

NOTICE TO COMMISSIONER/DIRECTOR OF INSURANCE (Section 6) (CONT'D)

REVIEW CRITERIA	NOTES (YES, NO, NOT APPLICABLE, OTHER)
4k. A description of efforts being undertaken to remediate the circumstances which permitted the Cybersecurity Event to occur?	
4l. A copy of the Licensee's privacy policy and a statement outlining the steps the Licensee will take to investigate the Cybersecurity Event and to notify affected Consumers?	
4m. The name of a contact person familiar with the Cybersecurity Event and authorized to act for the Licensee?	
5. Did the Licensee provide timely updates to the initial notification and Questions 4a–4m above? (Section 6B)	

OTHER NOTIFICATIONS (Section 6)

REVIEW CRITERIA	NOTES (YES, NO, NOT APPLICABLE, OTHER)
6. Did the Licensee provide timely and sufficient notice of the Cybersecurity Event to Consumers? (If YES, did the Licensee provide a copy of the notification to the Commissioner(s)/Directors of all affected states?) (Section 6C)	
7. Did the reinsurer Licensee provide timely and sufficient notice of the Cybersecurity Event to ceding insurers? (Section 6E)	
8. Did the Licensee provide timely and sufficient notice of the Cybersecurity Event to independent insurance producers and/or producers of record of affected Consumers? (Section 6F)	

THIRD-PARTY SERVICE PROVIDERS

REVIEW CRITERIA	NOTES (YES, NO, NOT APPLICABLE, OTHER)
9. Did the Cybersecurity Event occur at a Third-Party Service Provider? (If YES, did the Licensee fulfill its obligations to ensure compliance with this law, either directly or by the Third-Party Service Provider?) (Sections 5C and 6D)	

**ADDENDUM A TO OPERATIONS/MANAGEMENT STANDARD 17
CHAPTER 20—GENERAL EXAMINATION STANDARDS
MARKET REGULATION HANDBOOK
INSURANCE DATA SECURITY POST-BREACH CHECKLIST, CONT'D**

**Supplemental Incident Response Plan Investigation (Post-Breach) and Notification Cybersecurity Event Checklist for Operations/Management Standard #17
Model #668, Sections 5 and 6**

Company Name	
Period of Examination	
Examination Field Date	
Prepared By	
Date	

POST-EVENT ANALYSIS

REVIEW CRITERIA	NOTES (YES, NO, NOT APPLICABLE, OTHER)
10. What changes, if any, are being considered to the Licensee's ISP as a result of the Cybersecurity Event and the Licensee's response?	

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**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 18

All data required to be reported to departments of insurance is complete and accurate.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Claim files
- _____ Underwriting files
- _____ Regulated entity's medical professional liability closed claim reports (if applicable)
- _____ Regulated entity's Market Conduct Annual Statement (MCAS) submissions
- _____ Regulated entity's responses to state-specific data requests

Others Reviewed

Statutory or regulatory authority for state-specific data requests

NAIC Model References

- Unfair Claims Settlement Practices Act (#900)*
- Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)*
- Medical Professional Liability Closed Claim Reporting Model Law (#77)*
- Market Conduct Surveillance Model Law (#693)*

Review Procedures and Criteria

Interview the regulated entity's personnel who prepare loss statistical reports, medical professional liability loss reports, MCAS data and state-specific data requests; analyze regulated entity's internal communications between various departments which report same.

Determine that the regulated entity reviews data errors and subsequent changes are made.

Determine if the regulated entity's medical professional liability closed claims reports are accurate and reported within the required time frame.

Request that the regulated entity reconcile closed claims reports, state-specific data requests and MCAS data with the State Page of the annual statement to include payments, case reserves, and defense cost containment expenses, and explain differences.

Request that the regulated entity reconcile closed claims reports to data provided on the standardized data request.

B. Complaint Handling

1. Purpose

The NAIC definition of a complaint is “any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the state’s insurance laws. An oral communication, which is subsequently converted to a written form, would meet the definition of a complaint for this purpose.” The examiner should review the regulated entity’s procedures for processing consumer or other related complaints. Specific problem areas may necessitate an overall review of a particular segment of the regulated entity’s operation.

If a regulated entity is using social media, the examiner should review the regulated entity’s policies and procedures with regard to regulated entity handling of complaints received via social media, in which the regulated entity is active.

2. Techniques

A review of complaint handling should incorporate both consumer direct complaints to the regulated entity and those complaints filed with the insurance department. The examiner should reconcile the regulated entity’s complaint register with a list of complaints from the insurance department. A random sample of complaints should be selected for review from the regulated entity’s complaint register. If such a register is not maintained, alternative methods of isolating complaints may be implemented.

The examiner should review the frequency of similar complaints and be aware of any pattern of specific type of complaints. The examiner should take into consideration the increase of complaints that typically follows a catastrophe. Should the type of complaints generated be cause for unusual concern, specific measures should be instituted to investigate other areas of the regulated entity’s operations. This may include modifying the scope of examination to examine specific regulated entity behavior.

The examiner should review the NAIC Complaints Database System (CDS) to determine the regulated entity’s complaint index, along with any adverse trends in complaint volume. The examiner may wish to review complaint trends and the complaint index for the preceding three years.

The examiner should review the final disposition of the complaints and determine if the regulated entity has taken adequate steps to finalize the complaint. The examiner should determine if the actions taken are in compliance with statutes, rules and regulations.

In states that have established a statutory or regulatory standard of promptness, a study should be conducted to determine how promptly the regulated entity responds to complaints, the adequacy of the responses and what, if any, actions were taken to resolve the problems.

If the examination involves a depository institution or their affiliates, it may also be regulated by a federal agency, such as the Office of the Comptroller of the Currency, the Federal Reserve Board, the Office of Thrift Supervision or the Federal Deposit Insurance Corporation. In addition, banks may also be regulated at the state level. If the state has signed an agreement to share complaint information with these agencies, any adverse trends or pattern of concern to the examiners may be identified and relayed to the agency.

3. Tests and Standards

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

**STANDARDS
COMPLAINT HANDLING**

Standard 1

All complaints are recorded in the required format on the regulated entity's complaint register.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity complaint register

_____ Insurance department's complaint records

_____ Direct consumer complaints

_____ Complaints received electronically (i.e., via Internet or email)

Others Reviewed

NAIC Model References

Model Regulation for Complaint Records to be Maintained Pursuant to the NAIC Unfair Trade Practices Act (#884)

*Consumer Complaints White Paper
Unfair Trade Practices Act (#880), Section 4K*

Review Procedures and Criteria

All of the above should be reviewed to make sure the regulated entity is:

- Recording all complaints (both consumer direct and insurance department); and
- Recording required information in the regulated entity complaint register.

Determine if the regulated entity complaint register meets minimum standards as required by law. At a minimum, the complaint register should include:

- Line of business;
- Function (underwriting, marketing and sales, claims, policyholder services or miscellaneous); and
- Reason for complaint (underwriting, application, cancellation, rescission, nonrenewal).

Automation Tip:

Most companies maintain this information in some sort of PC-based spreadsheet format, such as Lotus or Excel. Request that this spreadsheet be copied in its usual format for comparison with insurance department records. Do not specify which data to be supplied, but instead go with exactly what the regulated entity tracks. A review can be made to see if they contain the information that should be collected from each complaint. Then, a sample can be pulled to review individual complaints to see if the regulated entity's procedures are being followed.

Obtain complaint data file from the insurance department (in whatever format available; e.g., ASCII text file, Microsoft Access, etc.). Convert the data file to a format compatible to the spreadsheet/database from the regulated entity. Compare the complainant name, claim number, policy number, etc., in both files to determine if all of the insurance department complaints were correctly logged by the regulated entity.

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**STANDARDS
COMPLAINT HANDLING**

Standard 2

The regulated entity has adequate complaint handling procedures in place and communicates such procedures to policyholders.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Complaint handling procedure manuals

_____ Policy files

Others Reviewed

NAIC Model References

Unfair Claims Settlement Practices Act (#900)

Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)

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

Consumer Complaints White Paper

Review Procedures and Criteria

Review the regulated entity's manuals to verify that complaint procedures exist.

Determine whether there are sufficient procedures in place to require satisfactory handling of complaints received, as well as internal procedures for analysis in areas developing complaints.

Determine whether there is a method for distribution of and obtaining and recording responses to complaints. This method should be sufficient to allow response within the time frame required by state law.

The regulated entity should provide a telephone number and address for consumer inquiries.

STANDARDS COMPLAINT HANDLING

Standard 3

The regulated entity takes adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules and regulations and contract language.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)
- _____ Regulated entity complaint register
- _____ Complaint letter or email and regulated entity complaint response
- _____ Supporting documentation (claim files, underwriting files, etc.)
- _____ Regulated entity correspondence

Others Reviewed

- _____
- _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Consumer Complaints White Paper

Review Procedures and Criteria

Review complaints documentation to determine if the regulated entity response fully addresses the issues raised. If the regulated entity did not properly address/resolve the complaint, the examiner should ask the regulated entity what corrective action it intends to take.

Criteria for reviewing complaint responses:

- The response is timely;
- The response is complete and responds to all issues raised;
- The response includes adequate documentation to support the respondent's position;
- The respondent's actions are appropriate from a business practice standpoint;
- The respondent's actions comply with all applicable statutes, rules and policy or contract provisions; and
- The appropriate remedies for the consumer are identified.

**STANDARDS
COMPLAINT HANDLING**

Standard 4

The time frame within which the regulated entity responds to complaints is in accordance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Complaint letter or email
- _____ Regulated entity response and supporting documentation
- _____ Regulated entity complaint register

Others Reviewed

- _____
- _____

NAIC Model References

- Unfair Claims Settlement Practices Act (#900)*
- Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)*
- Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)*
- Consumer Complaints White Paper*

Review Procedures and Criteria

Review complaints to ensure regulated entity is maintaining adequate documentation.

Determine if the regulated entity's response is timely. The examiner should refer to state laws for the required time frame.

Automation Tip:

Most companies maintain this information in some sort of PC-based spreadsheet format, such as Lotus or Excel. Request that this spreadsheet be copied in its usual format for comparison with insurance department records. Using either an Excel spreadsheet or a Microsoft Access database, calculate the number of days between the date the complaint was received and the date a final resolution was sent to the complainant. Use the features of either application to identify those complaints where the number of days to resolve the complaint exceeds the statutory standard.

C. Marketing and Sales

1. Purpose

The Marketing and Sales portion of the examination is designed to evaluate the representations made by the regulated entity about its product(s) or services. It is not typically based on sampling techniques. The areas to be considered in this kind of review include all media (radio, television, videotape, electronic medium, social media, etc.), written and verbal advertising and sales materials.

2. Techniques

This area of review should include all advertising and sales material and all producer sales training materials to determine compliance with 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 information provided or to obtain additional information.

As with all of its advertising, regardless of the medium, every regulated entity is required to have procedures in place to establish and, at all times, maintain a system of control over the content, form and method of dissemination of all of its advertisements. All of these advertisements maintained by or for the regulated entity and authorized by the regulated entity are the responsibility of the regulated entity.

The exact same regulations and statutes (such as the *Unfair Trade Practices Act* (#880)) that apply to conventional advertising also apply to Internet advertising. Bearing that in mind, when the examiner is reviewing a regulated entity's Internet advertisements, it is important to also review the safeguards implemented by the regulated 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 shall not have the capacity or tendency to mislead or deceive. Whether an advertisement has the capacity or tendency to mislead or deceive shall be determined upon reviewing the overall impression that the advertisement reasonably may be expected to create upon a person of average education or intelligence within the segment of the public to which the advertisement is directed.

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 priority of the standard.

**STANDARDS
MARKETING AND SALES**

Standard 1

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

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)
- _____ All regulated entity advertising and sales materials, including radio and audiovisual items such as television commercials, telemarketing scripts, pictorial materials, social media or other electronic medium
- _____ Policy forms as they coincide with advertising and sales materials
- _____ Producer’s own advertising and sales materials
- _____ Regulated entity policies and procedures

Others Reviewed

- _____
- _____

NAIC Model References

- Unfair Trade Practices Act (#880)*
- Advertisements of Life Insurance and Annuities Model Regulation (#570), Section 3B*
- Risk-Based Capital (RBC) for Insurers Model Act (#312), Section 8B*
- Life Insurance Disclosure Model Regulation (#580), Section 8C*
- Life and Health Insurance Guaranty Association Model Act (#520), Section 19A*
- Long-Term Care Insurance Model Act (#640)*
- Life Insurance Illustrations Model Regulation (#582)*
- Small Employer and Individual Health Insurance Availability Model Act (#35)*
- Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Model Act (#171), Section 7(H)(1)(a)(I)*
- Advertisements of Accident and Sickness Insurance Model Regulation (#40)*
- Individual Health Insurance Portability Model Act (#37), Section 5*
- Title Insurers Model Act (#628)*
- Title Insurance Agent Model Act (#230)*
- Home Service Disclosure Model Act (#920)*
- Marketing Insurance Over the Internet White Paper*
- Group Health Insurance Standards Model Act (#100)*
- Medicare Supplement Insurance Minimum Standards Model Act (#650)*
- Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)*
- The Use of Social Media in Insurance White Paper*
- [Insurance Holding Company System Regulatory Model Act \(#440\)](#)*

IIPRC Uniform Standard References

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

Review Procedures and Criteria

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

Materials should not:

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

Materials should:

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

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

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

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

For the review of Internet advertisements:

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

For the review of social media:

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

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

- Review the making, publishing, disseminating, circulating or placing before the public, or causing directly or indirectly to be made, published, disseminated, circulated or placed before the public in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station or any electronic means of communication available to the public, or in any other way as an advertisement, announcement or statement containing a representation or statement with regard to the group capital calculation, group capital ratio, the liquidity stress test results, or supporting disclosures for the liquidity stress test of any insurer or any insurer group, or of any component derived in the calculation by any insurer, broker, or other person engaged in any manner in the insurance business because it would be misleading and is therefore prohibited; and
- Review if any materially false statement with respect to the group capital calculation, resulting group capital ratio, an inappropriate comparison of any amount to an insurer’s or insurance group’s group capital calculation or resulting group capital ratio, liquidity stress test result, supporting disclosures for the liquidity stress test, or an inappropriate comparison of any amount to an insurer’s or insurance group’s liquidity stress test result or supporting disclosures is published in any written publication and if the insurer is able to demonstrate to the commissioner with substantial proof the falsity of such statement or the inappropriateness, as the case may be, then the insurer may publish announcements in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

Automation Tip:

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

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

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

**STANDARDS
MARKETING AND SALES**

Standard 2
Regulated entity internal producer training materials are in compliance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity’s producer training manuals, videos and sales scripts

Others Reviewed

NAIC Model References

Producer Licensing Model Act (#218)

Life Insurance Disclosure Model Regulation (#580), Section 5A(2)

Advertisements of Life Insurance and Annuities Model Regulation (#570)

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

Individual Health Insurance Portability Model Act (#37), Sections 11D and 11E

Title Insurers Model Act (#628)

Title Insurance Agent Model Act (#230)

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

Group Health Insurance Standards Model Act (#100)

Long-Term Care Insurance Model Act (#640)

Medicare Supplement Insurance Minimum Standards Model Act (#650)

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

Review Procedures and Criteria

Review all producers’ training materials for compliance with state statutes, rules and regulations.

Review materials for references to employing unfair discrimination tactics or avoiding statutory compliance.

Determine whether producers’ prepared materials are permitted and, if so, under what conditions and controls.

The examiners should be aware of the results of the review of common consumer complaints against the regulated entity, as that could point toward problems in this area.

Automation Tip:

Enter a summary of all training materials of whatever description in an Excel spreadsheet. Capture the regulated entity's name of the material; the form number, if any; the edition date, if any; source, if applicable; and media, such as video, sales script, etc. Include fields to note exceptions, such as incomplete disclosure or possible misleading statements. Insert each possible violation/exception in a separate field.

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

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

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**STANDARDS
MARKETING AND SALES**

Standard 3
Regulated entity communications to producers are in compliance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Bulletins, newsletters and memos

_____ Organizational chart of marketing division

Others Reviewed

NAIC Model References

Unfair Trade Practices Act (#880)

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

Title Insurers Model Act (#628)

Title Insurance Agent Model Act (#230)

Group Health Insurance Standards Model Act (#100)

Long-Term Care Insurance Model Act (#640)

Medicare Supplement Insurance Minimum Standards Model Act (#650)

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

Review Procedures and Criteria

Review written and electronic communication between the regulated entity and producers in accordance with applicable statutes, rules and regulations.

Determine if communication includes references to new rates, rules and regulations.

Determine if communication conforms to Marketing and Sales Examination Standard #1 in this chapter when referencing advertising and sales.

Determine if the regulated entity uses email to communicate with producers. The examiner should ask to review saved, stored or archived email that was broadcast to the sales force.

Automation Tip:

Enter a summary of all producer communications of whatever description in an Excel spreadsheet. Capture the regulated entity's title or subject line for the communication, the date of the communication, source of the communication, etc. Include fields to note exceptions, such as misleading statements or instructions to producers that are in conflict with statutes or regulations. Insert each possible violation/exception in a separate field.

Statistics and statements are likely to be repeated in more than one regulated entity communication. It is also possible that a single regulated entity communication will contain more than one violation/exception.

The Excel spreadsheet will make it easier to track any repeated statements and to identify any regulated entity communications containing apparent multiple violations/exceptions.

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D. Producer Licensing

1. Purpose

The producer licensing portion of the examination is designed to test a regulated entity's compliance with state producer licensing laws and rules. The focus of the standard relating to producer accounts current is to aid in the detection of fraud or misuse of funds held by the producer in a fiduciary capacity.

2. Techniques

The examiner should review and compare information obtained from insurance departments and regulated entity records pertaining to licenses held by individuals or entities soliciting business on behalf of the regulated entity. Information related to producer licensing may be obtained from the NAIC State Producer Licensing Database (SPLD). In addition to aggregate listings of licensed/appointed/terminated producers, compliance with producer licensing statutes should be verified during the review of individual policy files, which take place during other portions of the examination (see Section F Underwriting and Rating in this chapter).

The examiner should compare information obtained from insurance departments and regulated entity records pertaining to the licenses held by individuals or entities soliciting business on behalf of the regulated entity. Insurance department records may be obtained through the NAIC SPLD, if the state is actively submitting information to the database. The SPLD contains information about a producer's license and any appointments they have with a regulated entity.

3. Tests and Standards

The producer licensing review includes, but is not limited to, the following standards related to producer licensing. The sequence of the standards listed here does not indicate priority of the standard.

**STANDARDS
PRODUCER LICENSING**

Standard 1

Regulated entity records of licensed and appointed (if applicable) producers and in jurisdictions where applicable, licensed company or contracted independent adjusters agree with insurance department records.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Insurance department listing of producers and, if applicable, adjusters or the SPLD (State Producer Licensing Database)
- _____ Regulated entity listing of currently licensed and/or appointed producers and, if applicable, adjusters
- _____ Regulated entity listing of commissions

Others Reviewed

- _____
- _____

NAIC Model References

- Mass Marketing of Property and Liability Insurance Model Regulation (#710)*
- Producer Licensing Model Act (#218)*
- Title Insurance Agent Model Act (#230)*
- Independent Adjuster Licensing Guideline (#1224)*

Review Procedures and Criteria

Reconcile above regulated entity lists with corresponding insurance department lists to determine any discrepancies. If the state is actively participating in the State Producer Licensing Database (SPLD), the examiner should validate the producer's or adjuster's licensure status through the SPLD in lieu of obtaining a hardcopy of the producer's or adjuster's license.

Determine that any producer writing business in connection with a mass marketing plan is appropriately licensed.

Refer discrepancies to appropriate divisions within the insurance department.

Automation Tip:

Obtain from the regulated entity a list of all producers licensed and appointed at any time during the examination period, and, where applicable, all company or contracted independent adjusters licensed at any time during the examination period. Include the producer's or adjuster's National Producer Number (NPN) or, if unavailable, Social Security number, Federal Employer Identification number, name, address, licensed date, appointed date, type of license, and internal regulated entity or employee number for the producer. Obtain from the insurance department's licensing division a similar list. Obtain from the regulated entity a list of all producers who received commission during the examination period. Include the producer's National Producer Number (NPN) or, if unavailable, Social Security number, Federal Employer Identification number, name, address, licensed date, appointed date, type of license, date first commission received and internal regulated entity or employee number for the producer. Obtain from the regulated entity a list of all new business written during the examination period. Include the date the policy was issued and the producer's internal regulated entity or employee number.

- Compare the regulated entity's producer and adjuster licensing list to the insurance department's licensed producers list by comparing National Producer Numbers (NPN) or, if unavailable, Social Security numbers, Federal Employer Identification numbers, extracting any producers on the regulated entity's list who are not on the insurance department's list;
- Compare the regulated entity's commissions list to the insurance department's licensed producers list by comparing National Producer Numbers (NPN) or, if unavailable, Social Security numbers, Federal Employer Identification numbers, extracting any producers on the regulated entity's list who are not on the insurance department's list. Also compare commission first earned dates to the insurance department's license/appointment dates to see if commissions were earned prior to license/appointment date; and
- Compare the regulated entity's new business written list to the insurance department's licensed producers list by comparing National Producer Numbers (NPN) or, if unavailable, Social Security numbers, Federal Employer Identification numbers or internal regulated entity/employee numbers), extracting any producers on the regulated entity's list who are not on the insurance department's list. Also compare policy issued date to the insurance department's license/appointment dates to see if policies were written prior to license/appointment date. This may need to be cross-referenced with the regulated entity's licensed producer list to correlate the producer's National Producer Number (NPN) and the internal regulated entity/employee number.

**STANDARDS
PRODUCER LICENSING**

Standard 2

The producers are properly licensed and appointed and have appropriate continuing education (if required by state law) in the jurisdiction where the application was taken.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ New business application
- _____ Insurance department listing of licensed and/or appointed producers or the State Producer Licensing Database (SPLD)
- _____ Copy of producer's license or electronic verification of producer's license via the State Producer Licensing Database (SPLD)
- _____ Regulated entity listing of all currently licensed and/or appointed producers
- _____ Notice of appointment
- _____ Regulated entity procedures for appointing a producer
- _____ Regulated entity list of commissions paid by line of business

Others Reviewed

- _____
- _____

NAIC Model References

- Producer Licensing Model Act (#218)*
- Title Insurance Agent Model Act (#230)*
- Unfair Trade Practices Act (#880)*
- Long-Term Care Insurance Model Act (#640)*

Review Procedures and Criteria

Review the regulated entity's procedures for the appointment of producers.

Review the producer's license and the appointment records. Determine if the appointment was effective within 15 days of the producer writing business on behalf of the regulated entity.

Review the producer's authority for the types of business he/she is eligible to solicit. Determine if the producer is acting within the scope of that authority.

Determine that the producer has met continuing education requirements and, if appropriate, has met the producer training requirements for selling long-term care insurance (LTCI).

Identify the producer of each selected policy and determine proper licensure and appointment (if required).

Automation Tip:

Obtain from the regulated entity a list of all producers licensed and appointed at anytime during the examination period. Include the producer's National Producer Number (NPN) or, if unavailable, Social Security number or Federal Employer Identification number, name, address, licensed date, appointed date, type of license and internal regulated entity or employee number for the producer. Obtain from the insurance department's licensing division a list of all producers licensed and appointed at any time during the examination period. Include the producer's National Producer Number (NPN) or, if unavailable, Social Security number or Federal Employer Identification number, name, address, licensed date, appointed date, applicable jurisdictions and type of license. Obtain from the regulated entity a list of all applications taken during the examination period. Include the date the application was taken, the producer's internal regulated entity or employee number and the jurisdiction where the application was taken. Compare these files using National Producer Numbers (NPN) or, if unavailable, Social Security numbers or Federal Employer Identification numbers and internal regulated entity/employee number for the producer and jurisdictions. Extract any producers who took applications from jurisdictions where they were not licensed/appointed.

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**STANDARDS
PRODUCER LICENSING**

Standard 3

Termination of producers complies with applicable standards, rules and regulations regarding notification to the producer and notification to the state, if applicable.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity/agency contracts
- _____ Regulated entity listing of producer terminations for examination review period
- _____ Regulated entity listing of commissions
- _____ Insurance department listing of terminations
- _____ Copies of individual termination notifications sent to terminated producers
- _____ Copies of individual termination notifications sent to insurance department

Others Reviewed

- _____
- _____

NAIC Model References

Producer Licensing Model Act (#218)
Title Insurance Agent Model Act (#230)

Review Procedures and Criteria

Reconcile the regulated entity's listing of producer terminations with the listing of commissions paid to determine if payouts are being made properly to terminated producers.

Review individual termination notices from the regulated entity to producers to determine compliance with termination notification periods and allowance for renewal commissions.

Refer any discovery of terminated producers still submitting new business to appropriate divisions within the insurance department.

Review the regulated entity's contract with producers to determine how commissions are paid to producers who have been terminated (e.g., vesting provisions).

Compare the regulated entity's listing of producer terminations with the National Insurance Producer Registry (NIPR) to ensure accuracy in reporting.

**STANDARDS
PRODUCER LICENSING**

Standard 4

The regulated entity's policy of producer appointments and terminations does not result in unfair discrimination against policyholders.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Listing of appointments and terminations for examination review period
- _____ Listing of producer appointments by line of business (if applicable) by producer's business ZIP code
- _____ Listing of terminations by line of business (if applicable) by producer's business ZIP code
- _____ Regulated entity market plan or synopsis

Others Reviewed

- _____
- _____

NAIC Model References

Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Compare the number of appointments/terminations for the current review period with previous review period and, if difference is significant, determine the reason(s).

Review the regulated entity's marketing plan.

Review ZIP code listings to determine the placement of producers and if there is evidence of under-served or over-served geographical areas.

Automation Tip:

Obtain from the regulated entity a list of all producers licensed and appointed at any time during the examination period. Include the producer's National Producer Number (NPN) or, if unavailable, Social Security number, Federal Employer Identification number, name, address, county, ZIP code, licensed date, appointed date, termination date, type of license and internal regulated entity or employee number for the producer. Extract a list of all producers that were licensed/appointed and/or terminated during the examination period. Run a count on the number of producers that are licensed/appointed by ZIP code or county and a count on the number of producers terminated by ZIP code or county. Also run a count on the original file by ZIP code or county. A comparison of the counts may show ZIP codes or counties that are under-served or over-served.

**STANDARDS
PRODUCER LICENSING**

**Standard 5
Records of terminated producers adequately document reasons for terminations.**

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity listings of terminated producers for examination review period
- _____ Regulated entity individual files of terminated producers
- _____ Insurance department's list of acceptable reasons for terminations

Others Reviewed

- _____
- _____

NAIC Model References

Producer Licensing Model Act (#218)
Title Insurance Agent Model Act (#230)

Review Procedures and Criteria

Determine reasons for producer terminations.

Review all or sample of individual terminated producer files.

Review above documents for inadequately or inaccurately documented termination reasons. If necessary, refer to the appropriate division within the insurance department.

Compare the regulated entity's listing of producer terminations with NIPR to ensure accuracy in reporting.

Determine if the insurance department is notified of termination for cause (if applicable).

Automation Tip:

Obtain from the regulated entity a list of all producers terminated at any time during the examination period. Include the producer's National Producer Number (NPN) or, if unavailable, Social Security number, Federal Employer Identification number, name, address, termination date and reason for termination. Review the regulated entity's files for these producers to determine if the terminations were adequately documented.

**STANDARDS
PRODUCER LICENSING**

Standard 6

Producer account balances are in accordance with the producer's contract with the insurer.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Listing of producer accounts current exceeding contract limits

_____ Producer and/or agency contracts

Others Reviewed

NAIC Model References

Producer Licensing Model Act (#218)

Title Insurance Agent Model Act (#230)

Unfair Trade Practices Act (#880)

Insurance Fraud Prevention Model Act (#680)

Review Procedures and Criteria

Review listing of producer accounts current.

Discuss excessive balances with the regulated entity.

Accounts current exceeding contract limits may indicate producer mishandling of funds.

Refer to appropriate division within the insurance department.

E. Policyholder Service

1. Purpose

The policyholder service portion of the examination is designed to test a regulated entity's compliance with statutes regarding notice/billing, delays/no response, and premium refund and coverage questions.

2. Techniques

While larger companies may have a full staff to handle policyholder service, smaller companies may well do policyholder service as a function of the claims or underwriting department.

Policyholder service departments vary from regulated entity to regulated entity. Some companies do only what is required of them by state statute (i.e., notification of the toll-free number or policyholder complaint telephone number). In contrast, some actually contact policyholders that have had occasion to deal directly with the regulated entity, such as presenting a claim or requesting a policy change.

It is important that the examiner check with the examination coordinator to determine where the policyholder service function lies and then apply the following tests to determine the effectiveness of the unit.

3. Tests and Standards

The policyholder service review includes, but is not limited to, the following standards related to the adequacy and level of policyholder service provided by the regulated entity. The sequence of the standards listed here does not indicate priority of the standard.

**STANDARDS
POLICYHOLDER SERVICE**

Standard 1

Premium notices and billing notices are sent out with an adequate amount of advance notice.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

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

_____ Underwriting files

_____ Underwriting procedure manuals

Others Reviewed

NAIC Model References

Improper Termination Practices Model Act (#915)

Property Insurance Declination, Termination and Disclosure Model Act (#720)

Automobile Insurance Declination, Termination and Disclosure Model Act (#725)

Universal Life Insurance Model Regulation (#585), Section 7F

Review Procedures and Criteria

Check renewal business to determine if the regulated entity's procedures for handling renewals are in accordance with state guidelines.

Check underwriting files to determine if premium notices for endorsements were sent timely, and not at audit or policy expiration.

Check mailroom for billings sent out by the regulated entity to ensure timeliness.

Automation Tip:

Obtain from the regulated entity a data file of all cancellations due to nonpayment. Include in the file the policy number, the date the notice was generated/mailed and the effective date of the cancellation. Using either a spreadsheet or database (if the file is quite large, use ACL), calculate the number of days between the date the regulated entity represents the notice was generated/mailed and the effective date of the cancellation. Using ACL or some other sampling software, select a sample of cancellation and premium notices that appear to conform to state requirements. Request documentation that the notice was mailed on the date reported by the regulated entity. Also extract a report of all notices, which apparently fail to comply with state requirements and submit to the regulated entity for explanations.

**STANDARDS
POLICYHOLDER SERVICE**

Standard 2
Policy issuance and insured-requested cancellations are timely.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Underwriting manuals
- _____ Insured's request for cancellation
- _____ Cancellation notices
- _____ Procedure manuals
- _____ Underwriting files

Others Reviewed

- _____
- _____

NAIC Model References

Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Determine if insured-requested cancellations are handled in a timely manner without excessive paperwork requirements for the insured.

Perform a time study on policy issuance to determine that policies and endorsements are issued in a timely manner.

**STANDARDS
POLICYHOLDER SERVICE**

Standard 3

All correspondence directed to the regulated entity is answered in a timely and responsive manner by the appropriate department.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity correspondence files

_____ Electronic correspondence

_____ Policy/Underwriting files

Others Reviewed

NAIC Model References

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

Unfair Claims Settlement Practices Act (#990)

Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)

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

Title Insurers Model Act (#628)

Title Insurance Agent Model Act (#230)

Review Procedures and Criteria

Review correspondence to ensure that the response was made by the appropriate department.

Ensure the original question or problem was properly addressed in a timely manner.

Determine if the regulated entity responds to inquiries from the applicant regarding the specific reason(s) for adverse underwriting decisions.

Review correspondence contained in the policy files from the regulated entity to determine appropriateness and timeliness of handling.

**STANDARDS
POLICYHOLDER SERVICE**

Standard 4

Whenever the regulated entity transfers the obligation of its contracts to another regulated entity pursuant to an assumption reinsurance agreement, the regulated entity has gained prior approval of the insurance department, and the regulated entity has sent the required notices to affected policyholders.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Assumption reinsurance agreements
- _____ Order of insurance commissioner approving assumption reinsurance agreement
- _____ Notice of transfer sent to policyholders, producers and brokers
- _____ Response card sent to policyholders
- _____ Written regulated entity procedures for handling inquiries regarding the assumption transaction and for processing the policyholders' response cards

Others Reviewed

- _____
- _____

NAIC Model References

Assumption Reinsurance Model Act (#803)

Review Procedures and Criteria

According to the model act, “assumption reinsurance agreement” means any contract which both:

- Transfers insurance obligations and/or risks of existing or in force contracts of insurance from a transferring insurer to an assuming insurer; and
- Is intended to affect a novation of the transferred contract of insurance with the result that the assuming insurer becomes directly liable to the policyholders of the transferring insurer.

Determine if any assumption reinsurance agreements exist.

Obtain a list of policyholders covered by any assumption reinsurance agreements in order to determine sample.

Determine if the class of policyholder or type of product was covered by the assumption reinsurance agreement.

Determine if affected policyholders received the notice of transfer and the response card and that each includes appropriate language.

Determine whether the regulated entity appropriately handled a policyholder’s right to reject the transfer.

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**STANDARDS
POLICYHOLDER SERVICE**

Standard 5
Policy transactions are processed accurately and completely.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

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

_____ Regulated entity correspondence files

_____ Policy underwriting files involving nonforfeiture, surrenders, benefit changes, existing policy changes and other post-issue transactions

Others Reviewed

NAIC Model References

Modified Guaranteed Annuity Model Regulation (#255), Section 6B(1)(b)
Consumer Credit Insurance Model Act (#360)

Review Procedures and Criteria

Ensure proper documentation is maintained for the following:

- Cash surrenders;
- Policy loans;
- Bank draft acceptance and clearance; and
- Beneficiary changes.

Ensure that policyholder requests are processed as soon as reasonably possible.

Ensure that matured endowments are processed when due. Determine if the regulated entity takes appropriate steps to notify policyholders of guaranteed options to purchase additional insurance.

Premium refunds for modified guaranteed life products. Special requirements may exist, under policy provisions or state law, for calculation of refunds involving “10-day right to return” periods for life products, which include a separate account.

For credit insurance, if a debt is refinanced prior to the scheduled maturity date, the in force insurance must be terminated before any new insurance is issued.

**STANDARDS
POLICYHOLDER SERVICE**

Standard 6

Reasonable attempts to locate missing policyholders or beneficiaries are made.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Schedule F of the annual statement
- _____ Policies scheduled for matured endowments
- _____ Underwriting files
- _____ Unpaid payees of returned benefit checks

Others Reviewed

- _____
- _____

NAIC Model References

Review Procedures and Criteria

Determine if the regulated entity has made reasonable attempts to locate beneficiaries, policyholders and recipients of unclaimed properties.

**STANDARDS
POLICYHOLDER SERVICE**

Standard 7

Unearned premiums are correctly calculated and returned to the appropriate party in a timely manner and in accordance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)
- _____ Policy contract
- _____ Notice of cancellation/nonrenewal
- _____ Refund check or complete documentation of refund, if canceled check information is maintained on the computer system

Others Reviewed

- _____
- _____

NAIC Model References

Consumer Credit Insurance Model Regulation (#370)
Universal Life Insurance Model Regulation (#585)

Review Procedures and Criteria

Calculate the unearned premium (short rate, pro rata or sum of digits method) in accordance with policy provisions or state law.

Verify that refunds provided to producers are properly distributed.

Verify that unearned premiums were returned to the insured in a timely manner.

Verify that the regulated entity adheres to applicable “free look” periods.

For credit insurance:

- If the creditor has opened a line of credit for a debtor and is charging for the line of credit rather than the amount of debt (i.e., credit cards), at the debtor’s death the insured amount due is the amount of established credit against premium was last charged;
- If a debtor prepays the debt in full, any credit insurance shall be terminated and an appropriate refund of premium shall be paid or credited to the debtor; and
- In the event of termination, no charge may be made for the first 15 days of a month and a full month may be charged for over 16 days.

F. Underwriting and Rating

1. Purpose

These standards, in general, apply to insurance companies, although some or all of these standards may be applicable to other regulated entities to the extent that they address functions that have been delegated to them by insurance companies.

The underwriting portion of the examination is designed to provide a view of how the regulated entity treats the public and whether that treatment is in compliance with applicable statutes, rules and regulations. It is typically determined by testing a random sampling of files and applying various tests to the sampled files. It is concerned with compliance issues. The areas to be considered in this kind of review include:

- a. Rating practices;
- b. Underwriting practices;
- c. Use of correct and properly filed and approved forms and endorsements;
- d. Termination practices;
- e. Unfair discrimination;
- f. Use of proper disclosures, buyers' guides and delivery receipts;
- g. Reinsurance; and
- h. Statistical coding.

2. Techniques

During an examination, it is necessary for examiners to review a number of information sources, including:

- Rating manuals and rate cards;
- Rate classifications;
- Symbol manuals or tables;
- Rating systems filed with regulators;
- Payment plans;
- Minimum premiums;
- Policy fees;
- Discounts;
- Dividend rating plans;
- Regulated entity automated rating systems;
- Rating materials provided to producers;
- Reinsurer policies/treaties;
- Reinsurer guidelines and manuals;
- Documentation of required disclosures and delivery receipts;
- Premium statements and billing statements;
- Premium refund documentation;
- Replacement and conservation materials;
- Underwriting manuals, guidelines and classification manuals;
- Medical underwriting manuals;
- Issued and renewed policy and certificate files;
- Canceled and nonrenewed policy and certificate files;
- Declined applications and notices;
- Individual and group lapsed policy files and notices;
- Individual and group nonforfeiture files and notices;

- Rescission files;
- Underwriting guidelines;
- Sample of premium audit files;
- Applicable policy forms and endorsements and summaries;
- Producer licensing information;
- Group trust and association arrangements where applicable;
- Producer compensation agreements where applicable;
- Statistical reporting requirements; and
- Underwriting files content and structure.

For purposes of this chapter, “underwriting file” means the file or files containing the new business application; renewal application; rate calculation sheets; billings; audits, including binders; engineering reports; inspection reports; risk or hazard investigative or evaluation reports; motor vehicle reports (MVRs); credit reports; all underwriting information obtained or developed; policy declaration page; endorsements; premium finance agreements with regulated entities activities; cancellation or reinstatement notices; correspondence; and any other documentation supporting selection, classification, rating or termination of the risk.

In selecting samples for testing, personal lines should generally not be combined with commercial lines. These two areas are generally not homogeneous, and conclusions or inferences to be made from the results of sampling may not be valid if combined. The examiner should be familiar with any statutory or regulatory distinctions made between personal lines and commercial lines as respects the various tests to be developed. Then examiners also should be familiar with the process for gathering and processing underwriting information, and the quality controls for the issuance of policies, endorsements and premium statement/billings. The list of files from which a sample is to be drawn may be generated through a computer run or in some cases through a policy register covering the period of time selected in the notice or call of examination.

Determine the regulated entity’s policy population (policy count) by line of business. Review a random selection of business for application of a particular test or apply specific tests to a census population using automated tools. (In the event specific files are chosen for a target review, the examiner must be certain the examination results are clearly identified as being from the target selection.) The examiner should maintain a list of the various tests to be applied to each file in the sample. This will aid in consistency by ensuring that each test is considered for each file in the sample.

If exceptions are noted, the examiner must determine if the exception is caused by such practices as use of faulty automated rating systems, or development of improperly or vaguely worded manuals or guidelines. When exceptions are noted, it is advisable to determine the scope and extent of the problem. The examiner responses should maximize objectivity; the examiner should avoid replacing examiner judgment for regulated entity judgment.

a. Rating Practices

It is necessary to determine if the regulated entity is in compliance with rating systems that have been filed with, and, in some cases, approved by the various state insurance departments. Where rates are not required to be filed with an applicable regulatory agency, it is prudent to determine if rates are being applied consistently and in accordance with the regulated entity's own rating methods. In general, rates should not be unfairly discriminatory. Wide-scale application of incorrect rates by a regulated entity may raise financial solvency questions or be indicative of inadequate management oversight. Deviation from established rating plans may also indicate a regulated entity is engaged in unfair competitive practices. Inconsistent application of rates, individual risk premium modifications, modification factors and deviations can result in unfair discrimination.

The procedure for determining adherence to rates filed or used by a regulated entity varies between personal lines and commercial lines. There can also be considerable variation by kind of insurance. The examiner should become familiar with the regulated entity's policy form numbers or other identification procedures, inasmuch as references may be made to such numbers or procedures in lieu of having the particular form attached. If policies are issued by an automated system, the examiner should manually rate policies based on a selection of various classes and various territories to verify that the computer has been programmed correctly. Once this has been established, the examiner should check only the input data for other policies against the information included in the inspection report or from information obtained from other sources in order to determine that they have been rated correctly. If rating exceptions are noted, the examiner must determine if the exception is caused by such practices as use of faulty automated rating systems, or development of improperly or vaguely worded rating manuals. When exceptions are noted, it is advisable to determine the scope and extent of the problem.

When possible, the examination team should make use of audit software to verify correct application of specific rating components. This allows for a more thorough review and can save time during the examination process. All new automated audit applications that are developed should be submitted to the NAIC File Repository, in order to assist in building a comprehensive set of audit programs.

Rating practices of renewal policies, as well as newly issued policies, should be reviewed. By reviewing renewal policies, the examiner can verify whether the regulated entity is updating rating components, such as vehicle-identification number (VIN) symbol changes or property protection class changes. The examiner can look for cases where initial year premium rates were set at artificially low levels for competitive reasons.

The complexity of rating systems varies greatly from line to line. Some lines require little in the way of documentation focused on the appropriate use of the rating system. Some systems are so complex that appropriate determination is difficult if a worksheet is not maintained. This is generally more true of commercial lines than it is for personal lines. The examiner should ensure that the underwriting files contain sufficient information to support the rates that have been applied to a policy. Inherent in the more complex systems is the concern for unfair discrimination.

Examiners may wish to review situations involving multiple related companies under common underwriting management for issues involving unfair discrimination between similarly situated policyholders.

Restraint of trade issues also may be involved if there are indications of two or more unrelated companies attempting to conspire to monopolize an insurance market.

b. Underwriting Practices

The examiner should review relevant underwriting information; e.g., the regulated entity's underwriting guidelines, underwriting bulletins, declination procedures, agency agreements and correspondence with producers. Interoffice memoranda and regulated entity minutes, which may furnish evidence of anti-competitive behavior, may also be requested. In addition to reviewing the content of the above information for indications of unfairly discriminatory practices, the examination team also will use the above information to determine regulated entity compliance with its own manuals and guidelines. The examiner should confirm that the regulated entity's underwriters and producers consistently apply the regulated entity's guidelines for all business selected or rejected. The examination team should verify that the regulated entity has correctly classified insured individuals.

File documentation should also be sufficient to support underwriting decisions made. Underwriting decisions that are adequately documented generally afford management of the regulated entity the opportunity to know what business it has selected through its underwriters and producers. The examiner should verify that properly licensed and appointed (where applicable) producers have been used in the production of business.

Underwriting guidelines may vary by geographic areas in the jurisdiction and, therefore, such guidelines should be reviewed for each regional office being examined.

Any practice suggesting anti-competitive behavior may involve legal considerations that should be referred to insurance department counsel. Ultimately, the information so obtained may be useful in drafting legislation or regulations.

In some lines of business, a survey of nonstandard (e.g., surplus lines markets and consent-to-rate filings) and residual markets (e.g., FAIR—Fair Access to Insurance Requirements Plan, JUA—Joint Underwriting Association and high-risk health pools) may provide some insight into general industry underwriting practices.

c. Use of Correct and Properly Filed Forms and Endorsements

The examination team should verify that all policy forms and endorsements used have been filed with the appropriate regulatory authority, if applicable. Additionally, the examination team should verify the consistent and correct use of policy forms and endorsements. The examiner should also be mindful of possible outdated forms or endorsements. If coverages and riders requested by the applicant are not issued, proper notification should be provided to the applicant. In some cases, supplemental applications are appropriate.

If the forms have been approved by the Interstate Insurance Product Regulation Commission (IIPRC), the examiner should verify that the compacting state was included in the IIPRC-approved product filing and the form being marketed has a prefix of "ICCxx" (where "xx" represents the appropriate year the form was submitted for filing). If IIPRC-approved forms are being used or mixed and matched with forms approved by the compacting state, the examiner may wish to verify the forms approved by the compacting state were identified on the statement of intent schedule, which is required to be submitted, updated and maintained by the insurer in the product filing submitted to the IIPRC. Compacting states have access through the NAIC System for Electronic Rate and Form Filing (SERFF) to product filings submitted to the IIPRC for approval and use in their respective state or jurisdiction and can use the export tool in SERFF to extract relevant information.

d. Termination Practices

The examiner should review the regulated entity's declination, cancellation and nonrenewal of policy practices to determine compliance with applicable statutes, rules and regulations and to determine conformance with regulated entity rules, guidelines and policy provisions.

The review of cancellation and nonrenewal practices in a particular line of insurance should involve a request for the underwriting file for each policy selected from the random sample of canceled policies. For nonrenewals, the examiner should select the sample from the expiration list. Cancellations of specific lines of business have unique requirements. The sampling should be completed separately for each product line in order to get a fair sampling for each line of business to be reviewed. The examiner should review material submitted to determine that the cancellations comply with statutory provisions and policy provisions.

Cancellation processing for nonpayment of premium should include a formal notice to the insured. Some companies use the last billing notice as the cancellation notice. If this is the case, that billing notice must clearly state the effective date of termination of coverage, the insured's rights to an explanation, as provided by statutes where required, and a concise statement of the reason for termination of coverage. Make sure that the loss payee is receiving a copy of the same notice, or separate notice from the regulated entity, to advise that coverage is being terminated. Refer to the specific statute and rule that applies.

The accuracy of return premiums on canceled policies and, in particular, pro rata vs. short rate return of premiums should be verified. When coverage other than homeowners is canceled at the request of the insured, short rate methodology should be used. Cancellations initiated by the regulated entity and all homeowner cancellations should be pro rata.

The examination team should review reinstatement offers and determine what the regulated entity practice is for offering reinstatement. Additionally, the examination team should be mindful of billing practices that may encourage policy lapses.

e. Declination Practices

The examiner should review the regulated entity's declination of policy practices to determine compliance with applicable statutes, rules and regulations and to determine conformance with regulated entity rules and guidelines. "Declination" includes only refusal of an insurer to issue a policy upon receipt of a written nonbinding application or written request for coverage from a producer or an applicant, or the refusal of a producer or broker to transmit to an insurer a written nonbinding application or written request for coverage.

Insurers should maintain declination files and producers should maintain files on declinations made on behalf of the regulated entity. The applicant must be provided with a written, specific reason for the declination.

The review of declination practices in a particular line of insurance should involve a request for the underwriting file for each policy selected from the random sample of declinations. The sampling should be completed separately for each product line in order to get a fair sampling for each line of business to be reviewed. The examiner should review material submitted to determine that the declinations are in compliance with the applicable rules and regulations and in conformance with the rules and guidelines for the specific line of business.

f. Reinsurance

Most state statutes include a feature that for many lines of business the regulated entity is not permitted to place more than 10 percent of its surplus to policyholders at risk on any one placement of insurance. While this is primarily a solvency issue, it is one that market conduct examiners are in an ideal position to test in view of the sampling of underwriting files utilized for other tests.

Adherence to the requirement is easy to test but requires familiarity with the structure and content of the reinsurance treaties covering the business written by the regulated entity. This item is particularly important for companies that hold minimal policyholder surplus accounts (i.e., surplus of less than \$10 million). It may also reflect on the care the regulated entity's management places on its selection of business, and represent a danger to the financial health of the regulated entity. Errors in this area should result in alerts to the insurance department's financial examiners. Any tests of this type must be coordinated with the state's financial examiners.

3. Tests and Standards

The underwriting and rating review includes, but is not limited to, the following standards addressing various aspects of the regulated entity's underwriting activities. The sequence of the standards listed here does not indicate priority of the standard.

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**STANDARDS
UNDERWRITING AND RATING**

Standard 1

The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the regulated entity's rating plan.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ New business application
- _____ All underwriting information obtained
- _____ Rating manuals
- _____ Policy declaration page
- _____ Underwriter's file or notes on a system log

Others Reviewed

- _____
- _____

NAIC Model References

- Property and Casualty Model Rating Law Guideline (File and Use Version) (#1775)*
- Property and Casualty Model Rating Law Guideline (Prior Approval Version) (#1780)*
- Property and Casualty Commercial Rate and Policy Form Model Law (Condensed) (#777)*
- Small Employer and Individual Health Insurance Availability Model Act (#35)*
- Stop Loss Insurance Model Act (#92)*
- Individual Health Insurance Portability Model Act (#37), Sections 5A–H, 5J, 5K, 7 and 9*
- Medicare Supplement Insurance Minimum Standards Model Act (#650)*
- Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)*
- Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)*
- Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)*

Review Procedures and Criteria

Verify all rating factors, including class, territory, symbol assignment, surcharges, deductible factors and increased limit factors.

If no source document application exists, review what procedures the regulated entity has in place to determine the accuracy of the information that was given to issue the policy.

Calculate the policy premium to verify it is in accordance with filed rates.

Verify that the proper rules are being used.

Verify that the filed implementation date is used uniformly, including at different branches.

Confirm that rates in use were filed and approved prior to use, where required.

Confirm that rates in use have been submitted as required, if system is other than prior approval.

Verify the basis of premium is correct.

Verify that the protection classes and other rating factors are correct.

Verify that the rating rules are properly utilized. The examiner should be alert for incorrect interpretation of rating rules.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

Automation Tip:

Obtain from the regulated entity a data file that contains new business written during the examination period. The file should contain policy number, policy form, address, territory code or any other rating factor that is standardized by the regulated entity. Obtain from the regulated entity a data file that contains these standardized rating factors. For example, if the regulated entity underwrites by county, then obtain a data file that contains the county codes and a new business file that contains the policyholder's county. Compare the two files to see if the appropriate rating code is being applied. Since variations can happen, ask for explanations only in areas where the error rate is unacceptable.

**STANDARDS
UNDERWRITING AND RATING**

Standard 2

All mandated disclosures are documented and in accordance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)
- _____ Underwriting or policy files
- _____ Lapsed policies
- _____ Rating/Quote information provided electronically

Others Reviewed

- _____
- _____

NAIC Model References

- Cancer Insurance Shopper's Guide*
- Model Regulation to Implement the Small Employer Insurance Portability Model Act (#119)*
- Small Employer and Individual Health Insurance Availability Model Act (#35)*
- Accident and Sickness Insurance Minimum Standards Model Act (#170), Section 5*
- Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171), Sections 8A(10) and 8A(11)*
- Consumer Credit Insurance Model Act (#360)*
- Individual Health Insurance Portability Model Act (#37), Section 11*
- Unfair Trade Practices Act (#880)*
- Long-Term Care Insurance Model Act (#640)*
- Long-Term Care Insurance Model Regulation (#641)*
- Life Insurance Disclosure Model Regulation (#580), Section 5A(1)*
- Life Insurance Illustrations Model Regulation (#582)*
- Consumer Credit Insurance Model Regulation (#370)*
- Charitable Gift Annuities Model Act (#240)*
- Charitable Gift Annuities Exemption Model Act (#241)*
- Bulletin pertaining to Voluntary Expedited Filing Procedures for Insurance Applications Developed to allow Depository Institutions to meet their Disclosure Obligations under Section 305 of the Gramm-Leach-Bliley Act*
- Group Life Insurance Definition and Group Life Insurance Standard Provisions Model Act (#565)*
- Military Sales Practices Model Regulation (#568)*
- Group Health Insurance Standards Model Act (#100)*
- Medicare Supplement Insurance Minimum Standards Model Act (#650)*
- Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)*

Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Verify that written notice of Medicare supplement replacements are provided to applicants and existing insurers and that appropriate buyer's guides are used.

Verify that appropriate notices regarding credit-related coverages are documented.

Verify that notices regarding the existence of health insurance pools are provided, where applicable.

Review other notices and disclosures required by various jurisdictions.

Determine if state law requires that telephone help numbers be provided, including state insurance department telephone numbers and addresses.

Determine if changes in coverage are disclosed in a timely manner.

Determine if the regulated entity underwriting guidelines comply with applicable statutes, rules and regulations.

Determine if mandated optional coverages are disclosed and documented.

Verify that quotations are made accurately and in a timely manner.

Verify that delivery receipts are obtained where necessary.

Verify that changes in rates are disclosed in a timely manner and in accordance with applicable statutes, rules, regulations and policy provisions.

Determine if the regulated entity is in compliance with rules related to fair marketing.

Verify that the *Shopper's Guide to Cancer Insurance* complies with required disclosures and policy limitations.

Ensure disclosures to consumers represent the applicable consumer protections required by state law, including:

- Limits on preexisting condition exclusions;
- Prohibitions on discrimination based on health status and related factors;
- Guaranteed renewals for all policies, with certain exceptions;
- Limits on the factors that can be used to establish and change premium rates; and
- Descriptive information about all available health benefit plans.

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

Where required, individual accident and sickness insurance policies shall include with delivery or application an outline of coverage, in a prescribed format. Outlines of coverage delivered in connection with individual hospital confinement indemnity, specified disease or limited benefit health insurance coverages to persons eligible for Medicare by reason of age shall contain language that indicates "This policy IS NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the regulated entity."

Insurers shall give any person applying for specified disease insurance a buyer's guide approved by the insurance commissioner. Direct response insurers shall provide the buyer's guide upon request, but not later than the time the policy is delivered.

Credit disability income products

Ensure the debtor is provided a disclosure with the following information prior to the election to purchase insurance:

- That the purchase of consumer credit insurance is optional and not a condition of obtaining credit approval;
- If more than one kind of consumer credit insurance is being made available to the debtor, whether the debtor can purchase each kind separately or the multiple coverages only as a package;
- The conditions of eligibility;
- That, if the consumer has other insurance that covers the risk, he or she may not want or need credit insurance;
- That within the first 30 days after receiving the individual policy or group certificate, the debtor may cancel the coverage and have all premiums paid by the debtor refunded or credited. Thereafter, the debtor may cancel the policy at any time during the term of the loan and receive a refund of any of the unearned premium. However, only in those instances where insurance is a requirement for the extension of credit, the debtor may be required to offer evidence of alternative insurance acceptable to the creditor at the time of cancellation;
- A brief description of the coverage, including a description of the amount, the term, any exceptions, limitations and exclusions, the insured event, any waiting or elimination period, any deductible, any applicable waiver of premium provision, to whom the benefits would be paid and the premium rate for each coverage or for all coverages in a package; and
- That, if the premium or insurance charge is financed, it will be subject to finance charges at the rate applicable to the credit transaction.

LTC products

Verify that written notice of LTC replacements is provided to applicants and existing insurers, suitability worksheets are completed and submitted and that appropriate buyer's guides and contract or policy summaries are used.

Ensure the entity maintains, at its home office or principal office, a complete file containing one specimen copy of each disclosure document authorized and used by the entity (i.e., buyer's guide, contract, outline of coverage, statement of policy information for applicant, etc.). The file should contain one copy of each authorized form for a period of 3 years following the date of its last authorized use. Many jurisdictions have repealed the requirement for policy summaries if the product is declared to be marketed with an illustration that meets the requirements of statutes, rules and regulations.

Workers' compensation products

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

IIPRC-approved products

If the forms and advertisements have been approved by the Interstate Insurance Product Regulation Commission (IIPRC), please note that the notices and disclosures required to be included within the approved forms and advertisements are governed by the IIPRC uniform standards and not state law. State law that requires notices and disclosures during the sale, underwriting and claims processes are still applicable to products and advertisements approved by the IIPRC, provided such state law requirements do not pertain to or affect the content or approval of the IIPRC-approved products and advertisements.

**STANDARDS
UNDERWRITING AND RATING**

Standard 3

The regulated entity does not permit illegal rebating, commission-cutting or inducements.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Complaint files/logs

_____ Underwriting files

Others Reviewed

NAIC Model References

Unfair Trade Practices Act (#880)

Producer Licensing Model Act (#218)

Interest-Indexed Annuity Contracts Model Regulation (#235)

Consumer Credit Insurance Model Regulation (#370)

Individual Health Insurance Portability Model Act (#37), Section 11

Title Insurers Model Act (#628)

Title Insurance Agent Model Act (#230)

Medicare Supplement Insurance Minimum Standards Model Act (#650)

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

Review Procedures and Criteria

Check commission schedule for inappropriate variances.

Determine that producer commissions adhere to the commission schedule and, if not, verify that the file documentation reflects reasons for the variance.

Check billings and invoices for varying commission percentages.

Check regulated entity advertising for indications of illegal commission-cutting or inducements.

**STANDARDS
UNDERWRITING AND RATING**

Standard 4

The regulated entity's underwriting practices are not unfairly discriminatory. The regulated entity adheres to applicable statutes, rules and regulations and regulated entity guidelines in the selection of risks.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ New business and renewal applications
- _____ All underwriting information obtained
- _____ Regulated entity underwriting guidelines
- _____ Underwriting bulletins
- _____ Declination procedures
- _____ Agency agreements and correspondence with producers
- _____ Interoffice memoranda and regulated entity minutes
- _____ Policy declaration page
- _____ Underwriter's file or notes on a system log

Others Reviewed

- _____
- _____

NAIC Model References

- Insurance Fraud Prevention Model Act (#680)*
- Model Regulation on Unfair Discrimination in Life and Health Insurance on the Basis of Physical or Mental Impairment (#887)*
- Model Regulation on Unfair Discrimination on Basis of Blindness or Partial Blindness (#888)*
- Unfair Trade Practices Act (#880)*
- Title Insurers Model Act (#628)*
- Title Insurance Agent Model Act (#230)*
- Military Sales Practices Model Regulation (#568)*
- Medicare Supplement Insurance Minimum Standards Model Act (#650)*
- Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)*
- Small Employer and Individual Health Insurance Availability Model Act (#35)*
- Group Health Insurance Standards Model Act (#100)*
- Stranger-Originated Annuity Transactions (STOA) NAIC Sample Bulletin*

Review Procedures and Criteria

Review relevant underwriting information to ensure that no unfair discrimination is occurring according to the state's definition of unfair discrimination.

Determine if the regulated entity is following its underwriting guidelines, and that the guidelines conform to state laws and are not unfairly discriminatory.

Determine, if required, that the regulated entity's underwriting guidelines have been filed with the insurance department.

Review interoffice memoranda for evidence of anti-competitive behavior.

Underwriting guidelines may vary by geographic areas in the jurisdiction and, therefore, such guidelines should be reviewed for each regional office being examined.

Ensure that the regulated entity does not discriminate against individuals by using any of an individual's past lawful travel or future lawful travel plans to refuse life insurance, refuse to continue existing life insurance, or limit the amount, extent or kind of life insurance available to an individual.

Ensure that the regulated entity's procedures are in compliance with the Genetic Information Nondiscrimination Act (GINA).

Some indication of industry underwriting practices may be obtained by a survey of residual markets (FAIR Plan and JUA), surplus lines markets and consent-to-rate filings.

Inconsistent handling of rating or underwriting practices, even if not intentioned, can result in unfair discrimination, including requests for supplemental information.

Examine new business and renewal applications for the required fraud warning statement.

Review whether the insurer has established a system of STOA-related oversight (underwriting criteria). If not, discuss the existence of the STOA bulletin with the insurer. The examiner should be mindful that the provisions within the bulletin may not be legally required by their applicable jurisdiction.

**STANDARDS
UNDERWRITING AND RATING**

Standard 5

All forms, including policies, contracts, riders, amendments, endorsement forms and certificates are filed with the insurance department, if applicable.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)
- _____ New business application
- _____ Policy or contract determination page
- _____ Regulated entity's approval register
- _____ Insurance department's approval for all forms, including policies, contracts, riders, amendments, endorsements and certificates (Note: All forms submitted to the IIPRC for approval in the applicable compacting state can be verified through the NAIC System for Electronic Rate and Form Filing (SERFF) or by contacting the designated IIPRC representative(s) within the compacting state)

Others Reviewed

- _____
- _____

NAIC Model References

- Health Policy Rate and Form Model [Act] [Regulation] (#165)*
- Individual Health Insurance Portability Model Act (#37), Sections 7 and 9*
- Insurance Fraud Prevention Model Act (#680)*
- Unfair Trade Practices Act (#880)*
- Group Health Insurance Standards Model Act (#100)*
- Medicare Supplement Insurance Minimum Standards Model Act (#650)*
- Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)*
- Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)*
- Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)*

Review Procedures and Criteria

Determine if the forms and endorsements have been filed. Where required, determine that either prior approval has been obtained or that applicable waiting periods following the filing have been met.

Determine if the regulated entity lists, on the summary page, all forms that constitute a part of the contract.

Examine new business applications for the required fraud warning statement.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

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**STANDARDS
UNDERWRITING AND RATING**

Standard 6

Policies, contracts, riders, amendments and endorsements are issued or renewed accurately, timely and completely.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)
- _____ Underwriting files
- _____ Application
- _____ Underwriting procedure manuals
- _____ Underwriting and binding guidelines

Others Reviewed

- _____
- _____

NAIC Model References

- Anti-Arson Application Model Bill (#715)*
- Improper Termination Practices Model Act (#915)*
- Property Insurance Declination, Termination and Disclosure Model Act (#720)*
- Automobile Insurance Declination, Termination and Disclosure Model Act (#725)*
- Consumer Credit Insurance Model Regulation (#370)*
- Consumer Credit Insurance Model Act (#360)*
- Health Policy Rate and Form Model [Act] [Regulation] (#165)*
- Uniform Individual Accident and Sickness Policy Provision Law (#180), Sections 2A(7), 2B(5) and 5C*
- Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act (#171), Sections 6G and 8A(2)*
- Administrative Procedure Relative to Renewability and Cancellation Provisions in the Approval of Accident and Health Policies Drafted In Accordance with the Uniform Individual Accident and Sickness Provision Law, Section 8*
- Individual Health Insurance Portability Model Act (#37), Sections 6, 7, 8 and 11*
- Medicare Supplement Insurance Minimum Standards Model Act (#650)*
- Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)*
- Small Employer and Individual Health Insurance Availability Model Act (#35)*
- Group Health Insurance Standards Model Act (#100)*
- Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)*
- Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)*

Review Procedures and Criteria

Determine if policies and endorsements are issued in appropriate time frames.

Verify how much time elapses between completion of the application and issuance of coverage.

Note that this standard may need flexibility or special application when dealing with assigned risk plans, joint insurance arrangements, anti-arson applications, FAIR (Fair Access to Insurance Requirements) plans or other involuntary business.

Review new issues prior to mailing to ensure correct procedures, forms, disclosures, etc., are used.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

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**STANDARDS
UNDERWRITING AND RATING**

Standard 7

Rejections and declinations are not unfairly discriminatory.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Policy contract
- _____ Notice of declination
- _____ Regulated entity guidelines for cancellation/nonrenewal/declination
- _____ Producer records/issued policies and declinations

Others Reviewed

- _____ The Genetic Information Nondiscrimination Act (GINA)
- _____

NAIC Model References

- NAIC Insurance Information and Privacy Protection Model Act (#670), Sections 10-12*
- Small Employer and Individual Health Insurance Availability Model Act (#35)*
- Group Health Insurance Standards Model Act (#100)*
- Medicare Supplement Insurance Minimum Standards Model Act (#650)*
- Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)*
- Unfair Trade Practices Act (#880)*
- Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)*
- Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)*

Review Procedures and Criteria

Determine if the regulated entity provides valid reasons for rejection/declination when required.

Determine if the regulated entity responds to inquiries from the applicant regarding the specific reason(s) for adverse underwriting decisions. Was the adverse underwriting decision based on previous adverse underwriting decisions?

Determine if the regulated entity uses valid reasons for rejection/declination and documents these reasons.

Review the regulated entity's procedures for rejection/declination to determine if the regulated entity is following its own guidelines.

Determine if the regulated entity monitors agency rejection/declination for appropriate practices.

Review for any unfairly discriminatory practices.

Verify appropriate refund has been made to the applicant.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

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**STANDARDS
UNDERWRITING AND RATING**

Standard 8

Cancellation/nonrenewal, discontinuance and declination notices comply with policy and contract provisions, state laws and the regulated entity’s guidelines.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)
- _____ Policy contract
- _____ Notice of cancellation/nonrenewal
- _____ Agent’s/MGA’s/Underwriter’s file or notes on a system log
- _____ Producer records/notices issued
- _____ Insured’s request (if applicable)
- _____ Regulated entity cancellation/nonrenewal guidelines

Others Reviewed

- _____
- _____

NAIC Model References

- Property Insurance Declination, Termination and Disclosure Model Act (#720)*
- Automobile Insurance Declination, Termination and Disclosure Model Act (#725)*
- Improper Termination Practices Model Act (#915), Section 8A*
- Unfair Trade Practices Act (#880)*
- Group Coverage Discontinuance and Replacement Model Regulation (#110)*
- Individual Health Insurance Portability Model Act (#37), Section 11*
- Long-Term Care Insurance Model Act (#640)*
- Medicare Supplement Insurance Minimum Standards Model Act (#650)*
- Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)*
- Small Employer and Individual Health Insurance Availability Model Act (#35)*
- Group Health Insurance Standards Model Act (#100)*
- Guidelines for the Filing of Workers’ Compensation Large Deductible Policies and Programs (#1970)*
- Guidelines for Regulations and Legislation on Workers’ Compensation Coverage for Professional Employer Organization Arrangements (#1950)*

Review Procedures and Criteria

Determine if the reason for cancellation/nonrenewal or declination was valid according to policy provisions and state law.

Review the regulated entity's procedures for cancellation/nonrenewal and declinations to determine if the regulated entity is following its own guidelines.

Review regulated entity-initiated cancellations and consider a separate sample for insured-initiated cancellation.

Determine if the regulated entity monitors agency cancellation, declination and nonrenewals for appropriate practices.

Review for any unfairly discriminatory practices.

Review declinations, including declinations made by producers on behalf of the regulated entity. Declinations shall, as required, include the specific reasons for the declination.

Review notice of cancellation/nonrenewal to determine that it was mailed or delivered by the insurer to the first named insured's last known address.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

Automation Tip:

Obtain from the regulated entity a data file of all cancellations/nonrenewals and declinations during the examination period. Include in the file the policy number, the date the notice was generated/mailed and the effective date of the cancellation/nonrenewal or declination. Using either a spreadsheet or database (if the file is quite large, use ACL), calculate the number of days between the date the regulated entity represents the notice was generated/mailed and the effective date of the cancellation/nonrenewal or declination. Using ACL or some other sampling software, select a sample of cancellation and premium notices that appear to conform to state requirements. Request documentation that the notice was mailed on the date reported by the regulated entity. Also extract a report of all notices which apparently fail to comply with state requirements and submit to the regulated entity for explanations.

**STANDARDS
UNDERWRITING AND RATING**

Standard 9
Rescissions are not made for non-material misrepresentation.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ List of rescinded policies
- _____ Underwriting files and supporting documentation, including claim files

Others Reviewed

- _____ Case law for state impacted
- _____
- _____

NAIC Model References

- Improper Termination Practices Model Act (#915)*
- Unfair Trade Practices Act (#880)*
- Long-Term Care Insurance Model Act (#640)*
- Medicare Supplement Insurance Minimum Standards Model Act (#650)*
- Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)*
- Group Health Insurance Standards Model Act (#100)*

Review Procedures and Criteria

Determine if rescinded policies indicate a trend toward post-claim underwriting practices.

Determine if decisions to rescind policies are made in accordance with applicable statutes, rules and regulations.

G. Claims

1. Purpose

These standards, in general, apply to insurance companies, although some or all of these standards may be applicable to other regulated entities to the extent that they address functions that have been delegated to them by insurance companies. The claims portion of the examination is designed to provide a view of how the regulated entity treats claimants and whether that treatment is in compliance with applicable statutes, rules and regulations. It is determined by testing a random sampling of files and applying various tests to open and closed claims.

For purposes of this chapter, “claim file” means the file or files containing the notice of claim, claim forms, proof of loss, medical records, health facility pre-admission certification or utilization review documentation, settlement demands, accident reports, police reports, adjusters’ logs, claim investigation documentation, inspection reports, supporting bills (including electronic payment records, estimates and valuation worksheets), correspondence to and from insureds and claimants or their representatives, complaint correspondence, copies of claim checks and/or check numbers and amounts, releases, all applicable notices and correspondence used for determining and concluding claim payments or denials, subrogation and salvage documentation, and any other documentation necessary to support claim-handling activity.

The review is concerned with the regulated entity’s claims practices by line of business for compliance with statutes, rules and regulations and policy provisions. The areas to be considered in this kind of review include:

- a. Time studies to measure acknowledgment, investigation and settlement times;
- b. General handling study;
- c. Total loss valuation survey;
- d. Closed without payment survey;
- e. Subrogation survey;
- f. Litigation survey;
- g. Unfair claims practices survey;
- h. Claims form review;
- i. Loss statistical reporting survey;
- j. Time study on canceled checks; and
- k. Review of other procedures, as deemed necessary.

2. Techniques

Each area of claims review involves selecting a sample of claims (open, closed without payment, closed, denied). However, it is not necessary to use different samples to review timeliness of payment, conformity to policy language or adequacy of proof.

A general approach to examination would be to:

- Define the scope of the examination in terms of the lines of business and type of claims covered. Lines of business should be defined as specifically as possible; e.g., physical damage coverage rather than automobile coverage.
- Become familiar with the regulated entity’s claim handling procedures for the line of business identified. Review corresponding policy forms for coverage, exclusions and nonstandard provisions. Review the methods for processing claims from notification to conclusion. Review with the claim manager or other appropriate personnel the maintenance of claim records and draft and settlement authority.

- Select a representative sample of files to be reviewed. Chapter 17—Sampling of this handbook should be reviewed. If field sizes are relatively small and the regulated entity’s records appear complete, representative samples or a census should be selected. In the case of large field sizes and incomplete or complicated records, the use of audit software should be considered. Care should be taken that no adverse selection occurs.
 - a. Time studies to measure acknowledgment, investigation and settlement times

Record the date of loss/claim, the date reported to the producer or regulated entity, the date sufficient information was available to determine the regulated entity’s liability and the date the regulated entity accepted or rejected the claim. Record identifying data, such as the claim/policy number and the claimant’s name.

Determine for each claim the number of days the regulated entity took to accomplish each category. Compare days required by regulated entity to appropriate state standards and document those claims that exceed standards for inclusion in the report. Delays beyond the control of the regulated entity should be excluded; e.g., a delay caused by an uncooperative insured. Establish a mean and median time to acknowledge, investigate and accept/deny claims, if necessary, to determine a business practice.

Caution: If a file has a violation of a standard with multiple tests, and the standard is the item measured, the file can only fail one time. If the individual test is the item measured, the file can fail each test. If failure of a standard or of a test ensures failure of another standard or test under another standard, then no substitution of the file need occur. The relationship, however, should be explained.

- b. General handling study

Record identifying data such as claim/policy number, date of loss and claimant name. Files should be reviewed for adequate and accurate documentation. Correct application of deductibles, coinsurance and limits of coverage should be established. Mathematical accuracy should be determined. Reductions based on depreciation, obsolescence, etc., should be reviewed for fairness and accuracy.

Checks or drafts should be reviewed for correct payees. Files should be reviewed for specific state requirements. Compliance with the regulated entity’s own standards should be established.

- c. Closed without payment review

This includes denied, rejected, incomplete and claims not paid for any other reason, including deductibles/waiting periods not met. Conduct tests similar to “General handling study” above. Record identifying data such as claim/policy number, date of loss and claimant name. Review specific state requirements for content and method of denial notification to the claimant. Note general handling by the regulated entity to determine validity of its action in the final disposition of these types of claims.

- d. Litigation survey

Determine the extent of suits against the regulated entity. Separate first- and third-party actions. If a review is deemed appropriate, select a representative sample or census.

Record identifying data such as claim/policy number, date of loss and claimant name. Files should be reviewed to determine the basis for suit and the regulated entity's position for denial or settlement offer. Closed litigated files should be reviewed to determine accuracy, regulated entity position and if punitive or bad faith judgments were rendered. Recognition of attorney-client privileged documents or work products should occur during the file review. A principal focus is compliance with unfair claims practices statutes and regulations.

e. Unfair claims practices review

Record identifying data such as claim/policy number, date of loss and claimant name. Review selected files for violations of specific state unfair claims practices, such as misrepresentation of policy provisions or concealment of coverage.

Calculate error ratios for the sample and field sizes. This is especially important in this study, since most unfair claims practices statutes make reference to "business practices."

f. Claim forms

Request copies of all claim forms in use for the lines of business being examined. Forms should be reviewed for content and appropriate usage. Inappropriate forms should be documented and included in the report. Claim forms also may be reviewed as they are encountered in the file reviews.

g. Review of canceled drafts/checks

This review should be considered if solvency is an issue, if the examiner determines delays in issuing a payment, or if consumer complaints indicated delays that are not supported by other time studies.

From the regulated entity's records, select a representative sample of the type of claims being reviewed. The selection should include drafts/checks reflecting a substantial payment amount on any one claim. Compare the date the regulated entity indicated the draft/check was forwarded to the claimant with the date the draft/check was presented for payment. If the review indicates significant and numerous delays in presenting drafts/checks for payment, additional investigation to determine the causes should be done.

Canceled checks should be reviewed to verify that the amount paid and the claim amount approved are the same, that payees are the same and that the information recorded in the computer system matches what is on the check (payee, amount, date of check, etc.).

h. Review of other procedures

Other review, as deemed necessary, should follow the same format for objectivity and sampling techniques as those already described. These reviews may be instituted by consumer complaints regarding specific claims practices and should be tailored to resolve specific issues.

3. Tests and Standards

The claims review includes, but is not limited to, the following standards addressing various aspects of the regulated entity's claim handling practices. The sequence of the standards listed here does not indicate priority of the standard.

**STANDARDS
CLAIMS**

Standard 1

The initial contact by the regulated entity with the claimant is within the required time frame.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity claims procedure manuals
- _____ Claims training manuals
- _____ Internal regulated entity claims audit reports
- _____ Claim files

Others Reviewed

- _____
- _____

NAIC Model References

- Unfair Claims Settlement Practices Act (#900)*
- Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)*
- Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)*
- Title Insurers Model Act (#628)*
- Title Insurance Agent Model Act (#230)*
- Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)*
- Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)*

Review Procedures and Criteria

Review the regulated entity's procedures, training manuals and bulletins to determine if regulated entity standards exist. Determine whether the regulated entity's standards comply with applicable statutes, rules and regulations.

Determine if initial contact procedures are in place and in compliance with the mandated time frame. Perform a time study of acknowledgment times.

Determine if initial contact with claimants meets required contract standards.

Determine if subsequent responses and claim handling delay notices comply with applicable statutes, rules and regulations.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

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**STANDARDS
CLAIMS**

Standard 2
Timely investigations are conducted.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity claims procedure manuals
- _____ Claims training manual
- _____ Internal regulated entity claims audit reports
- _____ Claim bulletins
- _____ Antifraud procedures

Others Reviewed

- _____
- _____

NAIC Model References

- Unfair Claims Settlement Practices Act (#900)*
- Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)*
- Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)*
- Consumer Credit Insurance Model Act (#360)*
- Title Insurers Model Act (#628)*
- Title Insurance Agent Model Act (#230)*
- Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)*
- Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)*

Review Procedures and Criteria

Review the regulated entity's procedures, training manuals and claim bulletins to determine if regulated entity standards exist and whether standards comply with state statutes.

Determine if investigations are initiated and concluded in compliance with state statutes.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

**STANDARDS
CLAIMS**

Standard 3
Claims are resolved in a timely manner.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity claims procedure manuals
- _____ Claims training manuals
- _____ Internal regulated entity claims audit reports
- _____ Review of canceled claim checks
- _____ Claim files

Others Reviewed

- _____
- _____

NAIC Model References

- Unfair Claims Settlement Practices Act (#900)*
- Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)*
- Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)*
- Consumer Credit Insurance Model Act (#360)*
- Title Insurers Model Act (#628)*
- Title Insurance Agent Model Act (#230)*
- Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)*
- Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)*

Review Procedures and Criteria

Review the regulated entity's procedures, training manuals and claim bulletins to determine if regulated entity standards exist and whether standards comply with state statutes.

Determine if claim resolutions—i.e., liability, determinations, coverage questions and claims payment—are made in accordance with state requirements. Perform time studies to measure the settlement time of claims.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

Automation Tip:

Obtain from the regulated entity a listing of claims closed with payment or claims closed without payment by claim feature. Include in the file the claim number(s), date the claim was reported to the regulated entity, the first payment date (if applicable), and the date the claim feature was closed. Using ACL, a database or spreadsheet, calculate the number of days from the date the claim feature was closed to the date the claim was reported. Group the number of days in any appropriate time periods, for example, 1 to 15 days, 16 to 30 days, etc., and perform a count on each time period. Investigate any patterns of untimeliness.

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**STANDARDS
CLAIMS**

Standard 4
The regulated entity responds to claims correspondence in a timely manner.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity claims procedure manuals
- _____ Claims training manuals
- _____ Claim files
- _____ Electronic claims correspondence

Others Reviewed

- _____
- _____

NAIC Model References

- Unfair Claims Settlement Practices Act (#900)*
- Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)*
- Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)*
- Consumer Credit Insurance Model Act (#360)*
- Title Insurers Model Act (#628)*
- Title Insurance Agent Model Act (#230)*
- Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)*
- Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)*

Review Procedures and Criteria

Review the regulated entity's procedures, training manuals and claim bulletins to determine if regulated entity standards exist and whether standards comply with state statutes.

Determine if correspondence related to claims is responded to in accordance with state requirements.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

**STANDARDS
CLAIMS**

Standard 5
Claim files are adequately documented.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity claims procedure manuals
- _____ Electronic records of claims activities
- _____ Claims training manuals
- _____ Internal regulated entity claims audit reports
- _____ Claim bulletins
- _____ Claim files
- _____ Claim forms

Others Reviewed

- _____
- _____

NAIC Model References

- Insurance Fraud Prevention Model Act (#680)*
- Unfair Claims Settlement Practices Act (#900)*
- Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)*
- Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)*
- Title Insurers Model Act (#628)*
- Title Insurance Agent Model Act (#230)*
- Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)*
- Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)*

Review Procedures and Criteria

Review the regulated entity's procedures, training manuals and claim bulletins to determine if regulated entity standards exist and whether standards comply with state statutes.

Determine if quality of the claim documentation meets state requirements.

Determine if claim files retention/destruction program meets state requirements.

Determine if claim files documentation is sufficient to support or justify the ultimate claim determination.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

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**STANDARDS
CLAIMS**

Standard 6

Claims are properly handled in accordance with policy provisions and applicable statutes (including HIPAA), rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity claims procedure manuals
- _____ Claims training manuals
- _____ Internal regulated entity claims audit reports
- _____ Claim bulletins
- _____ Regulated entity claim forms manual
- _____ Regulated entity subrogation and salvage logs
- _____ Claim files
- _____ Regulated entity depreciation schedules
- _____ Auto—total loss evaluation procedures

Others Reviewed

- _____
- _____

NAIC Model References

- Insurance Fraud Prevention Model Act (#680)*
- Unfair Claims Settlement Practices Act (#900)*
- Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)*
- Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)*
- Retained Asset Accounts Sample Bulletin (#573)*
- Consumer Credit Insurance Model Regulation (#360)*
- Long-Term Care Insurance Model Act (#640)*
- Coordination of Benefits Model Regulation (#120)*
- Off-Label Drug Use Model Act (#148), Section 4*
- Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)*
- Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)*

Review Procedures and Criteria

Review regulated entity procedures, training manuals and claim bulletins to determine if regulated entity standards exist and whether standards comply with state statutes.

Determine if the regulated entity's procedures provide for the detection and reporting of fraudulent or potentially fraudulent insurance acts to the commissioner.

Determine if claim handling meets state-specific statutes and regulations as applied to total loss evaluations, sales tax payment, disposition of salvage, correct payees, improper release of claims, proper payment of non-disputed claims and proper referral of suspicious claims.

Determine if coverage was checked for proper application of deductible or appropriate exclusionary language.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

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**STANDARDS
CLAIMS**

Standard 7
Regulated entity claim forms are appropriate for the type of product.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Claim forms for product being examined

_____ Electronic claims notification screens

_____ Claim files

Others Reviewed

NAIC Model References

Insurance Fraud Prevention Model Act (#680)

Unfair Claims Settlement Practices Act (#900)

Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)

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

Standardized Health Claim Form Model Regulation (#30)

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

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

Review Procedures and Criteria

Determine if claim form(s) include appropriate content and are used appropriately. Use of inappropriate forms should be documented and included in the examination report.

Review claim forms as they are encountered in the file reviews.

Examine all claim forms for the required fraud warning statement.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

**STANDARDS
CLAIMS**

Standard 8

Claim files are reserved in accordance with the regulated entity's established procedures.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity claims procedure manuals
- _____ Claims training manuals
- _____ Internal claims audit reports
- _____ Individual claim file
- _____ Average reserve data

Others Reviewed

- _____
- _____

NAIC Model References

- Unfair Claims Settlement Practices Act (#900)*
- Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)*
- Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)*
- Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)*
- Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)*

Review Procedures and Criteria

Review the regulated entity's claims procedure manuals for established reserving practices.

Determine if individual reserves are evaluated and posted.

Determine if reserve adjustments are made.

Determine if reserves are excessive/inadequate.

Determine if reserves are reduced, if a redundancy is apparent.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

**STANDARDS
CLAIMS**

Standard 9
Denied and closed without payment claims are handled in accordance with policy provisions and state law.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity claims procedure manuals
- _____ Claims training manuals
- _____ Internal regulated entity claims audit reports
- _____ Claim bulletins
- _____ Claim files

Others Reviewed

- _____
- _____

NAIC Model References

- Insurance Fraud Prevention Model Act (#680)*
- Unfair Claims Settlement Practices Act (#900)*
- Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)*
- Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)*
- Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)*
- Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)*

Review Procedures and Criteria

Determine if denied and closed without payment claims are based on policy provisions and applicable state statutes and regulations.

Determine if notices of claim denials reference specific policy provisions or exclusions.

Determine if the regulated entity provides claimants with a reasonable basis for the denial, when required by statutes, rules or regulations.

Where required, determine if claimants are provided with instructions for having rebuttals to denials reviewed by the insurance department or by the regulated entity.

Determine if the regulated entity refers suspicious claims to a regulatory authority/law enforcement agency, when appropriate.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

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**STANDARDS
CLAIMS**

Standard 10
Canceled benefit checks and drafts reflect appropriate claim handling practices.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Cashed benefit checks and drafts
- _____ Regulated entity claims procedure manuals

Others Reviewed

- _____
- _____

NAIC Model References

- Unfair Claims Settlement Practices Act (#900)*
- Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)*
- Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)*

Review Procedures and Criteria

Perform a time study on canceled claim checks or drafts to ascertain whether claim proceeds are being promptly mailed or delivered.

Determine if canceled checks include the correct payee and are for the correct amount.

Ascertain whether payment checks indicate the payment is “final” when such is not the case.

Ascertain whether checks or drafts purport to release the insurer from total liability when such is not the case.

Review endorsements to see if they are consistent with the payee name listed on the check.

If drafts are used, ascertain whether there is prompt clearance by the insurer.

**STANDARDS
CLAIMS**

Standard 11

Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than is due under the policy.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Closed litigated claim files

_____ Regulated entity claims procedure manuals

Others Reviewed

NAIC Model References

Unfair Claims Settlement Practices Act (#900)

Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)

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

Review Procedures and Criteria

Review a sample or entire population of closed litigated claim files, if feasible. Determine if litigated files indicate problematic claim handling practices. If warranted, notify the insurance department's financial examination division.

Note: The examiner should review applicable state statutes to determine which particular claims should adhere to this standard. For example, bodily injury claims may not readily fit this standard.



Gabrielle Griffith
Senior Policy Analyst and NAIC Coordinator
202-624-2371 t
gabriellegriffith@acli.com

May 18, 2022

Mr. Damion Hughes, Chair
Director of Market Regulation
Department of Regulatory Agencies
Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado, 80202

Sent via email to Petra Wallace, Senior Market Regulation Specialist

**Re: NAIC Market Conduct Examinations Guidelines (D) Working Group Chapter 20
Proposed Changes**

Dear Mr. Hughes:

The American Council of Life Insurers (ACLI) appreciates the opportunity to submit the comments below, concerning the exposed draft revisions to Chapter 20 of the General Examination Standards in regard to the *Insurance Holding Company System Regulatory Model Act* (Model #440).

On the March 10, 2022 *Market Conduct Examination Guidelines (D) Working Group* call, regulators and industry stakeholders discussed the Working Groups proposed inclusion of the GCC and LST. It was discussed that if an exam is showing a problem that is ORSA, LST, GCC, etc related they will review what was filed with the financial division and then ask questions to the financial analyst/domestic assigned. We agree with the Working Group's need for including GCC and LST into the examination guidelines, but we propose language changes to the below review criteria:

- Determine if the NAIC Liquidity Stress Test Framework needs to be utilized for a specified data year.
- Determine if there is a holding company system in place. And if so, whether there should be a group capital calculation request from the U.S. Federal Reserve or whether a lead state commissioner should require a group capital calculation for US operations of any non-U.S. based insurance holding company system.

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

The ACLI recommends the Working Group change “determine” and other language around the criteria to read/incorporate “*review or discuss with domestic should there be issue with ORSA, LST or GCC related information.*”

We also recommend that direct reference to the GCC and LST be removed from the Marketing and Sales Standards on page 48 or, in the very least these could be made generic to apply to all prohibited marketing activity for any of the NAIC Model References listed on page 46.

Thank you again for the opportunity to submit comments.

Sincerely,



Gabrielle Griffith
Senior Policy Analyst
202-624-2371
gabriellegriffith@acli.com

Chapter 23—Conducting the Life and Annuity Examination

IMPORTANT NOTE:

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

This chapter provides a format for conducting life insurance and annuity company examinations. Procedures for conducting property/casualty insurance company examinations and other types of specialized examinations—such as managed care organizations, third-party administrators and surplus lines brokers—may be found in separate chapters.

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

- A. Operations/Management
- B. Complaint Handling
- C. Marketing and Sales ([Several specialized Supplemental Checklists are available in Sections H–N of this chapter](#))
- D. Producer Licensing
- E. Policyholder Service
- F. Underwriting and Rating
- G. Claims ([Several specialized checklists are available in Sections H–J of this chapter](#))
- H. [Supplemental Checklist for Marketing and Sales Standard #1](#)
- I. [Supplemental Checklist for Marketing and Sales Standard #4](#)
- J. [Supplemental Checklist for Marketing and Sales Standard #8](#)
- K. [Supplemental Checklist for Marketing and Sales Standard #10](#)
- L. [Supplemental Checklist for Marketing and Sales Standard #12](#)
- M. [Supplemental Checklist for Marketing and Sales Standard #16](#)
- N. [Supplemental Checklist for Marketing and Sales Standard #17](#)

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

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

IIPRC-Approved Products

When conducting an exam that includes products approved by the Interstate Insurance Product Regulation Commission (IIPRC) on behalf of a compacting state, it is important to keep in mind that the uniform standards—and not state-specific statutes, rules and regulations—are applicable to the content and approval of the product. The IIPRC website is www.insurancecompact.org and the uniform standards are located on its rulemaking record. Compacting states have access through the NAIC System for Electronic Rate and Form Filing (SERFF) to product filings submitted to the IIPRC for approval and use in their respective state or jurisdiction and can also

use the export tool in SERFF to extract relevant information. Each IIPRC-approved product filing has a completed reviewer checklist(s) to document the applicable uniform standards compliance review. The IIPRC office should be included when a compacting state(s) is concerned that an IIPRC-approved product constitutes a violation of the provisions, standards or requirements of the compact (including the uniform standards).

A. Operations/Management

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

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**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 1

The regulated entity files all certifications with the insurance department, as required by statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Insurance department records of certifications made by the regulated entity

Others Reviewed

NAIC Model References

Advertisements of Life Insurance and Annuities Model Regulation (#570)

Life Insurance Illustrations Model Regulation (#582) and Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest (AG 49)

Review Procedures and Criteria

The illustration actuary should file a certification with the insurance department annually for all policies for which illustrations are used (Model #582, Section 11). For indexed universal life (IUL) illustrations, AG 49 expands upon and supersedes the illustration requirements in Model #582.

A responsible officer of the insurer, other than the illustration actuary, should certify annually that the illustration formats meet all applicable requirements and that the scales used in insurer-authorized illustrations are those scales certified by the illustration actuary. In addition, the officer must certify that the regulated entity has provided its producers with information about the expense allocation method used and disclosed by the regulated entity in its illustrations (Model #582, Section 11).

Note: The annual certifications should be provided each year by a date determined by the insurer.

Each insurer should file with its annual statement a certificate of compliance executed by an authorized officer stating that the advertisements which were disseminated by or on behalf of the insurer during the statement year complied, or were made to comply, in all respects with the rules governing the advertising of life insurance (Model #570, Section 9C).

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 company about its product(s). It is not typically based on sampling techniques, but it can be. The areas to be considered in this kind of review include all written and verbal advertising and sales materials.

2. Techniques

This area of review should include all advertising and sales material and all producer sales training materials to determine compliance with 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 information provided or to obtain additional information.

As with all of its advertising, regardless of the medium, every insurance company is required to have procedures in place to establish and at all times maintain a system of control over the content, form and method of dissemination of all of its advertisements. All of these advertisements maintained by or for and authorized by the insurer are the responsibility of the insurer.

The exact same regulations and statutes (such as the *Unfair Trade Practices Act* (#880)) that apply to conventional advertising also apply to Internet advertising. Bearing that in mind, when the examiner is reviewing a company's Internet advertisements, it is important to also review the safeguards implemented by the company.

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 shall not have the capacity or tendency to mislead or deceive. Whether an advertisement has the capacity or tendency to mislead or deceive shall be determined upon reviewing the overall impression that the advertisement reasonably may be expected to create upon a person of average education or intelligence within the segment of the public to which the advertisement is directed.

There may be special requirements for applicants age 60 or older. The examiner should refer to statutes, rules and regulations to determine what requirements apply.

In addition to reviewing advertising, examiners should be aware that several NAIC models impose additional duties on regulated entities which go beyond the delivery of accurate information to consumers. If an insurance product is involved and a regulated entity, producer or a registered representative makes a recommendation regarding that insurance product, both insurance suitability laws and insurance replacement laws may apply to the transaction. A person who is advising a consumer about an insurance product, even if it is to replace it with a non-insurance product, must hold an insurance license. An insurance producer who does not hold a license as a registered representative should not give advice or recommendations about securities products.

The *Life Insurance and Annuities Replacement Model Regulation* (#613) was thoroughly updated and expanded in 1998. The new model applies to annuities and life insurance products and requires delivery of certain notices if the proposed purchaser has any existing life insurance or annuity products. Under the new model, insurers are required to have systems in place to monitor compliance with replacement procedures. Under the old model, which is still in place in a number of states, producers generally make a

decision at the point of sale as to whether the transaction involves a replacement. Under either model, market regulators should review insurer systems and should also sample transactions that are not reported as replacements to verify that the insurer's system is effective in properly identifying replacement transactions.

Historically, replacement ratios were quite low. This was due in part to the fact that the definition of a replacement under the "old" *Life Insurance and Annuities Replacement Model Regulation* (#613) only applied to life insurance products and external replacements. Under the prior model, either the producer or the insurer made a decision as to whether the transaction involved a "replacement."

The new model covers internal and external replacement and, if any funds for the new product come from an existing product, the transaction is a replacement and must be reported as such. There are several limited exceptions. Another factor in the increase in replacement activity is the tendency of consumers to move funds between investment and insurance products when the stock market fluctuates. In such transactions, an analysis should be performed to determine whether the insurer has systems in place to supervise its producers. Regulators should review transactions involving the sale or replacement of variable products involving the insurer and its products to verify that a system is in place to confirm that its producers are properly licensed. In the context of the examination, an examiner or analyst is only responsible for reviewing the conduct of insurance producers and conduct which requires an insurance producer license.

~~The *Suitability in Annuity Transactions Model Regulation* (#275) was adopted in 2006. Previously, this model was known as the *Senior Protection in Annuity Transactions Model Regulation*. The 2006 amendments to the previous model removed all references to "senior." The model has been adopted in some states in various forms. Model #275 was revised in 2010 to include new provisions regarding insurer supervision and monitoring of annuity recommendations and continuing education and training requirements for producers. While the previous version of the model imposed a duty on insurers and producers, or the entities they subcontract with, the revised model places the responsibility of supervision and monitoring on the insurer. The language of the revised model provides that an insurer's issuance of an annuity shall be reasonable under all the circumstances actually known to the insurer at the time the annuity is issued. The model was also updated to include a revised definition of annuity, a definition of "replacement" and provisions expanding the scope of the model to include replacement of annuity products.~~

~~The *Suitability in Annuity Transactions Model Regulation* (#275) was adopted in 2020. But it was initially adopted in 2006, and revised in 2010, and was a successor to the *Senior Protection in Annuity Transactions Model Regulation*. The 2006 amendments to the previous model removed all references to seniors among other improvements. Variations of the 2020 model have been adopted in some jurisdictions. Section 989J of the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 ("Dodd-Frank Act") specifically refers to this model regulation as the "Suitability in Annuity Transactions Model Regulation." Section 989J of the Dodd-Frank Act confirmed this exemption of certain annuities from the Securities Act of 1933 and confirmed state regulatory authority. This model also specifically identifies annuities which are exempt. This regulation is a successor regulation that exceeds the requirements of the 2010 model regulation. Examiners should reference their own jurisdiction's versions and adjust review standards accordingly.~~

~~The 2020 version of Model #275 requires producers to act in the best interest of consumers when making a sale or recommendation of an annuity and requires insurers to maintain a system of supervision, and the model lays out specific steps that are required to meet that best interest standard. Provisions of the model set forth duties for insurers and producers and indicate insurers are responsible for compliance with the regulation. The model also indicates the commissioner may order corrective action be taken by the insurer, producer, general agency, contracting agency or independent agency. Because of the different types of requirements, review standards are designed separately for examination of insurers and producers.~~

Licensees are required to maintain, or be able to make available to the commissioner, records of the information required in Model #275 that are collected from the consumer, disclosures made to the consumer, including summaries of oral disclosures and other information used in making the recommendations that were the basis for insurance transactions for state-specific numbers of years after the insurance transaction is completed by the insurer. An insurer is permitted, but shall not be required, to maintain documentation on behalf of a producer. Records required to be maintained by this regulation may be maintained in paper, photographic, micro-process, magnetic, mechanical, or electronic media or by any process that accurately reproduces the actual document.

Market regulators should also be aware that sales of products, such as fixed-index annuities (formerly referred to as equity-indexed annuities) and index life insurance products (such as universal index life insurance) continue to increase. These products typically include features that require an understanding of bonuses, guaranteed elements and an array of interest-crediting methods. In some cases, existing NAIC model laws and regulations may not give specific guidance on all aspects of all products. In such instances, examiners may rely on general principles found in Model #880, the *Life Insurance Disclosure Model Regulation* (#580) and the *Annuity Disclosure Model Regulation* (#245).

Model #582 sets out a variety of requirements to prevent insurers from using misleading illustrations in the sale of life insurance. AG 49, originally adopted by the NAIC in 2015, expands upon and supersedes some of the illustration requirements of Model #582. It provides guidance and limitations for indexed universal life (IUL) illustrations. In simple terms, Section 4 and Section 5 of AG 49 set maximum crediting rates for illustrations. Section 6 addresses illustrations of policy loans, and Section 7 requires illustrations beyond those required in Model #582. The implementation of AG 49 was phased as follows:

- Section 4 and Section 5 shall be effective for all new business and in force life insurance illustrations on policies sold on or after Sept. 1, 2015;
- Effective March 1, 2017, Section 4 and Section 5 shall be effective for all in force life insurance illustrations on policies within the scope of this actuarial guideline, regardless of the date the policy was sold; and
- Section 6 and Section 7 shall be effective for all new business and in force life insurance illustrations on policies sold on or after March 1, 2016.

Testing the compliance of illustrations with Model #582 and AG 49 will be complex, and the examiner will likely seek assistance from an actuary familiar with and capable of testing compliance with Model #582 and AG 49. In such cases, the examiner should work with the actuary to determine the appropriate information to request from the insurer necessary to enable the actuary and examiner in testing the compliance of the illustrations.

Evaluation of compliance with annuity suitability may best be accomplished through a process and procedure review coupled with sampling. The process and procedure portion of the review is a good example of a function where states may wish to coordinate their reviews and share responsibilities. A continuum approach, such as use of a desk audit, may also be appropriate. Sampling enables examiners to evaluate whether the established processes have been clearly communicated and implemented rather than to function as a means to “second-guess” each individual suitability determination. Company programs for reviewing suitability may vary widely and should not be considered a “once-size-fits-all” approach. Annuity products can be designed or tailored to serve a wide variety of clientele and customer objectives.

Some insurers may outsource the administration of their suitability review, while maintaining ultimate responsibility for the outcomes. It may be instructive for examiners to become familiar with the structure and practices of commonly used services that perform suitability reviews. Examiners may also want to become familiar with vendor-owned services commonly used by insurers to document their suitability reviews.

The NAIC *Stranger-Originated Annuity Transactions Sample Bulletin* was adopted by the NAIC in October 2011. The bulletin was developed to address stranger-originated annuity transactions (STOA). Similar to stranger-originated life insurance transactions (STOLI), STOA transactions provide annuity contracts for the benefit of investors.

In STOAs, insurance producers and/or investors offer an individual, who is usually a “stranger” to the producer and/or investor, a nominal fee for the use of the individual’s identity as the annuitant in an investment-oriented annuity.

Typically, individuals targeted to serve as annuitants are in extremely poor health and are not expected to live beyond the first year of the policy. In order to find individuals who meet the aforementioned criteria, producers and/or investors have been known to take out advertisements in papers as well as solicit individuals residing in nursing homes or hospice facilities.

Once an individual has agreed to the set of conditions posed, the producer will complete the annuity application, ensuring that particular riders, such as a bonus rider or a guaranteed minimum death benefit, are in place to maximize the rate of return for those financing the transaction. Depending on the number of companies the producer represents and the commission policies in effect, the producer may seek to use multiple policies from various companies.

To avoid added scrutiny of the policy or detection of the scheme, producers and/or investors involved in STOAs will often take precautions to ensure that the dollar amount of the annuity falls below specific underwriting guidelines, while other annuities above these dollar amounts are subject to more stringent underwriting. After the annuity is issued, then the investor will significantly increase their investment in the annuity. A trust or an organization may additionally be named as beneficiary of the annuity in order to hide the true identity of those who will benefit from the annuitant’s death.

As the financial implications of STOA transactions could be detrimental to both companies and consumers, the adopted bulletin recommends that insurance companies take certain actions to mitigate their exposure to STOA transactions, which are outlined in the NAIC *Stranger-Originated Annuity Transactions Sample Bulletin*.

It is appropriate for the examiner to remind annuity insurers of this bulletin and to ask if the insurer has considered this bulletin when implementing compliance and/or enterprise risk management procedures.

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 priority of the standard.

DRAFT

STANDARDS MARKETING AND SALES

Standard 1

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

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ All company advertising and sales materials, including radio and audiovisual items, such as television commercials, telemarketing scripts and pictorial materials
- _____ Policy forms, including any required buyers' guides as they coincide with advertising and sales materials
- _____ Producers' own advertising and sales materials
- _____ All documents related to the development of crediting rates used in illustrations

Others Reviewed

- _____
- _____

NAIC Model References

- Advertisements of Life Insurance and Annuities Model Regulation (#570), Section 3B*
- Risk-Based Capital (RBC) for Insurers Model Act (#312), Section 8B*
- Modified Guaranteed Annuity Model Regulation (#255), Section 4B*
- Life Insurance Disclosure Model Regulation (#580), Section 8C*
- Unfair Trade Practices Act (#880)*
- Annuity Disclosure Model Regulation (#245), Section 6 plus appendix*
- Long-Term Care Insurance Model Act (#640)*
- Life Insurance Illustrations Model Regulation (#582) and Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index Based Interest (AG 49)*
- [*Disclosure for Small-Face Amount Life Insurance Policies Model Act \(#605\)*](#)
- Suitability in Annuity Transactions Model Regulation (#275)*
- [*Suitability of Sales of Life Insurance and Annuities White Paper*](#)
- Military Sales Practices Model Regulation (#568)*

Review Procedures and Criteria

Evaluate the company's system for controlling advertisements. Every insurer should have and maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All advertisements—regardless of by whom written, created, designed or presented—are the responsibility of the insurer.

Ensure the company maintains, at its home or principal office, a complete file containing a specimen copy of every printed, published or prepared advertisement of its individual policies and specimen copies of typical printed, published or prepared advertisements of its blanket, franchise and group policies. There should be a notation indicating the manner and extent of distribution and the form number of every policy advertised. All advertisements should be maintained in the file for a period of either 4 years or until the filing of the next regular report on examination of the company, whichever is the longer period of time.

Review advertising materials in conjunction with the appropriate policy form.

Materials should not:

- Misrepresent policy benefits, advantages or conditions by failing to disclose limitations, exclusions or reductions, or use terms or expressions that are misleading or ambiguous;
- Make unfair or incomplete comparisons with other policies;
- Make false, deceptive or misleading statements or representations with respect to any person, company or organization in the conduct of insurance business;
- Offer unlawful rebates;
- Use terminology that would lead a prospective buyer to believe that he/she is purchasing an investment or savings plan. Problematic terminology may include such terms as: investment, investment plan, founder's plan, charter plan, deposit, expansion plan, profit, profits, profit sharing, interest plan, savings or savings plan;
- Omit material information or use words, phrases, statements, references or illustrations, if such omission or such use has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, premium payable, or state or federal tax consequences;
- Use terms such as "non-medical" or "no medical examination required" if the issue is not guaranteed, unless the terms are accompanied by a further disclosure of equal prominence and juxtaposition that issuance of the policy may depend on the answers to the health questions set forth in the application;
- State that a purchaser of a policy will share in or receive a stated percentage or portion of the earnings on the general account assets of the company;
- State or imply that the policy or combination of policies is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless that is the fact. Enrollment periods may not be described as terms such as "special" or "limited" when the insurer uses successive enrollment periods as its usual method of marketing its policies;
- State or imply that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised, because of special advantages available in the policy;
- Offer a policy that utilizes a reduced initial premium rate in a manner that overemphasizes the availability and the amount of the reduced initial premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, all references to the reduced initial premium should be followed by an asterisk or other appropriate symbol which refers the reader to that specific portion of the advertisement which contains the full rate schedule for the policy being advertised;
- Imply licensing beyond limits, if an advertisement is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed;
- Exaggerate the fact, suggest or imply that competing insurers or insurance producers may not be licensed, if the advertisement states that an insurer or insurance producer is licensed in the state where the advertisement appears;
- Create the impression that the insurer, its financial condition or status, the payment of its claims or the merits, desirability or advisability of its policy forms or kinds of plans of insurance are recommended or endorsed by any governmental entity. However, where a governmental entity has recommended or endorsed a policy form or plan, that fact may be stated, if the entity authorizes its recommendation or endorsement to be used in an advertisement;

- State or imply that prospective insureds are or become members of a special class, group or quasi-group and enjoy special rates, dividends or underwriting privileges, unless that is a fact;
- Contain an assertion, representation or statement with regard to the risk-based capital levels of any insurer or of any component derived in the calculation;
- Use the existence of the insurance guaranty association for the purpose of sales, solicitation or inducement to purchase any form of insurance covered by the association;
- Misrepresent the dividends or share of the surplus to be received on any policy;
- Make a false or misleading statement as to the dividends or share of surplus previously paid on a policy;
- Misrepresent any policy as being shares of stock; and
- Illustrations of benefits payable under any modified guaranteed life insurance²⁸ shall not include projections of past investment experience. Hypothetical assumed interest credits may only be used if it is made clear that such are hypothetical only.

Materials should:

- Clearly disclose name and address of insurer;
- If using a trade name, disclose the name of the insurer, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device or reference, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the insurer, or create the impression that a company other than the insurer would have any responsibility for the financial obligation under a policy;
- Prominently describe the type of policy being advertised;
- Indicate that the product being marketed is insurance;
- Comply with applicable statutes, rules and regulations;
- Cite the source of statistics used;
- Identify the policy form that is being advertised, where appropriate;
- Clearly define the scope and extent of a recommendation by any commercial rating system;
- Only include testimonials, appraisals or analysis if they are genuine, represent the current opinion of the author, are applicable to a policy advertised and accurately reproduced to avoid misleading or deceiving prospective insureds. Any financial interest by the person making the testimonial in the insurer or related entity must be prominently disclosed;
- Only state or imply endorsement by a group of individuals, society, association, etc., if it is a fact, and any proprietary relationship or payment for the testimonial must be disclosed; and
- The sales material for any modified guaranteed life insurance must clearly illustrate there can be both upward and downward adjustments to nonforfeiture benefits, due to the application of the market value adjustment formula.

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

Determine if the advertising and solicitation materials mislead consumers relative to the producer's capacity as a life insurance agent. Improper terms may include financial planner, investment advisor, financial consultant or financial counseling, if they imply the producer is primarily engaged in an advisory business in which compensation is unrelated to sales, if such is not the case.

Determine if the company has procedures in place to monitor the use of senior-specific certifications or professional designations used by producers that solicit for the company.

²⁸ "Modified Guaranteed Life Insurance Policy" means an individual policy of life insurance, the underlying assets of which are held in a separate account, and the values of which are guaranteed if held for specified periods. It contains nonforfeiture values that are based upon a market value adjustment formula if held for shorter periods. The formula may, or may not, reflect the value of assets held in the separate account. The assets underlying the policy must be in a separate account during the period or periods when the policyholder can surrender the policy.

Determine if the company allows its life and annuity products to be marketed to the military. If so, review the company procedures to ensure that the procedures are in compliance with all applicable laws and regulations regarding sales to military personnel.

Determine if analogies between a life insurance policy's cash values and savings accounts or other investments and between premium payments and contributions to savings accounts or other investments are complete and accurate.

Determine if the advertisement states or implies in any way that interest charged on a policy loan or the reduction of death benefits by the amount of outstanding policy loans is unfair, inequitable or in any manner an incorrect or an improper practice.

If nonforfeiture values are shown in any advertisement, ensure the values are shown, either for the entire amount of the basic life policy death benefit, or for each \$1,000 of initial death benefit.

Review the use of the words/phrases "free," "no cost," "without cost," "no additional cost," "at no extra cost" or words/phrases of similar import. Such words/phrases should not be used with respect to any benefit or service being made available with a policy, unless true. If there is no charge to the insured, then the identity of the payor must be prominently disclosed. An advertisement may specify the charge for a benefit or a service or may state that a charge is included in the premium or use other appropriate language.

Ensure the advertisement does not contain a statement or representation that premiums paid for a life insurance policy can be withdrawn under the terms of the policy. Reference may be made to amounts paid into an advance premium fund, which are intended to pay premiums at a future time, to the effect that they may be withdrawn under the conditions of the prepayment agreement. Reference may also be made to withdrawal rights under any unconditional premium refund offer.

If an advertisement represents a pure endowment benefit as a "profit" or "return" on the premium paid, rather than as a policy benefit for which a specified premium is paid, it is deemed deceptive and misleading and is prohibited.

Determine that company procedures and materials relative to long-term care (LTC) products comply with "right to free look" requirements.

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

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

For the review of Internet advertisements:

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

A summary of special requirements is available for the following:

- Products sold using enrollment periods;
- Direct response products;
- Graded or modified benefit policies;
- Policies with premium changes;
- Policies with non-guaranteed elements;
- Products sold to students;
- Individual deferred annuity products or deposit funds; and
- Combination life insurance and annuity products.

Review advertising carefully for use of the term “guarantee.” Verify that the scope and duration of any guarantee is accurately described. Determine that the regulated entity has accurately portrayed non-guaranteed elements. Verify that complete information is provided regarding the scope and duration of guarantees.

Review advertising carefully for use of the term “bonus.” Review the functioning of any such bonus payments and verify that the information provided is accurate in describing the amount and the conditions for payment, retention or recoupment of the bonus.

Review advertising carefully for explanations of surrender periods and charges. Review the functioning of any such surrender charge and, in particular, how the charge is calculated in death claims. Verify that the information provided regarding the amount of the charge and the conditions for assessment are accurate.

Index products

For advertising for interest-sensitive products, review explanations of the crediting methods and terms. Review the functioning of the crediting methods to determine that the explanations are understandable and accurate. Verify that accurate information is provided regarding the options available to the consumer and the methods by which the consumer is to exercise the options.

In addition to reviewing the advertising of indexed products, the examiner should review the illustration for compliance with Model #582 to ensure that, among other things, unreasonable or deceptive crediting rates are not being used in the illustrations and that the illustrations provide the consumer with the information required by Model #582 and, for indexed universal life (IUL) products, AG 49. Determine whether the explanations and information provided regarding the options available to the consumer are consistent with the requirements and limitations of Model #582 in AG 49.

Review the methods used by the regulated entity, annually or otherwise, to convey ongoing information about policy/contract values and options available to the consumer to change interest-crediting methods or exercise other policy/contract features in future terms.

**STANDARDS
MARKETING AND SALES**

Standard 2

The insurer's rules pertaining to producer requirements in connection with replacements are in compliance with applicable statutes, rules and regulations.

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Replacement register/Data

_____ Policy/Underwriting files

_____ Loan and surrender files

Others Reviewed

NAIC Model References

Life Insurance and Annuities Replacement Model Regulation (as adopted 1998) (#613)

Suitability in Annuity Transactions Model Regulation (#275)

[*Suitability of Sales of Life Insurance and Annuities White Paper*](#)

Military Sales Practices Model Regulation (#568)

Review Procedures and Criteria

Review loan and surrender files to determine if producers have identified replacement transactions on applications.

Review replacement register and policy/underwriting files to determine if required disclosure forms have been submitted on replacement transactions.

Review policy/underwriting files to confirm receipt of sales material or required statement. Copies of sales material other than regulated entity-approved sales material, if permitted, must also be in the file.

Review replacement disclosure forms for completeness and signatures, as required.

If the applicable state's definition of "recommendation" encompasses replacements, review policy/underwriting files to verify that the producer's treatment of and classification of replacements is in compliance with the applicable state's definition of "recommendation."

Review policy/underwriting files to ensure that the insurance producer, or the insurer where no producer is involved, when recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another insurance transaction or series of insurance transactions, has adequate written documentation of

reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to his or her investments and other insurance products and as to his or her financial situation and needs, including the consumer’s suitability information.

Ensure that producer written documentation regarding suitability contains adequate and complete information to demonstrate that there is a reasonable basis to believe all of the following:

- The consumer has been reasonably informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, potential charges for and features of riders, limitations on interest returns, insurance and investment components and market risk. (Note: If the applicable state has adopted the *Annuity Disclosure Model Regulation* (#245), examiners should be aware that the criteria of this examination standard are intended to supplement and not replace the disclosure requirements of the *Annuity Disclosure Model Regulation* (#245));
- The consumer would benefit from certain features of the annuity, such as tax-deferred growth, annuitization or death or living benefit;
- The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, and riders and similar product enhancements, if any, are suitable (and in the case of an exchange or replacement, the transaction as a whole is suitable) for the particular consumer based on his or her suitability information; and
- In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable including taking into consideration whether:
 - The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits (such as death, living or other contractual benefits), or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;
 - The consumer would benefit from product enhancements and improvements; and
 - The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 36 months.

Review policy/underwriting files to determine that prior to the execution of a replacement of an annuity resulting from a recommendation, an insurance producer has made reasonable efforts to obtain the consumer’s suitability information.

Examiners should be familiar with the term “suitability information” as defined in applicable state statutes, rules or regulations. “Suitability information” means information that is reasonably appropriate to determine the suitability of a recommendation, including:

- Age;
- Annual income;
- Financial situation and needs, including the financial resources used for the funding of the annuity;
- Financial experience;
- Financial objectives;
- Intended use of the annuity;
- Financial time horizon;
- Existing assets, including investment and life insurance holdings;
- Liquidity needs;
- Liquid net worth;
- Risk tolerance; and
- Tax status.

Examine the insurer’s procedures to verify that the insurer has not issued an annuity recommended to a consumer unless there was a reasonable basis to believe the annuity was suitable based on the consumer’s suitability information.

**STANDARDS
MARKETING AND SALES**

Standard 3

The insurer's rules pertaining to replacements are in compliance with applicable statutes, rules and regulations.

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Replacement register/Data
- _____ Policy/Underwriting files
- _____ Agency correspondence file/Agency bulletins
- _____ Agency procedural manual
- _____ Claim files
- _____ Agency sales/lapse records
- _____ Regulated entity systems manual

Others Reviewed

- _____
- _____

NAIC Model References

- Life Insurance and Annuities Replacement Model Regulation* (as adopted 1998) (#613)
- Suitability in Annuity Transactions Model Regulation* (#275)
- [*Suitability of Sales of Life Insurance and Annuities White Paper*](#)
- Military Sales Practices Model Regulation* (#568)
- Stranger-Originated Annuity Transactions (STOA) NAIC Sample Bulletin*

Review Procedures and Criteria

Determine if the regulated entity has advised its producers of its replacement policy.

Determine if the regulated entity has provided timely notice to the existing insurer(s) of the replacement.

Examine for effectiveness the regulated entity's system of identifying undisclosed replacements.

Determine if the regulated entity has the capacity to produce data required by replacement regulation to assess producer replacement activity.

Determine if the regulated entity has issued letters in a timely manner to policyholders, advising of the effects of loans and other disbursements on policy values.

Review policy/underwriting files to determine that the regulated entity is retaining required records for required time frames.

Examine the regulated entity's procedures for verifying producer compliance with requirements on replacement transactions.

Review claim files to determine if the regulated entity provides required credit for suicide and contestability periods on replacements.

If the applicable state's definition of "recommendation" encompasses replacements, review regulated entity procedures to verify that the regulated entity's treatment of and classification of replacements is in compliance with the state's definition of "recommendation."

Review policy/underwriting files to ensure that the insurance producer, or the insurer where no producer is involved, when recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another insurance transaction or series of insurance transactions, has adequate written documentation of reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to his or her investments and other insurance products and as to his or her financial situation and needs, including the consumer's suitability information.

Ensure that regulated entity written documentation regarding suitability contains adequate and complete information to demonstrate that there is a reasonable basis to believe all of the following:

- The consumer has been reasonably informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, potential charges for and features of riders, limitations on interest returns, insurance and investment components and market risk. (Note: If the applicable state has adopted the *Annuity Disclosure Model Regulation* (#245), examiners should be aware that the criteria of this examination standard are intended to supplement and not replace the disclosure requirements of the *Annuity Disclosure Model Regulation* (#245));
- The consumer would benefit from certain features of the annuity, such as tax-deferred growth, annuitization or death or living benefit;
- The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, and riders and similar product enhancements, if any, are suitable (and in the case of an exchange or replacement, the transaction as a whole is suitable) for the particular consumer based on his or her suitability information.
- In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable including taking into consideration whether:
 - The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits (such as death, living or other contractual benefits), or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;
 - The consumer would benefit from product enhancements and improvements; and
 - The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 36 months.

Review policy/underwriting files to ensure that prior to the execution of a replacement of an annuity resulting from a recommendation, an insurer, where no producer is involved, has made reasonable efforts to obtain the consumer's suitability information.

Examiners should be familiar with the term “suitability information” as defined in applicable state statutes, rules or regulations. “Suitability information” means information that is reasonably appropriate to determine the suitability of a recommendation, including:

- Age;
- Annual income;
- Financial situation and needs, including the financial resources used for the funding of the annuity;
- Financial experience;
- Financial objectives;
- Intended use of the annuity;
- Financial time horizon;
- Existing assets, including investment and life insurance holdings;
- Liquidity needs;
- Liquid net worth;
- Risk tolerance; and
- Tax status.

Examine the insurer’s procedures to verify that the insurer has not issued an annuity recommended to a consumer unless there was a reasonable basis to believe the annuity was suitable based on the consumer’s suitability information.

Note: All documents necessary to review the appropriateness of a sale may not be in the insurer’s possession. It may be necessary to give the insurer additional lead time to obtain the documents from a producer, a third party reviewer or other entity.

Examiners may wish to remind insurers that sell annuities of the existence of the *Stranger-Originated Annuity Transactions (STOA) NAIC Sample Bulletin* because sales of stranger-originated annuities may be an indicator of potentially fraudulent transactions.

**STANDARDS
MARKETING AND SALES**

Standard 4

An illustration used in the sale of a policy contains all required information and is delivered in accordance with statutes, rules and regulations.

Apply to: All life products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Actuarial records

_____ All documents related to the development of crediting rates used in illustrations

_____ Underwriting file

Others Reviewed

NAIC Model References

Life Insurance Illustrations Model Regulation (#582) and Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index Based Interest (AG 49)

Universal Life Insurance Model Regulation (#585)

Variable Life Insurance Model Regulation (#270)

Life Insurance Disclosure Model Regulation (#580)

[Disclosure for Small Face Amount Life Insurance Policies Model Act \(#605\)](#)

Review Procedures and Criteria

Note: Some policies may be deemed to be sold without an illustration.

If a jurisdiction continues to require surrender cost indices, ensure it is appropriately disclosed in the Statement of Policy Cost and Benefit.

Ensure that the insurer, its producers or authorized representatives do not:

- Represent the policy as anything other than a life insurance policy;
- Use or describe non-guaranteed elements in a manner that is misleading or has the capacity or tendency to mislead;
- State or imply that the payment or amount of non-guaranteed elements is guaranteed;
- Use an illustration that does not comply with statutes;
- Use an illustration that at any policy duration depicts policy performance more favorable to the policyowner than that produced by the illustrated scale of the insurer whose policy is being illustrated;
- Provide an applicant with an incomplete illustration;
- Represent in any way that premium payments will not be required for each year of the policy in order to maintain the illustrated death benefits, unless that is the fact;

- Use the terms “vanish,” “vanishing premium” or similar terms that imply that the policy becomes paid-up, to describe a plan for using non-guaranteed elements to pay a portion of future premiums;
- Except for policies that can never develop nonforfeiture values, use an illustration that is “lapse-supported”; or
- Use an illustration that is not “self-supporting.”

Ensure that the insurer has a documented, reasonable methodology for the manner in which it determines its index-crediting strategy. Verify that the insurer has a system which monitors the interest rates used by its insurance producers in illustrations for compliance with the insurer’s credited interest rates.

Model #582 sets out a variety of requirements to prevent insurers from using unreasonable or misleading illustrations in the sale of life insurance. AG 49, originally adopted by the NAIC in 2015, expands upon and supersedes some of the illustration requirements of Model #582 for indexed universal life (IUL) illustrations. In simple terms, Section 4 and Section 5 of AG 49 set maximum crediting rates for illustrations. Section 6 addresses illustrations of policy loans, and Section 7 requires illustrations beyond those required in Model #582. The implementation of AG 49 was phased as follows:

- Section 4 and Section 5 shall be effective for all new business and in force life insurance illustrations on policies sold on or after Sept. 1, 2015;
- Effective March 1, 2017, Section 4 and Section 5 shall be effective for all in force life insurance illustrations on policies within the scope of this actuarial guideline, regardless of the date the policy was sold; and
- Section 6 and Section 7 shall be effective for all new business and in force life insurance illustrations on policies sold on or after March 1, 2016.

Testing the compliance of illustrations with Model #582 and AG 49 will be complex, and the examiner will likely seek assistance from an actuary familiar with and capable of testing compliance with Model #582 and AG 49. In such cases, the examiner should work with the actuary to determine the appropriate information to request from the insurer necessary to enable the actuary and examiner in testing the compliance of the illustrations.

The examiner may be able to test implementation compliance issues by confirming that IUL illustration changes were made on or before the effective dates set out above. For example:

- Did the insurer implement on or before Sept. 15, 2015, a compliant crediting rate methodology for new and in force illustrations on policies sold on or after Sept. 15, 2015?
- Did the insurer implement on or before March 1, 2016, a compliant credit rate methodology for all new illustrations produced on or after March 1, 2016, on in force policies?
- Did the insurer implement the policy loan and additional illustration scales requirement of Section 6 and Section 7 of AG 49 on or before March 1, 2016?

The following are more complex requirements of AG 49, which may require the assistance of an actuary or other person with expertise in evaluating illustration crediting methodologies and calculations:

- For new business and in force life insurance illustrations on policies sold on or after Sept. 1, 2015, determine whether the credited rate for the Illustrated Scale has been limited according to the requirements of Section 4;
- For new business and in force life insurance illustrations on policies sold on or after Sept. 1, 2015, determine whether the earned interest rate for the Disciplined Current Scale has been limited according to the requirements of Section 5;
- For new business and in force life insurance illustrations on policies sold on or after March 1, 2016, ensure that if the illustration includes a loan, the illustrated rate credited as compared to the illustrated loan charge has been limited according to the requirements of Section 6;
- For new business and in force life insurance illustrations on policies sold on or after March 1, 2016, ensure that the basic illustration includes a ledger using the Alternate Scale shown alongside a ledger using the illustrated scale with equal prominence according to the requirements of Section 7.A;

- For new business and in force life insurance illustrations on policies sold on or after March 1, 2016, ensure that the basic illustration includes a table showing the minimum and maximum of the geometric average annual credited rates as referenced in Section 7.B; and
- For new business and in force life insurance illustrations on policies sold on or after March 1, 2016, ensure that the basic illustration includes a table showing actual historical index changes and corresponding hypothetical interest rates using current index parameters for the most recent 20-year period for each Index Account illustrated, as required by Section 7.C.

Ensure that the insurer has established requirements for producers to provide universal life applicants with a “Statement of Policy Information.” The statement should substantially follow the format set forth in the *Universal Life Insurance Model Regulation* (#585). Insurers that use direct response solicitation of universal life insurance products should provide such a statement at the time of policy delivery.

Ensure illustrations are retained in accordance with statutes, rules and regulations. A copy of the basic illustration and a revised basic illustration (if any) signed, as applicable, or a certification that either no illustration was used or that the policy was applied for other than as illustrated, should be retained until 3 years after the policy is no longer in force.

Determine if the illustration is submitted to the regulated entity as required.

- If a basic illustration is used by an insurance producer or other authorized representative of the insurer in the sale of a life insurance policy and the policy is applied for as illustrated, a copy of the illustration must be submitted to the insurer at the time of policy application. A copy must also be provided to the applicant.
- If the policy is issued other than as applied for:
 - A revised basic illustration conforming to the policy as issued should be sent with the policy;
 - The revised illustration should be labeled “Revised Illustration”;
 - The illustration should be signed and dated by the applicant or policyowner and producer or other authorized representative of the insurer no later than the time the policy is delivered; and
 - A copy must be provided to the insurer and the policyowner.
- If no illustration is used by an insurance producer or other authorized representative, or if the policy is applied for other than as illustrated:
 - The producer or representative must certify to that effect in writing on a form provided by the insurer;
 - The applicant should acknowledge (on the same form) that no illustration conforming to the policy applied for was provided and also acknowledge an understanding that an illustration conforming to the policy as issued will be provided no later than the time of policy delivery; and
 - The form must be submitted to the insurer at the time of application.
- If the basic or revised illustration is sent by mail from the insurer:
 - It should include instructions for the applicant/policyowner to sign the duplicate copy of the numeric summary page and return the signed copy; and
 - An insurer’s obligation will be satisfied if it demonstrates a diligent effort to obtain the signature. Diligent effort includes the mailing of a self-addressed postage-prepaid envelope with instructions for the return of the signed page.

Ensure a signed copy of the basic illustration and revised basic illustration, if any, or a certification that either no illustration was used or that the policy was applied for other than as illustrated is retained until 3 years after the policy is no longer in force. (A copy does not have to be retained if the policy is not issued.)

A summary of illustration requirements is available with special requirements for:

- Basic illustrations;
- Supplemental illustrations;
- Interest-indexed universal life;
- Universal life; and
- Variable life.

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**STANDARDS
MARKETING AND SALES**

Standard 5

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

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Producer records

_____ Training materials

_____ Procedure manuals

Others Reviewed

NAIC Model References

Variable Life Insurance Model Regulation (#270), Section 3C

Suitability in Annuity Transactions Model Regulation (#275)

[*Suitability of Sales of Life Insurance and Annuities White Paper*](#)

Stranger-Originated Annuity Transactions (STOA) NAIC Sample Bulletin

Review Procedures and Criteria

Determine if multiple sales of the same product have been made to individuals. Identify and review a random sample of policyholders for which multiple policies exist.

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

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

Determine if negative enrollment practices are permitted and used.

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

For annuity products, ensure the regulated entity maintains a written statement specifying the standards of suitability used by the insurer. The standards should specify that an insurer’s issuance of an annuity shall be reasonable under all the circumstances actually known to the insurer at the time the annuity is issued.

Review whether the insurer has established a system of STOA-related oversight (underwriting criteria). If not, discuss the existence of the STOA bulletin with the insurer. The examiner should be mindful that the provisions within the bulletin may not be legally required by their jurisdiction.

Inquire if the company has detected any STOA transactions and if so, the examiner may want to determine if there were any suitability issues surrounding the sale of the STOA. If there were suitability issues, the examiner may want to inquire as to what actions were taken by the company to prevent further suitability issues and if the company took any action against the producer.

Note: Sales made in compliance with Financial Industry Regulatory Authority (FINRA) requirements pertaining to suitability and supervision of annuity transactions shall satisfy the requirements under this regulation. Examiners should be mindful of the fact that both variable annuity sales and variable life sales are typically sold using FINRA requirements.

Examiners may wish to remind insurers that sell annuities of the existence of the *Stranger-Originated Annuity Transactions NAIC Sample Bulletin* because sales of stranger-originated annuities may result in adverse suitability situations.

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**STANDARDS
MARKETING AND SALES**

Standard 6

Preneed funeral contracts or prearrangement disclosures and advertisements are in compliance with statutes, rules and regulations.

Apply to: All preneed products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

Life Insurance Disclosure Model Regulation (#580), Section 7

Advertisements of Life Insurance and Annuities Model Regulation (#570), Section 5Y

Review Procedures and Criteria

Ensure there is evidence that the disclosures have been made in accordance with statutes, rules and regulations.

A summary of special requirements for preneed disclosures is available.

Advertisements for a preneed funeral contract or prearrangement that is funded or is to be funded by a life insurance policy or annuity contract should disclose the following:

- The fact that a life insurance or annuity contract is involved or being used to fund a prearrangement; and
- The nature of the relationship among the soliciting producer or producers, the provider of the funeral or cemetery merchandise or services, the administrator and any other person.

**STANDARDS
MARKETING AND SALES**

Standard 7

The regulated entity's policy forms provide required disclosure material regarding accelerated benefit provisions.

Apply to: All individual and group life insurance

Priority: Essential

Documents to be Reviewed

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

_____ Claim procedure/underwriting manuals

_____ Claim files

Others Reviewed

NAIC Model References

Accelerated Benefits Model Regulation (#620)

Review Procedures and Criteria

The terminology “accelerated benefit” shall be included in the descriptive title.

Disclosure is required that receipt of accelerated benefits may be a taxable event, and assistance should be sought from a personal tax advisor.

Disclosure providing description of accelerated benefit and definitions of the conditions or occurrences triggering payment of the benefits shall be given to the applicant.

Products marketed under this regulation shall not be described as long-term care insurance (LTCI) or as providing LTC benefits.

**STANDARDS
MARKETING AND SALES**

Standard 8

Policy and contract application forms used by depository institutions provide required disclosure material regarding insurance sales.

Apply to: All individual and group life insurers and depository institutions

All covered persons²⁹ as defined by the Gramm-Leach-Bliley Act. This includes any person who sells, solicits, advertises or offers an insurance product or annuity to a consumer at an office of the depository institution or on behalf of a depository institution.

Priority: Essential

Documents to be Reviewed

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

_____ Underwriting manuals

_____ Policy and contract application forms

_____ Policy files

Others Reviewed

NAIC Model References

Bulletin pertaining to Voluntary Expedited Filing Procedures for Insurance Applications Developed to allow Depository Institutions to meet their Disclosure Obligations under Section 305 of the Gramm-Leach-Bliley Act

Review Procedures and Criteria

One notice provides the written disclosures that must be given to a consumer in connection with an initial purchase of an insurance or annuity product that is unrelated to an extension of credit.

The other notice provides the written disclosures that must be given to a consumer in connection with the solicitation, offer or sale of an insurance or annuity product that is related to an extension of credit.

For notices unrelated to an extension of credit: (1) the disclosure notice must inform the consumer that neither insurance nor annuities are a deposit, other obligation of, or guaranteed by the bank or any affiliate of the bank; (2) that neither insurance nor annuities are insured by the Federal Deposit Insurance Corporation (FDIC) or any agency of the United States, the bank or any affiliate; and (3) that there is the potential for investment risk, including the possible loss of value. (Note: The last requirement may not be required for all products.)

²⁹ Please refer to the bulletin for a detailed explanation of what constitutes a covered person.

For notices related to an extension of credit (which includes solicited, offered or sold): (1) the bank or savings association must inform the consumer that it cannot condition the extension of credit upon the consumer also purchasing an insurance product or annuity from the bank or the bank's affiliate; (2) the bank or savings association must inform the consumer that it cannot condition the extension of credit upon the consumer not obtaining an insurance product or annuity from an entity not affiliated with the bank. In addition, (3) the disclosure notice must inform the consumer that neither insurance nor annuities are a deposit, other obligation of, or guaranteed by the bank or any affiliate of the bank; (4) that neither insurance nor annuities are insured by the Federal Deposit Insurance Corporation (FDIC) or any agency of the United States, the bank, or any affiliate; and (5) that there is the potential for investment risk, including the possible loss of value. Note: The last requirement may not be required for all products.

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**STANDARDS
MARKETING AND SALES**

Standard 9

Insurer rules pertaining to producer requirements with regard to suitability in annuity transactions are in compliance with applicable statutes, rules and regulations.

Apply to: All annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy/Other relevant files

_____ New business reports

_____ Policy/Underwriting files

Others Reviewed

NAIC Model References

Suitability in Annuity Transactions Model Regulation (#275)

[*Suitability of Sales of Life Insurance and Annuities White Paper*](#)

Review Procedures and Criteria

If the insurer has a business rule that calls for completion of a fact-finder or similar disclosure document, review policy files to determine if forms have been completed regarding suitability.

Review policy files. Copies of sales material other than insurer-approved materials, if permitted, must also be in the file or made available to the regulator upon request.

Examine for effectiveness the insurer's system of verifying that, prior to the execution of a purchase, exchange or replacement of an annuity resulting from a recommendation, an insurance producer, or an insurer where no producer is involved, has made reasonable efforts to obtain the consumer's suitability information.

Examiners should be familiar with the term "suitability information" as defined in applicable state statutes, rules or regulations. "Suitability information" means information that is reasonably appropriate to determine the suitability of a recommendation, including:

- Age;
- Annual income;
- Financial situation and needs, including the financial resources used for the funding of the annuity;
- Financial experience;
- Financial objectives;
- Intended use of the annuity;
- Financial time horizon;

- Existing assets, including investment and life insurance holdings;
- Liquidity needs;
- Liquid net worth;
- Risk tolerance; and
- Tax status.

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

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

Review the insurer's system of monitoring sales made in compliance with FINRA annuity suitability and supervision requirements and applicable state annuity suitability statutes, rules and regulations. An insurer may demonstrate compliance in this area by:

- Monitoring the FINRA member broker-dealer using information collected in the normal course of an insurer's business; and
- Providing to the FINRA member broker-dealer information and reports that are reasonably appropriate to assist the FINRA member broker-dealer to maintain its supervision system.

Examine for effectiveness the insurer's system for review or oversight of annuity transactions that either may have violated the insurer's suitability procedures or where no suitability analysis was performed because:

- No recommendation was made;
- A recommendation was made and was later found to have been prepared based on inaccurate material information provided by the consumer;
- A customer refused to provide relevant suitability information and the annuity transaction was not recommended; or;
- A consumer decided to enter into an annuity transaction that was not based on a recommendation of the insurer or the insurance producer.

Review completed annuity transactions and compare the information obtained by the insurance producer to the type of product purchased to verify that when recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another transaction or series of transactions, the insurance producer, or the insurer, where no producer is involved, had reasonable grounds for believing that the product was suitable on the basis of the facts disclosed by the consumer as to his/her investments and other insurance products and as to his/her financial situation and needs, including the consumer's suitability information, and that there is a reasonable basis to believe all of the following:

- The consumer has been reasonably informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, potential charges for and features of riders, limitations on interest returns, insurance and investment components and market risk. (Note: If the applicable state has adopted the *Annuity Disclosure Model Regulation* (#245), examiners should be aware that the criteria of this examination standard are intended to supplement and not replace the disclosure requirements of the *Annuity Disclosure Model Regulation* (#245));
- The consumer would benefit from certain features of the annuity, such as tax-deferred growth, annuitization or death or living benefit;

- The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, and riders and similar product enhancements, if any, are suitable (and in the case of an exchange or replacement, the transaction as a whole is suitable) for the particular consumer based on his or her suitability information; and

- In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable including taking into consideration whether:
 - The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits (such as death, living or other contractual benefits), or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;
 - The consumer would benefit from product enhancements and improvements; and
 - The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 36 months.

Review policy/underwriting/other files to verify that an insurance producer has at the time of sale:

- Made a record of any recommendation subject to applicable state annuity suitability statutes, rules and regulations;
- Obtained a customer signed statement documenting a customer's refusal to provide suitability information, if any; and
- Obtained a customer signed statement acknowledging that an annuity transaction is not recommended if a customer decides to enter into an annuity transaction that is not based on the insurance producer's or insurer's recommendation.

**STANDARDS
MARKETING AND SALES**

Standard 10

Insurer rules pertaining to suitability in annuity transactions are in compliance with applicable statutes, rules and regulations.

Apply to: All annuity products

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Policy/Underwriting files
- _____ Agency correspondence file/Agency bulletins
- _____ Agency procedural manual
- _____ Claim files
- _____ Complaint log
- _____ Agency sales/lapse records
- _____ Regulated entity's systems manual
- _____ Regulated entity's producer training materials

Others Reviewed

- _____
- _____

NAIC Model References

Suitability in Annuity Transactions Model Regulation (#275)
Suitability of Sales of Life Insurance and Annuities White Paper

Review Procedures and Criteria

~~Determine if the insurer has advised its producers of applicable state statutes, rules and regulations regarding suitability of annuity products and of the insurer's product specific standards, policy and procedures regarding verification of suitability of annuity products.~~

Determine if the insurer has established a system of supervision that includes but is not limited to requirements outlined in Supplemental Checklist K and has advised its producers of applicable state statutes, rules and regulations regarding suitability of annuity products and the insurer's product-specific standards, policy and procedures regarding verification of suitability of annuity products.

It is useful to become acquainted with the definitions in the *Suitability in Annuity Transactions Model Regulation* (#275).

Note: Determine if the insurer has the capacity to produce data required by the applicable state suitability statute, rule or regulation. If optional recordkeeping provisions of the *Suitability in Annuity Transactions Model Regulation* (#275) have been adopted, review policy files to determine that the insurer is retaining required records for required time frames.

~~Examine insurer's procedures for verifying producer supervision and compliance with requirements on suitability. Examine for effectiveness the insurer's system of monitoring and reviewing that when recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another insurance transaction or series of insurance transactions, the insurance producer, or the insurer where no producer is involved, shall have reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to his/her investments and other insurance products and as to his/her financial situation and needs, including the consumer's suitability information, and that there is a reasonable basis to believe all of the following:~~

- ~~• The consumer has been reasonably informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, potential charges for and features of riders, limitations on interest returns, insurance and investment components and market risk. (Note: If the applicable state has adopted the *Annuity Disclosure Model Regulation* (#245), examiners should be aware that the criteria of this examination standard are intended to supplement and not replace the disclosure requirements of the *Annuity Disclosure Model Regulation* (#245)).~~
- ~~• The consumer would benefit from certain features of the annuity, such as tax-deferred growth, annuitization or death or living benefit;~~
- ~~• The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, and riders and similar product enhancements, if any, are suitable (and in the case of an exchange or replacement, the transaction as a whole is suitable) for the particular consumer based on his or her suitability information; and~~
- ~~• In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable including taking into consideration whether:

 - ~~• The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits (such as death, living or other contractual benefits), or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;~~
 - ~~• The consumer would benefit from product enhancements and improvements; and~~
 - ~~• The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 36 months.~~~~

~~Monitor and determine that an insurance producer or, where no insurance producer is involved, the responsible insurer representative, has at the time of sale:~~

- ~~• Made a record of any recommendation subject to applicable state annuity suitability statutes, rules and regulations;~~
- ~~• Obtained a customer signed statement documenting a customer's refusal to provide suitability information, if any; and~~
- ~~• Obtained a customer signed statement acknowledging that an annuity transaction is not recommended if a customer decides to enter into an annuity transaction that is not based on the insurance producer's or insurer's recommendation.~~

~~Monitor and determine that, prior to the execution of a purchase, exchange or replacement of an annuity resulting from a recommendation, an insurance producer or an insurer where no producer is involved, has made reasonable efforts to obtain the consumer's suitability information.~~

~~Examiners should be familiar with the term “suitability information” as defined in applicable state statutes, rules or regulations. “Suitability information” means information that is reasonably appropriate to determine the suitability of a recommendation, including:~~

- ~~• Age;~~
- ~~• Annual income;~~
- ~~• Financial situation and needs, including the financial resources used for the funding of the annuity;~~
- ~~• Financial experience;~~
- ~~• Financial objectives;~~
- ~~• Intended use of the annuity;~~
- ~~• Financial time horizon;~~
- ~~• Existing assets, including investment and life insurance holdings;~~
- ~~• Liquidity needs;~~
- ~~• Liquid net worth;~~
- ~~• Risk tolerance; and~~
- ~~• Tax status.~~

~~Examine the insurer’s procedures to verify that the insurer has not issued an annuity recommended to a consumer unless there was a reasonable basis to believe the annuity was suitable based on the consumer’s suitability information.~~

~~Examine for effectiveness the insurer’s system of recording or monitoring whether an insurance producer or an insurer, proceeded with an annuity transaction that either may have violated the insurer’s suitability procedures or where no suitability analysis was performed because:~~

- ~~• No recommendation was made;~~
- ~~• A recommendation was made and was later found to have been prepared based on inaccurate material information provided by the consumer;~~
- ~~• A consumer refused to provide relevant suitability information and the annuity transaction was not recommended;~~
- ~~• A consumer decided to enter into an annuity transaction that was not based on a recommendation of the insurer or the insurance producer.~~

Verify that the insurer has established a supervision system that is reasonably designed to achieve the insurer’s and its insurance producers’ compliance with applicable state suitability statutes, rules and regulations, including, but not limited to the following criteria:

- Examine the regulated entity’s suitability policies and procedures to verify that the insurer maintains reasonable procedures to inform its insurance producers of the requirements of applicable state suitability statutes, rules and regulations. Verify that the requirements of applicable state suitability statutes, rules and regulations are incorporated into relevant insurance producer training manuals;
- ~~Review the regulated entity’s producer training materials to verify that the insurer establishes standards for insurance producer product training and maintains reasonable procedures to require its insurance producers to comply with the requirements of Section 7 of the *Suitability in Annuity Transactions Model Regulation* (#275). For more information on the requirements of Section 7 of Model #275, see Marketing and Sales Standard 11 in this chapter;~~
- ~~Examine the regulated entity’s producer training materials to ensure that the insurer provides adequate product specific training and training materials which fully explain all material features of its annuity products to its insurance producers;~~
- Review the regulated entity’s suitability policies and procedures to ensure that the insurer maintains adequate procedures for review of each recommendation, prior to issuance of an annuity, that are designed to ensure that there is a reasonable basis to determine that a recommendation is suitable. An insurer’s review procedures may apply a screening system for the purpose of identifying selected transactions for additional review and the insurer’s review process may be accomplished electronically or through other means including, but not limited to, physical review. Such an electronic or other system

may be designed to require additional review only of those transactions identified for additional review by the selection criteria. Additionally, the suitability reviews should consider all internal transactions for a customer even if those transactions occur in multiple states;

- Verify that the insurer maintains reasonable procedures to detect recommendations that are not suitable. Insurer procedures may include, but are not limited to, confirmation of consumer suitability information, systematic customer surveys, interviews, confirmation letters and programs of internal monitoring. If there is no provision in applicable state suitability statutes, rules or regulations to the contrary, an insurer may demonstrate compliance in this area by reviewing all transactions flagged for further internal review while either applying sampling procedures; or by confirming suitability information after issuance or delivery of the annuity; and
- Verify that the insurer annually provides a report to senior management (per Supplemental Checklist K), including to the senior manager responsible for audit functions, which details a review, with appropriate testing, reasonably designed to determine the effectiveness of the supervision system, the exceptions found, and corrective action taken or recommended, if any.

An insurer may contract for performance of one or more functions (including maintenance of procedures) under the criteria set forth in Section 6F(1) of the *Suitability in Annuity Transactions Model Regulation* (#275). An insurer is responsible for taking appropriate corrective action and may be subject to sanctions and penalties pursuant to Section 8 of Model #275 regardless of whether the insurer contracts for performance of a function and regardless of the insurer's compliance with subparagraph (b) of Section 6F(2) of Model #275.

An insurer's supervision system as described above should include supervision of contractual performance by third parties. This includes, but is not limited to, the following criteria:

- Verify that the insurer is monitoring and, as appropriate, conducting audits to assure that contracted function(s) are properly performed; and
- Review insurer procedures to verify that the insurer is annually obtaining a certification from a senior manager who has responsibility for the contracted function(s) that the manager has a reasonable basis to represent, and does represent, that the function is properly performed.

Review agency files and related documentation to verify that insurance producers do not dissuade, or attempt to dissuade, a consumer from:

- Truthfully responding to an insurer's request for confirmation of suitability information;
- Filing a complaint; or
- Cooperating with the investigation of a complaint.

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

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

Review the insurer's system of monitoring sales made in compliance with FINRA annuity suitability and supervision requirements and applicable state annuity suitability statutes, rules and regulations. An insurer may demonstrate compliance in this area by:

- Monitoring the FINRA member broker-dealer using information collected in the normal course of an insurer's business; and
- Providing to the FINRA member broker-dealer information and reports that are reasonably appropriate to assist the FINRA member broker-dealer to maintain its supervision system.

Review insurer records of corrective action taken in mitigation of apparent violations of suitability standards for sales directly by the insurer and by any insurance producers who are acting as agents for the entity.

Determine whether the insurer has elected to maintain records of the information collected from the consumer and other information used in making the recommendations that were the basis for insurance transactions, or if the insurer has elected to require its producers to maintain these records. Verify that such a system is in place and is monitored by the insurer.

Note: Review the insurer's denials for suitability reasons. Review underwriting data to determine if an annuity was subsequently issued to the client. If an annuity was subsequently issued, the examiner may want to select a sampling sample of those files to ensure the sale was appropriate.

It should be noted that the model's supervision system does not require the insurer to address the following:

- A producer's recommendations to consumers of products *other than* the annuities offered by the insurer; or
- Include consideration of or comparison to options available to the producer or compensation relating to those options other than annuities or other products offered by the insurer.

However, these limitations only apply to the insurer's system of supervision and does not exclude these considerations from an analysis of another licensee.

DRAFT

K. Supplemental Checklist for Marketing and Sales Standard #10

Yes	No	Requirement
<u>Ensure the insurer's system of annuity suitability supervision includes from Model #275:</u>		
		<u>The insurer shall establish and maintain reasonable procedures to inform its producers of the requirements of this regulation and shall incorporate the requirements of this regulation into relevant producer training manuals.</u>
		<u>The insurer shall establish and maintain standards for producer product training and shall establish and maintain reasonable procedures to require its producers to comply with the requirements of Section 7 of this regulation.</u>
		<u>The insurer shall provide product-specific training and training materials that explain all material features of its annuity products to its producers.</u>
		<u>The insurer shall establish and maintain procedures for the review of each recommendation prior to the issuance of an annuity that is designed to ensure there is a reasonable basis to determine that the recommended annuity would effectively address the particular consumer's financial situation, insurance needs and financial objectives. Such review procedures may apply a screening system to identify selected transactions for additional review and may be accomplished electronically or through other means including, but not limited to, physical review. These electronic or other monitoring techniques may be designed to require additional review only of those transactions identified for additional review by the selection criteria.</u>
		<u>The insurer shall establish and maintain reasonable procedures to detect recommendations that are not in compliance with Subsections A, B, D, and E. This may include, but is not limited to, confirmation of the consumer's consumer profile information, systematic customer surveys, producer and consumer interviews, confirmation letters, producer statements or attestations and programs of internal monitoring. Nothing in this subparagraph prevents an insurer from complying with this subparagraph by applying sampling procedures, or by confirming the consumer profile information or other required information under this section after issuance or delivery of the annuity.</u> <u>Note: In addition to this language from Model #275, examiners should make sure that the company is reviewing all transactions that have been flagged for further internal review.</u>
		<u>The insurer shall establish and maintain reasonable procedures to assess, prior to or upon issuance or delivery of an annuity, whether a producer has provided to the consumer the information required to be provided under this section.</u>
		<u>The insurer shall establish and maintain reasonable procedures to identify and address suspicious consumer refusals to provide consumer profile information.</u>
		<u>The insurer shall establish and maintain reasonable procedures to identify and eliminate any sales contests, sales quotas, bonuses, and non-cash compensation that are based on the sales of specific annuities within a limited period of time. The requirements of this subparagraph are not intended to prohibit the receipt of health insurance, office rent, office support, retirement benefits, or other employee benefits by employees as long as those benefits are not based upon the volume of sales of a specific annuity within a limited period of time.</u> <u>Note: The intent of this subparagraph (h) is to prohibit sales contests, sales</u>

		<u>quotas, bonuses, and non-cash compensation based on the sale of a particular product within a limited period of time, but not to prohibit general incentives regarding the sales of a company’s products with no emphasis on any particular product.</u>
		<u>The insurer shall annually provide a written report to senior management, including to the senior manager responsible for audit functions, which details a review, with appropriate testing, reasonably designed to determine the effectiveness of the supervision system, the exceptions found, and corrective action taken or recommended if any.</u>
		<u>Nothing in this subsection restricts an insurer from contracting for performance of a function (including maintenance of procedures) required under this subsection. An insurer is responsible for taking appropriate corrective action and may be subject to sanctions and penalties pursuant to Section 8 of this regulation regardless of whether the insurer contracts for performance of a function and regardless of the insurer’s compliance with subparagraph (b) of this paragraph.</u>
		<p><u>An insurer’s supervision system under this subsection shall include supervision of contractual performance under this subsection. This includes, but is not limited to, the following:</u></p> <ul style="list-style-type: none"> <u>• Monitoring and, as appropriate, conducting audits to assure that the contracted function is properly performed; and</u> <u>• Annually obtaining a certification from a senior manager who has responsibility for the contracted function that the manager has a reasonable basis to represent, and does represent, that the function is properly performed.</u>

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**STANDARDS
MARKETING AND SALES**

Standard 11

The insurer has procedures in place to educate and monitor compliance with insurer-specific education and training requirements and with applicable statutes, rules and regulations regarding the solicitation, recommendation and sale of annuity products.

Apply to: All annuity products

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity producer education/training files
- _____ Producer continuing education files
- _____ Producer new business/replacement log
- _____ Regulated entity producer training materials
- _____ Regulated entity standards for product training
- _____ Regulated entity policies and procedures
- _____ Complaint logs, complaint files and producer complaint logs/producer investigation files, if applicable

Others Reviewed

- _____
- _____

NAIC Model References

Suitability in Annuity Transactions Model Regulation (#275)
Unfair Trade Practices Act (#880)
Producer Licensing Model Act (#218)

Review Procedures and Criteria

Review regulated entity policies and procedures to ensure that the regulated entity has adequate procedures in place to provide training, including product-specific training that is appropriate to the specific product being sold. Review the regulated entity's procedures to inform producers of the regulated entity's standards for annuity product training and of applicable state statutes, rules or regulations regarding the solicitation, recommendation and sale of the annuity product.

Monitor and determine if the insurer has taken any actions against producers who lack adequate product knowledge and if so, was the action appropriate for the circumstances.

Compare data in producer continuing education files to applicable data in state insurance department producer continuing education records to monitor and determine that any insurance producer who engages in the sale of annuity products has met the one-time 4 hour credit training course in accordance with applicable state statutes, rules and regulations.

Determine that the regulated entity has adequate procedures in place to verify that a producer has completed necessary training, as required by applicable state statutes, rules and regulations, before allowing the producer to sell an annuity product for that insurer.

Review content of producer training materials for compliance with applicable state statutes, rules and regulations regarding solicitation, recommendation and sales of annuity products. Determine if the insurer product-specific training materials are appropriate and accurately reflect the features of the specific annuity.

Review complaint logs, any applicable complaint files and any producer investigation files for allegations of unsuitable, improper or misleading sales.

Automation Tip:

Examiners should request underwriting, policy and claim data using the NAIC standardized data requests for a period of three to five years. The expanded time frame allows the examiner to trend sales practices for a number of years.

Examiners should then use a program such as ACL to review underwriting data, product data and claims data for possible unsuitable sales.

Examiners can review and trend this data for:

- Sales from producers who were the subject of complaints and/or investigations that alleged unsuitable sales, misrepresentations, or improper sales activities;
- Sales of producers who had a materially large number of replacements or exchanges;
- Sales of producers who sell a materially large number of annuities that pay the highest commissions and have the longest surrender period or have the highest surrender amounts;
- Sales of producers who have had previous sales denied based on suitability reasons;
- Sales of producers who had disciplinary actions – Financial Industry Regulatory Authority (FINRA) and state disciplinary actions;
- Sales from producers who have sold a materially large number of deferred annuities to consumers over age 75;
- Withdrawals from products where the consumer incurred a penalty (a contractual penalty or IRS tax penalty) for taking the withdrawal within two years of purchase of the annuity; and
- Sales from producers who have sold multiple annuities to the same consumer.

Examiners should realize that trending data is not a definitive means to identify unsuitable sales. Further review of the individual transaction will be necessary to determine suitability.

Examiners should cross-reference new business data and data in the replacement logs with the regulated entity's producer education/training files to ensure that prior to a sale of an annuity product the insurance producer has been trained in the regulated entity's standards for the specific annuity product and trained in the applicable state statutes, rules and regulations regarding the solicitation, recommendation and sale of annuity products.

**STANDARDS
MARKETING AND SALES**

Standard 12

The insurer has product-specific training standards and materials designed to provide producers with adequate knowledge of the annuity products recommended prior to soliciting the sale of annuity products. The insurer also must have reasonable procedures in place to require its producers to comply with applicable producer training requirements.

Apply to: All annuity products

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Agency correspondence file/Agency bulletins
- _____ Agency procedural manual
- _____ Agency sales/lapse records
- _____ Systems manuals
- _____ Producer training materials
- _____ Contracts with third-party vendors with compliance responsibilities

Others Reviewed

NAIC Model References

- Suitability in Annuity Transactions Model Regulation (#275)*
- Unfair Trade Practices Act (#880)*
- Producer Licensing Model Act (#218)*
- Suitability of Sales of Life Insurance and Annuities White Paper*

Review Procedures and Criteria

Contact other regulators that may have conducted a recent review of the insurer’s training standards.

[Determine if the insurer has required appropriate training, as outlined in Supplemental Checklist L of this chapter, for its producers.](#)

[It is useful to become acquainted with the definitions and appendices set forth in the *Suitability in Annuity Transactions Model Regulation \(#275\)*.](#)

[The satisfaction of the training requirements of another state that are substantially similar to the provisions of this subsection shall be deemed to satisfy the training requirements.](#)

An insurer shall verify that a producer has completed the annuity training course required under this subsection before allowing the producer to sell an annuity product for that insurer. An insurer may satisfy its responsibility under this subsection by obtaining certificates of completion of the training course or obtaining reports provided by commissioner-sponsored database systems or vendors or from a reasonably reliable commercial database vendor that has a reporting arrangement with approved insurance education providers.

Per Supplemental Checklist L of this chapter Review regulated entity's records to confirm that it verifies producers complete a one-time 4 credit hour general annuity training course prior to soliciting the sale of an annuity product.

Determine if the insurer product-specific training materials are appropriate and accurately reflect the specific annuity being recommended. Review regulated entity's records to determine if, when and how product-specific training occurred prior to a producer recommending an annuity.

Note: Testing is not a requirement of the *Suitability in Annuity Transactions Model Regulation* (#275). Assessing compliance with this standard may require the examiner to access compliance with many facets of Model #275. The insurance producer training requirement of the model regulation requires that producers not solicit the sale of an annuity product unless the producer has adequate product knowledge to recommend the annuity. It is the insurer's responsibility to establish standards for product specific training for its producers. Insurers must also establish reasonable procedures to require its producers to have adequate product knowledge prior to the producer recommending an annuity.

If the examiners believe an unsuitable sale may have occurred, the examiner may need to determine the cause of the unsuitable sale.

Examiners will need to assess the product-specific training materials and determine if the materials were appropriate for the specific product. According to *Suitability in Annuity Transactions Model Regulation* (#275), insurance producers may rely on insurer-provided product-specific training materials and standards to comply with Section 7 of Model #275.

Examiners will also need to assess the procedures the insurer established to require its producers have an adequate product knowledge before the producer recommends the annuity. Specifically the examiners will need to determine if the training for the specific product took place before the recommendation of an annuity, how the producer was trained and if the training was reasonably designed to require the producer to have adequate product knowledge prior to the sale.

Based upon the complexity of the product being offered, there is an expectation that the content of training materials and the way the training occurs may differ.

L. Supplemental Checklist for Marketing and Sales Standard #12

Yes	No	Requirement
<u>Ensure the insurer's and applicable producer's system of annuity suitability supervision and training include:</u>		
		<u>A producer who engages in the sale of annuity products shall complete a one-time four (4) credit training course approved by the department of insurance and provided by the department of insurance-approved education provider.</u>
		<u>Producers who hold a life insurance line of authority on the effective date of this regulation and who desire to sell annuities shall complete the requirements of this subsection within six (6) months after the effective date of this regulation. Individuals who obtain a life insurance line of authority on or after the effective date of this regulation may not engage in the sale of annuities until the annuity training course required under this subsection has been completed.</u>
		<u>The training required under this subsection shall include information on the following topics:</u> <ul style="list-style-type: none"> • <u>The types of annuities and various classifications of annuities;</u> • <u>Identification of the parties to an annuity;</u> • <u>How product-specific annuity contract features affect consumers;</u> • <u>The application of income taxation of qualified and non-qualified annuities;</u> • <u>The primary uses of annuities; and</u> • <u>Appropriate standard of conduct, sales practices, replacement and disclosure requirements.</u>

**STANDARDS
MARKETING AND SALES**

Standard 13

The insurer has procedures in place to provide full disclosure to consumers regarding all sales of products involving fixed-index annuity products, and all sales are in compliance with applicable statutes, rules and regulations.

Apply to: All fixed-index annuity products

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Policy/Underwriting file
- _____ Agency correspondence file/Agency bulletins
- _____ Agency procedural manual
- _____ Claim files
- _____ Complaint log
- _____ Agency sales/lapse records
- _____ Systems manuals
- _____ Producer training materials
- _____ Contracts with third-party vendors with compliance responsibilities

Others Reviewed

NAIC Model References

Unfair Trade Practices Act (#880)

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

Annuity Disclosure Model Regulation (#245), Section 6 plus appendix

Suitability in Annuity Transactions Model Regulation (#275)

[Suitability of Sales of Life Insurance and Annuities White Paper](#)

Review Procedures and Criteria

Review policy files to determine that required records are retained for required time frames.

Examine procedures for verifying producer compliance with established policies and procedures.

Review complaint log for complaints alleging improper or misleading sales practices.

Review claim files for proper crediting and computation of surrender charges at death.

Review commission structure and note any differences between indexed and non-indexed annuity products. If it appears that the difference may be significant enough to provide incentive to a producer to recommend one product over another regardless of suitability, perform further analysis to test that hypothesis.

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**STANDARDS
MARKETING AND SALES**

Standard 14

The insurer has procedures in place to provide full disclosure to consumers regarding all sales of products involving index life, and all sales are in compliance with applicable statutes, rules and regulations.

Apply to: All index life products

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Policy/Underwriting file
- _____ Agency correspondence file/Agency bulletins
- _____ Agency procedural manual
- _____ All documentation demonstrating the development of crediting rates used in illustrations
- _____ Claim files
- _____ Complaint log
- _____ Agency sales/lapse records
- _____ Regulated entity's systems manual
- _____ Regulated entity's producer training materials
- _____ Contracts with third-party vendors with compliance responsibilities

Others Reviewed

NAIC Model References

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

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

Unfair Trade Practices Act (#880)

Life Insurance Illustrations Model Regulation (#582) and Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index Based Interest (AG 49)

Review Procedures and Criteria

Review policy files to determine that the regulated entity is retaining required records for required time frames.

Examine the regulated entity's procedures for verifying producer compliance with the regulated entity's policy and procedures

Review complaint log for complaints alleging improper or misleading sales practices.

Review documentation to ensure compliance of the insurer's illustration methodologies with Model #582, generally, and with AG 49, specifically for indexed universal life (IUL) products. Review documentation to confirm implementation of AG 49 at required effective dates.

Review claim files for proper interest crediting and computation of death claims.

Review commission structure and note any differences between indexed and non-indexed life insurance products. If it appears that differences noted may be significant enough to provide incentive to a producer to recommend one product over another regardless of suitability, perform further analysis to test that hypothesis.

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**STANDARDS
MARKETING AND SALES**

Standard 15

The insurer's underwriting requirements and guidelines pertaining to travel are in compliance with applicable statutes, rules and regulations.

Apply to: All life products

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Life insurance applications and related disclosure and consent forms
- _____ Related questionnaires for applicants
- _____ Underwriting guidelines and field underwriting guidelines for producers
- _____ Review contracts with reinsurers of life insurance and all applicable guidelines from the reinsurer
- _____ Regulated entity's guidelines regarding lawful travel

Others Reviewed

- _____
- _____

NAIC Model References

Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Ensure the regulated entity does not discriminate against individuals by using an individual's past lawful travel to refuse life insurance, refuse to continue existing life insurance, or limit the amount, extent or kind of life insurance available to an individual.

Ensure the regulated entity does not discriminate against individuals by using an individual's future lawful travel plans to refuse life insurance, refuse to continue existing life insurance, or limit the amount, extent or kind of life insurance available to an individual, unless:

- The risk of loss for individuals who travel to a specified destination at a specific time is reasonably anticipated to be greater than if the individuals did not travel to that destination at the time; and
- The risk classification is based on sound actuarial principles and actual or reasonably anticipated experience.

Examples of the exceptions outlined above are future lawful travel plans to areas where the Centers for Disease Control and Prevention (CDC) have issued a highest level alert, including a recommendation for non-essential travel or to areas where there is an ongoing armed conflict involving the military of a sovereign nation foreign to the country of conflict.

Review the life insurers' and reinsurers' underwriting guidelines for guidelines pertaining to past and future travel.

Review applications and any related questionnaires for questions related to past and future travel plans.

Review contracts with applicable reinsurers for content regarding past and future lawful travel plans.

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STANDARDS
MARKETING AND SALES

Standard 16

The insurer does not issue an annuity recommended to a consumer unless there is a reasonable basis to believe the annuity would effectively address the particular consumer’s financial situation, insurance needs and financial objectives based on the consumer’s consumer profile information.

Apply to: All annuity sales and recommendations for products not otherwise excluded by the *Suitability in Annuity Transactions Regulation*

Priority: Essential

Documents to be Reviewed

Applicable statutes, rules and regulations

Policy/Underwriting files including customer profile (if applicable). Note that insurers may (but are not required to) maintain documentation on behalf of their producers. It may be necessary to obtain applicable customer profiles and related materials from the producer(s).

Agency correspondence file/Agency bulletins

Agency procedural manual

Agency sales/lapse records

Regulated entity’s systems manual

Regulated entity’s producer training materials

Others Reviewed

NAIC Model References

Suitability in Annuity Transactions Model Regulation (#275)

Review Procedures and Criteria

Determine if the insurer has advised its producers of applicable state statutes, rules and regulations regarding suitability of annuity products and the insurer’s product-specific standards, policy and procedures regarding verification of the suitability of annuity products.

Note: Determine if the insurer has the capacity to produce data required by the applicable state suitability statute, rule or regulation. If optional recordkeeping provisions of the *Suitability in Annuity Transactions Model Regulation (#275)* have been adopted, review policy files to determine that the insurer is retaining required records for required time frames.

Examine insurer’s procedures for verifying producer supervision and compliance with requirements on suitability. Producer supervision and compliance requirements are set forth in Supplemental Checklist M.

It is useful to become acquainted with the definitions and appendices set forth in the *Suitability in Annuity Transactions Model Regulation* (#275).

The requirements set forth in Supplemental Checklist M do not create a fiduciary obligation or relationship and only create a regulatory obligation as established in this regulation.

The requirements apply to the particular annuity as a whole and the underlying subaccounts to which funds are allocated at the time of purchase or exchange of an annuity, and riders and similar producer enhancements, if any. The requirements do not mean the annuity with the lowest one-time or multiple occurrence compensation structures shall necessarily be recommended.

The requirements do not mean the producer has ongoing monitoring obligations under the care obligation under this paragraph, although such an obligation may be separately owed under the terms of a fiduciary, consulting, investment advising or financial planning agreement between the consumer and the producer.

Nothing in the *Suitability in Annuity Transactions Model Regulation* (#275) should be construed to require a producer to obtain any license other than a producer license with the appropriate line of authority to sell, solicit or negotiate insurance in this state, including but not limited to any securities license, in order to fulfill the duties and obligations contained in this regulation; provided the producer does not give advice or provide services that are otherwise subject to securities laws or engage in any other activity requiring other professional licenses.

Transactions not based on a recommendation (Editor's Note, the previous language "Transactions not based..." is a section heading and is underlined)

- Except as provided under paragraph (2), a producer shall have no obligation to a consumer under subsection A(1) related to any annuity transaction if:
 - No recommendation is made;
 - A recommendation was made and was later found to have been prepared based on materially inaccurate information provided by the consumer;
 - A consumer refuses to provide relevant consumer profile information and the annuity transaction is not recommended; or
 - A consumer decides to enter into an annuity transaction that is not based on a recommendation of the producer.
- An insurer's issuance of an annuity subject to paragraph (1) shall be reasonable under all the circumstances actually known to the insurer at the time the annuity is issued.

Application of the best interest obligation (Editor's Note, the previous language "Application of the..." is a section heading and is underlined)

Any requirement applicable to a producer under this subsection shall apply to every producer who has exercised material control or influence in the making of a recommendation and has received direct compensation as a result of the recommendation or sale, regardless of whether the producer has had any direct contact with the consumer. Activities such as providing or delivering marketing or educational materials, product wholesaling or other back office product support, and general supervision of a producer do not, in and of themselves, constitute material control or influence.

M. Supplemental Checklist for Marketing and Sales Standard #16

Yes	No	Requirement
<u>Ensure the insurer's and applicable producer's system of annuity suitability supervision include (per Model #275):</u>		
		<p><u>Care Obligation. The producer, in making a recommendation shall exercise reasonable diligence, care and skill to:</u></p> <ul style="list-style-type: none"> • <u>Know the consumer's financial situation, insurance needs and financial objectives;</u> • <u>Understand the available recommendation options after making a reasonable inquiry into options available to the producer;</u> • <u>Have a reasonable basis to believe the recommended option effectively addresses the consumer's financial situation, insurance needs and financial objectives over the life of the product, as evaluated in light of the consumer profile information; and</u> • <u>Communicate the basis or basis of the recommendation.</u>
		<p><u>The producer has made reasonable efforts to obtain consumer profile information from the consumer prior to the recommendation of an annuity.</u></p>
		<p><u>The producer considered the types of products the producer is authorized and licensed to recommend or sell that address the consumer's financial situation, insurance needs and financial objectives. This does not require analysis or consideration of any products outside the authority and license of the producer or other possible alternative products or strategies available in the market at the time of the recommendation. Producers shall be held to standards applicable to producers with similar authority and licensure.</u></p>
		<p><u>The consumer profile information, characteristics of the insurer, and product costs, rates, benefits and features are those factors generally relevant in making a determination whether an annuity effectively addresses the consumer's financial situation, insurance needs and financial objectives, but the level of importance of each factor under the care obligation of this paragraph may vary depending on the facts and circumstances of a particular case. However, each factor may not be considered in isolation.</u></p>
		<p><u>The producer has a reasonable basis to believe the consumer would benefit from certain features of the annuity, such as annuitization, death or living benefit or other insurance-related features.</u></p>
		<p><u>In the case of an exchange or replacement of an annuity, the producer shall consider the whole transaction, which includes taking into consideration whether:</u></p> <ul style="list-style-type: none"> • <u>The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits, such as death, living or other contractual benefits, or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;</u> • <u>The replacing product would substantially benefit the consumer in comparison to the replaced product over the life of the product; and</u> • <u>The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 60 months.</u>
		<p><u>Conflict of interest obligation. A producer shall identify and avoid or reasonably manage and disclose material conflicts of interest, including material conflicts of interest related to an ownership interest.</u></p>
		<p><u>Documentation obligation. A producer shall at the time of recommendation or sale:</u></p>

		<ul style="list-style-type: none"> • <u>Make a written record of any recommendation and the basis for the recommendation subject to this regulation;</u> • <u>Obtain a consumer signed statement on a form substantially similar to Appendix B documenting:</u> <ul style="list-style-type: none"> • <u>A customer’s refusal to provide the consumer profile information, if any; and</u> • <u>A customer’s understanding of the ramifications of not providing his or her consumer profile information or providing insufficient consumer profile information; and</u> • <u>Obtain a consumer signed statement on a form substantially similar to Appendix C acknowledging the annuity transaction is not recommended if a customer decides to enter into an annuity transaction that is not based on the producer’s recommendation.</u>
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STANDARDS
MARKETING AND SALES

Standard 17

The insurer has taken steps to ensure that prior to the recommendation or sale of an annuity, the producer has prominently disclosed to the consumer on a form similar to that set forth in the *Suitability in Annuity Transactions Model Regulation*.

Apply to: All annuity sales and recommendations for products not otherwise excluded by the *Suitability in Annuity Transactions Regulation*

Priority: Essential

Documents to be Reviewed

Applicable statutes, rules and regulations

Policy/Underwriting files including customer profile (if applicable). Note that insurers may (but are not required to) maintain documentation on behalf of their producers. It may be necessary to obtain applicable customer profiles and related materials from the producer(s).

Agency correspondence file/Agency bulletins

Agency procedural manual

Agency sales/lapse records

Regulated entity's systems manual

Regulated entity's producer training materials

Others Reviewed

NAIC Model References

Suitability in Annuity Transactions Model Regulation (#275)

Review Procedures and Criteria

Determine if the insurer has advised its producers of applicable state statutes, rules and regulations regarding suitability of annuity products and of the insurer's product-specific standards, policy and procedures regarding annuity product disclosure requirements.

Note: Determine if the insurer has the capacity to produce data required by the applicable state suitability statute, rule or regulation. If optional recordkeeping provisions of the *Suitability in Annuity Transactions Model Regulation* (#275) have been adopted, review policy files to determine that the insurer is retaining required records for required time frames.

Examine insurer's procedures for verifying producer supervision and compliance with requirements on suitability. Producer supervision and compliance requirements are set forth in Supplemental Checklist N.

It is useful to become acquainted with the definitions and appendices set forth in the *Suitability in Annuity Transactions Model Regulation* (#275).

If a state has adopted the *Annuity Disclosure Model Regulation* (#245), the state may have also adopted an additional phrase to explain that the requirements of this section are intended to supplement and not replace the disclosure requirements of the *Annuity Disclosure Model Regulation*. Refer to your state's specific regulation.

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N. Supplemental Checklist for Marketing and Sales Standard #17

Yes	No	Requirement
<u>Ensure the insurer's and applicable producer's system of annuity suitability supervision include:</u>		
		<u>The producer has disclosed a description of the scope and terms of the relationship with the consumer and the role of the producer in the transaction.</u>
		<u>The producer has provided an affirmative statement on whether the producer is licensed and authorized to sell the following products:</u> <ul style="list-style-type: none"> • <u>Fixed annuities;</u> • <u>Fixed indexed annuities;</u> • <u>Variable annuities;</u> • <u>Life insurance;</u> • <u>Mutual funds;</u> • <u>Stocks and bonds; and</u> • <u>Certificates of deposit.</u>
		<u>The producer has provided an affirmative statement describing the insurers the producer is authorized, contracted (or appointed), or otherwise able to sell insurance products for, using the following descriptions:</u> <ul style="list-style-type: none"> • <u>One insurer;</u> • <u>From two or more insurers; or</u> • <u>From two or more insurers although primarily contracted with one insurer.</u>
		<u>The producer has provided a description of the sources and types of cash compensation and non-cash compensation to be received by the producer, including whether the producer is to be compensated for the sale of a recommended annuity by commission as part of the premium or other remuneration received from the insurer, intermediary or other producer or by a fee as a result of a contract for advice or consulting services.</u>
		<u>A notice of the consumer's right to request additional information regarding cash compensation is described in subparagraph (b) of the following checklist provision.</u>
		<u>Upon request of the consumer or the consumer's designated representative, the producer shall disclose:</u> <ul style="list-style-type: none"> • <u>A reasonable estimate of the amount of cash compensation to be received by the producer, which may be stated as a range of amounts or percentages; and</u> • <u>Whether the cash compensation is a one-time or multiple occurrence amount, and if a multiple occurrence amount, the frequency and amount of the occurrence, which may be stated as a range of amounts or percentages.</u>
		<u>Prior to or at the time of the recommendation or sale of an annuity, the producer shall have a reasonable basis to believe the consumer has been informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, any annual fees, potential charges for and features of riders or other options of the annuity, limitations on interest returns, potential changes in non-guaranteed elements of the annuity, insurance and investment components and market risk.</u>

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 and the standards set forth below.

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**STANDARDS
POLICYHOLDER SERVICE**

Standard 1

Reinstatement is applied consistently and in accordance with policy provisions.

Apply to: All life products

Priority: Essential

Documents to be Reviewed

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

_____ Notice of reinstatement

Others Reviewed

NAIC Model References

Review Procedures and Criteria

Determine that notices were sent out in a timely manner.

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

Reinstatements should be applied per policy provisions.

**STANDARDS
POLICYHOLDER SERVICE**

Standard 2

Nonforfeiture options are communicated to the policyholder and contractholder and correctly applied in accordance with the policy contract.

Apply to: All life products

Priority: Essential

Documents to be Reviewed

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

_____ Underwriting file

_____ Policy and contract history file

_____ Regulated entity's procedures manual

Others Reviewed

NAIC Model References

Standard Nonforfeiture Law for Life Insurance (#808)

NAIC Procedure for Permitting Same Minimum Nonforfeiture Standards for Men and Women Insured Under 1980 CSO and 1980 CET Mortality Tables (#811)

Life Insurance Disclosure Model Regulation (#580)

Variable Life Insurance Model Regulation (#270)

Model Policy Loan Interest Rate Bill (#590)

Standard Nonforfeiture Law for Individual Deferred Annuities (#805)

Annuity Nonforfeiture Model Regulation (#806)

Review Procedures and Criteria

Determine if the correct policy option is provided in case of policy lapse.

Review correspondence with policyholders to determine if options were explained adequately.

If there are questions related to the nonforfeiture values, refer to statutes, rules and regulations regarding the calculation of nonforfeiture values for details on calculating the values.

Review the regulated entity's procedures and policies regarding the handling of each type of nonforfeiture transaction (including whether the request may be made verbally).

Cash Surrender Values

- Review the issue date of the policy to determine whether the policy is mature enough to provide surrender values (usually by the end of the second or third year);
- Calculate the service time to process the surrender by subtracting the date the request was received from the date the surrender check was mailed (should be within 60 days);
- Review the calculation of the net cash value to determine the appropriate surrender value (include any outstanding policy loans, policy loan interest and policy dividends);
- Compare calculated surrender value with illustration surrender value. Confirm that any variance can be explained and is in accordance with policy provisions (i.e., interest rates, surrender charges, policy fees);
- Confirm with the regulated entity that there is an audit procedure in place to verify the calculation of surrender values (they are usually calculated systematically);
- Review cash surrender check for accuracy, including mail date; and
- Review returned mail procedures.

Extended Term Insurance (ETI)

- Determine if the ETI was automatic at lapse or policyowner-requested;
- Review the policy's contract language for content;
- Confirm the regulated entity's calculated policy value by taking the face value of the policy adjusted for any indebtedness, such as policy loans or paid-up additions;
- Check to make sure the regulated entity issued the correct amount of term insurance; and
- Confirm with the regulated entity that there is an audit procedure in place to verify the values and calculations made.

Reduced Paid-Up (RPU)

- Determine how the RPU option came about, whether automatic at lapse or policyowner-requested;
- Review the policy's contract language for content;
- Review the calculation of net cash value (including years the policy was in force) to verify the amount used as the net single premium to purchase the paid-up life insurance. Verify that the paid-up insurance is of the same type of policy as the original policy; and
- Confirm with the regulated entity that there is an audit procedure in place to verify the values and calculations made.

Additional Paid-Up

- Review the policy for content and time schedule for allowed increases in coverage;
- Review the policyowner's request to elect the additional paid-up option benefit; and
- Check that evidence of insurability was required before the rider was added to the in force policy.

Automatic Premium Loan (APL)

- Review the policy's contract language for content;
- Review the application to see if the insured elected another option. If not, verify that the grace period expired prior to the initiation of the APL;
- Check the net cash value calculation to make sure that the proper amount was used to deduct the overdue premium; and
- Confirm with the regulated entity that there is an audit procedure in place to verify the values and calculations made.

Note: The examiner should be alert to occurrences of producers automatically selecting the APL option on the insurance application.

Ensure the regulated entity notifies policyowners of material changes to any non-guaranteed factors in accordance with statutes, rules and regulations.

For variable life products with flexible premiums, ensure that a report is sent to the policyholder if the amounts available under the policy on any policy processing day to pay the charges authorized by the policy are less than the amount necessary to keep the policy in force until the next following processing day. The report should include the minimum payment required under the terms of the policy to keep it in force and the length of the grace period for payment of the amount.

Ensure that at the time of processing policy loans, the insurer notifies policyholders of the initial rate of interest, maximum interest rates and the frequency at which rates may be adjusted. Such notice is to be provided within a reasonable time after processing premium loans.

Ensure the insurer sends advance notice to policyholders with loans, advising of any increases in loan rates.

For annuity contracts that provide cash surrender benefits, review the benefit provided to ensure it meets the requirements of statutes, rules and regulations. In no event shall any cash value benefit be less than the minimum nonforfeiture amount. The death benefit shall be at least equal to the cash surrender benefit.

For annuity contracts that do not provide cash surrender benefits, review the benefit provided to ensure it meets the requirements of statutes, rules and regulations. In no event shall the present value of a paid-up annuity be less than the minimum nonforfeiture amount.

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**STANDARDS
POLICYHOLDER SERVICE**

Standard 3

The regulated entity provides each policyowner with an annual report of policy values in accordance with statutes, rules and regulations and, upon request, an in force illustration or contract policy summary.

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

Life Insurance Illustrations Model Regulation (#582), Section 10

Life Insurance Disclosure Model Regulation (#580), Section 5C(1)

Variable Annuity Model Regulation (#250), Section 8

Variable Life Insurance Model Regulation (#270), Section 9

Modified Guaranteed Annuity Model Regulation (#255) Section 11

Universal Life Insurance Model Regulation (#585), Section 9

Review Procedures and Criteria

Note: Traditional life (not universal or variable life) products that are not illustrated or that were issued prior to a jurisdiction's adoption of the equivalent of the *Life Insurance Illustrations Model Regulation* (#582) may not be required to provide annual reports.

If required, ensure annual reports are being provided annually.

For universal life, ensure the report includes:

- The beginning and end date of the current report period;
- The policy value at the end of the previous report period and at the end of the current report period;
- The total amounts that have been credited or debited to the policy value during the current report period, identifying each by type (e.g., interest, mortality, expense and riders);
- The current death benefit at the end of the current report period on each life covered by the policy;
- The net cash surrender value of the policy as of the end of the current report period; and
- The amount of outstanding loans, if any, as of the end of the current report period.

For fixed premium universal life policies, ensure the report includes:

- If, assuming guaranteed interest, mortality and expense loads and continued scheduled premium payments, the policy's net cash surrender value is such that it would not maintain insurance in force until the end of the next reporting period, a notice to this effect should be included in the report.

For flexible premium universal life policies, ensure the report includes:

- If, assuming guaranteed interest, mortality and expense loads, the policy's net cash surrender value will not maintain insurance in force until the end of the next reporting period, unless further premium payments are made, a notice to this effect should be included in the report.

For traditional life policies, where applicable, ensure the report includes:

- Current death benefit;
- Annual contract premium;
- Current cash surrender value;
- Current dividend;
- Application of current dividend; and
- Amount of outstanding loan.

Ensure that if there are policies that do not build nonforfeiture values, an annual report is provided for those years when a change has been made to non-guaranteed policy elements by the insurer.

Determine if the annual report includes an in force illustration. If it does not, it should contain the following notice displayed prominently: **“IMPORTANT POLICYOWNER NOTICE:** You should consider requesting more detailed information about your policy to understand how it may perform in the future. You should not consider replacement of your policy or make changes in your coverage without requesting a current illustration. You may annually request, without charge, such an illustration by calling (insurer's telephone number), writing to (insurer's name) at (insurer's address) or contacting your producer. If you do not receive a current illustration of your policy within 30 days from your request, you should contact your state insurance department.” The insurer may vary the sequential order of the methods for obtaining an in force illustration.

If an adverse change in non-guaranteed elements that could affect the policy has been made by the insurer since the last annual report, the annual report should contain a notice of that fact and the nature of the change prominently displayed.

For variable annuity products, ensure there is a statement or statements reporting the investments held in a separate account. The statement report period should be not more than 4 months prior to the date of mailing. The statement should also include the number of accumulation units and the dollar value of an individual unit or the value of the contractholder's account.

For variable life products, ensure the annual report includes the following:

- The cash surrender value;
- Death benefit;
- Any partial withdrawal or policy loan;
- Any interest charge; and
- Any optional payments.
- The following disclosures:
 - In accordance with the investment experience of the separate account, the cash values and the variable death benefit may increase or decrease;
 - Prominent identification of any value which may be recomputed prior to the next annual report;
 - A statement if the policy guarantees the variable death benefit on the next policy anniversary date will not be less than the variable death benefit specified in the report;
 - For flexible premium policies, a reconciliation of the change since the previous report in cash value and cash surrender value, if different, because of payments made (less deductions for expense charges), withdrawals, investment experience, insurance charges and any other charges made to the cash value;

- The projected cash value and cash surrender value, if different, as of one year from the end of the period covered by the report, assuming that planned periodic premiums, if any, are paid as scheduled;
- Guaranteed costs of insurance are deducted;
- The net return is equal to the guaranteed rate or, in the absence of a guaranteed rate, is not greater than zero;
- If the projected value is less than zero, a warning message should be included that the policy may be in danger of terminating without value in the next 12 months, unless additional premium is paid;
- A summary of the financial statement of the separate account based on the last annual statement filed with the insurance department;
- The net investment return of the separate account for the last year, and, for each year after the first, a comparison of the investment rate of the separate account during the last year with the investment rate during prior years, up to a total of not less than 5 years, when available;
- A list of investments held by the separate account as of a date not earlier than the end of the last year for which an annual statement was filed with the insurance department;
- Any charges levied against the separate account during the previous year; and
- A statement of any change since the last report in the investment objective and orientation of the separate account, in any investment restriction or material quantitative or qualitative investment requirement applicable to the separate account or to the investment advisor of the separate account.

Annual reports for modified guaranteed life insurance policies shall state that the cash value may increase or decrease and shall prominently identify any value that may be recomputed prior to the next statement.

Determine if, upon the request of the policyowner, the insurer furnishes an in force illustration of current and future benefits and values based on the insurer's present illustrated scale. No signature or other acknowledgment of receipt of this illustration is required.

Also, determine, if a policyowner requests one, the insurer provides policy data for the policy. Unless otherwise requested, the data should be provided for 20 consecutive years beginning with the previous policy anniversary and include cash dividends according to the current dividend scale, the amount of outstanding policy loans and the current policy loan interest rate. Values shown should be based on the dividend option in effect at the time of the request. A reasonable fee may be charged for the preparation of the statement.

**STANDARDS
POLICYHOLDER SERVICE**

Standard 4

Upon receipt of a request from a policyholder for accelerated benefit payment, the regulated entity must disclose to the policyholder the effect of the request on the policy's cash value, accumulation account, death benefit, premium, policy loans and liens. The regulated entity must also advise that the request may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements.

Apply to: All individual and group life products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files

_____ Policy files

Others Reviewed

NAIC Model References

Accelerated Benefits Model Regulation (#620), Sections 4, 6D and 8

Review Procedures and Criteria

Review the above documents to determine that proper disclosure has been made.

Verify that prior to payment of accelerated benefits the insurer has obtained from any assignee or irrevocable beneficiary a signed acknowledgment of concurrence for accelerated benefit payout.

The regulated entity may offer waiver of premium in absence of such provision in an existing policy. At the time accelerated benefits are claimed, the insurer must explain any continuing premium requirements to maintain the policy in force.

Unfair discrimination is prohibited.

F. Underwriting and Rating

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

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**STANDARDS
UNDERWRITING AND RATING**

Standard 1
Pertinent information on applications that form a part of the policy and contract is complete and accurate.

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

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

_____ All applications

Others Reviewed

NAIC Model References

Review Procedures and Criteria

Determine if the requested coverage is issued.

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

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

Determine how automatic premium loan options are disclosed on the application.

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

Verify that supplemental applications are used, where appropriate.

**STANDARDS
UNDERWRITING AND RATING**

Standard 2

The regulated entity complies with the specific requirements for Acquired Immune Deficiency Syndrome (AIDS)-related concerns in accordance with statutes, rules and regulations.

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Life insurance applications and related disclosure and consent forms

_____ Health questionnaires for applicants

_____ Medical underwriting guidelines

_____ Regulated entity's guidelines regarding the handling of AIDS-related test results, if such tests are allowed

Others Reviewed

NAIC Model References**Review Procedures and Criteria**

Ensure the regulated entity does not use medical records indicating AIDS-related concerns to discriminate against applicants without medical evidence of disease. Companies shall establish reasonable procedures related to the administration of an AIDS-related test.

- Medical underwriting guidelines may consider factual matters that reveal the existence of a medical condition. For example, no adverse underwriting decision shall be based on medical records that only indicate the applicant demonstrated AIDS-related concerns by seeking counseling from a health care professional;
- Disclosure forms signed by the applicant must clearly disclose the requirement, if any, for applicants to take an AIDS-related test and should be a part of the underwriting file; and
- Applications must contain a consent form for such testing.

Review any application forms and health questionnaires used by the regulated entity or its producers for questions that would require the applicant to provide information regarding sexual orientation.

- Questions may ask if the applicant has been diagnosed with AIDS or AIDS-Related Complex (ARC), if they are designed to establish the existence of the condition, but are not used as a proxy to establish sexual orientation of the applicant.

Ensure the regulated entity or insurance support organization does not use the sexual orientation of an applicant in the underwriting process or in the determination of insurability.

Underwriting guidelines must not consider an applicant's sexual orientation to be a factor in the determination of insurability.

A sample of underwriting files for denied applications should be reviewed to verify that denials were non-discriminatory.

Review inspection reports to determine if they are being used in a discriminatory manner, or ordered on the basis of the regulated entity's guidelines (e.g., based on the amount of insurance).

Neither the marital status, living arrangements, occupation, gender, medical history, beneficiary designation, nor the ZIP code or other territorial classification may be used to establish the applicant's sexual orientation.

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G. Claims

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

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STANDARDS CLAIMS

Standard 1

The regulated entity provides the required disclosure material to policyholders at the time an accelerated benefit payment is requested.

Apply to: All life insurance products that contain a benefit provision or benefit rider for the payment of accelerated benefits

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Claim procedure manuals

_____ Claim files

_____ Claim complaint records

Others Reviewed

NAIC Model References

Accelerated Benefits Model Regulation (#620)

Review Procedures and Criteria

Review the regulated entity's procedures, training manuals and claim bulletins to determine if claim procedures meet the requirements for disclosure at the time benefits are requested. Required disclosures include:

- Disclosure of possible tax consequences and advice that the claimant seek assistance from a tax advisor;
- A written statement to the policyowner and to the irrevocable beneficiary explaining any effect the payment will have on the policy's cash value, accumulation account, death benefit, premium, policy loans and policy liens;
- A statement warning that receipt of accelerated benefits may adversely affect claimant eligibility for government benefits or entitlements;
- Administrative expense charges, if any, applicable to the payment of accelerated benefits;
- Any continuing premium requirement to keep the policy in force;
- Lump sum settlement options are required; and
- Any accidental death benefits remain intact.

Review claim files for documentation that required disclosure notices were issued in a timely manner.

Review claim-related complaint files for complaints from policyowners not receiving required disclosure material.

Accelerated benefits are available on the effective date of the policy or rider for accidents and no more than 30 days following the effective date for illness.

No restrictions are permitted on use of accelerated benefit proceeds.

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**STANDARDS
CLAIMS**

Standard 2

The regulated entity does not discriminate among insureds with differing qualifying events covered under the policy or among insureds with similar qualifying events covered under the policy.

Apply to: All life insurance products that contain a benefit provision or benefit rider for the payment of accelerated benefits

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity's claim procedures manual and claim bulletins

_____ Claims training manual

_____ Claim files

Others Reviewed

NAIC Model References

Accelerated Benefits Model Regulation (#620)

Review Procedures and Criteria

Review procedure manuals, training manuals and the regulated entity's internal claim bulletins to determine if regulated entity standards exist for consistent evaluation of criteria for approval of accelerated benefits payments.

Review claim files to verify that the regulated entity does not apply further conditions on the payment of accelerated benefits beyond those conditions specified in the policy or benefit rider.

STANDARDS CLAIMS

Standard 3

The regulated entity provides the beneficiary, at the time a claim is made, written information describing the settlement options available under the policy and how to obtain specific details relevant to the settlement options.

Apply to: All life insurance companies

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Claim procedure manuals/claim training manuals/claim bulletins
- _____ Claim files
- _____ Claim complaint records
- _____ Disclosures provided to beneficiaries

Others Reviewed

- _____
- _____

NAIC Model References

Retained Asset Accounts Sample Bulletin (#573)

Review Procedures and Criteria

Review the regulated entity's procedures, training manuals and claim bulletins to determine if claim procedures meet the requirements for disclosure at the time benefits are requested. Required disclosures include:

- Written information provided to the beneficiary describing available settlement options under the policy; and
- Written information provided to the beneficiary informing the beneficiary how to obtain specific details regarding available settlement options;

A "retained asset account" as defined in the *Retained Asset Accounts Sample Bulletin (#573)* means any mechanism whereby the settlement of proceeds payable under a life insurance policy is accomplished by the insurer or an entity acting on behalf of the insurer depositing the proceeds into an account with check or draft writing privileges, where those proceeds are retained by the insurer, pursuant to a supplementary contract not involving annuity benefits.

If the regulated entity settles benefits through a retained asset account, examiners should review and verify in accordance with the applicable state's record retention requirements that the regulated entity has established and implemented procedures to ensure that the regulated entity has:

- a) Provided the following written disclosures to the beneficiary before the account is selected, if optional, or established, if not:
 - Payment of the full benefit amount is accomplished by delivery of the “draft book”/“check book”;
 - One draft or check may be written to access the entire amount, including interest, of the retained asset account at any time;
 - Whether other available settlement options are preserved until the entire balance is withdrawn or the balance drops below the regulated entity's minimum balance requirements;
 - A statement identifying the account as either a checking or draft account and an explanation of how the account works;
 - Information about the account services provided and contact information where the beneficiary may request and obtain more details about such services;
 - A description of fees charged, if applicable;
 - The frequency of statements showing the current account balance, the interest credited, drafts/checks written and any other account activity;
 - The minimum interest rate to be credited to the account and how the actual interest rate will be determined;
 - The interest earned on the account may be taxable;
 - Retained asset account funds held by regulated entities are not guaranteed by the Federal Deposit Insurance Corporation (FDIC) but are guaranteed by the state guaranty associations (where permitted by state law). The beneficiary should be advised to contact the National Organization of Life and Health Insurance Guaranty Associations (www.nolhga.com) to learn more about the coverage limitations to his or her account;
 - A description of the regulated entity's policy regarding retained asset accounts that may become inactive; and
- b) Provided the beneficiary with a supplemental contract that clearly discloses the rights of the beneficiary and obligations of the regulated entity under the contract.

Review claim files for documentation that required disclosure notices were issued in a timely manner.

Review claim-related complaint files for complaints from beneficiaries not receiving required disclosure material.

H. Supplemental Checklist for Marketing and Sales Standard #1

Yes	No	Requirement
For companies that use enrollment periods:		
		Advertisements should specify the date by which the applicant must mail the application, which should be not less than 10 days and not more than 40 days from the date the enrollment period is advertised for the first time.
For direct response policies:		
		The advertisement should not state or imply there is a cost savings because there is no insurance producer or commission, unless true.
		The advertisement should not use the terms “inexpensive,” “low cost” or other similar language when the policies are being marketed to persons who are 50 years of age or older when the policy is guaranteed-issue.
For graded or modified benefit policies:		
		The advertisement must prominently display any limitation of benefits.
		If the premium is level and coverage decreases or increases with age or duration, that fact must be prominently disclosed.
		If the death benefit varies with the length of time the policy has been in force, the advertisement should accurately describe and clearly call attention to the amount of minimum death benefit under the policy.
		The advertisement should not use the terms “inexpensive,” “low cost” or other similar language when the policies are being marketed to persons who are 50 years of age or older, when the policy is guaranteed-issue.
For policies with premium changes:		
		The advertisement for a policy with non-level premiums should prominently describe the premium changes.
		An advertisement in which the insurer describes a policy where it reserves the right to change the amount of the premium during the policy term, but which does not prominently describe this feature, is deemed to be deceptive and misleading and is prohibited.
For policies with non-guaranteed policy elements:		
		An advertisement should not utilize or describe non-guaranteed policy elements in a manner that is misleading or has the capacity or tendency to mislead.
		An advertisement should not state or imply that the payment or amount of non-guaranteed policy elements is guaranteed. If non-guaranteed policy elements are illustrated, they must be based on the insurer’s current scale, and the illustration must contain a statement to the effect that they are not to be construed as guarantees or estimates of amounts to be paid in the future.

H. Supplemental Checklist for Marketing and Sales Standard #1 (cont'd)

		An advertisement that includes any illustrations or statements containing or based upon non-guaranteed elements should set forth with equal prominence comparable illustrations or statements containing or based upon the guaranteed elements.
		If an advertisement refers to any non-guaranteed policy element, it should indicate that the insurer reserves the right to change any such element at any time and for any reason. However, if an insurer has agreed to limit this right in any way—such as, for example, if it has agreed to change these elements only at certain intervals or only if there is a change in the insurer’s current or anticipated experience—the advertisement may indicate any such limitation on the insurer’s right.
		An advertisement should not refer to dividends as “tax free” or use words of similar import, unless the tax treatment of dividends is fully explained, and the nature of the dividend as a return of premium is indicated clearly.
For policies sold to students:		
		The envelope in which insurance solicitation material is contained may be addressed to the parent(s) of students. The address may not include any combination of words which imply that the correspondence is from a school, college, university or other education or training institution, nor may it imply that the institution has endorsed the material or supplied the insurer with information about the student, unless such is a correct and truthful statement.
		All advertisements including, but not limited to, informational flyers used in the solicitation of insurance must be identified clearly as coming from an insurer or insurance producer, if such is the case, and these entities must be clearly identified as such.
		The return address on the envelope may not imply that the soliciting insurer or insurance producer is affiliated with a university, college, school or other educational or training institution, unless true.
For individual deferred annuity products or deposit funds:		
		Any illustrations or statements containing or based upon interest rates higher than the guaranteed accumulation interest rates should set forth with equal prominence comparable illustrations or statements containing or based upon the guaranteed accumulation interest rates. The higher interest rates should not be greater than those currently being credited by the company, unless the higher rates have been publicly declared by the company with an effective date for new issues not more than 3 months subsequent to the date of declaration.

H. Supplemental Checklist for Marketing and Sales Standard #1 (cont'd)

		If an advertisement states the net premium accumulation interest rate, whether guaranteed or not, it should also disclose in close proximity thereto and with equal prominence, the actual relationship between the gross and the net premiums.
		If a contract does not provide a cash surrender benefit prior to commencement of payment of annuity benefits, an illustration or statement concerning such contract should prominently state that cash surrender benefits are not provided.
For combination life insurance and annuity products:		
		An advertisement of a life insurance product and an annuity as a single policy or life insurance policy with an annuity rider should include a disclosure before the application is taken (if the policy contains an unconditional refund provision of at least 10 days, the disclosure statement can be delivered with the policy, or upon the applicant's request, whichever occurs sooner). The disclosure defines the gross annual life and premium annuity percentages and guaranteed cash value of the annuity and should include the first 5 policy years, the tenth and twentieth policy years, at least one age from 60 to 70 and the scheduled commencement of annuity payments.

I. Supplemental Checklist for Marketing and Sales Standard #4

For all illustrations: Determine if the illustration contains the following:

Yes	No	Requirement
		The illustration should be clearly labeled "life insurance illustration."
		Name of insurer.
		Name and business address of producer or insurer's authorized representative, if any.
		Name, age and gender of proposed insured except where a composite illustration is permitted.
		Underwriting or rating classification upon which the illustration is based.
		Generic name of the policy, the company product name, if different, and the policy form number.
		Initial death benefit.
		Dividend option election or application of non-guaranteed elements, if applicable.

(*Life Insurance Illustrations Model Regulation* (#582), Section 6A)

Note: "Generic name" means a short title descriptive of the policy being illustrated, such as "whole life," "term life" or "flexible premium adjustable life."

I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

Determine if the *basic* illustration contains or complies with the following:

Yes	No	Requirement
		Date illustration prepared.
		Page numbers for entire illustration and explanatory notes.
		Assumed dates of payment receipt and benefit payout within a policy year.
		The issue age plus the number of years the policy is assumed to have been in force, if the age is shown as a component of tabular detail.
		Assumed payments on which the illustrated benefits and values are based are identified as premium outlay or contract premium. For policies that do not require a specific contract premium, the illustrated payments should be identified as premium outlay.
		Guaranteed death benefits and values available upon surrender, if any, for the illustrated premium outlay or contract premium should be shown and clearly labeled guaranteed.
		Non-guaranteed elements should not be based on a scale more favorable to the policyowner than the insurer's illustrated scale at any duration. These elements should be clearly labeled non-guaranteed.
		Guaranteed elements, if any, should be shown before corresponding non-guaranteed elements, and should be specifically referred to on any page of an illustration that shows or describes only the non-guaranteed elements.
		Account or accumulation value of a policy, if shown, should be identified by the name this value is given in the policy being illustrated and shown in close proximity to the corresponding value available upon surrender.
		Value available upon surrender should be identified by the name this value is given in the policy being illustrated and should be the amount available to the policyowner in a lump sum after deduction of surrender charges, policy loans and policy interest, as applicable.
		Illustration may show policy benefits and values in graphic or chart form in addition to tabular form.
		Non-guaranteed elements should be accompanied by a statement indicating that, "The benefits and values are not guaranteed; the assumptions on which they are based are subject to change by the insurer, and actual results may be more or less favorable."

I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

		If the illustration shows that the premium payor may have the option to allow policy charges to be paid using non-guaranteed values, the illustration must clearly disclose that a charge continues to be required and that, depending on the actual results, the premium payor may need to continue or resume premium outlays. Similar disclosure should be made for premium outlay of lesser amounts or shorter duration than the contract premium. If a contract premium is due, the premium outlay should not be left blank or show zero unless accompanied by an asterisk or similar mark to draw attention to the fact that the policy is not paid.
		If the applicant plans to use dividends or policy values, guaranteed or non-guaranteed, to pay all or a portion of the contract premium policy charges, or for any other purpose, the illustration may reflect those plans and the effect on future policy benefits and values.
		A brief description of the policy being illustrated, including a statement that it is a life insurance policy.
		A brief description of the premium outlay or contract premium, as applicable, for the policy. For a policy that does not require payment of a specific contract premium, the illustration should show the premium outlay that must be paid to guarantee coverage for the term of the policy, subject to maximum premiums allowable to qualify as a life insurance policy under the applicable provisions of the Internal Revenue Code.
		A brief description of any policy features, riders or options, guaranteed or non-guaranteed, shown in the basic illustration, and the effect they may have on the benefits and values of the policy.
		Identification and a brief definition of column headings and key terms used in the illustration.
		The following statement, “This illustration assumes that the currently illustrated non-guaranteed elements will continue unchanged for all years shown. This is not likely to occur. Actual results may be more or less favorable than those shown.”
		Following the narrative summary, a basic illustration should include a numeric summary of the death benefits and values and the premium outlay and contract premium as applicable. For a policy that provides for a contract premium, the guaranteed death benefits and values should be based on the contract premium. This summary should be shown for at least policy years 5, 10, 20 and at age 70, if applicable, on the three bases shown below. For multiple life policies the summary should show policy years 5, 10, 20 and 30.

I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

		<p>The columns of the numeric summary should include:</p> <p>Bases 1: Policy guarantees</p> <p>Bases 2: Insurer's illustrated scale</p> <p>Bases 3: Insurer's illustrated scale used, but with the non-guaranteed elements reduced as follows:</p> <ul style="list-style-type: none"> • Dividends at 50 percent of the dividends contained in the illustrated scale used; • Non-guaranteed credited interest at rates that are the average of the guaranteed rates and the rates contained in the illustrated scale used; and • All non-guaranteed charges, including, but not limited to, term insurance charges and mortality and expense charges, at rates that are the average of the guaranteed rates and the rates contained in the illustrated scale used.
		If coverage would cease before policy maturity or age 100, the year in which coverage ceases should be identified for each of the three bases.
		The following statement signed and dated by the applicant or policyowner: "I have received a copy of this illustration and understand that any non-guaranteed elements illustrated are subject to change and could be either higher or lower. The agent has told me they are not guaranteed."
		The following statement signed and dated by the insurance producer or other authorized representative of the insurer: "I certify that this illustration has been presented to the applicant, and that I have explained that any non-guaranteed elements illustrated are subject to change. I have made no statements that are inconsistent with the illustration."
		<p>A basic illustration must include the following for at least each policy year from one to 10 and for every fifth policy year thereafter, ending at age 100, policy maturity or final expiration, and except for term insurance beyond the 20th year, for any year in which the premium outlay and contract premium, if applicable, is to change:</p> <ul style="list-style-type: none"> • Premium outlay and mode the applicant plans to pay and the contract premium as applicable; • The corresponding guaranteed death benefit, as provided in the policy; • Corresponding guaranteed value available upon surrender, as provided in the policy; • Non-guaranteed elements may be shown if described in the contract. In the case of an illustration for a policy on which the insurer intends to credit terminal dividends, they may be shown if the insurer's current practice is to pay terminal dividends. If any non-guaranteed elements are shown, they must be shown at the same durations as the corresponding guaranteed elements, if any; and • If no guaranteed benefit value is available at any duration for which a non-guaranteed benefit or value is shown, a zero should be displayed in the guaranteed column.

"Basic illustration" means a ledger or proposal used in the sale of a life insurance policy that shows both guaranteed and non-guaranteed elements.

I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

A supplemental illustration may be provided as long as:

Yes	No	Requirement
		It is appended to, accompanied by, or preceded by a basic illustration.
		The non-guaranteed elements shown are not more favorable to the policyowner than the corresponding elements in the basic illustration.
		It contains the same statement required of a basic illustration that non-guaranteed elements are not guaranteed.
		The premium outlay/contract premium must be equal to the premium outlay/contract premium shown in the basic illustration.
		A notice is included referring to the basic illustration for guaranteed elements and other important information.

“Supplemental illustration” means an illustration furnished in addition to a basic illustration that meets the applicable requirements of [*Life Insurance Illustrations Model Regulation* (#582)], and that may be presented in a format differing from the basic illustration, but may only depict a scale of non-guaranteed elements that is permitted in a basic illustration.

I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

Determine if the universal life illustration has the following:

Yes	No	Requirement
		<p>Any statement of policy cost factors or benefits shall contain:</p> <ul style="list-style-type: none"> • The corresponding guaranteed policy cost factors or benefits, clearly identified; • A statement explaining the non-guaranteed nature of any current interest rates, charges or other fees applied to the policy, including the insurer’s rights to alter any of these factors; • Any limitations on the crediting of interest, including identification of those portions of the policy to which a specified interest rate shall be credited; • Any illustration of the policy value shall be accompanied by the corresponding net cash surrender value; • Any statement regarding the crediting of a specific current interest rate shall also contain the frequency and timing by which such rate is determined; • If any statement refers to the policy being interest-indexed, the index shall be described. In addition, a description shall be given of the frequency and timing of determining the interest rate and of any adjustments made to the index in arriving at the interest rate credited under the policy; • Any illustrated benefits based upon non-guaranteed interest, mortality or expense factors shall be accompanied by a statement indicating that these benefits are not guaranteed; and • If the guaranteed cost factors or initial policy cost factor assumptions would result in policy values becoming exhausted prior to the policy’s maturity date, such fact shall be disclosed, including notice that coverage will terminate under such circumstances.

(*Universal Life Insurance Model Regulation* (#585), Section 8A)

I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

Determine whether, in addition to all other illustration requirements, indexed universal life (IUL) illustrations contain or comply with the following requirements specified in *Actuarial Guideline XLIX— The Application of the Life Illustrations Model Regulation to Policies with Index Based Interest* (AG 49). (Section 4 and Section 5 apply to new business and in force illustrations for policies sold on or after Sept. 1, 2015, and Section 6 and Section 7 apply to new business and in force illustrations for policies sold on or after March 1, 2016.)

Yes	No	N/A	Requirement
			The illustration actuary uses the current annual cap for the Benchmark Index Account offered with the illustrated policy (AG 49, Section 4.A.i.).
			The illustration actuary uses a hypothetical, supportable current annual cap for a hypothetical, supportable Index Account that meets the definition of a Benchmark Index Account (AG 49, Section 4.A.ii.). Note: Actuarial judgment may be used by the illustration actuary. Support for the determination of the hypothetical cap may be requested of the illustration actuary by the examiner. The examiner may refer this support to an actuarial or investment specialist for review as necessary.
			The maximum credited rate used for the Illustrated Scale is the arithmetic mean of the geometric average annual credited rates calculated in 4.A. (per AG 49, Section 4.B.). Note: Review may be referred by the examiner to an actuarial or investment specialist as necessary.
			Where other Index Accounts are used in illustrations, the illustration actuary determined the Illustrated Scale (according to AG 49, Section 4.C.). Note: Review may be referred by the examiner to an actuarial or investment specialist as necessary.
			The insurer updated the credited rate for each Index Account (in accordance with AG 49 Section 4.B. and Section 4.C.) within three months of the beginning of the calendar year of the illustration (AG 49, Section 4.D.).
			The illustrated rate credited to the loan balance shall not exceed the illustrated loan charge by more than 100 basis points (AG 49, Section 6).
			The basic illustration includes a ledger using the Alternate Scale shown alongside the ledger using the Illustrated Scale with equal prominence (AG 49, Section 7.A.).
			The basic illustration includes a table showing the minimum and maximum of the geometric average annual credited rates calculated in AG 49, Section 4.A. (AG 49, Section 7.B.).
			The basic illustration includes a table showing actual historical index changes and corresponding hypothetical interest rates using current index parameters for the most recent 20-year period for each Index Account illustrated (AG 49, Section 7.C.).

(*Actuarial Guideline XLIX— The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest*)

I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

Ensure *variable life* illustrations contain or comply with the following:

Yes	No	Requirement
		The hypothetical interest rates used to illustrate accumulated policy values must be an annual effective gross rate after brokerage expenses and prior to any deduction for taxes, expenses and contract charges.
		If illustrations of accumulated policy values are shown, then for the highest interest rate used, one illustration must be based solely upon guarantees contained in the policy contract being illustrated.
		Except for illustrations contained in the prospectus, the pattern of premium payments used in an illustration should be the initial pattern requested by the proposed policyholder at inception or upon changes in face amount requested by the policyholder.
		If the illustrated policy contract provides for a variety of investment options, the illustration may either use an asset charge, which is reasonably representative, or use the asset charge of a particular option. The illustration should clearly identify the asset charge and either label it “hypothetical” or identify the fund.
		The illustration must disclose the transaction charges that will be levied against the contract because of transactions requested in accordance with rights and privileges specified in the policy contract. Any charge for the exercise of a right or privilege upon which the illustration is based must be reflected in the illustrated values. The nature of any other such charges must be disclosed in a clear statement accompanying such illustrations.
		A clear statement must be made following the table of illustrated accumulated policy values that use of hypothetical investment results does not in any way represent actual results or suggest that such results will be achieved and must indicate that the policy values which actually arise will differ from those shown, whenever the actual investment results differ from the hypothetical rates illustrated. Assumptions upon which illustrations are based must be clearly disclosed.
		Any sales illustration to a prospective policyholder must reflect the policy being presented accurately. Misleading statements or captions or other misrepresentations are prohibited.
		The requested sales illustration must be printed clearly and legibly on hard paper copy. An illustration displayed on a computer screen may be used in addition to, but not as a substitute for, hard paper copy.

I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

	<p>In connection with variable life insurance contracts offering both fixed and variable funding options:</p> <ul style="list-style-type: none"> • An illustration of the variable funding option must comply with these guidelines; • If an illustration of the fixed funding option is shown, accumulated policy values must be shown on the basis of guaranteed rates. One or more additional rates may also be shown, but such rates may not exceed current rates; and • A summary illustration may be given in which results from comparable illustrated and hypothetical interest rates are combined. Such summary must cross-reference to the accompanying separate illustrations of the fixed and variable funding options.
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(Life Insurance Illustrations Model Regulation (#582))

J. Supplemental Checklist for Marketing and Sales Standard #8

Yes	No	Requirement
Ensure the disclosures include:		
		The fact that a life insurance policy is involved or being used to fund a prearrangement.
		The nature of the relationship among the soliciting agent or agents, the provider of the funeral or cemetery merchandise or services, the administrator and any other person.
		The relationship of the life insurance policy to the funding of the prearrangement and the nature and existence of any guarantees relating to the prearrangement.
		<p>The impact on the prearrangement of the following:</p> <ul style="list-style-type: none"> • Any changes in the life insurance policy including, but not limited to, changes in the assignment, beneficiary designation or use of the proceeds; • Any penalties to be incurred by the policyholder as a result of failure to make premium payments; • Any penalties to be incurred or monies to be received as a result of cancellation or surrender of the life insurance policy; • A list of the merchandise and services which are applied or contracted for in the prearrangement and all relevant information concerning the price of the funeral services, including an indication that the purchase price is either guaranteed at the time of purchase or to be determined at the time of need; • All relevant information concerning what occurs and whether any entitlements or obligations arise, if there is a difference between the proceeds of the life insurance policy and the amount actually needed to fund the prearrangement; • Any penalties or restrictions, including, but not limited to, geographic restrictions or the inability of the provider to perform, on the delivery of merchandise, services or the prearrangement guarantee; and • The fact that a sales commission or other form of compensation is being paid and, if so, the identity of such individuals or entities to whom it is paid.

The Virginia Bureau of Insurance have the following comments on Chapter 23-Conducting the Life and Annuity Examination:

L. Supplemental Checklist for Marketing and Sales Standard #12, page 43- To be consistent with Checklist K, we recommend changing “Ensure the insurer’s and applicable producer’s system of annuity suitability supervision and training include:” to “Ensure the insurer’s and applicable producer’s system of annuity suitability supervision and training include from Model #275:”.

Also, changing the first requirement from “A producer who engages in the sale of annuity products shall complete a one-time four (4) credit training course approved by the department of insurance and provided by the department of insurance-approved education provider” to “A producer who engages in the sale of annuity products shall complete a one-time four (4) credit training course approved by the department of insurance and provided by the department of insurance-approved education provider to comply with Section 7 of this regulation.”

M. Supplemental Checklist for Marketing and Sales Standard #16, page 52-we recommend changing the fourth bullet point in the first requirement “Communicate the basis or basis of the recommendation” to “Communicate the basis or bases of the recommendation”

N. Supplemental Checklist for Marketing and Sales Standard #17, page 56- To be consistent with Checklist K, we recommend changing “Ensure the insurer’s and applicable producer’s system of annuity suitability supervision include:” to “Ensure the insurer’s and applicable producer’s system of annuity suitability supervision include from Model #275:”.

Also changing the first requirement from “The producer has disclosed a description of the scope and terms of the relationship with the consumer and the role of the producer in the transaction.” to “The producer has disclosed to the consumer, on a form substantially similar to Appendix A, a description of the scope and terms of the relationship with the consumer and the role of the producer in the transaction.”

Chapter 23—Conducting the Life and Annuity Examination

IMPORTANT NOTE:

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

This chapter provides a format for conducting life insurance and annuity company examinations. Procedures for conducting property/casualty insurance company examinations and other types of specialized examinations—such as managed care organizations, third-party administrators and surplus lines brokers—may be found in separate chapters.

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

- A. Operations/Management
- B. Complaint Handling
- C. Marketing and Sales [\(Several specialized Supplemental Checklists are available in Sections H–N of this chapter\)](#)
- D. Producer Licensing
- E. Policyholder Service
- F. Underwriting and Rating
- G. Claims [\(Several specialized checklists are available in Sections H–J of this chapter\)](#)
- H. [Supplemental Checklist for Marketing and Sales Standard #1](#)
- I. [Supplemental Checklist for Marketing and Sales Standard #4](#)
- J. [Supplemental Checklist for Marketing and Sales Standard #8](#)
- K. [Supplemental Checklist for Marketing and Sales Standard #10](#)
- L. [Supplemental Checklist for Marketing and Sales Standard #12](#)
- M. [Supplemental Checklist for Marketing and Sales Standard #16](#)
- N. [Supplemental Checklist for Marketing and Sales Standard #17](#)

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

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

IIPRC-Approved Products

When conducting an exam that includes products approved by the Interstate Insurance Product Regulation Commission (IIPRC) on behalf of a compacting state, it is important to keep in mind that the uniform standards—and not state-specific statutes, rules and regulations—are applicable to the content and approval of the product. The IIPRC website is www.insurancecompact.org and the uniform standards are located on its rulemaking record. Compacting states have access through the NAIC System for Electronic Rate and Form Filing (SERFF) to product filings submitted to the IIPRC for approval and use in their respective state or jurisdiction and can also

Commented [A1]: As it is, the new checklists are peppered in with the Standards. Will they be moved to where the other checklists reside in the handbook for Marketing and Sales? That would seem to make more sense and would be consistent with how it is currently handled elsewhere in the handbook.

use the export tool in SERFF to extract relevant information. Each IIPRC-approved product filing has a completed reviewer checklist(s) to document the applicable uniform standards compliance review. The IIPRC office should be included when a compacting state(s) is concerned that an IIPRC-approved product constitutes a violation of the provisions, standards or requirements of the compact (including the uniform standards).

A. Operations/Management

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

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**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 1
The regulated entity files all certifications with the insurance department, as required by statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Insurance department records of certifications made by the regulated entity

Others Reviewed

NAIC Model References

Advertisements of Life Insurance and Annuities Model Regulation (#570)
Life Insurance Illustrations Model Regulation (#582) and Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest (AG 49)

Review Procedures and Criteria

The illustration actuary should file a certification with the insurance department annually for all policies for which illustrations are used (Model #582, Section 11). For indexed universal life (IUL) illustrations, AG 49 expands upon and supersedes the illustration requirements in Model #582.

A responsible officer of the insurer, other than the illustration actuary, should certify annually that the illustration formats meet all applicable requirements and that the scales used in insurer-authorized illustrations are those scales certified by the illustration actuary. In addition, the officer must certify that the regulated entity has provided its producers with information about the expense allocation method used and disclosed by the regulated entity in its illustrations (Model #582, Section 11).

Note: The annual certifications should be provided each year by a date determined by the insurer.

Each insurer should file with its annual statement a certificate of compliance executed by an authorized officer stating that the advertisements which were disseminated by or on behalf of the insurer during the statement year complied, or were made to comply, in all respects with the rules governing the advertising of life insurance (Model #570, Section 9C).

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 company about its product(s). It is not typically based on sampling techniques, but it can be. The areas to be considered in this kind of review include all written and verbal advertising and sales materials.

2. Techniques

This area of review should include all advertising and sales material and all producer sales training materials to determine compliance with 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 information provided or to obtain additional information.

As with all of its advertising, regardless of the medium, every insurance company is required to have procedures in place to establish and at all times maintain a system of control over the content, form and method of dissemination of all of its advertisements. All of these advertisements maintained by or for and authorized by the insurer are the responsibility of the insurer.

The exact same regulations and statutes (such as the *Unfair Trade Practices Act* (#880)) that apply to conventional advertising also apply to Internet advertising. Bearing that in mind, when the examiner is reviewing a company's Internet advertisements, it is important to also review the safeguards implemented by the company.

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 shall not have the capacity or tendency to mislead or deceive. Whether an advertisement has the capacity or tendency to mislead or deceive shall be determined upon reviewing the overall impression that the advertisement reasonably may be expected to create upon a person of average education or intelligence within the segment of the public to which the advertisement is directed.

There may be special requirements for applicants age 60 or older. The examiner should refer to statutes, rules and regulations to determine what requirements apply.

In addition to reviewing advertising, examiners should be aware that several NAIC models impose additional duties on regulated entities which go beyond the delivery of accurate information to consumers. If an insurance product is involved and a regulated entity, producer or a registered representative makes a recommendation regarding that insurance product, both insurance suitability laws and insurance replacement laws may apply to the transaction. A person who is advising a consumer about an insurance product, even if it is to replace it with a non-insurance product, must hold an insurance license. An insurance producer who does not hold a license as a registered representative should not give advice or recommendations about securities products.

The *Life Insurance and Annuities Replacement Model Regulation* (#613) was thoroughly updated and expanded in 1998. The new model applies to annuities and life insurance products and requires delivery of certain notices if the proposed purchaser has any existing life insurance or annuity products. Under the new model, insurers are required to have systems in place to monitor compliance with replacement procedures. Under the old model, which is still in place in a number of states, producers generally make a

decision at the point of sale as to whether the transaction involves a replacement. Under either model, market regulators should review insurer systems and should also sample transactions that are not reported as replacements to verify that the insurer's system is effective in properly identifying replacement transactions.

Historically, replacement ratios were quite low. This was due in part to the fact that the definition of a replacement under the "old" *Life Insurance and Annuities Replacement Model Regulation* (#613) only applied to life insurance products and external replacements. Under the prior model, either the producer or the insurer made a decision as to whether the transaction involved a "replacement."

The new model covers internal and external replacement and, if any funds for the new product come from an existing product, the transaction is a replacement and must be reported as such. There are several limited exceptions. Another factor in the increase in replacement activity is the tendency of consumers to move funds between investment and insurance products when the stock market fluctuates. In such transactions, an analysis should be performed to determine whether the insurer has systems in place to supervise its producers. Regulators should review transactions involving the sale or replacement of variable products involving the insurer and its products to verify that a system is in place to confirm that its producers are properly licensed. In the context of the examination, an examiner or analyst is only responsible for reviewing the conduct of insurance producers and conduct which requires an insurance producer license.

~~The *Suitability in Annuity Transactions Model Regulation* (#275) was adopted in 2006. Previously, this model was known as the *Senior Protection in Annuity Transactions Model Regulation*. The 2006 amendments to the previous model removed all references to "senior." The model has been adopted in some states in various forms. Model #275 was revised in 2010 to include new provisions regarding insurer supervision and monitoring of annuity recommendations and continuing education and training requirements for producers. While the previous version of the model imposed a duty on insurers and producers, or the entities they subcontract with, the revised model places the responsibility of supervision and monitoring on the insurer. The language of the revised model provides that an insurer's issuance of an annuity shall be reasonable under all the circumstances actually known to the insurer at the time the annuity is issued. The model was also updated to include a revised definition of annuity, a definition of "replacement" and provisions expanding the scope of the model to include replacement of annuity products.~~

~~The *Suitability in Annuity Transactions Model Regulation* (#275) was adopted in 2020. But it and was initially adopted in 2006, and revised in 2010, and was a successor to the *Senior Protection in Annuity Transactions Model Regulation*. The 2006 amendments to the previous model removed all references to seniors among other improvements. Variations of the 2020 model have been adopted in some jurisdictions. Section 989J of the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 ("Dodd-Frank Act") specifically refers to this model regulation as the "*Suitability in Annuity Transactions Model Regulation*." Section 989J of the Dodd-Frank Act confirmed the ~~this~~ exemption of certain annuities from the Securities Act of 1933 and confirmed state regulatory authority. This model also specifically identifies annuities which are exempt. ~~This regulation is a successor regulation that~~ Model #275 exceeds the requirements of the 2010 model regulation. Examiners should reference their own jurisdiction's versions and adjust review standards accordingly.~~

~~The 2020 version of Model #275 requires producers to act in the best interest of consumers when making a sale or recommendation of an annuity and requires insurers to maintain a system of supervision, and the model lays out specific steps that are required to meet that best interest standard. Provisions of the model set forth duties for insurers and producers and indicate states insurers are responsible for compliance with the regulation. The model also indicates provides the commissioner may order corrective action be taken by the insurer, producer, general agency, contracting agency or independent agency. Because of the different types of requirements, review standards are designed separately for examination of insurers and producers.~~

Licenses are required to maintain, or be able to make available to the commissioner, records of the information required in Model #275. These include materials that are collected from the consumer, disclosures made to the consumer, including summaries of oral disclosures and other information used in making the recommendations that were the basis for insurance transactions for state-specific numbers of years after the insurance transaction is completed by the insurer. An insurer is permitted, but shall not be required, to maintain documentation on behalf of a producer. Records required to be maintained by this regulation may be maintained in paper, photographic, micro-process, magnetic, mechanical, or electronic media or by any process that accurately reproduces the actual document.

Market regulators should also be aware that sales of products, such as fixed-index annuities (formerly referred to as equity-indexed annuities) and index life insurance products (such as universal index life insurance) continue to increase. These products typically include features that require an understanding of bonuses, guaranteed elements and an array of interest-crediting methods. In some cases, existing NAIC model laws and regulations may not give specific guidance on all aspects of all products. In such instances, examiners may rely on general principles found in Model #880, the *Life Insurance Disclosure Model Regulation* (#580) and the *Annuity Disclosure Model Regulation* (#245).

Model #582 sets out a variety of requirements to prevent insurers from using misleading illustrations in the sale of life insurance. AG 49, originally adopted by the NAIC in 2015, expands upon and supersedes some of the illustration requirements of Model #582. It provides guidance and limitations for indexed universal life (IUL) illustrations. In simple terms, Section 4 and Section 5 of AG 49 set maximum crediting rates for illustrations. Section 6 addresses illustrations of policy loans, and Section 7 requires illustrations beyond those required in Model #582. The implementation of AG 49 was phased as follows:

- Section 4 and Section 5 shall be effective for all new business and in force life insurance illustrations on policies sold on or after Sept. 1, 2015;
- Effective March 1, 2017, Section 4 and Section 5 shall be effective for all in force life insurance illustrations on policies within the scope of this actuarial guideline, regardless of the date the policy was sold; and
- Section 6 and Section 7 shall be effective for all new business and in force life insurance illustrations on policies sold on or after March 1, 2016.

Testing the compliance of illustrations with Model #582 and AG 49 will be complex, and the examiner will likely seek assistance from an actuary familiar with and capable of testing compliance with Model #582 and AG 49. In such cases, the examiner should work with the actuary to determine the appropriate information to request from the insurer necessary to enable the actuary and examiner in testing the compliance of the illustrations.

Evaluation of compliance with annuity suitability may best be accomplished through a process and procedure review coupled with sampling. The process and procedure portion of the review is a good example of a function where states may wish to coordinate their reviews and share responsibilities. A continuum approach, such as use of a desk audit, may also be appropriate. Sampling enables examiners to evaluate whether the established processes have been clearly communicated and implemented rather than to function as a means to “second-guess” each individual suitability determination. Company programs for reviewing suitability may vary widely and should not be considered a “once-size-fits-all” approach. Annuity products can be designed or tailored to serve a wide variety of clientele and customer objectives.

Some insurers may outsource the administration of their suitability review, while maintaining ultimate responsibility for the outcomes. It may be instructive for examiners to become familiar with the structure and practices of commonly used services that perform suitability reviews. Examiners may also want to become familiar with vendor-owned services commonly used by insurers to document their suitability reviews.

The NAIC *Stranger-Originated Annuity Transactions Sample Bulletin* was adopted by the NAIC in October 2011. The bulletin was developed to address stranger-originated annuity transactions (STOA). Similar to stranger-originated life insurance transactions (STOLI), STOA transactions provide annuity contracts for the benefit of investors.

In STOAs, insurance producers and/or investors offer an individual, who is usually a “stranger” to the producer and/or investor, a nominal fee for the use of the individual’s identity as the annuitant in an investment-oriented annuity.

Typically, individuals targeted to serve as annuitants are in extremely poor health and are not expected to live beyond the first year of the policy. In order to find individuals who meet the aforementioned criteria, producers and/or investors have been known to take out advertisements in papers as well as solicit individuals residing in nursing homes or hospice facilities.

Once an individual has agreed to the set of conditions posed, the producer will complete the annuity application, ensuring that particular riders, such as a bonus rider or a guaranteed minimum death benefit, are in place to maximize the rate of return for those financing the transaction. Depending on the number of companies the producer represents and the commission policies in effect, the producer may seek to use multiple policies from various companies.

To avoid added scrutiny of the policy or detection of the scheme, producers and/or investors involved in STOAs will often take precautions to ensure that the dollar amount of the annuity falls below specific underwriting guidelines, while other annuities above these dollar amounts are subject to more stringent underwriting. After the annuity is issued, then the investor will significantly increase their investment in the annuity. A trust or an organization may additionally be named as beneficiary of the annuity in order to hide the true identity of those who will benefit from the annuitant’s death.

As the financial implications of STOA transactions could be detrimental to both companies and consumers, the adopted bulletin recommends that insurance companies take certain actions to mitigate their exposure to STOA transactions, which are outlined in the NAIC *Stranger-Originated Annuity Transactions Sample Bulletin*.

It is appropriate for the examiner to remind annuity insurers of this bulletin and to ask if the insurer has considered this bulletin when implementing compliance and/or enterprise risk management procedures.

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 priority of the standard.

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**STANDARDS
MARKETING AND SALES**

Standard 1
All advertising and sales materials are in compliance with applicable statutes, rules and regulations.

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ All company advertising and sales materials, including radio and audiovisual items, such as television commercials, telemarketing scripts and pictorial materials
- _____ Policy forms, including any required buyers' guides as they coincide with advertising and sales materials
- _____ Producers' own advertising and sales materials
- _____ All documents related to the development of crediting rates used in illustrations

Others Reviewed

- _____
- _____

NAIC Model References

- Advertisements of Life Insurance and Annuities Model Regulation (#570), Section 3B*
- Risk-Based Capital (RBC) for Insurers Model Act (#312), Section 8B*
- Modified Guaranteed Annuity Model Regulation (#255), Section 4B*
- Life Insurance Disclosure Model Regulation (#580), Section 8C*
- Unfair Trade Practices Act (#880)*
- Annuity Disclosure Model Regulation (#245), Section 6 plus appendix*
- Long-Term Care Insurance Model Act (#640)*
- Life Insurance Illustrations Model Regulation (#582) and Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index Based Interest (AG 49)*
- [*Disclosure for Small Face Amount Life Insurance Policies Model Act \(#605\)*](#)
- [*Suitability in Annuity Transactions Model Regulation \(#275\)*](#)
- [*Suitability of Sales of Life Insurance and Annuities White Paper*](#)
- Military Sales Practices Model Regulation (#568)*

Review Procedures and Criteria

Evaluate the company's system for controlling advertisements. Every insurer should have and maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All advertisements—regardless of by whom written, created, designed or presented—are the responsibility of the insurer.

Ensure the company maintains, at its home or principal office, a complete file containing a specimen copy of every printed, published or prepared advertisement of its individual policies and specimen copies of typical printed, published or prepared advertisements of its blanket, franchise and group policies. There should be a notation indicating the manner and extent of distribution and the form number of every policy advertised. All advertisements should be maintained in the file for a period of either 4 years or until the filing of the next regular report on examination of the company, whichever is the longer period of time.

Review advertising materials in conjunction with the appropriate policy form.

Materials should not:

- Misrepresent policy benefits, advantages or conditions by failing to disclose limitations, exclusions or reductions, or use terms or expressions that are misleading or ambiguous;
- Make unfair or incomplete comparisons with other policies;
- Make false, deceptive or misleading statements or representations with respect to any person, company or organization in the conduct of insurance business;
- Offer unlawful rebates;
- Use terminology that would lead a prospective buyer to believe that he/she is purchasing an investment or savings plan. Problematic terminology may include such terms as: investment, investment plan, founder's plan, charter plan, deposit, expansion plan, profit, profits, profit sharing, interest plan, savings or savings plan;
- Omit material information or use words, phrases, statements, references or illustrations, if such omission or such use has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, premium payable, or state or federal tax consequences;
- Use terms such as "non-medical" or "no medical examination required" if the issue is not guaranteed, unless the terms are accompanied by a further disclosure of equal prominence and juxtaposition that issuance of the policy may depend on the answers to the health questions set forth in the application;
- State that a purchaser of a policy will share in or receive a stated percentage or portion of the earnings on the general account assets of the company;
- State or imply that the policy or combination of policies is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless that is the fact. Enrollment periods may not be described as terms such as "special" or "limited" when the insurer uses successive enrollment periods as its usual method of marketing its policies;
- State or imply that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised, because of special advantages available in the policy;
- Offer a policy that utilizes a reduced initial premium rate in a manner that overemphasizes the availability and the amount of the reduced initial premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, all references to the reduced initial premium should be followed by an asterisk or other appropriate symbol which refers the reader to that specific portion of the advertisement which contains the full rate schedule for the policy being advertised;
- Imply licensing beyond limits, if an advertisement is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed;
- Exaggerate the fact, suggest or imply that competing insurers or insurance producers may not be licensed, if the advertisement states that an insurer or insurance producer is licensed in the state where the advertisement appears;
- Create the impression that the insurer, its financial condition or status, the payment of its claims or the merits, desirability or advisability of its policy forms or kinds of plans of insurance are recommended or endorsed by any governmental entity. However, where a governmental entity has recommended or endorsed a policy form or plan, that fact may be stated, if the entity authorizes its recommendation or endorsement to be used in an advertisement;

- State or imply that prospective insureds are or become members of a special class, group or quasi-group and enjoy special rates, dividends or underwriting privileges, unless that is a fact;
- Contain an assertion, representation or statement with regard to the risk-based capital levels of any insurer or of any component derived in the calculation;
- Use the existence of the insurance guaranty association for the purpose of sales, solicitation or inducement to purchase any form of insurance covered by the association;
- Misrepresent the dividends or share of the surplus to be received on any policy;
- Make a false or misleading statement as to the dividends or share of surplus previously paid on a policy;
- Misrepresent any policy as being shares of stock; and
- Illustrations of benefits payable under any modified guaranteed life insurance²⁸ shall not include projections of past investment experience. Hypothetical assumed interest credits may only be used if it is made clear that such are hypothetical only.

Materials should:

- Clearly disclose name and address of insurer;
- If using a trade name, disclose the name of the insurer, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device or reference, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the insurer, or create the impression that a company other than the insurer would have any responsibility for the financial obligation under a policy;
- Prominently describe the type of policy being advertised;
- Indicate that the product being marketed is insurance;
- Comply with applicable statutes, rules and regulations;
- Cite the source of statistics used;
- Identify the policy form that is being advertised, where appropriate;
- Clearly define the scope and extent of a recommendation by any commercial rating system;
- Only include testimonials, appraisals or analysis if they are genuine, represent the current opinion of the author, are applicable to a policy advertised and accurately reproduced to avoid misleading or deceiving prospective insureds. Any financial interest by the person making the testimonial in the insurer or related entity must be prominently disclosed;
- Only state or imply endorsement by a group of individuals, society, association, etc., if it is a fact, and any proprietary relationship or payment for the testimonial must be disclosed; and
- The sales material for any modified guaranteed life insurance must clearly illustrate there can be both upward and downward adjustments to nonforfeiture benefits, due to the application of the market value adjustment formula.

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

Determine if the advertising and solicitation materials mislead consumers relative to the producer's capacity as a life insurance agent. Improper terms may include financial planner, investment advisor, financial consultant or financial counseling, if they imply the producer is primarily engaged in an advisory business in which compensation is unrelated to sales, if such is not the case.

Determine if the company has procedures in place to monitor the use of senior-specific certifications or professional designations used by producers that solicit for the company.

²⁸ "Modified Guaranteed Life Insurance Policy" means an individual policy of life insurance, the underlying assets of which are held in a separate account, and the values of which are guaranteed if held for specified periods. It contains nonforfeiture values that are based upon a market value adjustment formula if held for shorter periods. The formula may, or may not, reflect the value of assets held in the separate account. The assets underlying the policy must be in a separate account during the period or periods when the policyholder can surrender the policy.

Determine if the company allows its life and annuity products to be marketed to the military. If so, review the company procedures to ensure that the procedures are in compliance with all applicable laws and regulations regarding sales to military personnel.

Determine if analogies between a life insurance policy's cash values and savings accounts or other investments and between premium payments and contributions to savings accounts or other investments are complete and accurate.

Determine if the advertisement states or implies in any way that interest charged on a policy loan or the reduction of death benefits by the amount of outstanding policy loans is unfair, inequitable or in any manner an incorrect or an improper practice.

If nonforfeiture values are shown in any advertisement, ensure the values are shown, either for the entire amount of the basic life policy death benefit, or for each \$1,000 of initial death benefit.

Review the use of the words/phrases "free," "no cost," "without cost," "no additional cost," "at no extra cost" or words/phrases of similar import. Such words/phrases should not be used with respect to any benefit or service being made available with a policy, unless true. If there is no charge to the insured, then the identity of the payor must be prominently disclosed. An advertisement may specify the charge for a benefit or a service or may state that a charge is included in the premium or use other appropriate language.

Ensure the advertisement does not contain a statement or representation that premiums paid for a life insurance policy can be withdrawn under the terms of the policy. Reference may be made to amounts paid into an advance premium fund, which are intended to pay premiums at a future time, to the effect that they may be withdrawn under the conditions of the prepayment agreement. Reference may also be made to withdrawal rights under any unconditional premium refund offer.

If an advertisement represents a pure endowment benefit as a "profit" or "return" on the premium paid, rather than as a policy benefit for which a specified premium is paid, it is deemed deceptive and misleading and is prohibited.

Determine that company procedures and materials relative to long-term care (LTC) products comply with "right to free look" requirements.

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

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

For the review of Internet advertisements:

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

A summary of special requirements is available for the following:

- Products sold using enrollment periods;
- Direct response products;
- Graded or modified benefit policies;
- Policies with premium changes;
- Policies with non-guaranteed elements;
- Products sold to students;
- Individual deferred annuity products or deposit funds; and
- Combination life insurance and annuity products.

Review advertising carefully for use of the term “guarantee.” Verify that the scope and duration of any guarantee is accurately described. Determine that the regulated entity has accurately portrayed non-guaranteed elements. Verify that complete information is provided regarding the scope and duration of guarantees.

Review advertising carefully for use of the term “bonus.” Review the functioning of any such bonus payments and verify that the information provided is accurate in describing the amount and the conditions for payment, retention or recoupment of the bonus.

Review advertising carefully for explanations of surrender periods and charges. Review the functioning of any such surrender charge and, in particular, how the charge is calculated in death claims. Verify that the information provided regarding the amount of the charge and the conditions for assessment are accurate.

Index products

For advertising for interest-sensitive products, review explanations of the crediting methods and terms. Review the functioning of the crediting methods to determine that the explanations are understandable and accurate. Verify that accurate information is provided regarding the options available to the consumer and the methods by which the consumer is to exercise the options.

In addition to reviewing the advertising of indexed products, the examiner should review the illustration for compliance with Model #582 to ensure that, among other things, unreasonable or deceptive crediting rates are not being used in the illustrations and that the illustrations provide the consumer with the information required by Model #582 and, for indexed universal life (IUL) products, AG 49. Determine whether the explanations and information provided regarding the options available to the consumer are consistent with the requirements and limitations of Model #582 in AG 49.

Review the methods used by the regulated entity, annually or otherwise, to convey ongoing information about policy/contract values and options available to the consumer to change interest-crediting methods or exercise other policy/contract features in future terms.

**STANDARDS
MARKETING AND SALES**

Standard 2

The insurer's rules pertaining to producer requirements in connection with replacements are in compliance with applicable statutes, rules and regulations.

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Replacement register/Data

_____ Policy/Underwriting files

_____ Loan and surrender files

Others Reviewed

NAIC Model References

Life Insurance and Annuities Replacement Model Regulation (as adopted 1998) (#613)

Suitability in Annuity Transactions Model Regulation (#275)

[Suitability of Sales of Life Insurance and Annuities White Paper](#)

Military Sales Practices Model Regulation (#568)

Review Procedures and Criteria

Review loan and surrender files to determine if producers have identified replacement transactions on applications.

Review replacement register and policy/underwriting files to determine if required disclosure forms have been submitted on replacement transactions.

Review policy/underwriting files to confirm receipt of sales material or required statement. Copies of sales material other than regulated entity-approved sales material, if permitted, must also be in the file.

Review replacement disclosure forms for completeness and signatures, as required.

If the applicable state's definition of "recommendation" encompasses replacements, review policy/underwriting files to verify that the producer's treatment of and classification of replacements is in compliance with the applicable state's definition of "recommendation."

Review policy/underwriting files to ensure that the insurance producer, or the insurer where no producer is involved, when recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another insurance transaction or series of insurance transactions, has adequate written documentation of

reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to his or her investments and other insurance products and as to his or her financial situation and needs, including the consumer's suitability information.

Ensure that producer written documentation regarding suitability contains adequate and complete information to demonstrate that there is a reasonable basis to believe all of the following:

- The consumer has been reasonably informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, potential charges for and features of riders, limitations on interest returns, insurance and investment components and market risk. (Note: If the applicable state has adopted the *Annuity Disclosure Model Regulation* (#245), examiners should be aware that the criteria of this examination standard are intended to supplement and not replace the disclosure requirements of the *Annuity Disclosure Model Regulation* (#245));
- The consumer would benefit from certain features of the annuity, such as tax-deferred growth, annuitization or death or living benefit;
- The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, and riders and similar product enhancements, if any, are suitable (and in the case of an exchange or replacement, the transaction as a whole is suitable) for the particular consumer based on his or her suitability information; and
- In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable including taking into consideration whether:
 - The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits (such as death, living or other contractual benefits), or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;
 - The consumer would benefit from product enhancements and improvements; and
 - The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 36 months.

Review policy/underwriting files to determine that prior to the execution of a replacement of an annuity resulting from a recommendation, an insurance producer has made reasonable efforts to obtain the consumer's suitability information.

Examiners should be familiar with the term "suitability information" as defined in applicable state statutes, rules or regulations. "Suitability information" means information that is reasonably appropriate to determine the suitability of a recommendation, including:

- Age;
- Annual income;
- Financial situation and needs, including the financial resources used for the funding of the annuity;
- Financial experience;
- Financial objectives;
- Intended use of the annuity;
- Financial time horizon;
- Existing assets, including investment and life insurance holdings;
- Liquidity needs;
- Liquid net worth;
- Risk tolerance; and
- Tax status.

Examine the insurer's procedures to verify that the insurer has not issued an annuity recommended to a consumer unless there was a reasonable basis to believe the annuity was suitable based on the consumer's suitability information.

**STANDARDS
MARKETING AND SALES**

Standard 3
The insurer's rules pertaining to replacements are in compliance with applicable statutes, rules and regulations.

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

- ___ Applicable statutes, rules and regulations
- ___ Replacement register/Data
- ___ Policy/Underwriting files
- ___ Agency correspondence file/Agency bulletins
- ___ Agency procedural manual
- ___ Claim files
- ___ Agency sales/lapse records
- ___ Regulated entity systems manual

Others Reviewed

- ___ _____
- ___ _____

NAIC Model References

- Life Insurance and Annuities Replacement Model Regulation* (as adopted 1998) (#613)
- Suitability in Annuity Transactions Model Regulation* (#275)
- [*Suitability of Sales of Life Insurance and Annuities White Paper*](#)
- Military Sales Practices Model Regulation* (#568)
- Stranger-Originated Annuity Transactions (STOA) NAIC Sample Bulletin*

Review Procedures and Criteria

- Determine if the regulated entity has advised its producers of its replacement policy.
- Determine if the regulated entity has provided timely notice to the existing insurer(s) of the replacement.
- Examine for effectiveness the regulated entity's system of identifying undisclosed replacements.
- Determine if the regulated entity has the capacity to produce data required by replacement regulation to assess producer replacement activity.

Determine if the regulated entity has issued letters in a timely manner to policyholders, advising of the effects of loans and other disbursements on policy values.

Review policy/underwriting files to determine that the regulated entity is retaining required records for required time frames.

Examine the regulated entity's procedures for verifying producer compliance with requirements on replacement transactions.

Review claim files to determine if the regulated entity provides required credit for suicide and contestability periods on replacements.

If the applicable state's definition of "recommendation" encompasses replacements, review regulated entity procedures to verify that the regulated entity's treatment of and classification of replacements is in compliance with the state's definition of "recommendation."

Review policy/underwriting files to ensure that the insurance producer, or the insurer where no producer is involved, when recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another insurance transaction or series of insurance transactions, has adequate written documentation of reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to his or her investments and other insurance products and as to his or her financial situation and needs, including the consumer's suitability information.

Ensure that regulated entity written documentation regarding suitability contains adequate and complete information to demonstrate that there is a reasonable basis to believe all of the following:

- The consumer has been reasonably informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, potential charges for and features of riders, limitations on interest returns, insurance and investment components and market risk. (Note: If the applicable state has adopted the *Annuity Disclosure Model Regulation* (#245), examiners should be aware that the criteria of this examination standard are intended to supplement and not replace the disclosure requirements of the *Annuity Disclosure Model Regulation* (#245));
- The consumer would benefit from certain features of the annuity, such as tax-deferred growth, annuitization or death or living benefit;
- The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, and riders and similar product enhancements, if any, are suitable (and in the case of an exchange or replacement, the transaction as a whole is suitable) for the particular consumer based on his or her suitability information.
- In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable including taking into consideration whether:
 - The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits (such as death, living or other contractual benefits), or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;
 - The consumer would benefit from product enhancements and improvements; and
 - The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 36 months.

Review policy/underwriting files to ensure that prior to the execution of a replacement of an annuity resulting from a recommendation, an insurer, where no producer is involved, has made reasonable efforts to obtain the consumer's suitability information.

Examiners should be familiar with the term “suitability information” as defined in applicable state statutes, rules or regulations. “Suitability information” means information that is reasonably appropriate to determine the suitability of a recommendation, including:

- Age;
- Annual income;
- Financial situation and needs, including the financial resources used for the funding of the annuity;
- Financial experience;
- Financial objectives;
- Intended use of the annuity;
- Financial time horizon;
- Existing assets, including investment and life insurance holdings;
- Liquidity needs;
- Liquid net worth;
- Risk tolerance; and
- Tax status.

Examine the insurer’s procedures to verify that the insurer has not issued an annuity recommended to a consumer unless there was a reasonable basis to believe the annuity was suitable based on the consumer’s suitability information.

Note: All documents necessary to review the appropriateness of a sale may not be in the insurer’s possession. It may be necessary to give the insurer additional lead time to obtain the documents from a producer, a third party reviewer or other entity.

Examiners may wish to remind insurers that sell annuities of the existence of the *Stranger-Originated Annuity Transactions (STOA) NAIC Sample Bulletin* because sales of stranger-originated annuities may be an indicator of potentially fraudulent transactions.

**STANDARDS
MARKETING AND SALES**

Standard 4
An illustration used in the sale of a policy contains all required information and is delivered in accordance with statutes, rules and regulations.

Apply to: All life products

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Actuarial records
- _____ All documents related to the development of crediting rates used in illustrations
- _____ Underwriting file

Others Reviewed

NAIC Model References

Life Insurance Illustrations Model Regulation (#582) and Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index Based Interest (AG 49)
Universal Life Insurance Model Regulation (#585)
Variable Life Insurance Model Regulation (#270)
Life Insurance Disclosure Model Regulation (#580)
[*Disclosure for Small Face Amount Life Insurance Policies Model Act \(#605\)*](#)

Review Procedures and Criteria

Note: Some policies may be deemed to be sold without an illustration.

If a jurisdiction continues to require surrender cost indices, ensure it is appropriately disclosed in the Statement of Policy Cost and Benefit.

Ensure that the insurer, its producers or authorized representatives do not:

- Represent the policy as anything other than a life insurance policy;
- Use or describe non-guaranteed elements in a manner that is misleading or has the capacity or tendency to mislead;
- State or imply that the payment or amount of non-guaranteed elements is guaranteed;
- Use an illustration that does not comply with statutes;
- Use an illustration that at any policy duration depicts policy performance more favorable to the policyowner than that produced by the illustrated scale of the insurer whose policy is being illustrated;
- Provide an applicant with an incomplete illustration;
- Represent in any way that premium payments will not be required for each year of the policy in order to maintain the illustrated death benefits, unless that is the fact;

- Use the terms “vanish,” “vanishing premium” or similar terms that imply that the policy becomes paid-up, to describe a plan for using non-guaranteed elements to pay a portion of future premiums;
- Except for policies that can never develop nonforfeiture values, use an illustration that is “lapse-supported”; or
- Use an illustration that is not “self-supporting.”

Ensure that the insurer has a documented, reasonable methodology for the manner in which it determines its index-crediting strategy. Verify that the insurer has a system which monitors the interest rates used by its insurance producers in illustrations for compliance with the insurer’s credited interest rates.

Model #582 sets out a variety of requirements to prevent insurers from using unreasonable or misleading illustrations in the sale of life insurance. AG 49, originally adopted by the NAIC in 2015, expands upon and supersedes some of the illustration requirements of Model #582 for indexed universal life (IUL) illustrations. In simple terms, Section 4 and Section 5 of AG 49 set maximum crediting rates for illustrations. Section 6 addresses illustrations of policy loans, and Section 7 requires illustrations beyond those required in Model #582. The implementation of AG 49 was phased as follows:

- Section 4 and Section 5 shall be effective for all new business and in force life insurance illustrations on policies sold on or after Sept. 1, 2015;
- Effective March 1, 2017, Section 4 and Section 5 shall be effective for all in force life insurance illustrations on policies within the scope of this actuarial guideline, regardless of the date the policy was sold; and
- Section 6 and Section 7 shall be effective for all new business and in force life insurance illustrations on policies sold on or after March 1, 2016.

Testing the compliance of illustrations with Model #582 and AG 49 will be complex, and the examiner will likely seek assistance from an actuary familiar with and capable of testing compliance with Model #582 and AG 49. In such cases, the examiner should work with the actuary to determine the appropriate information to request from the insurer necessary to enable the actuary and examiner in testing the compliance of the illustrations.

The examiner may be able to test implementation compliance issues by confirming that IUL illustration changes were made on or before the effective dates set out above. For example:

- Did the insurer implement on or before Sept. 15, 2015, a compliant crediting rate methodology for new and in force illustrations on policies sold on or after Sept. 15, 2015?
- Did the insurer implement on or before March 1, 2016, a compliant credit rate methodology for all new illustrations produced on or after March 1, 2016, on in force policies?
- Did the insurer implement the policy loan and additional illustration scales requirement of Section 6 and Section 7 of AG 49 on or before March 1, 2016?

The following are more complex requirements of AG 49, which may require the assistance of an actuary or other person with expertise in evaluating illustration crediting methodologies and calculations:

- For new business and in force life insurance illustrations on policies sold on or after Sept. 1, 2015, determine whether the credited rate for the Illustrated Scale has been limited according to the requirements of Section 4;
- For new business and in force life insurance illustrations on policies sold on or after Sept. 1, 2015, determine whether the earned interest rate for the Disciplined Current Scale has been limited according to the requirements of Section 5;
- For new business and in force life insurance illustrations on policies sold on or after March 1, 2016, ensure that if the illustration includes a loan, the illustrated rate credited as compared to the illustrated loan charge has been limited according to the requirements of Section 6;
- For new business and in force life insurance illustrations on policies sold on or after March 1, 2016, ensure that the basic illustration includes a ledger using the Alternate Scale shown alongside a ledger using the illustrated scale with equal prominence according to the requirements of Section 7.A;

- For new business and in force life insurance illustrations on policies sold on or after March 1, 2016, ensure that the basic illustration includes a table showing the minimum and maximum of the geometric average annual credited rates as referenced in Section 7.B; and
- For new business and in force life insurance illustrations on policies sold on or after March 1, 2016, ensure that the basic illustration includes a table showing actual historical index changes and corresponding hypothetical interest rates using current index parameters for the most recent 20-year period for each Index Account illustrated, as required by Section 7.C.

Ensure that the insurer has established requirements for producers to provide universal life applicants with a "Statement of Policy Information." The statement should substantially follow the format set forth in the *Universal Life Insurance Model Regulation* (#585). Insurers that use direct response solicitation of universal life insurance products should provide such a statement at the time of policy delivery.

Ensure illustrations are retained in accordance with statutes, rules and regulations. A copy of the basic illustration and a revised basic illustration (if any) signed, as applicable, or a certification that either no illustration was used or that the policy was applied for other than as illustrated, should be retained until 3 years after the policy is no longer in force.

Determine if the illustration is submitted to the regulated entity as required.

- If a basic illustration is used by an insurance producer or other authorized representative of the insurer in the sale of a life insurance policy and the policy is applied for as illustrated, a copy of the illustration must be submitted to the insurer at the time of policy application. A copy must also be provided to the applicant.
- If the policy is issued other than as applied for:
 - A revised basic illustration conforming to the policy as issued should be sent with the policy;
 - The revised illustration should be labeled "Revised Illustration";
 - The illustration should be signed and dated by the applicant or policyowner and producer or other authorized representative of the insurer no later than the time the policy is delivered; and
 - A copy must be provided to the insurer and the policyowner.
- If no illustration is used by an insurance producer or other authorized representative, or if the policy is applied for other than as illustrated:
 - The producer or representative must certify to that effect in writing on a form provided by the insurer;
 - The applicant should acknowledge (on the same form) that no illustration conforming to the policy applied for was provided and also acknowledge an understanding that an illustration conforming to the policy as issued will be provided no later than the time of policy delivery; and
 - The form must be submitted to the insurer at the time of application.
- If the basic or revised illustration is sent by mail from the insurer:
 - It should include instructions for the applicant/policyowner to sign the duplicate copy of the numeric summary page and return the signed copy; and
 - An insurer's obligation will be satisfied if it demonstrates a diligent effort to obtain the signature. Diligent effort includes the mailing of a self-addressed postage-prepaid envelope with instructions for the return of the signed page.

Ensure a signed copy of the basic illustration and revised basic illustration, if any, or a certification that either no illustration was used or that the policy was applied for other than as illustrated is retained until 3 years after the policy is no longer in force. (A copy does not have to be retained if the policy is not issued.)

A summary of illustration requirements is available with special requirements for:

- Basic illustrations;
- Supplemental illustrations;
- Interest-indexed universal life;
- Universal life; and
- Variable life.

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**STANDARDS
MARKETING AND SALES**

Standard 5
The insurer has suitability standards for its products, when required by applicable statutes, rules and regulations.

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Producer records

_____ Training materials

_____ Procedure manuals

Others Reviewed

NAIC Model References

Variable Life Insurance Model Regulation (#270), Section 3C
Suitability in Annuity Transactions Model Regulation (#275)
[Suitability of Sales of Life Insurance and Annuities White Paper](#)
Stranger-Originated Annuity Transactions (STOA) NAIC Sample Bulletin

Review Procedures and Criteria

Determine if multiple sales of the same product have been made to individuals. Identify and review a random sample of policyholders for which multiple policies exist.

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

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

Determine if negative enrollment practices are permitted and used.

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

For annuity products, ensure the regulated entity maintains a written statement specifying the standards of suitability used by the insurer. The standards should specify that an insurer’s issuance of an annuity shall be reasonable under all the circumstances actually known to the insurer at the time the annuity is issued.

Review whether the insurer has established a system of STOA-related oversight (underwriting criteria). If not, discuss the existence of the STOA bulletin with the insurer. The examiner should be mindful that the provisions within the bulletin may not be legally required by their jurisdiction.

Inquire if the company has detected any STOA transactions and if so, the examiner may want to determine if there were any suitability issues surrounding the sale of the STOA. If there were suitability issues, the examiner may want to inquire as to what actions were taken by the company to prevent further suitability issues and if the company took any action against the producer.

Note: Sales made in compliance with Financial Industry Regulatory Authority (FINRA) requirements pertaining to suitability and supervision of annuity transactions shall satisfy the requirements under this regulation. Examiners should be mindful of the fact that both variable annuity sales and variable life sales are typically sold using FINRA requirements.

Examiners may wish to remind insurers that sell annuities of the existence of the *Stranger-Originated Annuity Transactions NAIC Sample Bulletin* because sales of stranger-originated annuities may result in adverse suitability situations.

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**STANDARDS
MARKETING AND SALES**

Standard 6
Preneed funeral contracts or prearrangement disclosures and advertisements are in compliance with statutes, rules and regulations.

Apply to: All preneed products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

Life Insurance Disclosure Model Regulation (#580), Section 7
Advertisements of Life Insurance and Annuities Model Regulation (#570), Section 5Y

Review Procedures and Criteria

Ensure there is evidence that the disclosures have been made in accordance with statutes, rules and regulations.

A summary of special requirements for preneed disclosures is available.

Advertisements for a preneed funeral contract or prearrangement that is funded or is to be funded by a life insurance policy or annuity contract should disclose the following:

- The fact that a life insurance or annuity contract is involved or being used to fund a prearrangement; and
- The nature of the relationship among the soliciting producer or producers, the provider of the funeral or cemetery merchandise or services, the administrator and any other person.

**STANDARDS
MARKETING AND SALES**

Standard 7
The regulated entity's policy forms provide required disclosure material regarding accelerated benefit provisions.

Apply to: All individual and group life insurance

Priority: Essential

Documents to be Reviewed

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

_____ Claim procedure/underwriting manuals

_____ Claim files

Others Reviewed

NAIC Model References

Accelerated Benefits Model Regulation (#620)

Review Procedures and Criteria

The terminology "accelerated benefit" shall be included in the descriptive title.

Disclosure is required that receipt of accelerated benefits may be a taxable event, and assistance should be sought from a personal tax advisor.

Disclosure providing description of accelerated benefit and definitions of the conditions or occurrences triggering payment of the benefits shall be given to the applicant.

Products marketed under this regulation shall not be described as long-term care insurance (LTCI) or as providing LTC benefits.

**STANDARDS
MARKETING AND SALES**

Standard 8
Policy and contract application forms used by depository institutions provide required disclosure material regarding insurance sales.

Apply to: All individual and group life insurers and depository institutions

All covered persons²⁹ as defined by the Gramm-Leach-Bliley Act. This includes any person who sells, solicits, advertises or offers an insurance product or annuity to a consumer at an office of the depository institution or on behalf of a depository institution.

Priority: Essential

Documents to be Reviewed

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

___ Underwriting manuals

___ Policy and contract application forms

___ Policy files

Others Reviewed

NAIC Model References

Bulletin pertaining to Voluntary Expedited Filing Procedures for Insurance Applications Developed to allow Depository Institutions to meet their Disclosure Obligations under Section 305 of the Gramm-Leach-Bliley Act

Review Procedures and Criteria

One notice provides the written disclosures that must be given to a consumer in connection with an initial purchase of an insurance or annuity product that is unrelated to an extension of credit.

The other notice provides the written disclosures that must be given to a consumer in connection with the solicitation, offer or sale of an insurance or annuity product that is related to an extension of credit.

For notices unrelated to an extension of credit: (1) the disclosure notice must inform the consumer that neither insurance nor annuities are a deposit, other obligation of, or guaranteed by the bank or any affiliate of the bank; (2) that neither insurance nor annuities are insured by the Federal Deposit Insurance Corporation (FDIC) or any agency of the United States, the bank or any affiliate; and (3) that there is the potential for investment risk, including the possible loss of value. (Note: The last requirement may not be required for all products.)

²⁹ Please refer to the bulletin for a detailed explanation of what constitutes a covered person.

For notices related to an extension of credit (which includes solicited, offered or sold): (1) the bank or savings association must inform the consumer that it cannot condition the extension of credit upon the consumer also purchasing an insurance product or annuity from the bank or the bank's affiliate; (2) the bank or savings association must inform the consumer that it cannot condition the extension of credit upon the consumer not obtaining an insurance product or annuity from an entity not affiliated with the bank. In addition, (3) the disclosure notice must inform the consumer that neither insurance nor annuities are a deposit, other obligation of, or guaranteed by the bank or any affiliate of the bank; (4) that neither insurance nor annuities are insured by the Federal Deposit Insurance Corporation (FDIC) or any agency of the United States, the bank, or any affiliate; and (5) that there is the potential for investment risk, including the possible loss of value. Note: The last requirement may not be required for all products.

DRAFT

**STANDARDS
MARKETING AND SALES**

Standard 9
Insurer rules pertaining to producer requirements with regard to suitability in annuity transactions are in compliance with applicable statutes, rules and regulations.

Apply to: All annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy/Other relevant files

_____ New business reports

_____ Policy/Underwriting files

Others Reviewed

NAIC Model References

Suitability in Annuity Transactions Model Regulation (#275)
[Suitability of Sales of Life Insurance and Annuities White Paper](#)

Review Procedures and Criteria

If the insurer has a business rule that calls for completion of a fact-finder or similar disclosure document, review policy files to determine if forms have been completed regarding suitability.

Review policy files. Copies of sales material other than insurer-approved materials, if permitted, must also be in the file or made available to the regulator upon request.

Examine for effectiveness the insurer's system of verifying that, prior to the execution of a purchase, exchange or replacement of an annuity resulting from a recommendation, an insurance producer, or an insurer where no producer is involved, has made reasonable efforts to obtain the consumer's suitability information.

Examiners should be familiar with the term "suitability information" as defined in applicable state statutes, rules or regulations. "Suitability information" means information that is reasonably appropriate to determine the suitability of a recommendation, including:

- Age;
- Annual income;
- Financial situation and needs, including the financial resources used for the funding of the annuity;
- Financial experience;
- Financial objectives;
- Intended use of the annuity;
- Financial time horizon;

- Existing assets, including investment and life insurance holdings;
- Liquidity needs;
- Liquid net worth;
- Risk tolerance; and
- Tax status.

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

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

Review the insurer's system of monitoring sales made in compliance with FINRA annuity suitability and supervision requirements and applicable state annuity suitability statutes, rules and regulations. An insurer may demonstrate compliance in this area by:

- Monitoring the FINRA member broker-dealer using information collected in the normal course of an insurer's business; and
- Providing to the FINRA member broker-dealer information and reports that are reasonably appropriate to assist the FINRA member broker-dealer to maintain its supervision system.

Examine for effectiveness the insurer's system for review or oversight of annuity transactions that either may have violated the insurer's suitability procedures or where no suitability analysis was performed because:

- No recommendation was made;
- A recommendation was made and was later found to have been prepared based on inaccurate material information provided by the consumer;
- A customer refused to provide relevant suitability information and the annuity transaction was not recommended; or;
- A consumer decided to enter into an annuity transaction that was not based on a recommendation of the insurer or the insurance producer.

Review completed annuity transactions and compare the information obtained by the insurance producer to the type of product purchased to verify that when recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another transaction or series of transactions, the insurance producer, or the insurer, where no producer is involved, had reasonable grounds for believing that the product was suitable on the basis of the facts disclosed by the consumer as to his/her investments and other insurance products and as to his/her financial situation and needs, including the consumer's suitability information, and that there is a reasonable basis to believe all of the following:

- The consumer has been reasonably informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, potential charges for and features of riders, limitations on interest returns, insurance and investment components and market risk. (Note: If the applicable state has adopted the *Annuity Disclosure Model Regulation* (#245), examiners should be aware that the criteria of this examination standard are intended to supplement and not replace the disclosure requirements of the *Annuity Disclosure Model Regulation* (#245));
- The consumer would benefit from certain features of the annuity, such as tax-deferred growth, annuitization or death or living benefit;

- The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, and riders and similar product enhancements, if any, are suitable (and in the case of an exchange or replacement, the transaction as a whole is suitable) for the particular consumer based on his or her suitability information; and
- In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable including taking into consideration whether:
 - The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits (such as death, living or other contractual benefits), or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;
 - The consumer would benefit from product enhancements and improvements; and
 - The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 36 months.

Review policy/underwriting/other files to verify that an insurance producer has at the time of sale:

- Made a record of any recommendation subject to applicable state annuity suitability statutes, rules and regulations;
- Obtained a customer signed statement documenting a customer's refusal to provide suitability information, if any; and
- Obtained a customer signed statement acknowledging that an annuity transaction is not recommended if a customer decides to enter into an annuity transaction that is not based on the insurance producer's or insurer's recommendation.

**STANDARDS
MARKETING AND SALES**

Standard 10
Insurer rules pertaining to suitability in annuity transactions are in compliance with applicable statutes, rules and regulations.

Apply to: All annuity products

Priority: Essential

Documents to be Reviewed

- ___ Applicable statutes, rules and regulations
- ___ Policy/Underwriting files
- ___ Agency correspondence file/Agency bulletins
- ___ Agency procedural manual
- ___ Claim files
- ___ Complaint log
- ___ Agency sales/lapse records
- ___ Regulated entity's systems manual
- ___ Regulated entity's producer training materials

Others Reviewed

- ___
- ___

NAIC Model References

Suitability in Annuity Transactions Model Regulation (#275)
[*Suitability of Sales of Life Insurance and Annuities White Paper*](#)

Review Procedures and Criteria

~~Determine if the insurer has advised its producers of applicable state statutes, rules and regulations regarding suitability of annuity products and of the insurer's product-specific standards, policy and procedures regarding verification of suitability of annuity products.~~

~~Determine if the insurer has established a system of supervision that includes but is not limited to requirements outlined in Supplemental Checklist K and has advised its producers of applicable state statutes, rules and regulations regarding suitability of annuity products and the insurer's product-specific standards, policy and procedures regarding verification of suitability of annuity products.~~

~~It is useful to become acquainted with the definitions in the *Suitability in Annuity Transactions Model Regulation* (#275).~~

Note: Determine if the insurer has the capacity to produce data required by the applicable state suitability statute, rule or regulation. If optional recordkeeping provisions of the *Suitability in Annuity Transactions Model Regulation* (#275) have been adopted, review policy files to determine that the insurer is retaining required records for required time frames.

~~Examine insurer's procedures for verifying producer supervision and compliance with requirements on suitability. Examine for effectiveness the insurer's system of monitoring and reviewing that when recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another insurance transaction or series of insurance transactions, the insurance producer, or the insurer where no producer is involved, shall have reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to his/her investments and other insurance products and as to his/her financial situation and needs, including the consumer's suitability information, and that there is a reasonable basis to believe all of the following:~~

- ~~• The consumer has been reasonably informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, potential charges for and features of riders, limitations on interest returns, insurance and investment components and market risk. (Note: If the applicable state has adopted the *Annuity Disclosure Model Regulation* (#245), examiners should be aware that the criteria of this examination standard are intended to supplement and not replace the disclosure requirements of the *Annuity Disclosure Model Regulation* (#245)).~~
- ~~• The consumer would benefit from certain features of the annuity, such as tax deferred growth, annuitization or death or living benefit;~~
- ~~• The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, and riders and similar product enhancements, if any, are suitable (and in the case of an exchange or replacement, the transaction as a whole is suitable) for the particular consumer based on his or her suitability information; and~~
- ~~• In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable including taking into consideration whether:
 - ~~• The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits (such as death, living or other contractual benefits), or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;~~
 - ~~• The consumer would benefit from product enhancements and improvements; and~~
 - ~~• The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 36 months.~~~~

~~Monitor and determine that an insurance producer or, where no insurance producer is involved, the responsible insurer representative, has at the time of sale:~~

- ~~• Made a record of any recommendation subject to applicable state annuity suitability statutes, rules and regulations;~~
- ~~• Obtained a customer signed statement documenting a customer's refusal to provide suitability information, if any; and~~
- ~~• Obtained a customer signed statement acknowledging that an annuity transaction is not recommended if a customer decides to enter into an annuity transaction that is not based on the insurance producer's or insurer's recommendation.~~

~~Monitor and determine that, prior to the execution of a purchase, exchange or replacement of an annuity resulting from a recommendation, an insurance producer or an insurer where no producer is involved, has made reasonable efforts to obtain the consumer's suitability information.~~

~~Examiners should be familiar with the term “suitability information” as defined in applicable state statutes, rules or regulations. “Suitability information” means information that is reasonably appropriate to determine the suitability of a recommendation, including:~~

- ~~• Age;~~
- ~~• Annual income;~~
- ~~• Financial situation and needs, including the financial resources used for the funding of the annuity;~~
- ~~• Financial experience;~~
- ~~• Financial objectives;~~
- ~~• Intended use of the annuity;~~
- ~~• Financial time horizon;~~
- ~~• Existing assets, including investment and life insurance holdings;~~
- ~~• Liquidity needs;~~
- ~~• Liquid net worth;~~
- ~~• Risk tolerance; and~~
- ~~• Tax status.~~

~~Examine the insurer’s procedures to verify that the insurer has not issued an annuity recommended to a consumer unless there was a reasonable basis to believe the annuity was suitable based on the consumer’s suitability information.~~

~~Examine for effectiveness the insurer’s system of recording or monitoring whether an insurance producer or an insurer, proceeded with an annuity transaction that either may have violated the insurer’s suitability procedures or where no suitability analysis was performed because:~~

- ~~• No recommendation was made;~~
- ~~• A recommendation was made and was later found to have been prepared based on inaccurate material information provided by the consumer;~~
- ~~• A consumer refused to provide relevant suitability information and the annuity transaction was not recommended;~~
- ~~• A consumer decided to enter into an annuity transaction that was not based on a recommendation of the insurer or the insurance producer.~~

Verify that the insurer has established a supervision system that is reasonably designed to achieve the insurer’s and its insurance producers’ compliance with applicable state suitability statutes, rules and regulations, including, but not limited to the following criteria:

- Examine the regulated entity’s suitability policies and procedures to verify that the insurer maintains reasonable procedures to inform its insurance producers of the requirements of applicable state suitability statutes, rules and regulations. Verify that the requirements of applicable state suitability statutes, rules and regulations are incorporated into relevant insurance producer training manuals;
- ~~Review the regulated entity’s producer training materials to verify that the insurer establishes standards for insurance producer product training and maintains reasonable procedures to require its insurance producers to comply with the requirements of Section 7 of the *Suitability in Annuity Transactions Model Regulation* (#275). For more information on the requirements of Section 7 of Model #275, see Marketing and Sales Standard 11 in this chapter;~~
- ~~Examine the regulated entity’s producer training materials to ensure that the insurer provides adequate product specific training and training materials which fully explain all material features of its annuity products to its insurance producers;~~
- Review the regulated entity’s suitability policies and procedures to ensure that the insurer maintains adequate procedures for review of each recommendation, prior to issuance of an annuity, that are designed to ensure that there is a reasonable basis to determine that a recommendation is suitable. An insurer’s review procedures may apply a screening system for the purpose of identifying selected transactions for additional review and the insurer’s review process may be accomplished electronically or through other means including, but not limited to, physical review. Such an electronic or other system

may be designed to require additional review only of those transactions identified for additional review by the selection criteria.

- Verify suitability review procedures include a review of all internal transactions for the consumer, even if those transactions occur or occurred in multiple states. Additionally, the suitability reviews should consider all internal transactions for a customer even if those transactions occur in multiple states;
- Verify that the insurer maintains reasonable procedures to detect recommendations that are not suitable. Insurer procedures may include, but are not limited to, confirmation of consumer suitability information, systematic customer surveys, interviews, confirmation letters and programs of internal monitoring. If there is no provision in applicable state suitability statutes, rules or regulations to the contrary, an insurer may demonstrate compliance in this area by reviewing all transactions flagged for further internal review while either applying sampling procedures, or by confirming suitability information after issuance or delivery of the annuity; and
- Verify that the insurer annually provides a report to senior management (per Supplemental Checklist K), including to the senior manager responsible for audit functions, which details a review, with appropriate testing, reasonably designed to determine the effectiveness of the supervision system, the exceptions found, and corrective action taken or recommended, if any.

Commented [A2]: This seems very vague and confusing. It could be the duplication of the phrase "additional review" in the sentence.

Commented [A3]: Should be a separate review item?

An insurer may contract for performance of one or more functions (including maintenance of procedures) under the criteria set forth in Section 6F(1) of the *Suitability in Annuity Transactions Model Regulation* (#275). An insurer is responsible for taking appropriate corrective action and may be subject to sanctions and penalties pursuant to Section 8 of Model #275 regardless of whether the insurer contracts for performance of a function and regardless of the insurer's compliance with subparagraph (b) of Section 6F(2) of Model #275.

An insurer's supervision system as described above should include supervision of contractual performance by third parties. This includes, but is not limited to, the following criteria:

- Verify that the insurer is monitoring and, as appropriate, conducting audits to assure that contracted function(s) are properly performed; and
- Review insurer procedures to verify that the insurer is annually obtaining a certification from a senior manager who has responsibility for the contracted function(s) that the manager has a reasonable basis to represent, and does represent, that the function is properly performed.

Review agency files and related documentation to verify that insurance producers do not dissuade, or attempt to dissuade, a consumer from:

- Truthfully responding to an insurer's request for confirmation of suitability information;
- Filing a complaint; or
- Cooperating with the investigation of a complaint.

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

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

Review the insurer's system of monitoring sales made in compliance with FINRA annuity suitability and supervision requirements and applicable state annuity suitability statutes, rules and regulations. An insurer may demonstrate compliance in this area by:

- Monitoring the FINRA member broker-dealer using information collected in the normal course of an insurer's business; and

- Providing to the FINRA member broker-dealer information and reports that are reasonably appropriate to assist the FINRA member broker-dealer to maintain its supervision system.

Review insurer records of corrective action taken in mitigation of apparent violations of suitability standards for sales directly by the insurer and by any insurance producers who are acting as agents for the entity.

Determine whether the insurer has elected to maintain records of the information collected from the consumer and other information used in making the recommendations that were the basis for insurance transactions, or if the insurer has elected to require its producers to maintain these records. Verify that such a system is in place and is monitored by the insurer.

Note: Review the insurer's denials for suitability reasons. Review underwriting data to determine if an annuity was subsequently issued to the client. If an annuity was subsequently issued, the examiner may want to select a [sampling sample of those files](#) to ensure the sale was appropriate.

[It should be noted that the model's supervision system does not require the insurer to address the following:](#)

- [A producer's recommendations to consumers of products other than the annuities offered by the insurer;](#)
[or](#)
- [Include consideration of or comparison to options available to the producer or compensation relating to those options other than annuities or other products offered by the insurer.](#)

~~[However, these limitations only apply to the insurer's system of supervision and does not exclude these considerations from an analysis of another licensee.](#)~~

Commented [A4]: It seems like this statement is not necessary.

K. Supplemental Checklist for Marketing and Sales Standard #10

Yes	No	Requirement
<u>Ensure the insurer's system of annuity suitability supervision includes from Model #275:</u>		
		The insurer shall establish and maintain reasonable procedures to inform its producers of the requirements of this regulation and shall incorporate the requirements of this regulation into relevant producer training manuals.
		The insurer shall establish and maintain standards for producer product training and shall establish and maintain reasonable procedures to require its producers to comply with the requirements of Section 7 of this regulation.
		The insurer shall provide product-specific training and training materials that explain all material features of its annuity products to its producers.
		The insurer shall establish and maintain procedures for the review of each recommendation prior to the issuance of an annuity that is designed to ensure there is a reasonable basis to determine that the recommended annuity would effectively address the particular consumer's financial situation, insurance needs and financial objectives. Such review procedures may apply a screening system to identify selected transactions for additional review and may be accomplished electronically or through other means including, but not limited to, physical review. These electronic or other monitoring techniques may be designed to require additional review only of those transactions identified for additional review by the selection criteria.
		<p>The insurer shall establish and maintain reasonable procedures to detect recommendations that are not in compliance with Subsections A, B, D, and E. This may include, but is not limited to, confirmation of the consumer's consumer profile information, systematic customer surveys, producer and consumer interviews, confirmation letters, producer statements or attestations and programs of internal monitoring. Nothing in this subparagraph prevents an insurer from complying with this subparagraph by applying sampling procedures, or by confirming the consumer profile information or other required information under this section after issuance or delivery of the annuity.</p> <p>Note: In addition to this language from Model #275, examiners should make sure that the company is reviewing all transactions that have been flagged for further internal review.</p>
		The insurer shall establish and maintain reasonable procedures to assess, prior to or upon issuance or delivery of an annuity, whether a producer has provided to the consumer the information required to be provided under this section.
		The insurer shall establish and maintain reasonable procedures to identify and address suspicious consumer refusals to provide consumer profile information.
		The insurer shall establish and maintain reasonable procedures to identify and eliminate any sales contests, sales quotas, bonuses, and non-cash compensation that are based on the sales of specific annuities within a limited period of time. The requirements of this subparagraph are not intended to prohibit the receipt of health insurance, office rent, office support, retirement benefits, or other employee benefits by employees as long as those benefits are not based upon the volume of sales of a specific annuity within a limited period of time.
Note: The intent of this subparagraph (h) is to prohibit sales contests, sales		

		<u>quotas, bonuses, and non-cash compensation based on the sale of a particular product within a limited period of time, but not to prohibit general incentives regarding the sales of a company's products with no emphasis on any particular product.</u>
		<u>The insurer shall annually provide a written report to senior management, including to the senior manager responsible for audit functions, which details the results of a review, with appropriate testing, reasonably designed to determine the effectiveness of the supervision system, the exceptions found, and corrective action taken or recommended, if any.</u>
		<u>Nothing in this subsection restricts an insurer from contracting for delegating the— performance of a function (including maintenance of procedures) required under this subsection. An insurer is responsible for taking appropriate corrective action and may be subject to sanctions and penalties pursuant to Section 8 of this regulation regardless of whether the insurer contracts for performance of a function and regardless of the insurer's compliance with subparagraph (b) of this paragraph.</u>
		<u>An insurer's supervision system under this subsection shall include supervision of contractual performance under this subsection. This includes, but is not limited to, the following:</u> <ul style="list-style-type: none"> • <u>Monitoring and, as appropriate, conducting audits to assure that the contracted function is properly performed; and</u> • <u>Annually obtaining a certification from a senior manager who has responsibility for the contracted function that the manager has a reasonable basis to represent, and does represent, that the function is properly performed.</u>

Commented [A5]: This requirement appears to be a bit confusing and difficult to understand. The 'not' seems to contradict the requirement. Perhaps this can be clarified.

DRAFT

**STANDARDS
MARKETING AND SALES**

Standard 11

The insurer has procedures in place to educate and monitor compliance with insurer-specific education and training requirements and with applicable statutes, rules and regulations regarding the solicitation, recommendation and sale of annuity products.

Apply to: All annuity products

Priority: Essential

Documents to be Reviewed

- ___ Applicable statutes, rules and regulations
- ___ Regulated entity producer education/training files
- ___ Producer continuing education files
- ___ Producer new business/replacement log
- ___ Regulated entity producer training materials
- ___ Regulated entity standards for product training
- ___ Regulated entity policies and procedures
- ___ Complaint logs, complaint files and producer complaint logs/producer investigation files, if applicable

Others Reviewed

___ _____
___ _____

NAIC Model References

Suitability in Annuity Transactions Model Regulation (#275)
Unfair Trade Practices Act (#880)
Producer Licensing Model Act (#218)

Review Procedures and Criteria

Review regulated entity policies and procedures to ensure that the regulated entity has adequate procedures in place to provide training, including product-specific training that is appropriate to the specific product being sold. Review the regulated entity's procedures to inform producers of the regulated entity's standards for annuity product training and of applicable state statutes, rules or regulations regarding the solicitation, recommendation and sale of the annuity product.

Monitor and determine if the insurer has taken any actions against producers who lack adequate product knowledge and if so, was the action appropriate for the circumstances.

Compare data in producer continuing education files to applicable data in state insurance department producer continuing education records to monitor and determine that any insurance producer who engages in the sale of annuity products has met the one-time 4 hour credit training course in accordance with applicable state statutes, rules and regulations.

Determine that the regulated entity has adequate procedures in place to verify that a producer has completed necessary training, as required by applicable state statutes, rules and regulations, before allowing the producer to sell an annuity product for that insurer.

Review content of producer training materials for compliance with applicable state statutes, rules and regulations regarding solicitation, recommendation and sales of annuity products. Determine if the insurer product-specific training materials are appropriate and accurately reflect the features of the specific annuity.

Review complaint logs, any applicable complaint files and any producer investigation files for allegations of unsuitable, improper or misleading sales.

Automation Tip:

Examiners should request underwriting, policy and claim data using the NAIC standardized data requests for a period of three to five years. The expanded time frame allows the examiner to trend sales practices for a number of years.

Examiners should then use a program such as ACL to review underwriting data, product data and claims data for possible unsuitable sales.

Examiners can review and trend this data for:

- Sales from producers who were the subject of complaints and/or investigations that alleged unsuitable sales, misrepresentations, or improper sales activities;
- Sales of producers who had a materially large number of replacements or exchanges;
- Sales of producers who sell a materially large number of annuities that pay the highest commissions and have the longest surrender period or have the highest surrender amounts;
- Sales of producers who have had previous sales denied based on suitability reasons;
- Sales of producers who had disciplinary actions – Financial Industry Regulatory Authority (FINRA) and state disciplinary actions;
- Sales from producers who have sold a materially large number of deferred annuities to consumers over age 75;
- Withdrawals from products where the consumer incurred a penalty (a contractual penalty or IRS tax penalty) for taking the withdrawal within two years of purchase of the annuity; and
- Sales from producers who have sold multiple annuities to the same consumer.

Examiners should realize that trending data is not a definitive means to identify unsuitable sales. Further review of the individual transaction will be necessary to determine suitability.

Examiners should cross-reference new business data and data in the replacement logs with the regulated entity's producer education/training files to ensure that prior to a sale of an annuity product the insurance producer has been trained in the regulated entity's standards for the specific annuity product and trained in the applicable state statutes, rules and regulations regarding the solicitation, recommendation and sale of annuity products.

**STANDARDS
MARKETING AND SALES**

Standard 12

The insurer has product-specific training standards and materials designed to provide producers with adequate knowledge of the annuity products recommended prior to soliciting the sale of annuity products. The insurer also must have reasonable procedures in place to require its producers to comply with applicable producer training requirements.

Apply to: All annuity products

Priority: Essential

Documents to be Reviewed

- ___ Applicable statutes, rules and regulations
- ___ Agency correspondence file/Agency bulletins
- ___ Agency procedural manual
- ___ Agency sales/lapse records
- ___ Systems manuals
- ___ Producer training materials
- ___ Contracts with third-party vendors with compliance responsibilities

Others Reviewed

- ___ _____
- ___ _____

NAIC Model References

Suitability in Annuity Transactions Model Regulation (#275)
Unfair Trade Practices Act (#880)
Producer Licensing Model Act (#218)
Suitability of Sales of Life Insurance and Annuities White Paper

Review Procedures and Criteria

Contact other regulators that may have conducted a recent review of the insurer's training standards.

Determine if the insurer has required appropriate training, as outlined in Supplemental Checklist L of this chapter, for its producers.

It is useful to become acquainted with the definitions and appendices set forth in the *Suitability in Annuity Transactions Model Regulation (#275)*.

The satisfaction of the training requirements of another state that are substantially similar to the provisions of this subsection shall be deemed to satisfy the training requirements.

Commented [A6]: Should this be moved above the sentence ahead of it?

[An insurer shall verify that a producer has completed the annuity training course required under this subsection before allowing the producer to sell an annuity product for that insurer. An insurer may satisfy its responsibility under this subsection by obtaining certificates of completion of the training course or obtaining reports provided by commissioner-sponsored database systems or vendors or from a reasonably reliable commercial database vendor that has a reporting arrangement with approved insurance education providers.](#)

[Per Supplemental Checklist L of this chapter, R](#)review regulated entity's records to confirm that it verifies producers complete a one-time 4 credit hour general annuity training course prior to soliciting the sale of an annuity product.

Determine if the insurer product-specific training materials are appropriate and accurately reflect the specific annuity being recommended. Review regulated entity's records to determine if, when and how product-specific training occurred prior to a producer recommending an annuity.

Note: Testing is not a requirement of the *Suitability in Annuity Transactions Model Regulation (#275)*. Assessing compliance with this standard may require the examiner to access compliance with many facets of Model #275. The insurance producer training requirement of the model regulation requires that producers not solicit the sale of an annuity product unless the producer has adequate product knowledge to recommend the annuity. It is the insurer's responsibility to establish standards for product specific training for its producers. Insurers must also establish reasonable procedures to require its producers to have adequate product knowledge prior to the producer recommending an annuity.

If the examiners believe an unsuitable sale may have occurred, the examiner may need to determine the cause of the unsuitable sale.

Examiners will need to assess the product-specific training materials and determine if the materials were appropriate for the specific product. According to *Suitability in Annuity Transactions Model Regulation (#275)*, insurance producers may rely on insurer-provided product-specific training materials and standards to comply with Section 7 of Model #275.

Examiners will also need to assess the procedures the insurer established to require its producers have an adequate product knowledge before the producer recommends the annuity. Specifically the examiners will need to determine if the training for the specific product took place before the recommendation of an annuity, how the producer was trained and if the training was reasonably designed to require the producer to have adequate product knowledge prior to the sale.

Based upon the complexity of the product being offered, there is an expectation that the content of training materials and the way the training occurs may differ.

L. Supplemental Checklist for Marketing and Sales Standard #12

Yes	No	Requirement
<u>Ensure the insurer’s and applicable producer’s system of annuity suitability supervision and training include:</u>		
		<u>A producer who engages in the sale of annuity products shall complete a one-time four (4) credit training course approved by the department of insurance and provided by the department of insurance-approved education provider.</u>
		<u>Producers who hold a life insurance line of authority on the effective date of this regulation and who desire to sell annuities shall complete the requirements of this subsection within six (6) months after the effective date of this regulation. Individuals who obtain a life insurance line of authority on or after the effective date of this regulation may not engage in the sale of annuities until the annuity training course required under this subsection has been completed.</u>
		<u>The training required under this subsection shall include information on the following topics:</u> <ul style="list-style-type: none"> • <u>The types of annuities and various classifications of annuities;</u> • <u>Identification of the parties to an annuity;</u> • <u>How product-specific annuity contract features affect consumers;</u> • <u>The application of income taxation of qualified and non-qualified annuities;</u> • <u>The primary uses of annuities; and</u> • <u>Appropriate standard of conduct, sales practices, replacement and disclosure requirements.</u>

Commented [A7]: This references a “regulation” multiple times without specifying the regulation. Should it be clarified to make it more clear about what regulation is being referenced?

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**STANDARDS
MARKETING AND SALES**

Standard 13

The insurer has procedures in place to provide full disclosure to consumers regarding all sales of products involving fixed-index annuity products, and all sales are in compliance with applicable statutes, rules and regulations.

Apply to: All fixed-index annuity products

Priority: Essential

Documents to be Reviewed

- Applicable statutes, rules and regulations
- Policy/Underwriting file
- Agency correspondence file/Agency bulletins
- Agency procedural manual
- Claim files
- Complaint log
- Agency sales/lapse records
- Systems manuals
- Producer training materials
- Contracts with third-party vendors with compliance responsibilities

Others Reviewed

NAIC Model References

Unfair Trade Practices Act (#880)
Advertisements of Life Insurance and Annuities Model Regulation (#570), Section 3B
Annuity Disclosure Model Regulation (#245), Section 6 plus appendix
Suitability in Annuity Transactions Model Regulation (#275)
[Suitability of Sales of Life Insurance and Annuities White Paper](#)

Review Procedures and Criteria

Review policy files to determine that required records are retained for required time frames.

Examine procedures for verifying producer compliance with established policies and procedures.

Review complaint log for complaints alleging improper or misleading sales practices.

Review claim files for proper crediting and computation of surrender charges at death.

Review commission structure and note any differences between indexed and non-indexed annuity products. If it appears that the difference may be significant enough to provide incentive to a producer to recommend one product over another regardless of suitability, perform further analysis to test that hypothesis.

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**STANDARDS
MARKETING AND SALES**

Standard 14

The insurer has procedures in place to provide full disclosure to consumers regarding all sales of products involving index life, and all sales are in compliance with applicable statutes, rules and regulations.

Apply to: All index life products

Priority: Essential

Documents to be Reviewed

- ___ Applicable statutes, rules and regulations
- ___ Policy/Underwriting file
- ___ Agency correspondence file/Agency bulletins
- ___ Agency procedural manual
- ___ All documentation demonstrating the development of crediting rates used in illustrations
- ___ Claim files
- ___ Complaint log
- ___ Agency sales/lapse records
- ___ Regulated entity's systems manual
- ___ Regulated entity's producer training materials
- ___ Contracts with third-party vendors with compliance responsibilities

Others Reviewed

NAIC Model References

Advertisements of Life Insurance and Annuities Model Regulation (#570), Section 3B
Life Insurance Disclosure Model Regulation (#580), Section 8C
Unfair Trade Practices Act (#880)
Life Insurance Illustrations Model Regulation (#582) and Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index Based Interest (AG 49)

Review Procedures and Criteria

Review policy files to determine that the regulated entity is retaining required records for required time frames.

Examine the regulated entity's procedures for verifying producer compliance with the regulated entity's policy and procedures

Review complaint log for complaints alleging improper or misleading sales practices.

Review documentation to ensure compliance of the insurer's illustration methodologies with Model #582, generally, and with AG 49, specifically for indexed universal life (IUL) products. Review documentation to confirm implementation of AG 49 at required effective dates.

Review claim files for proper interest crediting and computation of death claims.

Review commission structure and note any differences between indexed and non-indexed life insurance products. If it appears that differences noted may be significant enough to provide incentive to a producer to recommend one product over another regardless of suitability, perform further analysis to test that hypothesis.

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**STANDARDS
MARKETING AND SALES**

Standard 15
The insurer's underwriting requirements and guidelines pertaining to travel are in compliance with applicable statutes, rules and regulations.

Apply to: All life products

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Life insurance applications and related disclosure and consent forms
- _____ Related questionnaires for applicants
- _____ Underwriting guidelines and field underwriting guidelines for producers
- _____ Review contracts with reinsurers of life insurance and all applicable guidelines from the reinsurer
- _____ Regulated entity's guidelines regarding lawful travel

Others Reviewed

- _____
- _____

NAIC Model References

Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Ensure the regulated entity does not discriminate against individuals by using an individual's past lawful travel to refuse life insurance, refuse to continue existing life insurance, or limit the amount, extent or kind of life insurance available to an individual.

Ensure the regulated entity does not discriminate against individuals by using an individual's future lawful travel plans to refuse life insurance, refuse to continue existing life insurance, or limit the amount, extent or kind of life insurance available to an individual, unless:

- The risk of loss for individuals who travel to a specified destination at a specific time is reasonably anticipated to be greater than if the individuals did not travel to that destination at the time; and
- The risk classification is based on sound actuarial principles and actual or reasonably anticipated experience.

Examples of the exceptions outlined above are future lawful travel plans to areas where the Centers for Disease Control and Prevention (CDC) have issued a highest level alert, including a recommendation for non-essential travel or to areas where there is an ongoing armed conflict involving the military of a sovereign nation foreign to the country of conflict.

Review the life insurers' and reinsurers' underwriting guidelines for guidelines pertaining to past and future travel.

Review applications and any related questionnaires for questions related to past and future travel plans.

Review contracts with applicable reinsurers for content regarding past and future lawful travel plans.

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**STANDARDS
MARKETING AND SALES**

Standard 16

The insurer does not issue an annuity recommended to a consumer unless there is a reasonable basis to believe the annuity would effectively address the particular consumer's financial situation, insurance needs and financial objectives based on the consumer's consumer profile information.

Apply to: All annuity sales and recommendations for products not otherwise excluded by the *Suitability in Annuity Transactions Regulation*

Priority: Essential

Documents to be Reviewed

Applicable statutes, rules and regulations

Policy/Underwriting files including customer profile (if applicable). Note that insurers may (but are not required to) maintain documentation on behalf of their producers. It may be necessary to obtain applicable customer profiles and related materials from the producer(s).

Agency correspondence file/Agency bulletins

Agency procedural manual

Agency sales/lapse records

Regulated entity's systems manual

Regulated entity's producer training materials

Others Reviewed

NAIC Model References

Suitability in Annuity Transactions Model Regulation (#275)

Review Procedures and Criteria

Determine if the insurer has advised its producers of applicable state statutes, rules and regulations regarding suitability of annuity products and the insurer's product-specific standards, policy and procedures regarding verification of the suitability of annuity products.

Note: Determine if the insurer has the capacity to produce data required by the applicable state suitability statute, rule or regulation. If optional recordkeeping provisions of the *Suitability in Annuity Transactions Model Regulation (#275)* have been adopted, review policy files to determine that the insurer is retaining required records for required time frames.

Examine insurer's procedures for verifying producer supervision and compliance with requirements on suitability. Producer supervision and compliance requirements are set forth in Supplemental Checklist M.

Commented [A8]: Usually, the standards aren't negative statements. What about... "The insurer issues annuities to consumers after determining there is a reasonable basis to believe the annuity would effectively address the particular consumer's financial situation, insurance needs and financial objectives based on the consumer's consumer profile."

Commented [A9]: Should the references to "Agency" be changed to Business Entity Producer?

It is useful to become acquainted with the definitions and appendices set forth in the *Suitability in Annuity Transactions Model Regulation* (#275).

The requirements set forth in Supplemental Checklist M do not create a fiduciary obligation or relationship and only create a regulatory obligation as established in this regulation.

The requirements apply to the particular annuity as a whole and the underlying subaccounts to which funds are allocated at the time of purchase or exchange of an annuity, and riders and similar producer enhancements, if any. The requirements do not mean the annuity with the lowest one-time or multiple occurrence compensation structures shall necessarily be recommended.

The requirements do not mean the producer has ongoing monitoring obligations under the care obligation under this paragraph, although such an obligation may be separately owed under the terms of a fiduciary, consulting, investment advising or financial planning agreement between the consumer and the producer.

Nothing in the *Suitability in Annuity Transactions Model Regulation* (#275) should be construed to require a producer to obtain any license other than a producer license with the appropriate line of authority to sell, solicit or negotiate insurance in this state, including but not limited to any securities license, in order to fulfill the duties and obligations contained in this regulation; provided the producer does not give advice or provide services that are otherwise subject to securities laws or engage in any other activity requiring other professional licenses.

Transactions not based on a recommendation (Editor's Note, the previous language "Transactions not based..." is a section heading and is underlined)

- Except as provided under paragraph (2), a producer shall have no obligation to a consumer under subsection A(1) related to any annuity transaction if:
 - No recommendation is made;
 - A recommendation was made and was later found to have been prepared based on materially inaccurate information provided by the consumer;
 - A consumer refuses to provide relevant consumer profile information and the annuity transaction is not recommended; or
 - A consumer decides to enter into an annuity transaction that is not based on a recommendation of the producer.
- An insurer's issuance of an annuity subject to paragraph (1) shall be reasonable under all the circumstances actually known to the insurer at the time the annuity is issued.

Application of the best interest obligation (Editor's Note, the previous language "Application of the..." is a section heading and is underlined)

Any requirement applicable to a producer under this subsection shall apply to every producer who has exercised material control or influence in the making of a recommendation and has received direct compensation as a result of the recommendation or sale, regardless of whether the producer has had any direct contact with the consumer. Activities such as providing or delivering marketing or educational materials, product wholesaling or other back office product support, and general supervision of a producer do not, in and of themselves, constitute material control or influence.

Commented [A10]: This doesn't seem like a testing criteria only an informational note. Does it need to be included here?

Commented [A11]: These two paragraphs reference "The requirements" without setting forth which "requirements". Are these generally all of the requirements from Checklist M? Clarification on which requirements are being referenced would be helpful.

Commented [A12]: All of these seem to be informational notes and not testing or review procedures. Should these be put into a different section of the Standard titled notes?

Commented [A13]: Paragraph 2 of what? Does the reference need updating?

Commented [A14]: Paragraph 1 of what? Does the reference need updating?

Commented [A15]: Which Subsection? Does the reference need updating?

M. Supplemental Checklist for Marketing and Sales Standard #16

Yes	No	Requirement
<u>Ensure the insurer's and applicable producer's system of annuity suitability supervision include (per Model #275):</u>		
		<p><u>Care Obligation. The producer, in making a recommendation shall exercise reasonable diligence, care and skill to:</u></p> <ul style="list-style-type: none"> • <u>Know the consumer's financial situation, insurance needs and financial objectives;</u> • <u>Understand the available recommendation options after making a reasonable inquiry into options available to the producer;</u> • <u>Have a reasonable basis to believe the recommended option effectively addresses the consumer's financial situation, insurance needs and financial objectives over the life of the product, as evaluated in light of the consumer profile information; and</u> • <u>Communicate the basis or basis of the recommendation.</u>
		<p><u>The producer has made reasonable efforts to obtain consumer profile information from the consumer prior to the recommendation of an annuity.</u></p>
		<p><u>The producer considered the types of products the producer is authorized and licensed to recommend or sell that address the consumer's financial situation, insurance needs and financial objectives. This does not require analysis or consideration of any products outside the authority and license of the producer or other possible alternative products or strategies available in the market at the time of the recommendation. Producers shall be held to standards applicable to producers with similar authority and licensure.</u></p>
		<p><u>The consumer profile information, characteristics of the insurer, and product costs, rates, benefits and features are those factors generally relevant in making a determination whether an annuity effectively addresses the consumer's financial situation, insurance needs and financial objectives, but the level of importance of each factor under the care obligation of this paragraph may vary depending on the facts and circumstances of a particular case. However, each factor may not be considered in isolation.</u></p>
		<p><u>The producer has a reasonable basis to believe the consumer would benefit from certain features of the annuity, such as annuitization, death or living benefit or other insurance-related features.</u></p>
		<p><u>In the case of an exchange or replacement of an annuity, the producer shall consider the whole transaction, which includes taking into consideration whether:</u></p> <ul style="list-style-type: none"> • <u>The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits, such as death, living or other contractual benefits, or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;</u> • <u>The replacing product would substantially benefit the consumer in comparison to the replaced product over the life of the product; and</u> • <u>The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 60 months.</u>
		<p><u>Conflict of interest obligation. A producer shall identify and avoid or reasonably manage and disclose material conflicts of interest, including material conflicts of interest related to an ownership interest.</u></p>
		<p><u>Documentation obligation. A producer shall at the time of recommendation or sale:</u></p>

		<ul style="list-style-type: none">• <u>Make a written record of any recommendation and the basis for the recommendation subject to this regulation;</u>• <u>Obtain a consumer signed statement on a form substantially similar to Appendix B documenting:</u><ul style="list-style-type: none">• <u>A customer's refusal to provide the consumer profile information, if any; and</u>• <u>A customer's understanding of the ramifications of not providing his or her consumer profile information or providing insufficient consumer profile information; and</u>• <u>Obtain a consumer signed statement on a form substantially similar to Appendix C acknowledging the annuity transaction is not recommended if a customer decides to enter into an annuity transaction that is not based on the producer's recommendation.</u>
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**STANDARDS
MARKETING AND SALES**

Standard 17

The insurer has taken steps to ensure that prior to the recommendation or sale of an annuity, the producer has prominently disclosed to the consumer on a form similar to that set forth in the Suitability in Annuity Transactions Model Regulation.

Apply to: All annuity sales and recommendations for products not otherwise excluded by the *Suitability in Annuity Transactions Regulation*

Priority: Essential

Documents to be Reviewed

Applicable statutes, rules and regulations

Policy/Underwriting files including customer profile (if applicable). Note that insurers may (but are not required to) maintain documentation on behalf of their producers. It may be necessary to obtain applicable customer profiles and related materials from the producer(s).

Agency correspondence file/Agency bulletins

Agency procedural manual

Agency sales/lapse records

Regulated entity's systems manual

Regulated entity's producer training materials

Others Reviewed

NAIC Model References

Suitability in Annuity Transactions Model Regulation (#275)

Review Procedures and Criteria

Determine if the insurer has advised its producers of applicable state statutes, rules and regulations regarding suitability of annuity products and of the insurer's product-specific standards, policy and procedures regarding annuity product disclosure requirements.

Note: Determine if the insurer has the capacity to produce data required by the applicable state suitability statute, rule or regulation. If optional recordkeeping provisions of the *Suitability in Annuity Transactions Model Regulation (#275)* have been adopted, review policy files to determine that the insurer is retaining required records for required time frames.

Examine insurer's procedures for verifying producer supervision and compliance with requirements on suitability. Producer supervision and compliance requirements are set forth in Supplemental Checklist N.

Commented [A16]: Prominently disclosed what? It seems that there are things to be disclosed as per Suitability in Annuity Transactions Model Regulation that should be referenced more specifically in this standard.

[It is useful to become acquainted with the definitions and appendices set forth in the *Suitability in Annuity Transactions Model Regulation* \(#275\).](#)

[If a state has adopted the *Annuity Disclosure Model Regulation* \(#245\), the state may have also adopted an additional phrase to explain that the requirements of this section are intended to supplement and not replace the disclosure requirements of the *Annuity Disclosure Model Regulation*. Refer to your state's specific regulation.](#)

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N. Supplemental Checklist for Marketing and Sales Standard #17

Yes	No	Requirement
<u>Ensure the insurer's and applicable producer's system of annuity suitability supervision include:</u>		
		The producer has disclosed a description of the scope and terms of the relationship with the consumer and the role of the producer in the transaction.
		The producer has provided an affirmative statement on whether the producer is licensed and authorized to sell the following products: <ul style="list-style-type: none"> • Fixed annuities; • Fixed indexed annuities; • Variable annuities; • Life insurance; • Mutual funds; • Stocks and bonds; and • Certificates of deposit.
		The producer has provided an affirmative statement describing the insurers the producer is authorized, contracted (or appointed), or otherwise able to sell insurance products for, using the following descriptions: <ul style="list-style-type: none"> • One insurer; • From two or more insurers; or • From two or more insurers although primarily contracted with one insurer.
		The producer has provided a description of the sources and types of cash compensation and non-cash compensation to be received by the producer, including whether the producer is to be compensated for the sale of a recommended annuity by commission as part of the premium or other remuneration received from the insurer, intermediary or other producer or by a fee as a result of a contract for advice or consulting services.
		A notice of the consumer's right to request additional information regarding cash compensation is described in subparagraph (b) of the following checklist provision.
		Upon request of the consumer or the consumer's designated representative, the producer shall disclose: <ul style="list-style-type: none"> • A reasonable estimate of the amount of cash compensation to be received by the producer, which may be stated as a range of amounts or percentages; and • Whether the cash compensation is a one-time or multiple occurrence amount, and if a multiple occurrence amount, the frequency and amount of the occurrence, which may be stated as a range of amounts or percentages.
		Prior to or at the time of the recommendation or sale of an annuity, the producer shall have a reasonable basis to believe the consumer has been informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, any annual fees, potential charges for and features of riders or other options of the annuity, limitations on interest returns, potential changes in non-guaranteed elements of the annuity, insurance and investment components and market risk.

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 and the standards set forth below.

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**STANDARDS
POLICYHOLDER SERVICE**

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

Apply to: All life products

Priority: Essential

Documents to be Reviewed

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

_____ Notice of reinstatement

Others Reviewed

NAIC Model References

Review Procedures and Criteria

Determine that notices were sent out in a timely manner.

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

Reinstatements should be applied per policy provisions.

**STANDARDS
POLICYHOLDER SERVICE**

Standard 2
Nonforfeiture options are communicated to the policyholder and contractholder and correctly applied in accordance with the policy contract.

Apply to: All life products

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)
- _____ Underwriting file
- _____ Policy and contract history file
- _____ Regulated entity's procedures manual

Others Reviewed

- _____
- _____

NAIC Model References

- Standard Nonforfeiture Law for Life Insurance (#808)*
- NAIC Procedure for Permitting Same Minimum Nonforfeiture Standards for Men and Women Insured Under 1980 CSO and 1980 CET Mortality Tables (#811)*
- Life Insurance Disclosure Model Regulation (#580)*
- Variable Life Insurance Model Regulation (#270)*
- Model Policy Loan Interest Rate Bill (#590)*
- Standard Nonforfeiture Law for Individual Deferred Annuities (#805)*
- Annuity Nonforfeiture Model Regulation (#806)*

Review Procedures and Criteria

Determine if the correct policy option is provided in case of policy lapse.

Review correspondence with policyholders to determine if options were explained adequately.

If there are questions related to the nonforfeiture values, refer to statutes, rules and regulations regarding the calculation of nonforfeiture values for details on calculating the values.

Review the regulated entity's procedures and policies regarding the handling of each type of nonforfeiture transaction (including whether the request may be made verbally).

Cash Surrender Values

- Review the issue date of the policy to determine whether the policy is mature enough to provide surrender values (usually by the end of the second or third year);
- Calculate the service time to process the surrender by subtracting the date the request was received from the date the surrender check was mailed (should be within 60 days);
- Review the calculation of the net cash value to determine the appropriate surrender value (include any outstanding policy loans, policy loan interest and policy dividends);
- Compare calculated surrender value with illustration surrender value. Confirm that any variance can be explained and is in accordance with policy provisions (i.e., interest rates, surrender charges, policy fees);
- Confirm with the regulated entity that there is an audit procedure in place to verify the calculation of surrender values (they are usually calculated systematically);
- Review cash surrender check for accuracy, including mail date; and
- Review returned mail procedures.

Extended Term Insurance (ETI)

- Determine if the ETI was automatic at lapse or policyowner-requested;
- Review the policy's contract language for content;
- Confirm the regulated entity's calculated policy value by taking the face value of the policy adjusted for any indebtedness, such as policy loans or paid-up additions;
- Check to make sure the regulated entity issued the correct amount of term insurance; and
- Confirm with the regulated entity that there is an audit procedure in place to verify the values and calculations made.

Reduced Paid-Up (RPU)

- Determine how the RPU option came about, whether automatic at lapse or policyowner-requested;
- Review the policy's contract language for content;
- Review the calculation of net cash value (including years the policy was in force) to verify the amount used as the net single premium to purchase the paid-up life insurance. Verify that the paid-up insurance is of the same type of policy as the original policy; and
- Confirm with the regulated entity that there is an audit procedure in place to verify the values and calculations made.

Additional Paid-Up

- Review the policy for content and time schedule for allowed increases in coverage;
- Review the policyowner's request to elect the additional paid-up option benefit; and
- Check that evidence of insurability was required before the rider was added to the in force policy.

Automatic Premium Loan (APL)

- Review the policy's contract language for content;
- Review the application to see if the insured elected another option. If not, verify that the grace period expired prior to the initiation of the APL;
- Check the net cash value calculation to make sure that the proper amount was used to deduct the overdue premium; and
- Confirm with the regulated entity that there is an audit procedure in place to verify the values and calculations made.

Note: The examiner should be alert to occurrences of producers automatically selecting the APL option on the insurance application.

Ensure the regulated entity notifies policyowners of material changes to any non-guaranteed factors in accordance with statutes, rules and regulations.

For variable life products with flexible premiums, ensure that a report is sent to the policyholder if the amounts available under the policy on any policy processing day to pay the charges authorized by the policy are less than the amount necessary to keep the policy in force until the next following processing day. The report should include the minimum payment required under the terms of the policy to keep it in force and the length of the grace period for payment of the amount.

Ensure that at the time of processing policy loans, the insurer notifies policyholders of the initial rate of interest, maximum interest rates and the frequency at which rates may be adjusted. Such notice is to be provided within a reasonable time after processing premium loans.

Ensure the insurer sends advance notice to policyholders with loans, advising of any increases in loan rates.

For annuity contracts that provide cash surrender benefits, review the benefit provided to ensure it meets the requirements of statutes, rules and regulations. In no event shall any cash value benefit be less than the minimum nonforfeiture amount. The death benefit shall be at least equal to the cash surrender benefit.

For annuity contracts that do not provide cash surrender benefits, review the benefit provided to ensure it meets the requirements of statutes, rules and regulations. In no event shall the present value of a paid-up annuity be less than the minimum nonforfeiture amount.

**STANDARDS
POLICYHOLDER SERVICE**

Standard 3

The regulated entity provides each policyowner with an annual report of policy values in accordance with statutes, rules and regulations and, upon request, an in force illustration or contract policy summary.

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

Life Insurance Illustrations Model Regulation (#582), Section 10
Life Insurance Disclosure Model Regulation (#580), Section 5C(1)
Variable Annuity Model Regulation (#250), Section 8
Variable Life Insurance Model Regulation (#270), Section 9
Modified Guaranteed Annuity Model Regulation (#255) Section 11
Universal Life Insurance Model Regulation (#585), Section 9

Review Procedures and Criteria

Note: Traditional life (not universal or variable life) products that are not illustrated or that were issued prior to a jurisdiction's adoption of the equivalent of the *Life Insurance Illustrations Model Regulation (#582)* may not be required to provide annual reports.

If required, ensure annual reports are being provided annually.

For universal life, ensure the report includes:

- The beginning and end date of the current report period;
- The policy value at the end of the previous report period and at the end of the current report period;
- The total amounts that have been credited or debited to the policy value during the current report period, identifying each by type (e.g., interest, mortality, expense and riders);
- The current death benefit at the end of the current report period on each life covered by the policy;
- The net cash surrender value of the policy as of the end of the current report period; and
- The amount of outstanding loans, if any, as of the end of the current report period.

For fixed premium universal life policies, ensure the report includes:

- If, assuming guaranteed interest, mortality and expense loads and continued scheduled premium payments, the policy's net cash surrender value is such that it would not maintain insurance in force until the end of the next reporting period, a notice to this effect should be included in the report.

For flexible premium universal life policies, ensure the report includes:

- If, assuming guaranteed interest, mortality and expense loads, the policy's net cash surrender value will not maintain insurance in force until the end of the next reporting period, unless further premium payments are made, a notice to this effect should be included in the report.

For traditional life policies, where applicable, ensure the report includes:

- Current death benefit;
- Annual contract premium;
- Current cash surrender value;
- Current dividend;
- Application of current dividend; and
- Amount of outstanding loan.

Ensure that if there are policies that do not build nonforfeiture values, an annual report is provided for those years when a change has been made to non-guaranteed policy elements by the insurer.

Determine if the annual report includes an in force illustration. If it does not, it should contain the following notice displayed prominently: **"IMPORTANT POLICYOWNER NOTICE:** You should consider requesting more detailed information about your policy to understand how it may perform in the future. You should not consider replacement of your policy or make changes in your coverage without requesting a current illustration. You may annually request, without charge, such an illustration by calling (insurer's telephone number), writing to (insurer's name) at (insurer's address) or contacting your producer. If you do not receive a current illustration of your policy within 30 days from your request, you should contact your state insurance department." The insurer may vary the sequential order of the methods for obtaining an in force illustration.

If an adverse change in non-guaranteed elements that could affect the policy has been made by the insurer since the last annual report, the annual report should contain a notice of that fact and the nature of the change prominently displayed.

For variable annuity products, ensure there is a statement or statements reporting the investments held in a separate account. The statement report period should be not more than 4 months prior to the date of mailing. The statement should also include the number of accumulation units and the dollar value of an individual unit or the value of the contractholder's account.

For variable life products, ensure the annual report includes the following:

- The cash surrender value;
- Death benefit;
- Any partial withdrawal or policy loan;
- Any interest charge; and
- Any optional payments.
- The following disclosures:
 - In accordance with the investment experience of the separate account, the cash values and the variable death benefit may increase or decrease;
 - Prominent identification of any value which may be recomputed prior to the next annual report;
 - A statement if the policy guarantees the variable death benefit on the next policy anniversary date will not be less than the variable death benefit specified in the report;
 - For flexible premium policies, a reconciliation of the change since the previous report in cash value and cash surrender value, if different, because of payments made (less deductions for expense charges), withdrawals, investment experience, insurance charges and any other charges made to the cash value;

- The projected cash value and cash surrender value, if different, as of one year from the end of the period covered by the report, assuming that planned periodic premiums, if any, are paid as scheduled;
- Guaranteed costs of insurance are deducted;
- The net return is equal to the guaranteed rate or, in the absence of a guaranteed rate, is not greater than zero;
- If the projected value is less than zero, a warning message should be included that the policy may be in danger of terminating without value in the next 12 months, unless additional premium is paid;
- A summary of the financial statement of the separate account based on the last annual statement filed with the insurance department;
- The net investment return of the separate account for the last year, and, for each year after the first, a comparison of the investment rate of the separate account during the last year with the investment rate during prior years, up to a total of not less than 5 years, when available;
- A list of investments held by the separate account as of a date not earlier than the end of the last year for which an annual statement was filed with the insurance department;
- Any charges levied against the separate account during the previous year; and
- A statement of any change since the last report in the investment objective and orientation of the separate account, in any investment restriction or material quantitative or qualitative investment requirement applicable to the separate account or to the investment advisor of the separate account.

Annual reports for modified guaranteed life insurance policies shall state that the cash value may increase or decrease and shall prominently identify any value that may be recomputed prior to the next statement.

Determine if, upon the request of the policyowner, the insurer furnishes an in force illustration of current and future benefits and values based on the insurer's present illustrated scale. No signature or other acknowledgment of receipt of this illustration is required.

Also, determine, if a policyowner requests one, the insurer provides policy data for the policy. Unless otherwise requested, the data should be provided for 20 consecutive years beginning with the previous policy anniversary and include cash dividends according to the current dividend scale, the amount of outstanding policy loans and the current policy loan interest rate. Values shown should be based on the dividend option in effect at the time of the request. A reasonable fee may be charged for the preparation of the statement.

**STANDARDS
POLICYHOLDER SERVICE**

Standard 4

Upon receipt of a request from a policyholder for accelerated benefit payment, the regulated entity must disclose to the policyholder the effect of the request on the policy's cash value, accumulation account, death benefit, premium, policy loans and liens. The regulated entity must also advise that the request may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements.

Apply to: All individual and group life products

Priority: Essential

Documents to be Reviewed

___ Applicable statutes, rules and regulations

___ Underwriting files

___ Policy files

Others Reviewed

___ _____

___ _____

NAIC Model References

Accelerated Benefits Model Regulation (#620), Sections 4, 6D and 8

Review Procedures and Criteria

Review the above documents to determine that proper disclosure has been made.

Verify that prior to payment of accelerated benefits the insurer has obtained from any assignee or irrevocable beneficiary a signed acknowledgment of concurrence for accelerated benefit payout.

The regulated entity may offer waiver of premium in absence of such provision in an existing policy. At the time accelerated benefits are claimed, the insurer must explain any continuing premium requirements to maintain the policy in force.

Unfair discrimination is prohibited.

F. Underwriting and Rating

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

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**STANDARDS
UNDERWRITING AND RATING**

Standard 1
Pertinent information on applications that form a part of the policy and contract is complete and accurate.

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

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

_____ All applications

Others Reviewed

NAIC Model References

Review Procedures and Criteria

Determine if the requested coverage is issued.

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

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

Determine how automatic premium loan options are disclosed on the application.

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

Verify that supplemental applications are used, where appropriate.

**STANDARDS
UNDERWRITING AND RATING**

Standard 2
The regulated entity complies with the specific requirements for Acquired Immune Deficiency Syndrome (AIDS)-related concerns in accordance with statutes, rules and regulations.

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Life insurance applications and related disclosure and consent forms
- _____ Health questionnaires for applicants
- _____ Medical underwriting guidelines
- _____ Regulated entity's guidelines regarding the handling of AIDS-related test results, if such tests are allowed

Others Reviewed

NAIC Model References

Review Procedures and Criteria

Ensure the regulated entity does not use medical records indicating AIDS-related concerns to discriminate against applicants without medical evidence of disease. Companies shall establish reasonable procedures related to the administration of an AIDS-related test.

- Medical underwriting guidelines may consider factual matters that reveal the existence of a medical condition. For example, no adverse underwriting decision shall be based on medical records that only indicate the applicant demonstrated AIDS-related concerns by seeking counseling from a health care professional;
- Disclosure forms signed by the applicant must clearly disclose the requirement, if any, for applicants to take an AIDS-related test and should be a part of the underwriting file; and
- Applications must contain a consent form for such testing.

Review any application forms and health questionnaires used by the regulated entity or its producers for questions that would require the applicant to provide information regarding sexual orientation.

- Questions may ask if the applicant has been diagnosed with AIDS or AIDS-Related Complex (ARC), if they are designed to establish the existence of the condition, but are not used as a proxy to establish sexual orientation of the applicant.

Ensure the regulated entity or insurance support organization does not use the sexual orientation of an applicant in the underwriting process or in the determination of insurability.

Underwriting guidelines must not consider an applicant's sexual orientation to be a factor in the determination of insurability.

A sample of underwriting files for denied applications should be reviewed to verify that denials were non-discriminatory.

Review inspection reports to determine if they are being used in a discriminatory manner, or ordered on the basis of the regulated entity's guidelines (e.g., based on the amount of insurance).

Neither the marital status, living arrangements, occupation, gender, medical history, beneficiary designation, nor the ZIP code or other territorial classification may be used to establish the applicant's sexual orientation.

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G. Claims

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

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**STANDARDS
CLAIMS**

Standard 1
The regulated entity provides the required disclosure material to policyholders at the time an accelerated benefit payment is requested.

Apply to: All life insurance products that contain a benefit provision or benefit rider for the payment of accelerated benefits

Priority: Essential

Documents to be Reviewed

- ___ Applicable statutes, rules and regulations
- ___ Claim procedure manuals
- ___ Claim files
- ___ Claim complaint records

Others Reviewed

NAIC Model References

Accelerated Benefits Model Regulation (#620)

Review Procedures and Criteria

Review the regulated entity's procedures, training manuals and claim bulletins to determine if claim procedures meet the requirements for disclosure at the time benefits are requested. Required disclosures include:

- Disclosure of possible tax consequences and advice that the claimant seek assistance from a tax advisor;
- A written statement to the policyowner and to the irrevocable beneficiary explaining any effect the payment will have on the policy's cash value, accumulation account, death benefit, premium, policy loans and policy liens;
- A statement warning that receipt of accelerated benefits may adversely affect claimant eligibility for government benefits or entitlements;
- Administrative expense charges, if any, applicable to the payment of accelerated benefits;
- Any continuing premium requirement to keep the policy in force;
- Lump sum settlement options are required; and
- Any accidental death benefits remain intact.

Review claim files for documentation that required disclosure notices were issued in a timely manner.

Review claim-related complaint files for complaints from policyowners not receiving required disclosure material.

Accelerated benefits are available on the effective date of the policy or rider for accidents and no more than 30 days following the effective date for illness.

No restrictions are permitted on use of accelerated benefit proceeds.

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**STANDARDS
CLAIMS**

Standard 2

The regulated entity does not discriminate among insureds with differing qualifying events covered under the policy or among insureds with similar qualifying events covered under the policy.

Apply to: All life insurance products that contain a benefit provision or benefit rider for the payment of accelerated benefits

Priority: Essential

Documents to be Reviewed

- Applicable statutes, rules and regulations
- Regulated entity's claim procedures manual and claim bulletins
- Claims training manual
- Claim files

Others Reviewed

- _____
- _____

NAIC Model References

Accelerated Benefits Model Regulation (#620)

Review Procedures and Criteria

Review procedure manuals, training manuals and the regulated entity's internal claim bulletins to determine if regulated entity standards exist for consistent evaluation of criteria for approval of accelerated benefits payments.

Review claim files to verify that the regulated entity does not apply further conditions on the payment of accelerated benefits beyond those conditions specified in the policy or benefit rider.

**STANDARDS
CLAIMS**

Standard 3

The regulated entity provides the beneficiary, at the time a claim is made, written information describing the settlement options available under the policy and how to obtain specific details relevant to the settlement options.

Apply to: All life insurance companies

Priority: Essential

Documents to be Reviewed

- ___ Applicable statutes, rules and regulations
- ___ Claim procedure manuals/claim training manuals/claim bulletins
- ___ Claim files
- ___ Claim complaint records
- ___ Disclosures provided to beneficiaries

Others Reviewed

- ___ _____
- ___ _____

NAIC Model References

Retained Asset Accounts Sample Bulletin (#573)

Review Procedures and Criteria

Review the regulated entity's procedures, training manuals and claim bulletins to determine if claim procedures meet the requirements for disclosure at the time benefits are requested. Required disclosures include:

- Written information provided to the beneficiary describing available settlement options under the policy; and
- Written information provided to the beneficiary informing the beneficiary how to obtain specific details regarding available settlement options;

A "retained asset account" as defined in the *Retained Asset Accounts Sample Bulletin (#573)* means any mechanism whereby the settlement of proceeds payable under a life insurance policy is accomplished by the insurer or an entity acting on behalf of the insurer depositing the proceeds into an account with check or draft writing privileges, where those proceeds are retained by the insurer, pursuant to a supplementary contract not involving annuity benefits.

If the regulated entity settles benefits through a retained asset account, examiners should review and verify in accordance with the applicable state's record retention requirements that the regulated entity has established and implemented procedures to ensure that the regulated entity has:

- a) Provided the following written disclosures to the beneficiary before the account is selected, if optional, or established, if not:
 - Payment of the full benefit amount is accomplished by delivery of the "draft book"/"check book";
 - One draft or check may be written to access the entire amount, including interest, of the retained asset account at any time;
 - Whether other available settlement options are preserved until the entire balance is withdrawn or the balance drops below the regulated entity's minimum balance requirements;
 - A statement identifying the account as either a checking or draft account and an explanation of how the account works;
 - Information about the account services provided and contact information where the beneficiary may request and obtain more details about such services;
 - A description of fees charged, if applicable;
 - The frequency of statements showing the current account balance, the interest credited, drafts/checks written and any other account activity;
 - The minimum interest rate to be credited to the account and how the actual interest rate will be determined;
 - The interest earned on the account may be taxable;
 - Retained asset account funds held by regulated entities are not guaranteed by the Federal Deposit Insurance Corporation (FDIC) but are guaranteed by the state guaranty associations (where permitted by state law). The beneficiary should be advised to contact the National Organization of Life and Health Insurance Guaranty Associations (www.nolhga.com) to learn more about the coverage limitations to his or her account;
 - A description of the regulated entity's policy regarding retained asset accounts that may become inactive; and
- b) Provided the beneficiary with a supplemental contract that clearly discloses the rights of the beneficiary and obligations of the regulated entity under the contract.

Review claim files for documentation that required disclosure notices were issued in a timely manner.

Review claim-related complaint files for complaints from beneficiaries not receiving required disclosure material.

H. Supplemental Checklist for Marketing and Sales Standard #1

Yes	No	Requirement
For companies that use enrollment periods:		
		Advertisements should specify the date by which the applicant must mail the application, which should be not less than 10 days and not more than 40 days from the date the enrollment period is advertised for the first time.
For direct response policies:		
		The advertisement should not state or imply there is a cost savings because there is no insurance producer or commission, unless true.
		The advertisement should not use the terms “inexpensive,” “low cost” or other similar language when the policies are being marketed to persons who are 50 years of age or older when the policy is guaranteed-issue.
For graded or modified benefit policies:		
		The advertisement must prominently display any limitation of benefits.
		If the premium is level and coverage decreases or increases with age or duration, that fact must be prominently disclosed.
		If the death benefit varies with the length of time the policy has been in force, the advertisement should accurately describe and clearly call attention to the amount of minimum death benefit under the policy.
		The advertisement should not use the terms “inexpensive,” “low cost” or other similar language when the policies are being marketed to persons who are 50 years of age or older, when the policy is guaranteed-issue.
For policies with premium changes:		
		The advertisement for a policy with non-level premiums should prominently describe the premium changes.
		An advertisement in which the insurer describes a policy where it reserves the right to change the amount of the premium during the policy term, but which does not prominently describe this feature, is deemed to be deceptive and misleading and is prohibited.
For policies with non-guaranteed policy elements:		
		An advertisement should not utilize or describe non-guaranteed policy elements in a manner that is misleading or has the capacity or tendency to mislead.
		An advertisement should not state or imply that the payment or amount of non-guaranteed policy elements is guaranteed. If non-guaranteed policy elements are illustrated, they must be based on the insurer’s current scale, and the illustration must contain a statement to the effect that they are not to be construed as guarantees or estimates of amounts to be paid in the future.

H. Supplemental Checklist for Marketing and Sales Standard #1 (cont'd)

		An advertisement that includes any illustrations or statements containing or based upon non-guaranteed elements should set forth with equal prominence comparable illustrations or statements containing or based upon the guaranteed elements.
		If an advertisement refers to any non-guaranteed policy element, it should indicate that the insurer reserves the right to change any such element at any time and for any reason. However, if an insurer has agreed to limit this right in any way—such as, for example, if it has agreed to change these elements only at certain intervals or only if there is a change in the insurer’s current or anticipated experience—the advertisement may indicate any such limitation on the insurer’s right.
		An advertisement should not refer to dividends as “tax free” or use words of similar import, unless the tax treatment of dividends is fully explained, and the nature of the dividend as a return of premium is indicated clearly.
For policies sold to students:		
		The envelope in which insurance solicitation material is contained may be addressed to the parent(s) of students. The address may not include any combination of words which imply that the correspondence is from a school, college, university or other education or training institution, nor may it imply that the institution has endorsed the material or supplied the insurer with information about the student, unless such is a correct and truthful statement.
		All advertisements including, but not limited to, informational flyers used in the solicitation of insurance must be identified clearly as coming from an insurer or insurance producer, if such is the case, and these entities must be clearly identified as such.
		The return address on the envelope may not imply that the soliciting insurer or insurance producer is affiliated with a university, college, school or other educational or training institution, unless true.
For individual deferred annuity products or deposit funds:		
		Any illustrations or statements containing or based upon interest rates higher than the guaranteed accumulation interest rates should set forth with equal prominence comparable illustrations or statements containing or based upon the guaranteed accumulation interest rates. The higher interest rates should not be greater than those currently being credited by the company, unless the higher rates have been publicly declared by the company with an effective date for new issues not more than 3 months subsequent to the date of declaration.

H. Supplemental Checklist for Marketing and Sales Standard #1 (cont'd)

		If an advertisement states the net premium accumulation interest rate, whether guaranteed or not, it should also disclose in close proximity thereto and with equal prominence, the actual relationship between the gross and the net premiums.
		If a contract does not provide a cash surrender benefit prior to commencement of payment of annuity benefits, an illustration or statement concerning such contract should prominently state that cash surrender benefits are not provided.
For combination life insurance and annuity products:		
		An advertisement of a life insurance product and an annuity as a single policy or life insurance policy with an annuity rider should include a disclosure before the application is taken (if the policy contains an unconditional refund provision of at least 10 days, the disclosure statement can be delivered with the policy, or upon the applicant's request, whichever occurs sooner). The disclosure defines the gross annual life and premium annuity percentages and guaranteed cash value of the annuity and should include the first 5 policy years, the tenth and twentieth policy years, at least one age from 60 to 70 and the scheduled commencement of annuity payments.

I. Supplemental Checklist for Marketing and Sales Standard #4

For all illustrations: Determine if the illustration contains the following:

Yes	No	Requirement
		The illustration should be clearly labeled "life insurance illustration."
		Name of insurer.
		Name and business address of producer or insurer's authorized representative, if any.
		Name, age and gender of proposed insured except where a composite illustration is permitted.
		Underwriting or rating classification upon which the illustration is based.
		Generic name of the policy, the company product name, if different, and the policy form number.
		Initial death benefit.
		Dividend option election or application of non-guaranteed elements, if applicable.

(Life Insurance Illustrations Model Regulation (#582), Section 6A)

Note: "Generic name" means a short title descriptive of the policy being illustrated, such as "whole life," "term life" or "flexible premium adjustable life."

I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

Determine if the *basic* illustration contains or complies with the following:

Yes	No	Requirement
		Date illustration prepared.
		Page numbers for entire illustration and explanatory notes.
		Assumed dates of payment receipt and benefit payout within a policy year.
		The issue age plus the number of years the policy is assumed to have been in force, if the age is shown as a component of tabular detail.
		Assumed payments on which the illustrated benefits and values are based are identified as premium outlay or contract premium. For policies that do not require a specific contract premium, the illustrated payments should be identified as premium outlay.
		Guaranteed death benefits and values available upon surrender, if any, for the illustrated premium outlay or contract premium should be shown and clearly labeled guaranteed.
		Non-guaranteed elements should not be based on a scale more favorable to the policyowner than the insurer's illustrated scale at any duration. These elements should be clearly labeled non-guaranteed.
		Guaranteed elements, if any, should be shown before corresponding non-guaranteed elements, and should be specifically referred to on any page of an illustration that shows or describes only the non-guaranteed elements.
		Account or accumulation value of a policy, if shown, should be identified by the name this value is given in the policy being illustrated and shown in close proximity to the corresponding value available upon surrender.
		Value available upon surrender should be identified by the name this value is given in the policy being illustrated and should be the amount available to the policyowner in a lump sum after deduction of surrender charges, policy loans and policy interest, as applicable.
		Illustration may show policy benefits and values in graphic or chart form in addition to tabular form.
		Non-guaranteed elements should be accompanied by a statement indicating that, "The benefits and values are not guaranteed; the assumptions on which they are based are subject to change by the insurer, and actual results may be more or less favorable."

I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

		If the illustration shows that the premium payor may have the option to allow policy charges to be paid using non-guaranteed values, the illustration must clearly disclose that a charge continues to be required and that, depending on the actual results, the premium payor may need to continue or resume premium outlays. Similar disclosure should be made for premium outlay of lesser amounts or shorter duration than the contract premium. If a contract premium is due, the premium outlay should not be left blank or show zero unless accompanied by an asterisk or similar mark to draw attention to the fact that the policy is not paid.
		If the applicant plans to use dividends or policy values, guaranteed or non-guaranteed, to pay all or a portion of the contract premium policy charges, or for any other purpose, the illustration may reflect those plans and the effect on future policy benefits and values.
		A brief description of the policy being illustrated, including a statement that it is a life insurance policy.
		A brief description of the premium outlay or contract premium, as applicable, for the policy. For a policy that does not require payment of a specific contract premium, the illustration should show the premium outlay that must be paid to guarantee coverage for the term of the policy, subject to maximum premiums allowable to qualify as a life insurance policy under the applicable provisions of the Internal Revenue Code.
		A brief description of any policy features, riders or options, guaranteed or non-guaranteed, shown in the basic illustration, and the effect they may have on the benefits and values of the policy.
		Identification and a brief definition of column headings and key terms used in the illustration.
		The following statement, "This illustration assumes that the currently illustrated non-guaranteed elements will continue unchanged for all years shown. This is not likely to occur. Actual results may be more or less favorable than those shown."
		Following the narrative summary, a basic illustration should include a numeric summary of the death benefits and values and the premium outlay and contract premium as applicable. For a policy that provides for a contract premium, the guaranteed death benefits and values should be based on the contract premium. This summary should be shown for at least policy years 5, 10, 20 and at age 70, if applicable, on the three bases shown below. For multiple life policies the summary should show policy years 5, 10, 20 and 30.

I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

		<p>The columns of the numeric summary should include: Bases 1: Policy guarantees Bases 2: Insurer's illustrated scale Bases 3: Insurer's illustrated scale used, but with the non-guaranteed elements reduced as follows:</p> <ul style="list-style-type: none"> • Dividends at 50 percent of the dividends contained in the illustrated scale used; • Non-guaranteed credited interest at rates that are the average of the guaranteed rates and the rates contained in the illustrated scale used; and • All non-guaranteed charges, including, but not limited to, term insurance charges and mortality and expense charges, at rates that are the average of the guaranteed rates and the rates contained in the illustrated scale used.
		<p>If coverage would cease before policy maturity or age 100, the year in which coverage ceases should be identified for each of the three bases.</p>
		<p>The following statement signed and dated by the applicant or policyowner: "I have received a copy of this illustration and understand that any non-guaranteed elements illustrated are subject to change and could be either higher or lower. The agent has told me they are not guaranteed."</p>
		<p>The following statement signed and dated by the insurance producer or other authorized representative of the insurer: "I certify that this illustration has been presented to the applicant, and that I have explained that any non-guaranteed elements illustrated are subject to change. I have made no statements that are inconsistent with the illustration."</p>
		<p>A basic illustration must include the following for at least each policy year from one to 10 and for every fifth policy year thereafter, ending at age 100, policy maturity or final expiration, and except for term insurance beyond the 20th year, for any year in which the premium outlay and contract premium, if applicable, is to change:</p> <ul style="list-style-type: none"> • Premium outlay and mode the applicant plans to pay and the contract premium as applicable; • The corresponding guaranteed death benefit, as provided in the policy; • Corresponding guaranteed value available upon surrender, as provided in the policy; • Non-guaranteed elements may be shown if described in the contract. In the case of an illustration for a policy on which the insurer intends to credit terminal dividends, they may be shown if the insurer's current practice is to pay terminal dividends. If any non-guaranteed elements are shown, they must be shown at the same durations as the corresponding guaranteed elements, if any; and • If no guaranteed benefit value is available at any duration for which a non-guaranteed benefit or value is shown, a zero should be displayed in the guaranteed column.

"Basic illustration" means a ledger or proposal used in the sale of a life insurance policy that shows both guaranteed and non-guaranteed elements.

I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

A supplemental illustration may be provided as long as:

Yes	No	Requirement
		It is appended to, accompanied by, or preceded by a basic illustration.
		The non-guaranteed elements shown are not more favorable to the policyowner than the corresponding elements in the basic illustration.
		It contains the same statement required of a basic illustration that non-guaranteed elements are not guaranteed.
		The premium outlay/contract premium must be equal to the premium outlay/contract premium shown in the basic illustration.
		A notice is included referring to the basic illustration for guaranteed elements and other important information.

“Supplemental illustration” means an illustration furnished in addition to a basic illustration that meets the applicable requirements of [*Life Insurance Illustrations Model Regulation* (#582)], and that may be presented in a format differing from the basic illustration, but may only depict a scale of non-guaranteed elements that is permitted in a basic illustration.

I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

Determine if the universal life illustration has the following:

Yes	No	Requirement
		<p>Any statement of policy cost factors or benefits shall contain:</p> <ul style="list-style-type: none"> • The corresponding guaranteed policy cost factors or benefits, clearly identified; • A statement explaining the non-guaranteed nature of any current interest rates, charges or other fees applied to the policy, including the insurer’s rights to alter any of these factors; • Any limitations on the crediting of interest, including identification of those portions of the policy to which a specified interest rate shall be credited; • Any illustration of the policy value shall be accompanied by the corresponding net cash surrender value; • Any statement regarding the crediting of a specific current interest rate shall also contain the frequency and timing by which such rate is determined; • If any statement refers to the policy being interest-indexed, the index shall be described. In addition, a description shall be given of the frequency and timing of determining the interest rate and of any adjustments made to the index in arriving at the interest rate credited under the policy; • Any illustrated benefits based upon non-guaranteed interest, mortality or expense factors shall be accompanied by a statement indicating that these benefits are not guaranteed; and • If the guaranteed cost factors or initial policy cost factor assumptions would result in policy values becoming exhausted prior to the policy’s maturity date, such fact shall be disclosed, including notice that coverage will terminate under such circumstances.

(*Universal Life Insurance Model Regulation* (#585), Section 8A)

I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

Determine whether, in addition to all other illustration requirements, indexed universal life (IUL) illustrations contain or comply with the following requirements specified in *Actuarial Guideline XLIX— The Application of the Life Illustrations Model Regulation to Policies with Index Based Interest* (AG 49). (Section 4 and Section 5 apply to new business and in force illustrations for policies sold on or after Sept. 1, 2015, and Section 6 and Section 7 apply to new business and in force illustrations for policies sold on or after March 1, 2016.)

Yes	No	N/A	Requirement
			The illustration actuary uses the current annual cap for the Benchmark Index Account offered with the illustrated policy (AG 49, Section 4.A.i.).
			The illustration actuary uses a hypothetical, supportable current annual cap for a hypothetical, supportable Index Account that meets the definition of a Benchmark Index Account (AG 49, Section 4.A.ii.). Note: Actuarial judgment may be used by the illustration actuary. Support for the determination of the hypothetical cap may be requested of the illustration actuary by the examiner. The examiner may refer this support to an actuarial or investment specialist for review as necessary.
			The maximum credited rate used for the Illustrated Scale is the arithmetic mean of the geometric average annual credited rates calculated in 4.A. (per AG 49, Section 4.B.). Note: Review may be referred by the examiner to an actuarial or investment specialist as necessary.
			Where other Index Accounts are used in illustrations, the illustration actuary determined the Illustrated Scale (according to AG 49, Section 4.C.). Note: Review may be referred by the examiner to an actuarial or investment specialist as necessary.
			The insurer updated the credited rate for each Index Account (in accordance with AG 49 Section 4.B. and Section 4.C.) within three months of the beginning of the calendar year of the illustration (AG 49, Section 4.D.).
			The illustrated rate credited to the loan balance shall not exceed the illustrated loan charge by more than 100 basis points (AG 49, Section 6).
			The basic illustration includes a ledger using the Alternate Scale shown alongside the ledger using the Illustrated Scale with equal prominence (AG 49, Section 7.A.).
			The basic illustration includes a table showing the minimum and maximum of the geometric average annual credited rates calculated in AG 49, Section 4.A. (AG 49, Section 7.B.).
			The basic illustration includes a table showing actual historical index changes and corresponding hypothetical interest rates using current index parameters for the most recent 20-year period for each Index Account illustrated (AG 49, Section 7.C.).

(Actuarial Guideline XLIX— The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest)

I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

Ensure variable life illustrations contain or comply with the following:

Yes	No	Requirement
		The hypothetical interest rates used to illustrate accumulated policy values must be an annual effective gross rate after brokerage expenses and prior to any deduction for taxes, expenses and contract charges.
		If illustrations of accumulated policy values are shown, then for the highest interest rate used, one illustration must be based solely upon guarantees contained in the policy contract being illustrated.
		Except for illustrations contained in the prospectus, the pattern of premium payments used in an illustration should be the initial pattern requested by the proposed policyholder at inception or upon changes in face amount requested by the policyholder.
		If the illustrated policy contract provides for a variety of investment options, the illustration may either use an asset charge, which is reasonably representative, or use the asset charge of a particular option. The illustration should clearly identify the asset charge and either label it "hypothetical" or identify the fund.
		The illustration must disclose the transaction charges that will be levied against the contract because of transactions requested in accordance with rights and privileges specified in the policy contract. Any charge for the exercise of a right or privilege upon which the illustration is based must be reflected in the illustrated values. The nature of any other such charges must be disclosed in a clear statement accompanying such illustrations.
		A clear statement must be made following the table of illustrated accumulated policy values that use of hypothetical investment results does not in any way represent actual results or suggest that such results will be achieved and must indicate that the policy values which actually arise will differ from those shown, whenever the actual investment results differ from the hypothetical rates illustrated. Assumptions upon which illustrations are based must be clearly disclosed.
		Any sales illustration to a prospective policyholder must reflect the policy being presented accurately. Misleading statements or captions or other misrepresentations are prohibited.
		The requested sales illustration must be printed clearly and legibly on hard paper copy. An illustration displayed on a computer screen may be used in addition to, but not as a substitute for, hard paper copy.

I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

	<p>In connection with variable life insurance contracts offering both fixed and variable funding options:</p> <ul style="list-style-type: none"> • An illustration of the variable funding option must comply with these guidelines; • If an illustration of the fixed funding option is shown, accumulated policy values must be shown on the basis of guaranteed rates. One or more additional rates may also be shown, but such rates may not exceed current rates; and • A summary illustration may be given in which results from comparable illustrated and hypothetical interest rates are combined. Such summary must cross-reference to the accompanying separate illustrations of the fixed and variable funding options.
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(Life Insurance Illustrations Model Regulation (#582))

J. Supplemental Checklist for Marketing and Sales Standard #8

Yes	No	Requirement
Ensure the disclosures include:		
		The fact that a life insurance policy is involved or being used to fund a prearrangement.
		The nature of the relationship among the soliciting agent or agents, the provider of the funeral or cemetery merchandise or services, the administrator and any other person.
		The relationship of the life insurance policy to the funding of the prearrangement and the nature and existence of any guarantees relating to the prearrangement.
		<p>The impact on the prearrangement of the following:</p> <ul style="list-style-type: none"> • Any changes in the life insurance policy including, but not limited to, changes in the assignment, beneficiary designation or use of the proceeds; • Any penalties to be incurred by the policyholder as a result of failure to make premium payments; • Any penalties to be incurred or monies to be received as a result of cancellation or surrender of the life insurance policy; • A list of the merchandise and services which are applied or contracted for in the prearrangement and all relevant information concerning the price of the funeral services, including an indication that the purchase price is either guaranteed at the time of purchase or to be determined at the time of need; • All relevant information concerning what occurs and whether any entitlements or obligations arise, if there is a difference between the proceeds of the life insurance policy and the amount actually needed to fund the prearrangement; • Any penalties or restrictions, including, but not limited to, geographic restrictions or the inability of the provider to perform, on the delivery of merchandise, services or the prearrangement guarantee; and • The fact that a sales commission or other form of compensation is being paid and, if so, the identity of such individuals or entities to whom it is paid.

May 27, 2022

Submitted electronically to pwallace@naic.org

Re: Chapter 23-Annuity Suitability April 19, 2022 Draft (Revisions related to the February 2020 adopted revisions to the Suitability in Annuity Transactions Model Regulation #275)

To: The NAIC Market Conduct Examination Guidelines (D) Working Group (“Working Group”)

On behalf of our members, the Insured Retirement Institute, Inc. (“IRI”)¹ appreciates the opportunity to comment on the Chapter 23 – Annuity Suitability, April 19, 2022 Draft (“Draft Guidelines”).

We also appreciate the Working Group’s efforts to update the Chapter 23 of the Market Conduct Examination Guidelines to align them with the February 2020 adopted revisions to the Suitability in Annuity Transactions Model Regulation #275 (“Model #275”), and we are pleased to support the Draft Guidelines.

In order to ensure consistency with all the updates to Model #275, however, we would like to respectfully offer the following comments on the Draft Guidelines:

On page 30 and 35 of the Draft Guidelines, under Standards 9 and 10, we propose the following revisions in order to fully align the Draft Guidelines with the Model #275 updates:

Verify that the insurer has adequate procedures in place for monitoring that sales are made in compliance with comparable standards as defined in Section 6(E)(5) of Model #275. Sales made in compliance with comparable standards shall satisfy the requirements under this regulation. This subsection applies to all recommendations and sales of annuities made by financial professionals in compliance with business rules, controls and procedures that satisfy a comparable standard even if such standard would not otherwise apply to the product or recommendation at issue.. However, nothing in this subsection shall limit the insurance commissioner’s ability to enforce (including investigate) the provisions of this regulation.

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

¹ IRI is the leading association for the entire supply chain of insured retirement strategies, including life insurers, asset managers, and distributors such as broker-dealers, banks, and marketing organizations. IRI members account for more than 95 percent of annuity assets in the U.S., the top 10 distributors of annuities ranked by assets under management and are represented by financial professionals serving millions of Americans. IRI champions retirement security for all through leadership in advocacy, awareness, research, and the advancement of digital solutions within a collaborative industry community.

Review the insurer's system of monitoring sales made in compliance with comparable standards and applicable state annuity suitability statutes, rules and regulations. An insurer may demonstrate compliance in this area by:

- Monitoring the relevant conduct of the financial professional seeking to rely on the safe harbor or the entity responsible for supervising the financial professional, such as the financial professional's broker-dealer or an investment adviser registered under federal [or state] securities laws using information collected in the normal course of an insurer's business; and
- Providing to the entity responsible for supervising the financial professional seeking to rely on the safe harbor, such as the financial professional's broker-dealer or investment adviser registered under federal [or state] securities laws, information and reports that are reasonably appropriate to assist such entity to maintain its supervision system.

On behalf of IRI and our members, thank you again for the opportunity to provide these comments, and we appreciate your consideration of our recommended changes. We would be happy to discuss further with you and look forward to collaboration and partnership with the Working Group.

Sincerely,

Sarah E. Wood

Sarah Wood
Director, State Policy & Regulatory Affairs
Insured Retirement Institute
swood@irionline.org

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

Introduction

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

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

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

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

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

Mental Health and Substance Use Disorder Parity

1. Purpose

Mental health and substance use disorder parity compliance examinations should be designed to ensure that all companies are in compliance with all the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 (as amended by the Consolidated Appropriations Act of 2020) found at 42 U.S.C. § 300gg-26 and its implementing regulations found at 45 CFR § 146.136 and 45 CFR § 147.160.

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

2. Definitions

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

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

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

Classifications of benefits used for applying parity rules:

(1) Inpatient, In-network. Benefits furnished on an inpatient basis and within a network of providers established or recognized under a plan or health insurance coverage (45 CFR § 146.136(c)(2)(ii)(A)(1)).

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

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

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

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

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

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

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

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

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

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

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

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

(for example, the most current version of the International Classification of Diseases (ICD) or State guidelines) (45 CFR § 146.136(a)).

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

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

Treatment Limitations include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations (QTLs), which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations (NQTLs), which are not expressed numerically but otherwise limit the scope or duration of benefits for treatment under a plan or coverage. A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition (45 CFR § 146.136(a)).

3. Techniques

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

4. Standards and the Regulatory Tests

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

Standards for Mental Health and Substance Use Disorder Parity Compliance

Standard 1

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

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

Documents to be Reviewed

- _____ Applicable state and federal statutes, rules, regulations and published sub-regulatory guidance
- _____ Type of generally recognized independent standards of current medical practice, state law or guidance, used to define mental health conditions, substance use disorders and medical/surgical conditions (e.g., the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Statistical Classification of Diseases and Related Health Problems (ICD code), etc.)
- _____ List of specific mental health conditions or substance use disorders by diagnosis excluded from coverage as stated in the policy documents
- _____ Mental health and/or substance use disorder and medical/surgical claim files
- _____ Health carrier complaint/grievances/appeals records concerning mental health and/or substance use disorders (supporting documentation, including, but not limited to: written and phone records of inquiries, call center scripts, complaints, complainant correspondence and health carrier response)
- _____ Internal department appeals/grievance files
- _____ Applicable external appeals register/logs/files, external appeal resolution and associated documentation

Others Reviewed

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

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

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

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

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

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

Review Procedures and Criteria

The health carrier shall identify which independent standards were used to define mental health conditions, substance use disorders and medical/surgical conditions.

The health carrier shall specify applicable state statutes or guidelines that stipulate the standard or definition of mental health conditions, substance use disorders, or medical/surgical conditions.

The carrier shall identify excluded diagnoses and stipulate that such exclusions are not prohibited by state or federal law.

The health carrier shall identify how it defines items or services as mental health benefits, substance use disorder benefits, or medical/surgical benefits, including items and services that are sometimes used for the treatment of mental health or substance use disorders and medical/surgical conditions (e.g., nutritional counseling, occupational therapy).

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**Standards for
Mental Health and Substance Use Disorder Parity Compliance**

Standard 2

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

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

Documents to be Reviewed

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

Others Reviewed

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

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

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

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

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

Review Procedures and Criteria

The health carrier shall provide a list that specifies to which classification (or applicable sub-classification) all benefits were assigned.

The health carrier shall identify which, if any, benefits were classified into sub-classifications. Please note that the only permissible sub-classifications are: multiple tiers for prescription drugs benefits that are based on reasonable factors¹ (45 CFR § 146.136(c)(3)(iii)(A)); multiple network tiers that are based on reasonable factors within the inpatient in-network and outpatient in-network classifications (45 CFR § 146.136(c)(3)(iii)(B)); outpatient office visits and outpatient other services within the outpatient in-network and outpatient out-of-network classifications (45 CFR § 146.136(c)(3)(iii)(C)). The carrier shall retain sub-classifications for all parity analyses and testing for financial requirements, quantitative treatments limitations and nonquantitative treatment limitations.

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

The health carrier shall demonstrate that mental health or substance use disorder benefits are covered in each classification in which medical/surgical benefits are covered.

¹ Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up (45 CFR § 146.136(c)(3)(iii)(A))

Standards for Mental Health and Substance Use Disorder Parity Compliance

Standard 3

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

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

Documents to be Reviewed

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

Others Reviewed

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

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

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

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

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

Review Procedures and Criteria

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

The health carrier shall demonstrate the reasonable method used to perform the analysis that determines expected plan payments within each classification of benefits (or applicable sub-classification) for medical/surgical benefits. A carrier must always use appropriate and sufficient data to perform the analysis in compliance with applicable Actuarial Standards of Practice (ACA FAQ 34 Q3).

The health carrier shall demonstrate that any type of financial requirement applied to mental health or substance use disorder benefits in a classification (or applicable sub-classification) applies to at least two-thirds of expected plan payments on medical/surgical benefits within that classification (or applicable sub-classification) (45 CFR § 146.136(c)(3)(i)(A)). If no cost analysis was relied upon within this demonstration, the carrier shall specify how it concluded that the substantially all test was satisfied (e.g., it applies the financial requirement to all medical/surgical benefits within the classification). No financial requirements shall apply only to mental health or substance use disorder benefits.

The health carrier shall demonstrate that the level of financial requirement applied to mental health or substance use disorder benefits in a classification (or applicable sub-classification) is comparable and no more restrictive than the level of financial requirement that applies to more than one-half of expected plan payments that are subject to the financial requirement within that classification for medical/surgical benefits (45 CFR § 146.136(c)(3)(i)(B)(1)). The carrier shall demonstrate how it combined levels of the financial requirement to satisfy the predominant test if there is no single level that applies to more than one-half of medical/surgical benefits in the classification (45 CFR § 146.136(c)(3)(i)(B)(2)).

**Standards for
Mental Health and Substance Use Disorder Parity Compliance**

Standard 4

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

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

Documents to be Reviewed

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

Others Reviewed

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

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

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

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

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

Review Procedures and Criteria

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

The health carrier shall demonstrate the reasonable method used to perform the analysis that determines expected plan payments within each classification of benefits (or applicable sub-classification) for medical/surgical benefits. A carrier must always use appropriate and sufficient data to perform the analysis in compliance with applicable Actuarial Standards of Practice (ACA FAQ 34 Q3).

The health carrier shall demonstrate that any type of QTL applied to mental health or substance use disorder benefits in a classification (or applicable sub-classification) applies to at least two-thirds of expected plan payments on medical/surgical benefits within that classification (or applicable sub-classification) (45 CFR § 146.136(c)(3)(i)(A)). If no cost analysis was relied upon within this demonstration, the carrier shall specify how it concluded that the substantially all test was satisfied (e.g., it applies the quantitative limitation to all medical/surgical benefits within the classification). No quantitative treatment limitations shall apply only to mental health or substance use disorder benefits.

The health carrier shall demonstrate that the level of QTL applied to mental health or substance use disorder benefits in a classification (or applicable sub-classification) is no more restrictive than the level of QTL that applies to more than one-half of expected plan payments that are subject to the quantitative treatment limitation within that classification for medical/surgical benefits (45 CFR § 146.136(c)(3)(i)(B)(1)). The carrier shall demonstrate how it combined levels of the QTL to satisfy the predominant test If there is no single level that applies to more than one-half of medical/surgical benefits in the classification (45 CFR § 146.136(c)(3)(i)(B)(2)).

**Standards for
Mental Health and Substance Use Disorder Parity**

Standard 5

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

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

Documents to be Reviewed

- _____ Applicable state and federal statutes, rules, regulations and published sub-regulatory guidance
- _____ A list of all NQTs imposed upon mental health or substance use disorder benefits within each classification of benefits (or applicable sub-classification), including the methodology used to determine those NQTs. A state may focus its review on a subset of NQTs rather than all NQTs. (See reference link to DOL Self-Compliance Tool for a non-exhaustive list)
- _____ Utilization management manuals and utilization review documents such as: utilization review criteria; criteria hierarchies for performing utilization review; case management referral criteria; initial screening scripts and algorithms; policies relating to reviewer discretion; processes for identifying and evaluating clinical issues and utilizing performance goals
- _____ Notes and/or logs kept during utilization review, such as those describing: peer clinical review; telephonic consultations with attending providers; consultations with expert reviewers; clinical rationale used in approving or denying benefits; the selection of information deemed reasonably necessary to make a medical necessity determination; adherence to utilization review criteria and criteria hierarchy; professional judgment used in lieu of utilization review criteria; actions taken when incomplete information is received from attending providers
- _____ Company claim procedure manuals and bulletins/communications
- _____ Claims processor and customer services MHPAEA training materials
- _____ Company fraud, waste, and abuse policies and procedures
- _____ Internal company claim audit reports
- _____ Prescription drug formulary for each product/plan design
- _____ Prescription drug utilization management documentation
- _____ Fail-first policies or step therapy protocols
- _____ Network development/contracting policies and procedures
- _____ Standards for provider admission to participate in a network, including credentialing requirements

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

Others Reviewed

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

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

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

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

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

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

Review Procedures and Criteria

The health carrier shall perform and document comparative analyses demonstrating that within any classification of benefits, as written and in operation, the process, strategies, evidentiary standards, or other factors used in applying an NQTL to mental health or substance disorder benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification. The comparative analyses shall include the following, for each NQTL applied to mental health or substance use disorder benefits, separately for each classification of benefits (42 U.S.C. § 300gg-26(a)(8)(A):

- The specific coverage terms or other relevant terms regarding the NQTL and a description of all mental health or substance use disorder and medical or surgical benefits to which such NQTL applies in each respective benefits classification;

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

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

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

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

1. Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis;
2. Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations;
3. Identification of processes, strategies, sources and factors without the required or clear and detailed comparative analysis;
4. Identification of factors, evidentiary standards and strategies without a clear explanation of how they were defined and applied in practice;

5. Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application; and
6. Analysis that is outdated due to the passage of time, a change in plan structure, or for any other reason.

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**Standards for
Mental Health and Substance Use Disorder Parity Compliance**

Standard 6

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

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

Documents to be Reviewed

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

Others Reviewed

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

Review Procedures and Criteria

The health carrier shall demonstrate the method by which it makes available to any current or potential participant, beneficiary, or contracting provider upon request the medical necessity criteria used to make mental health or substance use disorder medical necessity determinations (45 CFR § 146.136(d)(1)). This shall include a reporting of how the health carrier ensures prompt release of the criteria upon request.

The health carrier shall demonstrate that it provides the reason for any denial of reimbursement for mental health or substance use disorder benefits (45 CFR § 146.136(d)(2)). This shall include a reporting of how the health carrier ensures prompt delivery of the reason for the denial to the beneficiary.

The health carrier shall demonstrate its method for responding to requests for all documents, records and other information relevant to the claimant's claim for benefits after an adverse benefit determination (45 CFR § 146.136(d)(3)). This shall include the health carrier's protocol for ensuring that it discloses medical necessity criteria for both medical/ surgical benefits and mental health and substance use disorder benefits, as well as disclosures pertaining to the processes, strategies, evidentiary standards and other factors the health carrier used to apply a NQTL with respect to medical/ surgical benefits and mental health or substance use disorder benefits under the plan, when those specific items are requested. This shall also include a reporting of how the health carrier ensures prompt disclosure of all information requested.

The carrier must demonstrate that all claims processing and disclosure regarding adverse benefit determinations complies with the federal claims and appeals regulations. (45 CFR § 147.136)

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**Standards for
Mental Health and Substance Use Disorder Parity Compliance**

Standard 7

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

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

Documents to be Reviewed

- _____ Contractual agreements between the carrier and vendors having administrative, claims and/or medical management responsibilities
- _____ Policies and procedures for ensuring availability of health carrier information needed for vendor analysis of compliance with MHPAEA
- _____ A narrative summary outlining how the vendor and the carrier coordinate benefit design and application to ensure compliance with MHPAEA
- _____ Any written communications between the carrier and the vendor in regard to the administration of mental health and substance use disorder benefits

Others Reviewed

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

Review Procedures and Criteria

The health carrier shall provide documentation of the protocols and procedures in place to ensure that any contracted vendor that provides mental health or substance use disorder benefits is collaborating with the health carrier to satisfy compliance with MHPAEA. This shall include explanation of how both the design of benefits and the application of benefits, in operation, are compliant with MHPAEA.

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

Introduction

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

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

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

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

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

Mental Health and Substance Use Disorder Parity

1. Purpose

Mental health and substance use disorder parity compliance examinations should be designed to ensure that all ~~companies~~ ~~health carriers~~ are in compliance with all the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 (as amended by the Consolidated Appropriations Act of 2020) found at 42 U.S.C. § 300gg-26 and its implementing regulations found at 45 CFR § 146.136 and 45 CFR § 147.160.

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

2. Definitions

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

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

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

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Classifications of benefits used for applying parity rules:

- (1) Inpatient, In-network.** Benefits furnished on an inpatient basis and within a network of providers established or recognized under a plan or health insurance coverage (45 CFR § 146.136(c)(2)(ii)(A)(1)).
- (2) Inpatient, Out-of-network.** Benefits furnished on an inpatient basis and outside any network of providers established or recognized under a plan or health insurance coverage. This classification includes inpatient benefits under a plan (or health insurance coverage) that has no network of providers (45 CFR § 146.136(c)(2)(ii)(A)(2)).
- (3) Outpatient, In-network.** Benefits furnished on an outpatient basis and within a network of providers established or recognized under a plan or health insurance coverage. See special rules for office visits and plans with multiple network tiers in paragraph (c)(3)(iii) of 45 CFR §146.136 (45 CFR § 146.136(c)(2)(ii)(A)(3)).
- (4) Outpatient, Out-of-network.** Benefits furnished on an outpatient basis and outside any network of providers established or recognized under a plan or. This classification includes outpatient benefits under a plan (or health insurance coverage) that has no network of providers (45 CFR § 146.136(c)(2)(ii)(A)(4)).
- (5) Emergency Care.** Benefits for emergency care (45 CFR § 146.136(c)(2)(ii)(A)(5)).
- (6) Prescription Drugs.** Benefits for prescription drugs (45 CFR § 146.136(c)(2)(ii)(A)(6)).

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

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

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

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

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

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

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

(for example, the most current version of the International Classification of Diseases (ICD) or State guidelines) (45 CFR § 146.136(a)).

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

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

Treatment Limitations include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations (QTLs), which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations (NQTLs), which are not expressed numerically but otherwise limit the scope or duration of benefits for treatment under a plan or coverage. A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition (45 CFR § 146.136(a)).

3. Techniques

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

4. Standards and the Regulatory Tests

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

Standards for Mental Health and Substance Use Disorder Parity Compliance

Standard 1

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

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

Documents to be Reviewed

- _____ Applicable state and federal statutes, rules, regulations and published sub-regulatory guidance
- _____ Type of generally recognized independent standards of current medical practice, state law or guidance, used to define mental health conditions, substance use disorders and medical/surgical conditions (e.g., the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Statistical Classification of Diseases and Related Health Problems (ICD code), etc.)
- _____ List of specific mental health conditions or substance use disorders by diagnosis excluded from coverage as stated in the policy documents
- _____ Mental health and/or substance use disorder and medical/surgical claim files
- _____ Health carrier complaint/grievances/appeals records concerning mental health and/or substance use disorders (supporting documentation, including, but not limited to: written and phone records of inquiries, call center scripts, complaints, complainant correspondence and health carrier response)
- _____ Internal department appeals/grievance files
- _____ Applicable external appeals register/logs/files, external appeal resolution and associated documentation

Others Reviewed References

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

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

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

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

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

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

Review Procedures and Criteria

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

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

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

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

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

~~The health carrier shall identify which independent standards were used to define mental health conditions, substance use disorders and medical/surgical conditions.~~

~~The health carrier shall specify applicable state statutes or guidelines that stipulate the standard or definition of mental health conditions, substance use disorders, or medical/surgical conditions.~~

~~The carrier shall identify excluded diagnoses and stipulate that such exclusions are not prohibited by state or federal law~~

For services the health carrier has determined are both medical/surgical and mental health/substance use disorders, review the explanation of how they determine the correct expected dollar amount for these services. The health carrier shall identify how it defines items or services as mental health benefits, substance use disorder benefits, or medical/surgical benefits, including items and services that are sometimes used for the treatment of mental health or substance use disorders and medical/surgical conditions REv (e.g., nutritional counseling, occupational therapy).

**Standards for
Mental Health and Substance Use Disorder Parity Compliance**

Standard 2

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

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

Documents to be Reviewed

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

Others ReviewedReferences

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

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

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

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

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

Review Procedures and Criteria

~~Review the health carrier's list that specified the classification or sub-classification to which each benefit was assigned. The health carrier shall provide a list that specifies to which classification (or applicable sub-classification) all benefits were assigned~~

~~Determine whether the health carrier uses permissible sub-classifications for any benefits. The health carrier shall identify which, if any, benefits were classified into sub-classifications~~

Please note that the only permissible sub-classifications are: multiple tiers for prescription drugs benefits that are based on reasonable factors¹ (45 CFR § 146.136(c)(3)(iii)(A)); multiple network tiers that are based on reasonable factors within the inpatient in-network and outpatient in-network classifications (45 CFR § 146.136(c)(3)(iii)(B)); outpatient office visits and outpatient other services within the outpatient in-network and outpatient out-of-network classifications (45 CFR § 146.136(c)(3)(iii)(C)).

~~The carrier shall retain sub-classifications for all parity analyses and testing for financial requirements, quantitative treatments limitations and nonquantitative treatment limitations. Review the standard used by the~~ The health carrier shall identify the standards used to determine which classification of benefits (or applicable sub-classification) a particular benefit was assigned to and ~~indicate~~ verify that the same standards were used for assigning medical/surgical benefits and mental health or substance use disorder benefits.

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

¹ Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up (45 CFR § 146.136(c)(3)(iii)(A))

Standards for Mental Health and Substance Use Disorder Parity Compliance

Standard 3

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

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

Documents to be Reviewed

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

Others Reviewed References

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

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

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

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

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

Review Procedures and Criteria

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

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

Review the health carrier's documentation that demonstrates that any type of financial requirement applied to mental health or substance use disorder benefits in a classification (or applicable sub-classification) applies to at least two-thirds of expected plan payments on medical/surgical benefits within that classification (or applicable sub-classification) (45 CFR § 146.136(c)(3)(i)(A)). ~~The health carrier shall demonstrate that any type of financial requirement applied to mental health or substance use disorder benefits in a classification (or applicable sub-classification) applies to at least two-thirds of expected plan payments on medical/surgical benefits within that classification (or applicable sub-classification) (45 CFR § 146.136(c)(3)(i)(A)).~~ Note: If the financial requirement applies to all medical/surgical benefits in the classification, no cost analysis is required. no cost analysis was relied upon within this demonstration, the carrier shall specify how it concluded that the substantially all test was satisfied (e.g., it applies the financial requirement to all medical/surgical benefits within the classification). No financial requirements shall apply only to mental health or substance use disorder benefits.

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

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

**Standards for
Mental Health and Substance Use Disorder Parity Compliance**

Standard 4

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

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

Documents to be Reviewed

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

Others ReviewedReferences

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

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

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

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

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

Review Procedures and Criteria

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

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

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

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

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

Standards for Mental Health and Substance Use Disorder Parity

Standard 5

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

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

Documents to be Reviewed

- _____ Applicable state and federal statutes, rules, regulations and published sub-regulatory guidance
- _____ A list of all NQTs imposed upon mental health or substance use disorder benefits within each classification of benefits (or applicable sub-classification), including the methodology used to determine those NQTs. A state may focus its review on a subset of NQTs rather than all NQTs. (See reference link to DOL Self-Compliance Tool for a non-exhaustive list)
- _____ Utilization management manuals and utilization review documents such as: utilization review criteria; criteria hierarchies for performing utilization review; case management referral criteria; initial screening scripts and algorithms; policies relating to reviewer discretion; processes for identifying and evaluating clinical issues and utilizing performance goals
- _____ Notes and/or logs kept during utilization review, such as those describing: peer clinical review; telephonic consultations with attending providers; consultations with expert reviewers; clinical rationale used in approving or denying benefits; the selection of information deemed reasonably necessary to make a medical necessity determination; adherence to utilization review criteria and criteria hierarchy; professional judgment used in lieu of utilization review criteria; actions taken when incomplete information is received from attending providers
- _____ Company claim procedure manuals and bulletins/communications
- _____ Claims processor and customer services MHPAEA training materials
- _____ Company fraud, waste, and abuse policies and procedures
- _____ Internal company claim audit reports
- _____ Prescription drug formulary for each product/plan design
- _____ Prescription drug utilization management documentation
- _____ Fail-first policies or step therapy protocols
- _____ Network development/contracting policies and procedures
- _____ Standards for provider admission to participate in a network, including credentialing requirements

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

Others Reviewed References

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

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

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

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

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

Review Procedures and Criteria

[Review the list of all NQTLs imposed on mental health/substance use disorders and choose a sample.](#)

[Review the](#) ~~The health carrier's shall perform and document~~ comparative analyses [to verify that](#) ~~demonstrating that within any classification of benefits, as written and in operation,~~ the process, strategies, evidentiary standards, ~~or other factors~~ used in applying an NQTL ~~to mental health or substance disorder benefits~~ are comparable to, and are applied no more stringently than, ~~the processes, strategies, evidentiary standards, or other factors~~ [those](#) used in applying the limitation [with respect](#) to medical/surgical benefits ~~in the classification~~. The comparative analyses shall include the following, for each NQTL applied to mental health or substance use disorder benefits, separately for each classification of benefits (42 U.S.C. § 300gg-26(a)(8)(A):

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

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

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

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

1. Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis;
2. Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations;

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

DRAFT

Standards for Mental Health and Substance Use Disorder Parity Compliance

Standard 6

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

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

Documents to be Reviewed

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

Others [Reviewed References](#)

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

Review Procedures and Criteria

[Review the](#)The health carrier's ~~shall demonstrate the~~ method [by which it makes for providing available](#) to any current or potential participant, beneficiary, or contracting provider ~~upon request~~ the medical necessity criteria used to make mental health or substance use disorder [determinations. medical necessity determinations](#) (45 CFR § 146.136(d)(1)). [This shall include a reporting of how the health carrier ensures prompt release of the criteria upon request](#)

Review the health carrier's letters shall demonstrate that it provides providing the reason for any denial of reimbursement for mental health or substance use disorder benefits and verify that the letters are dated within 30 days of the request. (45 CFR § 146.136(d)(2)).~~This shall include a reporting of how the health carrier ensures prompt delivery of the reason for the denial to the beneficiary~~

Review the health carrier's shall demonstrate its method-policy & procedure for responding promptly to requests for all documents, records and other information relevant to the claimant's claim for benefits after an adverse benefit determination, including medical necessity criteria and disclosures referenced above. (45 CFR § 146.136(d)(3)).~~This shall include the health carrier's protocol for ensuring that it discloses medical necessity criteria for both medical/ surgical benefits and mental health and substance use disorder benefits, as well as disclosures pertaining to the processes, strategies, evidentiary standards and other factors the health carrier used to apply a NQTL with respect to medical/ surgical benefits and mental health or substance use disorder benefits under the plan, when those specific items are requested. This shall also include a reporting of how the health carrier ensures prompt disclosure of all information requested~~

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

DRAFT

Standards for Mental Health and Substance Use Disorder Parity Compliance

Standard 7

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

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

Documents to be Reviewed

- _____ Contractual agreements between the carrier and vendors having administrative, claims and/or medical management responsibilities
- _____ Policies and procedures for ensuring availability of health carrier information needed for vendor analysis of compliance with MHPAEA
- _____ A narrative summary outlining how the vendor and the carrier coordinate benefit design and application to ensure compliance with MHPAEA
- _____ Any written communications between the carrier and the vendor in regard to the administration of mental health and substance use disorder benefits

Others ~~Reviewed~~ References

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

Review Procedures and Criteria

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

Review the ~~The health carrier's shall provide documentation of the~~ protocols and procedures ~~in place to ensure to document~~ that any contracted vendors ~~that provides mental health or substance use disorder benefits is~~are collaborating with the health carriers to satisfy compliance with MHPAEA. This shall include explanation of how both the design of benefits and the application of benefits, in operation, are compliant with MHPAEA.

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

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

Introduction

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

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

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

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

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

Mental Health and Substance Use Disorder Parity

1. Purpose

Mental health and substance use disorder parity compliance examinations should be designed to ensure that all companies are in compliance with all the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 (as amended by the Consolidated Appropriations Act of 2020) found at 42 U.S.C. § 300gg-26 and its implementing regulations found at 45 CFR § 146.136 and 45 CFR § 147.160.

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

2. Definitions

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

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

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

Commented [A1]: The entire chapter is based off the federal law which only applies to group. There is no discussion of this and no distinction of where to look for law applicable to individual policies.

Commented [A2R1]: It looks the ACA did amend the law in 2013 to include individual health insurance and non-grandfathered individual and small group health plans.

This background would be important to include in the introduction so examiners can understand which plans this applies to and a bit about the history of MHPAEA.

Commented [A3]: These definitions do not appear to be exactly the same as the Federal law cited. Should they be?

Classifications of benefits used for applying parity rules:

(1) Inpatient, In-network. Benefits furnished on an inpatient basis and within a network of providers established or recognized under a plan or health insurance coverage (45 CFR § 146.136(c)(2)(ii)(A)(1)).

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

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

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

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

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

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

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

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

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

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

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

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

Commented [A4]: This definition doesn't appear to be exactly as the federal law. Should it be?

(for example, the most current version of the International Classification of Diseases (ICD) or State guidelines) (45 CFR § 146.136(a)).

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

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

Treatment Limitations include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations (QTLs), which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations (NQTLs), which are not expressed numerically but otherwise limit the scope or duration of benefits for treatment under a plan or coverage. A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition (45 CFR § 146.136(a)).

3. Techniques

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

4. Standards and the Regulatory Tests

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

**Standards for
Mental Health and Substance Use Disorder Parity Compliance**

Standard 1

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

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

Documents to be Reviewed

- _____ Applicable state and federal statutes, rules, regulations and published sub-regulatory guidance
- _____ Type of generally recognized independent standards of current medical practice, state law or guidance, used to define mental health conditions, substance use disorders and medical/surgical conditions (e.g., the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Statistical Classification of Diseases and Related Health Problems (ICD code), etc.)
- _____ List of specific mental health conditions or substance use disorders by diagnosis excluded from coverage as stated in the policy documents
- _____ Mental health and/or substance use disorder and medical/surgical claim files
- _____ Health carrier complaint/grievances/appeals records concerning mental health and/or substance use disorders (supporting documentation, including, but not limited to: written and phone records of inquiries, call center scripts, complaints, complainant correspondence and health carrier response)
- _____ Internal department appeals/grievance files
- _____ Applicable external appeals register/logs/files, external appeal resolution and associated documentation

Others Reviewed

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

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

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

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Commented [A5]: This component would seem to be better as a note under the Review Procedures and Criteria section. The standards themselves are not typically so dense.

Commented [A6]: Citation of law is unusual in the Standard description. This comment applies to all standards in this chapter.

Commented [A7]: The federal law only applies to group. If the standard is for both group and individual, there should be a distinction somewhere in the chapter that federal law only applies to group. This comment applies to all standards in this chapter.

Commented [A8]: Wouldn't the best documents to review be the coverage documents and maybe advertising materials such as SOB.

Commented [A9]: Why would you need to review claim files to determine how the carrier defines covered services? We understand that claim file review would be important to ensure proper implementation; but the standard is looking at definition – not implementation.

Commented [A10]: Why would you need to review complaints or grievances to determine how a carrier defines MHSUD. If the intent for this standard is to also review implementation, then perhaps the standard itself should be revised to make that clear.

Commented [A11]: Same as above.

Commented [A12]: Same as above

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

Review Procedures and Criteria

The health carrier shall identify which independent standards were used to define mental health conditions, substance use disorders and medical/surgical conditions.

The health carrier shall specify applicable state statutes or guidelines that stipulate the standard or definition of mental health conditions, substance use disorders, or medical/surgical conditions.

The carrier shall identify excluded diagnoses and stipulate that such exclusions are not prohibited by state or federal law.

The health carrier shall identify how it defines items or services as mental health benefits, substance use disorder benefits, or medical/surgical benefits, including items and services that are sometimes used for the treatment of mental health or substance use disorders and medical/surgical conditions (e.g., nutritional counseling, occupational therapy).

Commented [A13]: Do we want to expand on and explain what documentation the examiners should ask for in order for the carrier to demonstrate compliance.

**Standards for
Mental Health and Substance Use Disorder Parity Compliance**

Standard 2

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

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

Documents to be Reviewed

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

Others Reviewed

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

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

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ERISA 104(b) (29 U.S.C. § 1024(b))

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

Commented [A14]: The standards appear to be related to the benefit classification. Not clear on how the review of claim files, provider contracts, or UR guidelines will aid an examiner in determining the classification of a benefit. None of the review criteria relate to these listed "Documents to be reviewed". Perhaps this could be expanded to provide the necessary guidance to the examiners.

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

Review Procedures and Criteria

The health carrier shall provide a list that specifies to which classification (or applicable sub-classification) all benefits were assigned.

The health carrier shall identify which, if any, benefits were classified into sub-classifications. Please note that the only permissible sub-classifications are: multiple tiers for prescription drugs benefits that are based on reasonable factors¹ (45 CFR § 146.136(c)(3)(iii)(A)); multiple network tiers that are based on reasonable factors within the inpatient in-network and outpatient in-network classifications (45 CFR § 146.136(c)(3)(iii)(B)); outpatient office visits and outpatient other services within the outpatient in-network and outpatient out-of-network classifications (45 CFR § 146.136(c)(3)(iii)(C)). The carrier shall retain sub-classifications for all parity analyses and testing for financial requirements, quantitative treatments limitations and nonquantitative treatment limitations.

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

The health carrier shall demonstrate that mental health or substance use disorder benefits are covered in each classification in which medical/surgical benefits are covered.

¹ Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up (45 CFR § 146.136(c)(3)(iii)(A))

**Standards for
Mental Health and Substance Use Disorder Parity Compliance**

Standard 3

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

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

Documents to be Reviewed

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

Others Reviewed

- Enforcement of the Public Health Services Act
42 U.S. Code § 300gg-22
- Preemption relating to the Public Health Services Act
42 U.S. Code § 300gg-23
- Mental Health Parity and Addiction Equity Act of 2008
42 U.S. Code § 300gg-26
- Publication of summary plan description
ERISA 104(b) (29 U.S.C. § 1024(b))

Commented [A15]: The review procedure and criteria doesn't specify how to make use of these types of documents.

How will the use of Appeals or Complaint files allow an examiner to determine if the financial requirement is not more restrictive than the predominate financial requirement of substantially all medical/surgical benefits in the same classification?

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

Review Procedures and Criteria

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

The health carrier shall demonstrate the reasonable method used to perform the analysis that determines expected plan payments within each classification of benefits (or applicable sub-classification) for medical/surgical benefits. A carrier must always use appropriate and sufficient data to perform the analysis in compliance with applicable Actuarial Standards of Practice (ACA FAQ 34 Q3).

The health carrier shall demonstrate that any type of financial requirement applied to mental health or substance use disorder benefits in a classification (or applicable sub-classification) applies to at least two-thirds of expected plan payments on medical/surgical benefits within that classification (or applicable sub-classification) (45 CFR § 146.136(c)(3)(i)(A)). If no cost analysis was relied upon within this demonstration, the carrier shall specify how it concluded that the substantially all test was satisfied (e.g., it applies the financial requirement to all medical/surgical benefits within the classification). No financial requirements shall apply only to mental health or substance use disorder benefits.

The health carrier shall demonstrate that the level of financial requirement applied to mental health or substance use disorder benefits in a classification (or applicable sub-classification) is comparable and no more restrictive than the level of financial requirement that applies to more than one-half of expected plan payments that are subject to the financial requirement within that classification for medical/surgical benefits (45 CFR § 146.136(c)(3)(i)(B)(1)). The carrier shall demonstrate how it combined levels of the financial requirement to satisfy the predominant test if there is no single level that applies to more than one-half of medical/surgical benefits in the classification (45 CFR § 146.136(c)(3)(i)(B)(2)).

**Standards for
Mental Health and Substance Use Disorder Parity Compliance**

Standard 4

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

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

Documents to be Reviewed

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

Others Reviewed

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

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

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

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

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

Commented [A16]: The review criteria and procedures do not document how the examiners are to use these documents to assess compliance with this standard. Should they be expanded to include this type of information?

Review Procedures and Criteria

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

The health carrier shall demonstrate the reasonable method used to perform the analysis that determines expected plan payments within each classification of benefits (or applicable sub-classification) for medical/surgical benefits. A carrier must always use appropriate and sufficient data to perform the analysis in compliance with applicable Actuarial Standards of Practice (ACA FAQ 34 Q3).

The health carrier shall demonstrate that any type of QTL applied to mental health or substance use disorder benefits in a classification (or applicable sub-classification) applies to at least two-thirds of expected plan payments on medical/surgical benefits within that classification (or applicable sub-classification) (45 CFR § 146.136(c)(3)(i)(A)). If no cost analysis was relied upon within this demonstration, the carrier shall specify how it concluded that the substantially all test was satisfied (e.g., it applies the quantitative limitation to all medical/surgical benefits within the classification). No quantitative treatment limitations shall apply only to mental health or substance use disorder benefits.

The health carrier shall demonstrate that the level of QTL applied to mental health or substance use disorder benefits in a classification (or applicable sub-classification) is no more restrictive than the level of QTL that applies to more than one-half of expected plan payments that are subject to the quantitative treatment limitation within that classification for medical/surgical benefits (45 CFR § 146.136(c)(3)(i)(B)(1)). The carrier shall demonstrate how it combined levels of the QTL to satisfy the predominant test If there is no single level that applies to more than one-half of medical/surgical benefits in the classification (45 CFR § 146.136(c)(3)(i)(B)(2)).

**Standards for
Mental Health and Substance Use Disorder Parity**

Standard 5

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

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

Documents to be Reviewed

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

___ A list of all NQTs imposed upon mental health or substance use disorder benefits within each classification of benefits (or applicable sub-classification), including the methodology used to determine those NQTs. A state may focus its review on a subset of NQTs rather than all NQTs. (See reference link to DOL Self-Compliance Tool for a non-exhaustive list)

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

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

___ Company claim procedure manuals and bulletins/communications

___ Claims processor and customer services MHPAEA training materials

___ Company fraud, waste, and abuse policies and procedures

___ Internal company claim audit reports

___ Prescription drug formulary for each product/plan design

___ Prescription drug utilization management documentation

___ Fail-first policies or step therapy protocols

___ Network development/contracting policies and procedures

___ Standards for provider admission to participate in a network, including credentialing requirements

Commented [A17]: Should this be a separate standard?

Commented [A18]: Should this be provided by the carrier or developed by the regulator?

Commented [A19]: Suggest this be broken into two items:
1) Claim Processor Manuals for Mental Health or Substance Use Disorder Benefits
2) Customer Service training manuals or directives related to Mental Health or Substance Use Disorder Benefits

Commented [A20]: Why is this included for NQTs? If there is a valid reason; perhaps more guidance as to why they should be reviewed could be included.

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

Others Reviewed

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

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

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

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

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

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

Review Procedures and Criteria

The health carrier shall perform and document comparative analyses demonstrating that within any classification of benefits, as written and in operation, the process, strategies, evidentiary standards, or other factors used in applying an NQTL to mental health or substance use disorder benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification. The comparative analyses shall include the following, for each NQTL applied to mental health or substance use disorder benefits, separately for each classification of benefits (42 U.S.C. § 300gg-26(a)(8)(A)):

- The specific coverage terms or other relevant terms regarding the NQTL and a description of all mental health or substance use disorder and medical or surgical benefits to which such NQTL applies in each respective benefits classification;

Commented [A21]: Most of the documents listed in the documents to review are not discussed in the review procedures or criteria. Should the discussion be expanded to address each item?

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

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

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

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

1. Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis;
2. Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations;
3. Identification of processes, strategies, sources and factors without the required or clear and detailed comparative analysis;
4. Identification of factors, evidentiary standards and strategies without a clear explanation of how they were defined and applied in practice;

5. Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application; and
6. Analysis that is outdated due to the passage of time, a change in plan structure, or for any other reason.

DRAFT

**Standards for
Mental Health and Substance Use Disorder Parity Compliance**

Standard 6

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

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

Documents to be Reviewed

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

Others Reviewed

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

Review Procedures and Criteria

The health carrier shall demonstrate the method by which it makes available to any current or potential participant, beneficiary, or contracting provider upon request the medical necessity criteria used to make mental health or substance use disorder medical necessity determinations (45 CFR § 146.136(d)(1)). This shall include a reporting of how the health carrier ensures prompt release of the criteria upon request.

Commented [A22]: This seems like a lot to review in a single standard. Can this be broken up into 4 separate standards? If an examiner is to look for all of these things in one standard, some items may be overlooked.

Commented [A23]: Would it be useful to cite back to other portions of Chapter 24 like Standard 5 from the UR section regarding the review of adverse benefit determinations?

The health carrier shall demonstrate that it provides the reason for any denial of reimbursement for mental health or substance use disorder benefits (45 CFR § 146.136(d)(2)). This shall include a reporting of how the health carrier ensures prompt delivery of the reason for the denial to the beneficiary.

The health carrier shall demonstrate its method for responding to requests for all documents, records and other information relevant to the claimant's claim for benefits after an adverse benefit determination (45 CFR § 146.136(d)(3)). This shall include the health carrier's protocol for ensuring that it discloses medical necessity criteria for both medical/ surgical benefits and mental health and substance use disorder benefits, as well as disclosures pertaining to the processes, strategies, evidentiary standards and other factors the health carrier used to apply a NQTL with respect to medical/ surgical benefits and mental health or substance use disorder benefits under the plan, when those specific items are requested. This shall also include a reporting of how the health carrier ensures prompt disclosure of all information requested.

The carrier must demonstrate that all claims processing and disclosure regarding adverse benefit determinations complies with the federal claims and appeals regulations. (45 CFR § 147.136)

DRAFT

**Standards for
Mental Health and Substance Use Disorder Parity Compliance**

Standard 7

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

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

Documents to be Reviewed

- _____ Contractual agreements between the carrier and vendors having administrative, claims and/or medical management responsibilities
- _____ Policies and procedures for ensuring availability of health carrier information needed for vendor analysis of compliance with MHPAEA
- _____ A narrative summary outlining how the vendor and the carrier coordinate benefit design and application to ensure compliance with MHPAEA
- _____ Any written communications between the carrier and the vendor in regard to the administration of mental health and substance use disorder benefits

Others Reviewed

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

Review Procedures and Criteria

The health carrier shall provide documentation of the protocols and procedures in place to ensure that any contracted vendor that provides mental health or substance use disorder benefits is collaborating with the health carrier to satisfy compliance with MHPAEA. This shall include explanation of how both the design of benefits and the application of benefits, in operation, are compliant with MHPAEA.

Commented [A24]: Should this be a note under the Review Procedures and Criteria? It seems like an explanation for the preceding sentence rather than an actual standard.

Commented [A25]: Should this cite back to other standards from other relevant chapters such as Chapter 20 Operations and Management Standard 6 and Chapter 24 UR Standards 1 & 2?

From: Julie Fairbanks <Julie.Fairbanks@scc.virginia.gov>
Sent: Friday, May 27, 2022 1:32 PM
To: Wallace, Petra <PWallace@naic.org>
Cc: Lyons, Brant <Brant.Lyons@scc.virginia.gov>
Subject: RE: NAIC Notice: Comments Due Date Extended to May 27, 2022 Market Conduct Examination Guidelines (D) Working Group Exposure Drafts

Hi Petra,

VA would like to submit the following comment to the proposed Chapter 24B MHPAEA:

To be consistent with the other chapters in the Market Regulation Handbook, the *Review Procedures and Criteria* section should not dictate what the “health carrier shall” do to be compliant with each requirement. The MRH should provide guidance to the examiner to explain what needs to be done to determine whether the health carrier is in compliance with each requirement or not and the Chapter should be revised accordingly.

Thank you,

Julie R. Fairbanks, CIE, FLMI, AIRC, MCM
BOI Manager, Market Conduct Section
Life and Health Division
804-371-9385
julie.fairbanks@scc.virginia.gov

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601 Pennsylvania Avenue, NW T 202.778.3200
South Building, Suite 500 F 202.331.7487
Washington, D.C. 20004 ahip.org

May 27, 2022

Ms. Erica Weyhenmeyer, Chair, MHPAEA (B) Working Group
Mr. Damion Hughes, Chair, MCEG (D) Working Group
National Association of Insurance Commissioners
444 North Capitol Street NW, Suite 700
Washington, D.C. 20001-1512

Forwarded via email to: Ms. Petra Wallace, Ms. Lois Alexander, and Mr. Joe Touschner

RE: AHIP Comments on Market Regulation Handbook, MHPAEA Chapter 24B Update

Dear Ms. Weyhenmeyer and Mr. Hughes;

AHIP appreciates the opportunity to provide comments on the Chapter 24B draft as the MHPAEA and MCEG Working Groups coordinate to update the Market Regulation Handbook to align with new federal guidance. AHIP is committed to working with the NAIC and fellow stakeholders to have consistent mental health parity regulations among the federal government, the states, and markets.

From AHIP's review, the *legal requirements* of the new draft are generally consistent with the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, as amended by the new provisions included in the Consolidated Appropriations Act of 2021, with a few exceptions highlighted below. AHIP fully supports consistency with the federal MHPAEA requirements and has no concerns where the draft Handbook "mirrors" the federal standard. However, where there are multiple variations of MHPAEA compliance requests between the states and the federal agencies, it becomes incredibly challenging for carriers who offer coverage in a number of states to demonstrate compliance. Notably, the draft Handbook "Documents to be Reviewed" sections list a number of documents that are not required under federal MHPAEA guidance and are not consistent with federal enforcement activity related to MHPAEA compliance.

In several instances, clarification on how the requested documents will support demonstrating compliance with MHPAEA would be helpful. For example, in Standard 5, the large volume of documents to be requested in addition to the comparative analyses is directly contrary to the federal guidance which states carriers shall avoid the "production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis" The comparative analyses should be sufficient to demonstrate compliance with the nonquantitative treatment limitation (NQTL) requirement, and state regulators can request additional information, if needed to further demonstrate compliance.

In addition, the draft Handbook requires states to review health carrier complaint/grievances/appeals records concerning mental health and/or substance use disorders, internal department appeals/grievance files, external appeals register/logs/files, and external appeal resolution and associated documentation. While AHIP appreciates the nature of these documents generally, it would seem more appropriate to review these documents as part of a market conduct examination of the ACA claims and appeals requirements, as opposed to a review for MHPAEA compliance.

Recommendation 1: MHPAEA permits plans to divide certain benefit classifications into sub-classifications for parity. AHIP recommends that Section 2 of the Handbook include these allowable sub-classifications to make certain regulators are familiar with them and the parity rules that apply.

Recommendation 2: As written, Standard 5 notes that carriers are required under federal law to prepare comparative analyses for NQTLs. As noted above, the submission of these analyses should satisfy the Standard. While the additional documentation listed may be helpful to the examiners, not all documents would be needed for each exam. AHIP recommends describing the additional documents

May 27, 2022
Page 2

as ones that may be needed when additional information or clarification is necessary, while eliminating document requirements that are not in line with federal MHPAEA documentation requirements. Further, Standard 5 requires the submission of analyses for all NQTLs, as well as a listing of all NQTLs within each classification of services, including the methodology used to determine each NQTL. We recommend the NAIC take a similar approach as the Tri-Departments in [FAQ Part 45](#) and identify a subset of priority NQTLs to focus on initially, phasing in additional NQTLs as appropriate, as a full listing could mean hundreds of service variations.

Recommendation 3: Standard 7 discusses oversight of vendors by their contracted health plans. It is standard practice for health insurance providers to require within their contracts that vendors and third-party service providers be compliant with all laws, regardless of the task, making this specific standard unnecessary. However, if Standard 7 is retained, we recommend the requirement to provide all written communication between the issuer and the vendor related to the provision of benefits, which could encompass tens of thousands of emails and random communications not relevant to the insurance department, be stricken. Instead, we suggest additional language pertaining to resource documentation to allow for a broader narrative for explaining how vendors and carriers coordinate to achieve MHPAEA compliance.

The federal Tri-Departments have announced they will be updating the federal MHPAEA regulations, issuing a Notice of Proposed Rulemaking this summer. AHIP notes the Market Regulation Handbook may need additional updates in response to changes in the Departments' regulations and recommends the NAIC seek alignment with those changes once they are finalized.

Following our comments is a redline version of Chapter 24B which incorporates our recommendations above as well as a few minor technical corrections.

Mental health is a key component to a person's overall wellbeing and health insurance providers remain steadfast in our support of promoting safe, evidence-based behavioral health care on par with medical/surgical care.

We look forward to working together to identify best practices for reviewing health plans' compliance with behavioral health parity laws and regulations. We truly appreciate the Working Group's commitment in focusing on such an important topic. Please reach out to Kristen Hathaway (khathaway@ahip.org) with any questions or concerns related to our comments.

Thank you,



Meghan Stringer
Senior Policy Advisor
Product and Commercial Policy

AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. Visit www.ahip.org to learn how working together, we are Guiding Greater Health.

AHIP Comments and Redline Edits

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

Introduction

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

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

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

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

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

Mental Health and Substance Use Disorder Parity

1. Purpose

Mental health and substance use disorder parity compliance examinations should be designed to ensure that all companies are in compliance with all the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 (as amended by the Consolidated Appropriations Act of ~~2020~~2021) found at 42 U.S.C. § 300gg-26 and its implementing regulations found at 45 CFR § 146.136 and 45 CFR § 147.160.

Commented [A1]: Technical correction

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

Commented [A2]: This is not a separate standard under federal MHPAEA.

2. Definitions

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

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

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

Classifications of benefits used for applying parity rules:

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

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

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

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

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

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

Commented [A3]: Recommendation 1: AHIP recommends noting the inserted special rules.

requirement or treatment limitation that applies to substantially all medical/surgical benefits in the tier.

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

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

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

(6) Prescription Drugs. Benefits for prescription drugs (45 CFR § 146.136(c)(2)(ii)(A)(6)). See special rule for prescription drug benefits in paragraph (c)(3)(iii)(A) of 45 CFR §146.136.

a. Multi-tiered drug formularies involve different levels of drugs that are classified based primarily on cost, with the lowest-tier (Tier 1) drugs having the lowest cost-sharing. If a plan applies different levels of financial requirements to different tiers of prescription drug benefits, the plan complies with the mental health parity provisions if it establishes the different levels of financial requirements based on reasonable factors determined in accordance with the rules for NQTLs and without regard to whether a drug is generally prescribed for medical/surgical or MH/SUD benefits. Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up.

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

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

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

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

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

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

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

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

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

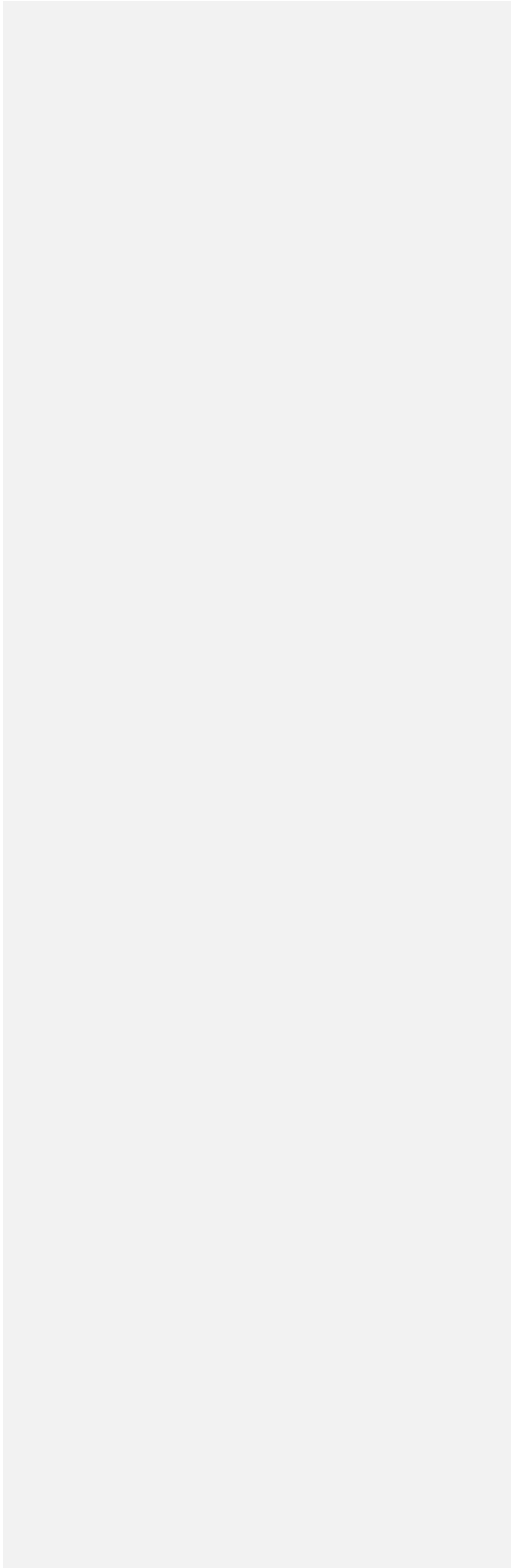
Treatment Limitations include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations (QTLs), which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations (NQTLs), which are not expressed numerically but otherwise limit the scope or duration of benefits for treatment under a plan or coverage. A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition (45 CFR § 146.136(a)).

3. Techniques

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

4. Standards and the Regulatory Tests

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



**Standards for
Mental Health and Substance Use Disorder Parity Compliance**

Standard 1
The health carrier shall define all covered services as mental health or substance use disorder benefits or as medical or surgical benefits. Mental health benefits or substance use disorder benefits must be defined to mean items or services for the treatment of a mental health condition or substance use disorder, as defined by the terms of the health plan and applicable state and federal law. Any definition of a condition or disorder as being or as not being a mental health condition or substance use disorder must be consistent with generally recognized independent standards of current medical practice or state guideline. (45 CFR § 146.136(a)).

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

Documents to be Reviewed

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

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

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

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

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

_____ Internal department appeals/grievance files

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

Others Reviewed

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

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

Commented [A4]: As passed at the federal level, MHPAEA is not a benefit mandate. It allows exclusions for MH/SUD conditions, and while some state laws may alter that allowance, it's unclear what this is evaluating (since this is not an assessment of EHB).

Commented [A5]: Production of this information is overly burdensome and not probative of MHPAEA compliance. Depending on the specific NQTL, denial/overturn rates on appeal may be probative of stringency, but not as a general matter. This comment applies throughout.

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

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

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

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

Review Procedures and Criteria

The health carrier shall identify which independent standards were used to define mental health conditions, substance use disorders and medical/surgical conditions.

The health carrier shall specify applicable state statutes or guidelines that stipulate the standard or definition of mental health conditions, substance use disorders, or medical/surgical conditions.

The carrier shall identify excluded diagnoses and stipulate that such exclusions are not prohibited by state or federal law.

The health carrier shall identify how it defines items or services as mental health benefits, substance use disorder benefits, or medical/surgical benefits, including items and services that are sometimes used for the treatment of mental health or substance use disorders and medical/surgical conditions (e.g., nutritional counseling, occupational therapy).

Commented [A6]: Same as comment above. Instead of identifying excluded diagnoses, issuers could identify that they meet state mandates.

**Standards for
Mental Health and Substance Use Disorder Parity Compliance**

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

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

Documents to be Reviewed

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

Others Reviewed

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

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

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

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

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

Review Procedures and Criteria

The health carrier shall provide a list that specifies to which classification (or applicable sub-classification) all benefits were assigned.

The health carrier shall identify which, if any, benefits were classified into sub-classifications. Please note that the only permissible sub-classifications are: multiple tiers for prescription drugs benefits that are based on reasonable factors¹ (45 CFR § 146.136(c)(3)(iii)(A)); multiple network tiers that are based on reasonable factors within the inpatient in-network and outpatient in-network classifications (45 CFR § 146.136(c)(3)(iii)(B)); outpatient office visits and outpatient other services within the outpatient in-network and outpatient out-of-network classifications (45 CFR § 146.136(c)(3)(iii)(C)). The carrier shall retain, as relevant, sub-classifications for all parity analyses and testing for financial requirements, quantitative treatments limitations and nonquantitative treatment limitations.

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

The health carrier shall demonstrate that mental health or substance use disorder benefits are covered in each classification in which medical/surgical benefits are covered.

Commented [A7]: This statement is not consistent with federal law. Subclassifications are not required; they are voluntary. Further, all testing for MHPAEA is done on a policy by policy (plan by plan) basis and, therefore, federal law does not require that if a plan/issuer subclassifies for one policy/plan that the plan/issuer must subclassify for all policies/plans.

We would agree that if a plan/issuer subclassifies and make determinations about what services are covered under each subclassification that this should be consistent.

¹ Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up (45 CFR § 146.136(c)(3)(iii)(A))

**Standards for
Mental Health and Substance Use Disorder Parity Compliance**

Standard 3
The health carrier shall not apply any financial requirement on mental health or substance use disorder benefits in any classification (or applicable sub-classification) that is more restrictive than the predominant financial requirement of that type applied to substantially all medical/surgical benefits in the same classification (or applicable sub-classification) (45 CFR § 146.136(c)(2)(i)).

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

Documents to be Reviewed

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

Commented [A8]: The standard is that a reasonable method be used to determine expected plan payment for medical surgical benefits. The documentation and communications with vendors is extraneous.

Others Reviewed

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

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

Mental Health Parity and Addiction Equity Act of 2008

42 U.S. Code § 300gg–26

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

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Review Procedures and Criteria

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

The health carrier shall demonstrate the reasonable method used to perform the analysis that determines expected plan payments within each classification of benefits (or applicable sub-classification) for medical/surgical benefits. A carrier must always use appropriate and sufficient data to perform the analysis in compliance with applicable Actuarial Standards of Practice (ACA FAQ 34 Q3).

The health carrier shall demonstrate that any type of financial requirement applied to mental health or substance use disorder benefits in a classification (or applicable sub-classification) applies to at least two-thirds of expected plan payments on medical/surgical benefits within that classification (or applicable sub-classification) (45 CFR § 146.136(c)(3)(i)(A)). If no cost analysis was relied upon within this demonstration, the carrier shall specify how it concluded that the substantially all test was satisfied (e.g., it applies the financial requirement to all medical/surgical benefits within the classification). No financial requirements shall apply only to mental health or substance use disorder benefits.

The health carrier shall demonstrate that the level of financial requirement applied to mental health or substance use disorder benefits in a classification (or applicable sub-classification) is comparable and no more restrictive than the level of financial requirement that applies to more than one-half of expected plan payments that are subject to the financial requirement within that classification for medical/surgical benefits (45 CFR § 146.136(c)(3)(i)(B)(1)). The carrier shall demonstrate how it combined levels of the financial requirement to satisfy the predominant test if there is no single level that applies to more than one-half of medical/surgical benefits in the classification (45 CFR § 146.136(c)(3)(i)(B)(2)).

**Standards for
Mental Health and Substance Use Disorder Parity Compliance**

Standard 4
The health carrier shall not apply any QTL on mental health or substance use disorder benefits in any classification (or applicable sub-classification) that is more restrictive than the predominant QTL of that type applied to substantially all medical/surgical benefits in the same classification (or applicable sub-classification) (45 CFR § 146.136(c)(2)(i)).

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

Documents to be Reviewed

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

Commented [A9]: The standard is that a reasonable method be used to determine expected plan payment for medical surgical benefits. The documentation and communications with vendors is extraneous.

Others Reviewed

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

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

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

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

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

Review Procedures and Criteria

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

The health carrier shall demonstrate the reasonable method used to perform the analysis that determines expected plan payments within each classification of benefits (or applicable sub-classification) for medical/surgical benefits. A carrier must always use appropriate and sufficient data to perform the analysis in compliance with applicable Actuarial Standards of Practice (ACA FAQ 34 Q3).

The health carrier shall demonstrate that any type of QTL applied to mental health or substance use disorder benefits in a classification (or applicable sub-classification) applies to at least two-thirds of expected plan payments on medical/surgical benefits within that classification (or applicable sub-classification) (45 CFR § 146.136(c)(3)(i)(A)). If no cost analysis was relied upon within this demonstration, the carrier shall specify how it concluded that the substantially all test was satisfied (e.g., it applies the quantitative limitation to all medical/surgical benefits within the classification). No quantitative treatment limitations shall apply only to mental health or substance use disorder benefits.

The health carrier shall demonstrate that the level of QTL applied to mental health or substance use disorder benefits in a classification (or applicable sub-classification) is no more restrictive than the level of QTL that applies to more than one-half of expected plan payments that are subject to the quantitative treatment limitation within that classification for medical/surgical benefits (45 CFR § 146.136(c)(3)(i)(B)(1)). The carrier shall demonstrate how it combined levels of the QTL to satisfy the predominant test If there is no single level that applies to more than one-half of medical/surgical benefits in the classification (45 CFR § 146.136(c)(3)(i)(B)(2)).

**Standards for
Mental Health and Substance Use Disorder Parity**

Standard 5

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

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

Documents to be Reviewed

Documentation, including but not limited to eComparative analyses (required under 42 U.S.C. § 300gg-26(a)(8)(A)), demonstrating that within each of the 6 classifications of benefits (and applicable sub-classifications), the as-written and in-operation processes, strategies, evidentiary standards, or other factors used in applying a NQTL are comparable to and applied no more stringently to mental health or substance use disorder benefits than to medical/surgical benefits in the classification. (States should specify a subset of NQTL analyses carriers must have on hand or should provide in response to a specific request.)

Commented [A10]: Recommendation 2

Additional Documents that may be Requested

- _____ Applicable state and federal statutes, rules, regulations and published sub-regulatory guidance
- _____ A list of ~~all~~ NQTL analyses requested for review that are imposed upon mental health or substance use disorder benefits within ~~each classification of benefits (or an applicable classification or sub-classification)~~, including the methodology used to determine those NQTLS. A state may request focus its further NQTL subsets for review on a subset of NQTLS rather than all NQTLS where appropriate. States should review federal guidance for initial listing of ~~includes four subsets. to include: (See reference link to DOL Self-Compliance Tool for a non-exhaustive list)~~
- _____ Utilization management manuals and utilization review documents such as: utilization review criteria; criteria hierarchies for performing utilization review; case management referral criteria; initial screening scripts and algorithms; policies relating to reviewer discretion; processes for identifying and evaluating clinical issues and utilizing performance goals
- _____ Notes and/or logs kept during utilization review, such as those describing: peer clinical review; telephonic consultations with attending providers; consultations with expert reviewers; clinical rationale used in approving or denying benefits; the selection of information deemed reasonably necessary to make a medical necessity determination; adherence to utilization review criteria and criteria hierarchy; professional judgment used in lieu of utilization review criteria; actions taken when incomplete information is received from attending providers
- _____ Company claim procedure manuals and bulletins/communications

- ___ Claims processor and customer services MHPAEA training materials
- ___ Company fraud, waste, and abuse policies and procedures
- ___ Internal company claim audit reports
- ___ Prescription drug formulary for each product/plan design
- ___ Prescription drug utilization management documentation
- ___ Fail-first policies or step therapy protocols
- ___ Network development/contracting policies and procedures
- ___ Standards for provider admission to participate in a network, including credentialing requirements
- ___ Standards for determining provider reimbursement rates
- ___ Samples of provider/facility contracts in use during the exam period
- ___ Plan methods for determining usual, customary and reasonable charges for each product/plan design
- ___ Mental health and/or substance use disorder and medical/surgical claim files.
- ___ Mental health and/or substance use disorder and medical/surgical utilization review
- ___ Management files (prospective, concurrent and retrospective)
- ___ Complaint files, logs and disposition notes

Commented [A11]: This is not listed as an NQTL under federal guidance, so unclear why this is part of MHPAEA review.

Commented [A12]: It's unclear what is being requested.

~~Documentation, including but not limited to comparative analyses, demonstrating that within each of the 6 classifications of benefits (and applicable sub-classifications), the as written and in operation processes, strategies, evidentiary standards, or other factors used in applying a NQTL are comparable to and applied no more stringently to mental health or substance disorder benefits than to medical/surgical benefits in the classification.~~

Others Reviewed

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

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

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

Publication of summary plan description

ERISA 104(b) (29 U.S.C. § 1024(b))

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

FAQs about Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 Part 45 (ACA FAQ 45):

<https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf>

Review Procedures and Criteria

The health carrier shall perform and document comparative analyses demonstrating that within any classification of benefits, as written and in operation, the process, strategies, evidentiary standards, or other factors used in applying an NQTL to mental health or substance disorder benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification. The comparative analyses shall include the following, for each NQTL applied to mental health or substance use disorder benefits, separately for each classification of benefits (42 U.S.C. § 300gg-26(a)(8)(A)):

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

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

1. A clear description of the specific NQTL, plan terms and policies at issue;
2. Identification of the specific mental health or substance use disorder and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as mental health or substance use disorder and which are treated as medical/surgical;
3. Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both mental health or substance use disorder benefits and medical/surgical benefits, are subject to the NQTL.

Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination;

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

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

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

**Standards for
Mental Health and Substance Use Disorder Parity Compliance**

Standard 6

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

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

Documents to be Reviewed

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

Others Reviewed

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

Review Procedures and Criteria

The health carrier shall demonstrate the method by which it makes available to any current or potential participant, beneficiary, or contracting provider upon request the medical necessity criteria used to make mental health or substance use disorder medical necessity determinations (45 CFR § 146.136(d)(1)). This shall include a reporting of how the health carrier ensures prompt release of the criteria upon request.

The health carrier shall demonstrate that it provides the reason for any denial of reimbursement for mental health or substance use disorder benefits (45 CFR § 146.136(d)(2)). This shall include a reporting of how the health carrier ensures prompt delivery of the reason for the denial to the beneficiary.

The health carrier shall demonstrate its method for responding to requests for all documents, records and other information relevant to the claimant's claim for benefits after an adverse benefit determination (45 CFR § 146.136(d)(3)). This shall include the health carrier's protocol for ensuring that it discloses medical necessity criteria for both medical/ surgical benefits and mental health and substance use disorder benefits, as well as disclosures pertaining to the processes, strategies, evidentiary standards and other factors the health carrier used to apply a NQTL with respect to medical/ surgical benefits and mental health or substance use disorder benefits under the plan, when those specific items are requested. This shall also include a reporting of how the health carrier ensures prompt disclosure of all information requested.

The carrier must demonstrate that all claims processing and disclosure regarding adverse benefit determinations complies with the federal claims and appeals regulations. (45 CFR § 147.136)

Commented [A13]: Alternatively, PHSA and ERISA include specific timing requirements for disclosures. Ask for states to defer to existing claims and appeals standards.

**Standards for
Mental Health and Substance Use Disorder Parity Compliance**

Standard 7

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

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

Documents to be Reviewed

- _____ Contractual agreements between the carrier and vendors having administrative, claims and/or medical management responsibilities
- _____ Policies and procedures for ensuring availability of health carrier information needed for vendor analysis of compliance with MHPAEA
- _____ A narrative summary outlining how the vendor and the carrier coordinate ~~benefit design and application~~ to ensure compliance with MHPAEA
- _____ ~~Any written communications between the carrier and the vendor in regard to the administration of mental health and substance use disorder benefits~~

Commented [A14]: Recommendation 3 - The edits allow for a broader narrative for explaining how vendors and carriers coordinate to achieve MHPAEA compliance.

Others Reviewed

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

Review Procedures and Criteria

The health carrier shall provide documentation of the protocols and procedures in place to ensure that any contracted vendor that provides mental health or substance use disorder benefits is collaborating with the health carrier to satisfy compliance with MHPAEA. This shall include explanation of how both the design of benefits and the application of benefits, in operation, are compliant with MHPAEA.

May 27, 2022

Ms. Erica Weyhenmeyer
Chair, MHPAEA (B) Working Group
National Association of Insurance Commissioners
444 North Capitol Street NW, Suite 700
Washington, D.C. 20001-1512

Mr. Damion Hughes
Chair, MCEG (D) Working Group
National Association of Insurance Commissioners
444 North Capitol Street NW, Suite 700
Washington, D.C. 20001-1512

RE: ABHW Comments on Market Regulation Handbook, MHPAEA Chapter
24B Update

Dear Ms. Weyhenmeyer and Mr. Hughes:

The Association for Behavioral Health and Wellness (ABHW) appreciates the opportunity to provide comments on the draft of Chapter 24B as the Mental Health Parity and Addiction Equity Act (MHPAEA) and Market Conduct Examination Guidelines (MCEG) Working Groups coordinate to update the Market Regulation Handbook to align with new federal guidance. In addition to the comments below, ABHW supports the comments submitted by AHIP.

ABHW is the trade association that serves as the national voice for payers that manage behavioral health insurance benefits. ABHW member companies provide coverage to approximately 200 million people in both the public and private sectors to treat mental health, substance use disorders, and other behaviors that impact health and wellness. For more than two decades, ABHW

has supported mental health and substance use disorder parity and our members work vigorously to understand and implement MHPAEA.

One of ABHW's objectives with MHPAEA implementation is to have uniformity among regulators at the federal and state level. We believe a unified interpretation of MHPAEA and approach to assessing compliance would be beneficial to consumers, providers, employers, insurers/health plans, and regulators. Given the significantly increased activity around MHPAEA compliance this past year; and the forthcoming federal proposed rule, updated U.S. Department of Labor Self-Compliance Tool, and the Department of Labor, Department of Health and Human Services, and the Department of the Treasury (collectively the Tri-Departments) Report to Congress, we urge NAIC to wait to finalize the proposed updates to Chapter 24B until the aforementioned documents have been finalized.

Insurers and payers are working diligently to ensure compliance with the evolving federal reporting requirements pursuant to the Consolidated Appropriations Act (CAA) while simultaneously keeping up with the changes introduced at the state level. The lack of uniformity between state and federal requirements leads to confusion when preparing the non-quantitative treatment limitations (NQTL) analyses. As such, we strongly urge NAIC to completely align its reporting template with the U.S. Department of Labor's Self-Compliance Tool for MHPAEA, along with federal guidance, and remove any unnecessary or contrary items such as additional required documentation.

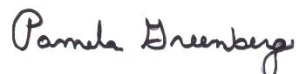
The Tri-Departments have committed to issuing further guidance on CAA implementation. In their recent FAQs, the Tri-Departments indicated that using the DOL Self-Compliance Tool will put plans and issuers "in a strong position to comply with the CAA's requirement." Therefore, any additional requirements would be unnecessary for CAA compliance. The proposed documents to be submitted for review in Chapter 24B go well beyond the current DOL Self-Compliance Tool and CAA requirements and should therefore be removed.

ABHW members strive to ensure access to behavioral health services and are committed to meeting MHPAEA compliance requirements. The CAA provides a foundation for improved compliance by codifying the NQTL comparative analysis requirements from the DOL Self-Compliance Tool, thus clarifying for both states and insurers/plans the NQTL reporting requirements. Since this is

an evolving issue, we strongly encourage NAIC to align its handbook revisions to mirror federal standards in totality and not add additional documentation.

Thank you for the opportunity to provide our comments on parity compliance. If you would like to discuss our comments, I can be reached at greenberg@abhw.org.

Sincerely,

A handwritten signature in cursive script that reads "Pamela Greenberg".

Pamela Greenberg, MPP
President and CEO

Attachment: AHIP's comments

cc via email to: Ms. Petra Wallace, Ms. Lois Alexander, and Mr. Joe Tuschner



May 27, 2022

Erica Weyhenmeyer
Chair, Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group
Damion Hughes
Chair, Market Conduct Examination Guidelines (D) Working Group
444 North Capitol Street NW, Suite 700
Washington, D.C. 20001-1512

Submitted electronically to: Petra Wallace (pwallace@naic.org)

Dear Ms. Weyhenmeyer and Mr. Hughes,

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to provide comments on the proposed update to chapter 24B of the 2022 Market Regulation Handbook, *Conducting the Mental Health Parity and Addiction Equity Act (MHPAEA) Related Examination* (Handbook).

BCBSA is a national federation of 34 independent, community-based and locally operated Blue Cross and Blue Shield companies that collectively provide health care coverage for one in three Americans. For more than 90 years, Blue Cross and Blue Shield companies have offered quality health care coverage in all markets across America – serving those who purchase coverage on their own as well as those who obtain coverage through an employer, Medicare and Medicaid.

BCBSA and BCBS companies are committed to robust access to quality mental health and substance use disorder services (MH/SUD) for members and want to continue to work with policymakers to improve the ability of regulators, payers and employers to meet the aims of MHPAEA and promote compliance with the requirements. Since the passage of MHPAEA, BCBS companies have actively worked to support the legislation and comply with its requirements. Concurrently, BCBS companies have made strides in addressing broader issues that limit access to care through efforts to fill the gaps created by workforce shortages and support for the integration of physical and behavioral health care.

We recognize there is room for improvement in mental health parity compliance. However, health plans that are working in good faith to comply with the requirements continue to struggle to understand the expectations of regulators on certain facets of MHPAEA compliance, specifically what constitutes compliance for parity between medical/surgical (M/S) benefits and MH/SUD benefits for non-quantitative treatment limits (NQTLs). As such, we appreciate NAIC's efforts to work towards greater clarity in MHPAEA compliance through this update to the Handbook. With consistent and transparent guidance, health plans will be better able to ensure compliance with existing laws and continue to enhance access to care for members.

However, we have some concerns about the quantity of information to be submitted for compliance that is proposed in the updates, among a few other technical issues. We have outlined questions and recommended edits in the draft MHPAEA chapter of the Handbook below. Our recommendations focus on:

- **Aligning the Market Regulation Handbook guidance with the federal standards for the required documents.** We recommend NAIC make any additional documentation which go beyond the federal guidance, be at the request of the state regulators. Under the documents proposed to be reviewed, it is unclear how some of the documents will support regulators' understanding of whether the health plan is compliant with the standard. Aligning the required document with federal guidance, while providing the option to request additional resources as needed, will help streamline the regulators' investigations to focus on the documents specific to the individual inquiries. It will also protect against creating two different MHPAEA standards which could lead to unnecessary confusion for all stakeholders.
- **Identifying a subset of NQTLs in Standard 5 rather than requiring a list of all NQTLs.** This can help regulators focus on the most pressing needs. For the initial focus areas, we recommend NAIC align with the initial four NQTLs identified by the federal Tri-agencies in [FAQ Part 45](#).
- **Amending language in Standard 7 on written communications between the health plan and the vendor to focus on the contractual terms between the health plan and vendor.** While we agree that the health plan must ensure that any contracted vendor that provides MH/SUD benefits is collaborating to satisfy compliance, we do not believe this expectation is specific to MHPAEA. For any law that the issuer is subject to and for which the issuer contracts with a vendor to provide services, this coordination is necessary. However, it is not typically investigated by regulators, as is proposed in this Handbook.

This level of oversight will require significant resources by state regulators to perform a function which the plan or issuer is required to perform. In addition, as written, the Handbook requires submission of all written communications, which could include emails, working documents, drafts, and other communications that may not be relevant to how the entities coordinate to achieve compliance. As such, we recommend limiting the burden on regulators and focusing these reviews on the contractual terms between the health plan and vendor. However, if Standard is retained, we recommend amending the documentation requirements to require health plans to produce a description of how coordination is done and compliance achieved to simplify reviews for regulators.

Also, as you know, the federal Tri-agencies are currently aiming to issue additional guidance on MHPAEA compliance by early summer. In addition, the Tri-agencies will be issuing a second report to Congress on MHPAEA compliance under the Consolidated Appropriations act in October. This report will hopefully provide all stakeholders with a clearer sense of NQTL compliance. Since the federal guidance and reporting may impact what is outlined in the Market Regulation Handbook, we recommend that NAIC delay finalizing the Handbook until the federal resources are issued to ensure alignment.

We appreciate your consideration of our comments. We look forward to continuing to work with NAIC on MHPAEA implementation and compliance. If you have any questions or would like additional information, please contact Randi Chapman, at Randi.Chapman@bcbsa.com, or Jennifer Jones, at Jennifer.Jones@bcbsa.com.

Sincerely,



Keysha Brooks-Coley
Vice President, Advocacy

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

Introduction

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

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

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

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

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

Mental Health and Substance Use Disorder Parity

1. Purpose

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

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

2. Definitions

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

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

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

Commented [A1]: We would note that this is not a separate standard under MHPAEA and, as proposed in Standard 7, could impose significant burden on regulators.

Classifications of benefits used for applying parity rules:

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

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

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

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

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

(6) Prescription Drugs. Benefits for prescription drugs (45 CFR § 146.136(c)(2)(ii)(A)(6)). See special rule for multi-tiered prescription drug benefits (45 CFR 146.136(c)(2)(ii)(A)(6)).

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

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

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

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

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

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

Medical/Surgical Benefits means benefits with respect to items or services for medical conditions or surgical procedures, as defined under the terms of the plan or health insurance coverage and in accordance

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

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

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

Treatment Limitations include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations (QTLs), which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations (NQTLs), which are not expressed numerically but otherwise limit the scope or duration of benefits for treatment under a plan or coverage. A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition (45 CFR § 146.136(a)).

3. Techniques

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

4. Standards and the Regulatory Tests

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

**Standards for
Mental Health and Substance Use Disorder Parity Compliance**

Standard 1

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

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

Documents to be Reviewed

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

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

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

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

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

_____ Internal department appeals/grievance files

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

Others Reviewed

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

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

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

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

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

Commented [A2]: Since MHPAEA allows exclusions for MH/SUD conditions, can you clarify what this is evaluating? Our read this is that this section is not an assessment of essential health benefits so we are not clear on the intent of the review.

Commented [A3]: This is a significant amount of information being requested. It is greater than what is required under federal enforcement and may not be applicable for each inquiry. We recommend NAIC make the additional documentation outside of federal guidance be at the request of the regulators. This will help streamline the regulators' investigations to focus on the documents specific to the individual inquiries as all resources may not be applicable for each inquiry.

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

Review Procedures and Criteria

The health carrier shall identify which independent standards were used to define mental health conditions, substance use disorders and medical/surgical conditions.

The health carrier shall specify applicable state statutes or guidelines that stipulate the standard or definition of mental health conditions, substance use disorders, or medical/surgical conditions.

The carrier shall identify excluded diagnoses and stipulate that such exclusions are not prohibited by state or federal law.

The health carrier shall identify how it defines items or services as mental health benefits, substance use disorder benefits, or medical/surgical benefits, including items and services that are sometimes used for the treatment of mental health or substance use disorders and medical/surgical conditions (e.g., nutritional counseling, occupational therapy).

Commented [A4]: This is a significant amount of information being requested. It is greater than what is required under federal enforcement and may add significant burden to regulators' reviews. Instead of identifying excluded diagnoses, we recommend asking issuers to identify that they meet state mandates.

Commented [A5]: We recommend aligning with the federal law here, which defines MH/SUD benefits as "benefits with respect to items or services for mental health conditions."

**Standards for
Mental Health and Substance Use Disorder Parity Compliance**

Standard 2

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

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

Documents to be Reviewed

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

Others Reviewed

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

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

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

Publication of summary plan description
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Commented [A6]: This is a significant amount of information being requested. It is greater than what is required under federal enforcement and may not be applicable for each inquiry. We recommend NAIC make the additional documentation outside of federal guidance be at the request of the regulators. This will help streamline the regulators' investigations to focus on the documents specific to the individual inquiries as all resources may not be applicable for each inquiry.

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

Review Procedures and Criteria

The health carrier shall provide a list that specifies to which classification (or applicable sub-classification) all benefits were assigned.

The health carrier shall identify which, if any, benefits were classified into sub-classifications. Please note that the only permissible sub-classifications are: multiple tiers for prescription drugs benefits that are based on reasonable factors¹ (45 CFR § 146.136(c)(3)(iii)(A)); multiple network tiers that are based on reasonable factors within the inpatient in-network and outpatient in-network classifications (45 CFR § 146.136(c)(3)(iii)(B)); outpatient office visits and outpatient other services within the outpatient in-network and outpatient out-of-network classifications (45 CFR § 146.136(c)(3)(iii)(C)). The carrier shall retain sub-classifications for all parity analyses and testing for financial requirements, quantitative treatments limitations and nonquantitative treatment limitations.

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

The health carrier shall demonstrate that mental health or substance use disorder benefits are covered in each classification in which medical/surgical benefits are covered.

Commented [A7]: Our understanding is that subclassifications are voluntary under MHPAEA. In addition, all testing for MHPAEA is done on a policy by policy (plan by plan) basis and, therefore, federal law does not require that if a plan/issuer subclassifies for one policy/plan that the plan/issuer must subclassify for all policies/plans. We recommend aligning with these standards.

¹ Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up (45 CFR § 146.136(c)(3)(iii)(A))

**Standards for
Mental Health and Substance Use Disorder Parity Compliance**

Standard 3

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

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

Documents to be Reviewed

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

Others Reviewed

- Enforcement of the Public Health Services Act
42 U.S. Code § 300gg-22
- Preemption relating to the Public Health Services Act
42 U.S. Code § 300gg-23
- Mental Health Parity and Addiction Equity Act of 2008
42 U.S. Code § 300gg-26
- Publication of summary plan description
ERISA 104(b) (29 U.S.C. § 1024(b))

Commented [A8]: As referenced for Standard 7, we recommend NAIC amend language on written communications between the carrier and the vendor to focus on the contractual terms between the health plan and vendor. This level of detail would impose significant burden on regulators and is the responsibility and standard practice of health plans to ensure alignment and compliance when engaging vendors.

Commented [A9]: This is a significant amount of information being requested. It is greater than what is required under federal enforcement and may not be applicable for each inquiry. We recommend NAIC make the additional documentation outside of federal guidance be at the request of the regulators. This will help streamline the regulators' investigations to focus on the documents specific to the individual inquiries as all resources may not be applicable for each inquiry.

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

Review Procedures and Criteria

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

The health carrier shall demonstrate the reasonable method used to perform the analysis that determines expected plan payments within each classification of benefits (or applicable sub-classification) for medical/surgical benefits. A carrier must always use appropriate and sufficient data to perform the analysis in compliance with applicable Actuarial Standards of Practice (ACA FAQ 34 Q3).

The health carrier shall demonstrate that any type of financial requirement applied to mental health or substance use disorder benefits in a classification (or applicable sub-classification) applies to at least two-thirds of expected plan payments on medical/surgical benefits within that classification (or applicable sub-classification) (45 CFR § 146.136(c)(3)(i)(A)). If no cost analysis was relied upon within this demonstration, the carrier shall specify how it concluded that the substantially all test was satisfied (e.g., it applies the financial requirement to all medical/surgical benefits within the classification). No financial requirements shall apply only to mental health or substance use disorder benefits.

The health carrier shall demonstrate that the level of financial requirement applied to mental health or substance use disorder benefits in a classification (or applicable sub-classification) is comparable and no more restrictive than the level of financial requirement that applies to more than one-half of expected plan payments that are subject to the financial requirement within that classification for medical/surgical benefits (45 CFR § 146.136(c)(3)(i)(B)(1)). The carrier shall demonstrate how it combined levels of the financial requirement to satisfy the predominant test if there is no single level that applies to more than one-half of medical/surgical benefits in the classification (45 CFR § 146.136(c)(3)(i)(B)(2)).

Standards for
Mental Health and Substance Use Disorder Parity Compliance

Standard 4

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

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

Documents to be Reviewed

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

Others Reviewed

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

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

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

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

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Commented [A10]: As referenced for Standard 7, we recommend NAIC amend language on written communications between the carrier and the vendor to focus on the contractual terms between the health plan and vendor. This level of detail would impose significant burden on regulators and is the responsibility and standard practice of health plans to ensure alignment and compliance when engaging vendors.

Commented [A11]: This is a significant amount of information being requested. It is greater than what is required under federal enforcement and may not be applicable for each inquiry. We recommend NAIC make the additional documentation outside of federal guidance be at the request of the regulators. This will help streamline the regulators' investigations to focus on the documents specific to the individual inquiries as all resources may not be applicable for each inquiry.

Review Procedures and Criteria

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

The health carrier shall demonstrate the reasonable method used to perform the analysis that determines expected plan payments within each classification of benefits (or applicable sub-classification) for medical/surgical benefits. A carrier must always use appropriate and sufficient data to perform the analysis in compliance with applicable Actuarial Standards of Practice (ACA FAQ 34 Q3).

The health carrier shall demonstrate that any type of QTL applied to mental health or substance use disorder benefits in a classification (or applicable sub-classification) applies to at least two-thirds of expected plan payments on medical/surgical benefits within that classification (or applicable sub-classification) (45 CFR § 146.136(c)(3)(i)(A)). If no cost analysis was relied upon within this demonstration, the carrier shall specify how it concluded that the substantially all test was satisfied (e.g., it applies the quantitative limitation to all medical/surgical benefits within the classification). No quantitative treatment limitations shall apply only to mental health or substance use disorder benefits.

The health carrier shall demonstrate that the level of QTL applied to mental health or substance use disorder benefits in a classification (or applicable sub-classification) is no more restrictive than the level of QTL that applies to more than one-half of expected plan payments that are subject to the quantitative treatment limitation within that classification for medical/surgical benefits (45 CFR § 146.136(c)(3)(i)(B)(1)). The carrier shall demonstrate how it combined levels of the QTL to satisfy the predominant test If there is no single level that applies to more than one-half of medical/surgical benefits in the classification (45 CFR § 146.136(c)(3)(i)(B)(2)).

**Standards for
Mental Health and Substance Use Disorder Parity**

Standard 5

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

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

Documents to be Reviewed

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

_____ A list of all NQTLs imposed upon mental health or substance use disorder benefits within each classification of benefits (or applicable sub-classification), including the methodology used to determine those NQTLs. A state may focus its review on a subset of NQTLs rather than all NQTLs. (See reference link to DOL Self-Compliance Tool for a non-exhaustive list)

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

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

_____ Company claim procedure manuals and bulletins/communications

_____ Claims processor and customer services MHPAEA training materials

_____ Internal company claim audit reports

_____ Prescription drug formulary for each product/plan design

_____ Prescription drug utilization management documentation

_____ Fail-first policies or step therapy protocols

_____ Network development/contracting policies and procedures

_____ Standards for provider admission to participate in a network, including credentialing requirements

Commented [A12]: We recommend NAIC identify a subset of rather than requiring a list of all NQTLs. This can help regulators focus on the most pressing needs. For the initial focus areas, we recommend NAIC align with the initial four NQTLs identified by the federal Tri-agencies.

Commented [A13]: This is a significant amount of information being requested. It is greater than what is required under federal enforcement and may not be applicable for each inquiry. We recommend NAIC make the additional documentation outside of federal guidance be at the request of the regulators. This will help streamline the regulators' investigations to focus on the documents specific to the individual inquiries as all resources may not be applicable for each inquiry.

Commented [A14]: Our understanding is that fraud, waste, and abuse is not listed as an NQTL. We would recommend removing this language or clarifying why it is included here.

Commented [A15]: This is a significant amount of information being requested. It is greater than what is required under federal enforcement and may not be applicable for each inquiry. We recommend NAIC make the additional documentation outside of federal guidance be at the request of the regulators. This will help streamline the regulators' investigations to focus on the documents specific to the individual inquiries as all resources may not be applicable for each inquiry.

- _____ Standards for determining provider reimbursement rates
- _____ Samples of provider/facility contracts in use during the exam period
- _____ Plan methods for determining usual, customary and reasonable charges for each product/plan design

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

Commented [A16]: Can you clarify how this would be related to a parity review?

_____ Mental health and/or substance use disorder and medical/surgical utilization review

_____ Management files (prospective, concurrent and retrospective)

Commented [A17]: Can you clarify what a management file would be?

_____ Complaint files, logs and disposition notes

Commented [A18]: Can you clarify how this would be related to a parity review?

_____ Documentation, including but not limited to comparative analyses, demonstrating that within each of the 6 classifications of benefits (and applicable sub-classifications), the as written and in operation processes, strategies, evidentiary standards, or other factors used in applying a NQTL are comparable to and applied no more stringently to mental health or substance disorder benefits than to medical/surgical benefits in the classification.

Others Reviewed

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

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

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

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

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

Review Procedures and Criteria

The health carrier shall perform and document comparative analyses demonstrating that within any classification of benefits, as written and in operation, the process, strategies, evidentiary standards, or other factors used in applying an NQTL to mental health or substance disorder benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification. The comparative analyses shall include the following, for each NQTL applied to mental health or substance use disorder benefits, separately for each classification of benefits (42 U.S.C. § 300gg-26(a)(8)(A)):

- The specific coverage terms or other relevant terms regarding the NQTL and a description of all mental health or substance use disorder and medical or surgical benefits to which such NQTL applies in each respective benefits classification;

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

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

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

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

1. Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis;
2. Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations;
3. Identification of processes, strategies, sources and factors without the required or clear and detailed comparative analysis;
4. Identification of factors, evidentiary standards and strategies without a clear explanation of how they were defined and applied in practice;

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5. Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application; and
6. Analysis that is outdated due to the passage of time, a change in plan structure, or for any other reason.

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**Standards for
Mental Health and Substance Use Disorder Parity Compliance**

Standard 6

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

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

Documents to be Reviewed

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

Others Reviewed

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

Review Procedures and Criteria

The health carrier shall demonstrate the method by which it makes available to any current or potential participant, beneficiary, or contracting provider upon request the medical necessity criteria used to make mental health or substance use disorder medical necessity determinations (45 CFR § 146.136(d)(1)). This shall include a reporting of how the health carrier ensures prompt release of the criteria upon request.

The health carrier shall demonstrate that it provides the reason for any denial of reimbursement for mental health or substance use disorder benefits (45 CFR § 146.136(d)(2)).

The health carrier shall demonstrate its method for responding to requests for all documents, records and other information relevant to the claimant's claim for benefits after an adverse benefit determination (45 CFR § 146.136(d)(3)). This shall include the health carrier's protocol for ensuring that it discloses medical necessity criteria for both medical/ surgical benefits and mental health and substance use disorder benefits, as well as disclosures pertaining to the processes, strategies, evidentiary standards and other factors the health carrier used to apply a NQTL with respect to medical/ surgical benefits and mental health or substance use disorder benefits under the plan, when those specific items are requested.

Commented [A19]: We recommend revising to align with the PHSA and ERISA timing requirements for disclosures as those are established, measurable standards.

DRAFT

Standards for
Mental Health and Substance Use Disorder Parity Compliance

Standard 7

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

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

Documents to be Reviewed

- _____ Contractual agreements between the carrier and vendors having administrative, claims and/or medical management responsibilities
- _____ Policies and procedures for ensuring availability of health carrier information needed for vendor analysis of compliance with MHPAEA
- _____ A narrative summary outlining how the vendor and the carrier coordinate to ensure compliance with MHPAEA
- _____

Others Reviewed

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

Review Procedures and Criteria

The health carrier shall provide documentation of the protocols and procedures in place to ensure that any contracted vendor that provides mental health or substance use disorder benefits is collaborating with the health carrier to satisfy compliance with MHPAEA. This shall include explanation of how both the design of benefits and the application of benefits, in operation, are compliant with MHPAEA.

Commented [A20]: While we agree that the health carrier must ensure that any contracted vendor that provides mental health or substance use disorder benefits is collaborating to satisfy compliance, we do not believe this standard is specific to MHPAEA. For any law that the issuer is subject to and for which the issuer contracts with an entity to provide services, this coordination is necessary. However, it is not typically investigated by regulators, as proposed in this Handbook. This level of oversight will require significant resources by state regulators to perform a function that the plan or issuer is required to perform. In addition, as written, the Handbook requires submission of all written communications, which could include emails, working documents, drafts, and other communications that may not be relevant to how the entities coordinate to achieve compliance. As such, we recommend limiting the burden on regulators and focusing these reviews on the contractual terms between the health plan and vendor.