

Date: 7/12/22

*Virtual Meeting*

**MARKET CONDUCT EXAMINATION GUIDELINES (D) WORKING GROUP**

Thursday, July 14, 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 Towsen	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 June 9 Minutes—*Damion Hughes (CO)* Attachment 1
2. Consider Adoption of Revisions to Chapter 20—General Examination Standards of the *Market Regulation Handbook*, July 6 Draft— *Damion Hughes (CO)* Attachment 2
3. Consider Adoption of Revisions to Chapter 1—Introduction of the *Market Regulation Handbook*, July 6 Draft—*Damion Hughes (CO)* Attachment 2a
4. Consider Adoption of Revisions to Chapter 24B—Conducting the Mental Health Parity and Addiction Equity Act (MHPAEA)-Related Examination of the *Market Regulation Handbook*, July 11 Draft—*Erica Weyhenmeyer (IL)* Attachment 3

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

6. Adjournment

Draft: 6/16/22

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

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

1. Heard Opening Remarks

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

2. Adopted its April 21 Minutes

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

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

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

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

Gabrielle Griffith (ACLI) said the word “determine” in the Review Procedures and Criteria section of Operations/Management Standard 1 is of concern; she suggested that the Working Group change “determine” to instead read “review or discuss with the domestic should there be an issue with ORSA, LST or GCC-related

information.” She also recommended that the references to the group capital calculation (GCC) and liquidity stress test (LST) be removed from Marketing and Sales Standard 1; alternatively, she said the references could instead be made more generic to apply to all prohibited marketing activity for any of the model references listed in Marketing and Sales Standard 1.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

be changed to the following:

Verify that the insurer has adequate procedures in place for monitoring that sales are made in compliance with comparable standards as defined in Section 6(E)(5) of Model #275. Sales made in compliance with comparable standards shall satisfy the requirements under this regulation. This subsection applies to all recommendations and sales of annuities made by financial

professionals in compliance with business rules, controls and procedures that satisfy a comparable standard even if such standard would not otherwise apply to the product or recommendation at issue. However, nothing in this subsection shall limit the insurance commissioner’s ability to enforce (including investigate) the provisions of this regulation.

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

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

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

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

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

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

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

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

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

- Clarification needs to be added to the chapter that the MHPAEA does not apply to all types of health insurance products.
- There are instances in the chapter where there is a lengthy list of documents to review, which do not necessarily align with the review procedures and criteria, and there is no information provided in the review procedures and criteria to instruct examiners why they need to review the documents.

- To shorten Standard 1 and remove some of the language from the standard itself into the Review Procedures and Criteria section of Standard 1.
- Standard 6 is lengthy and Missouri suggests that it be broken up into four separate examination standards.
- Standards 6 and 7 should cite back to other standards from relevant chapters, such as Chapter 20 Operations/Management Standard 6 and Chapter 24 Utilization Review Standards 1, 2, and 5.

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

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

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

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

Randi Chapman (BCBSA) presented the BCBSA comments. She said she agrees with AHIP's comments on Standard 7 regarding health carriers and vendors/third-party service providers, as outlined by Ms. Stringer. She said the proposed documents to be submitted in the exposure draft go beyond federal guidance. She suggested that the exposure draft instead be aligned with the federal standards for required documents and any additional documentation be provided at the request of state insurance regulators. She suggested that Standard 5 be changed to identify a subset of NQTLs so state insurance regulators can have a more targeted approach. She said the Tri-Departments will set forth additional guidance on MHPAEA compliance and a second report to the U.S. Congress (Congress) this year, and she requested that the NAIC delay finalizing this exposure draft until that time so the guidance in the exposure draft can better align with federal MHPAEA guidance.

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

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

#### 6. Discussed Other Matters

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

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



## 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](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.

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**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*

**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.

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.

**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 acknowledgment 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.

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**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](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](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 undertake 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)**

<b>REVIEW CRITERIA</b>	<b>NOTES (YES, NO, NOT APPLICABLE, OTHER)</b>
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)**

<b>REVIEW CRITERIA</b>	<b>NOTES (YES, NO, NOT APPLICABLE, OTHER)</b>
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**  
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**NOTICE TO COMMISSIONER/DIRECTOR OF INSURANCE (Section 6) (CONT'D)**

<b>REVIEW CRITERIA</b>	<b>NOTES (YES, NO, NOT APPLICABLE, OTHER)</b>
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)**

<b>REVIEW CRITERIA</b>	<b>NOTES (YES, NO, NOT APPLICABLE, OTHER)</b>
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**

<b>REVIEW CRITERIA</b>	<b>NOTES (YES, NO, NOT APPLICABLE, OTHER)</b>
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**

<b>REVIEW CRITERIA</b>	<b>NOTES (YES, NO, NOT APPLICABLE, OTHER)</b>
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 \(#440\), Section 8G\*](#)

## **IIPRC Uniform Standard References**

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

### **Review Procedures and Criteria**

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

Materials should not:

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

Materials should:

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

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

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

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

For the review of Internet advertisements:

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

For the review of social media:

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

**Automation Tip:**

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

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

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

**STANDARDS  
MARKETING AND SALES**

**Standard 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 intended, 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.

DRAFT

**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.

DRAFT

**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.

DRAFT

**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.

DRAFT

**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.

DRAFT

**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.

DRAFT

**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.

DRAFT

**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

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**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.

## Chapter 1—Introduction

### A. Resources Available to Market Regulation Professionals

The evolving market regulation process necessitates the need for identification of key players, as well as the need for increased communication. There are many new players that have been identified and many tools have been created to help facilitate this communication.

#### **Collaborative Action Designee (CAD)**

The Collaborative Action Designee (CAD) is the one contact identified by the director/commissioner of each state/territory to have full responsibility for all communications related to market regulation collaborative efforts. This includes participating, or assigning a designee to participate, in Market Actions (D) Working Group meetings or conference calls. While the Market Analysis Chief (MAC) oversees the internal state process of identifying entities with potential market regulatory issues, the CAD oversees the process of communicating about those entities and collaborating with other CADs, potentially through the Market Actions (D) Working Group. The CAD and MAC are responsible for exchanging information with other state insurance departments via the NAIC Market Regulation and Market Analysis bulletin boards.

#### **Consumer Assistance Bulletin Board**

The NAIC Consumer Assistance Bulletin Board is a regulator-only bulletin board designed for state consumer services regulators to communicate global issues, concerns, questions and information about consumer services issues. The bulletin board is available on iSite+ and on StateNet.

#### **Core Competencies**

Core competencies were developed by regulators to meet expectations from consumers, the insurance industry and all interested parties for effective state-based regulatory oversight of the insurance marketplace. Core competency standards are uniform standards that measure an individual state insurance department's overall ability to effectively and efficiently regulate the insurance marketplace. The four broad categories of core competency are set forth below. The currently adopted core competency standards are contained within Chapter 5 of this handbook.

- Resources—Standards regarding a state's regulatory authority, staff and training, and standards relating to a state's utilization of contract examiners;
- Market Analysis—Standards regarding market analysis, data collection, the role and responsibilities of a state insurance department Market Analysis Chief (MAC) and required skills and knowledge of a market analyst;
- Continuum—Standards regarding the use of continuum options, market conduct examinations, investigations and consumer complaints; and
- Interstate Collaboration—Standards regarding the NAIC Collaborative Actions Guide document and the role and responsibilities of a state insurance department Collaborative Action Designee (CAD).

#### **Market Action Tracking System (MATS)**

The Market Action Tracking System (MATS) allows market conduct examiners and analysts to communicate schedules and results of examinations and other market actions. MATS allows for the calling of market conduct examinations and non-examination inquiries and market actions, in addition to providing easy access to complete information about the entities involved in the action. Market actions captured in MATS are: comprehensive examinations, targeted examinations, focused inquiries (typically inquiries made of multiple market participants) and other non-examination regulatory interventions.



### **Market Actions (D) Working Group**

The NAIC Market Actions (D) Working Group is the national forum to identify and address issues of multistate concern and for states to coordinate multistate regulatory actions, including market conduct examinations. States can explore, for example, whether they are targeting the same companies, nationally or regionally. The more states that follow this handbook, the better the Market Actions (D) Working Group will be able to function, and the more effective the Working Group's market oversight will become.

The Market Actions (D) Working Group consists of a minimum of 16 members and their alternates, and provides policy oversight and direction to the Collaborative Action Designees (CADs), facilitates interstate communication, recommends appropriate corrective actions, coordinates collaborative state regulatory actions and facilitates the use of a broader continuum of market actions. The Working Group focuses its efforts on those nationally significant insurers that exhibit characteristics indicating current or potential market regulatory issues that impact multiple jurisdictions.

### **Market Analysis Bulletin Board**

The NAIC Market Analysis Bulletin Board is a regulator-only bulletin board designed for state market analysts to communicate issues, questions, concerns and information about the market analysis process. The bulletin board is available on iSite+ and on StateNet.

### **Market Analysis Chief (MAC)**

The Market Analysis Chief (MAC) is the principal liaison with the NAIC Market Regulation Department and the Market Analysis Procedures (D) Working Group and is responsible for communication with other work units within the department. The CAD and MAC are responsible for communicating with other state insurance departments via the NAIC Market Regulation and Market Analysis bulletin boards.

### **Market Analysis Prioritization Tool (MAPT)**

The Market Analysis Prioritization Tool (MAPT), released in 2006, expanded upon the Market Analysis Company Listings<sup>1</sup> by creating a scoring system so companies can more easily be prioritized. MAPT is designed to provide regulators with a web-based tool that serves as a starting point in the analysis process by prioritizing companies for further analysis. This prioritization of companies allows states to better focus their resources and to develop more efficient regulatory policies and practices. MAPT utilizes key market and financial components, from state and national sources, to generate weighted ratios on which the prioritization is based. Key market regulation components vary by line of business. They include, but are not limited to: losses, expenses and premiums; enrollments, market components, regulatory actions, complaints, examinations and demographics.

### **Market Analysis Review System (MARS)**

The Market Analysis Review System (MARS) is available to specific state regulator users for the purpose of tracking, recording and reviewing Level 1 Analysis and Level 2 Analysis completed by other state regulators.

### **Market Conduct Annual Statement (MCAS)**

The Market Conduct Annual Statement (MCAS) was developed with the input of state regulators and representatives from the insurance industry. It provides an analysis tool for certain key market data elements that help regulators allocate market analysis resources where they can be most effective. States participating in MCAS intend to review their markets and share the results of their respective analyses and work to coordinate any needed responses or examinations.

### **Market Information Systems (MIS)**

The Market Information Systems (MIS) are regulator-only databases containing information related to the iSite+ market applications, which include the Complaints Database System (CDS), Market Action Tracking System (MATS) and the Regulatory Information Retrieval System (RIRS).

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<sup>1</sup> As of December 2009, the Market Analysis Company Listings report is no longer available. The data elements and functionality contained within the Market Analysis Company Listings report were incorporated into the Market Analysis Prioritization Tool, as described in Section D of Chapter 7.

### **Market Regulation Bulletin Board**

The Market Regulation Bulletin Board is a regulator-only bulletin board designed for state market conduct regulators to communicate global issues, concerns and information about entities engaged in the business of insurance or the specific rules/laws that help govern the industry. The bulletin board is available on iSite+ and on StateNet.

### **NAIC Staff/Research Resources**

The NAIC offers financial, actuarial, legal, computer, research, market conduct and economic expertise. The NAIC Market Regulation Department supports state insurance regulators in fulfilling the state insurance departments' responsibility of protecting the interests of insurance consumers by helping coordinate state market regulatory functions, such as consumer complaints, market analysis, producer licensing and regulatory interventions.

The NAIC Market Regulation Department offers education and training to regulators and non-regulators in various formats: as instructor-led sessions, webinars, online training and web-based "on-demand" training. Some of the areas/topics in which the Market Regulation Department has provided training include: Baseline Analysis, Market Analysis Techniques, Producer Licensing, Consumer Assistance Training, Market Conduct Examinations and Market Conduct Annual Statement data collection and analysis. Other NAIC education and training topics will continue to be added in the future.

The NAIC Financial Regulatory Services Department provides technical expertise in areas of financial regulation, solvency regulation, financial reporting, as well as other financial-related expertise.

The NAIC Research Library supports state insurance department regulators and NAIC staff by providing a free inquiry and reference service and maintaining an extensive archive of NAIC publications. Research librarians answer information requests on a variety of issues and strive to provide responses to regulators within 24 hours.

The NAIC Help Desk provides technical support and customer service for NAIC applications, products and services to enhance productivity within the insurance regulatory community. Regulators may access NAIC Help Desk services at 816-783-8500 or via email at [help@naic.org](mailto:help@naic.org).

## **B. Resources Within State Insurance Departments**

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

### **Market Conduct and Financial Examinations**

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

### **Financial Analysis**

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

### **Rates and Forms Information**

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

### **Organized Intra-Department Communication**

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

### **C. myNAIC**

MyNAIC was created by the NAIC in June 2016 as web page from which publicly available NAIC tools can be accessed, and also as a web page which allows regulators to have a single page from which to access regulator-only NAIC/NIPR/IIPRC tools. Regulators may access myNAIC by clicking on the myNAIC link on [www.naic.org](http://www.naic.org); regulators may then login to the regulator-only portion of myNAIC by clicking on “Login” in the upper right corner of the myNAIC public applications web page. The applications on the myNAIC regulator-only web page are based upon the roles associated with a regulator’s iSite+ password and user ID.

### **D. Center for Insurance Policy Research (CIPR)**

The Center for Insurance Policy and Research (CIPR) provides research and education to drive discussion and advance thought leadership as well as action on current and emerging insurance issues amongst state insurance regulators, the insurance industry, academics and other policymakers. This is achieved through a series of integrated research activities including: 1) hosting big picture insurance market issue programs (e.g., the State of Long-Term Care Insurance) as well as more focused research policy sessions (TRIA policy workshop) at NAIC National Meetings; 2) publishing CIPR-developed research on NAIC key initiatives as well as facilitating the wide distribution of rigorous, high-quality research from the academic community regarding insurance regulatory issues through the *Journal of Insurance Regulation*; 3) application of research findings to regulatory operations via various training curriculums; and 4) the maintenance of numerous issue briefs on the CIPR website that explain complex insurance issues and link to relevant state insurance supervisory activity, with these topics linked to the extensive NAIC library collection.

The CIPR website contains research content touching all aspects of insurance regulation. The Topics & Key Initiatives section of the website contains issue briefs for dozens of key insurance regulatory issues. The Events & Education section lists information on CIPR events, both in-person and online. The *Journal of Insurance Regulation* provides open access to this NAIC peer-reviewed journal, featuring evidence-based research from academics and other experts. The NAIC Library section contains the NAIC archives, including the complete collection of the NAIC Proceedings, as well as thousands of other insurance-related resources, and the CIPR Newsroom section provides access to a complete listing of CIPR research content.

## E. The Interstate Insurance Product Regulation Commission (IIPRC)

The Interstate Insurance Product Regulation Compact (Compact) is an agreement, which is enacted by law, amongst member states (“compacting states”) to participate in a multistate regulatory system for the filing, review and approval of asset-based insurance products, including individual and group life, annuities, long-term care and disability income insurance. The Compact established a multistate public entity, the Interstate Insurance Product Regulation Commission (IIPRC). The IIPRC is a member-driven organization that serves as a central point of filing, review and approval for asset-based insurance products under detailed and comprehensive uniform standards.

The IIPRC website is [www.insurancecompact.org](http://www.insurancecompact.org) and includes the Compact legislation, as well as the IIPRC bylaws, annual reports, budgets, uniform standards, operating procedures and other relevant tools, tutorials and information. In June 2007, the IIPRC became operational and received its first product filings. As of June 2021, more than 360 companies have filed one or more product filings with the IIPRC for approval since June 2007. The uniform standards require that all forms submitted for approval to the IIPRC have a form identification number in the lower left-hand corner where the form number must include a prefix of “ICCxx” (where “xx” represents the appropriate year the form was submitted for filing). Within the NAIC System for Electronic Rate and Form Filing (SERFF), compacting states have read-only access to product filings submitted to the IIPRC for approval and use in their respective state (each compacting state administers the roles and access to the IIPRC information stored within SERFF). Regulators may want to refer to the IIPRC map on the IIPRC website, which shows the compacting states in yellow.

The uniform standards are the applicable content requirements for Compact-approved products rather than state-specific content requirements and laws. When working with an IIPRC-approved product, market regulators should be familiar with the uniform standards as they are the applicable requirements of the provisions and content of the IIPRC-approved forms.

Compacting states work together to develop strong and detailed uniform standards for the content of asset-based products that protect consumers equally across the compacting states. Companies use these uniform standards to submit a set of standard forms in a product filing to the IIPRC. The IIPRC reviews these product filings, working with the filer toward compliance and approval in an average review time of much less than the required 60-day turnaround time.

The IIPRC’s uniform standards development and rulemaking process has continually demonstrated state insurance regulators work collaboratively with their fellow regulators among the compacting states to address concerns about the uniform standards, which generally results in further strengthening the standards. On its rulemaking docket located on the IIPRC website, the IIPRC publishes draft uniform standards in the rulemaking process that are being considered by the compacting states. When uniform standards are adopted, the IIPRC publishes these uniform standards, along with all relevant rulemaking material, on its rulemaking record on the IIPRC website.

The IIPRC includes one member from each of the compacting states, which is generally the state’s chief insurance regulator. The IIPRC operates in an open and transparent manner, holding public hearings and soliciting public comments as a fundamental part of its decision-making process. The IIPRC, its management committee and its other committees regularly request input from a legislative committee, an industry advisory committee, a consumer advisory committee and interested parties.

As of June 2021, the IIPRC has adopted over 100 uniform standards covering a wide range of products and benefit features for the four individual asset-based insurance product lines authorized by the Compact as well as for group life, annuities and disability income insurance products, specifically for employer/employee groups. As authorized by the Compact, the IIPRC reviews rate filings for individual long-term care and disability income insurance products, as well as advertising associated with IIPRC-approved individual long-term care insurance products.

## F. Other Regulatory Sources

### Federal Regulators and Databases

Expanded information sharing with federal regulators assists both state and federal regulators in conducting more efficient and effective oversight. States can enhance information sharing by reporting information to federal databases, such as the National Practitioner Data Bank (NPDB), which contains information on medical malpractice payments and certain adverse actions related to health care practitioners, entities, providers and suppliers. To eliminate NPDB data reporting/querying overlap with the Healthcare Integrity and Protection Data Bank (HIPDB), the U.S. Congress passed Section 6403 of the *Affordable Care Act of 2010* (ACA), Public Law 111-148. As a result of the legislation, effective May 6, 2013, NPDB operations were consolidated with those of the former HIPDB. Information previously collected and disclosed by the HIPDB is collected and disclosed by the NPDB. Regulators may also pursue access to other federal databases (for example, the FBI database for producer licensing purposes). Each state should have ongoing arrangements with the various federal financial services regulators to share consumer complaint information arising out of cross-sector market activities.

The U.S. Securities and Exchange Commission (SEC) oversees the key participants in the securities world, including securities exchanges, securities brokers and dealers, investment advisors and mutual funds. The SEC is concerned primarily with promoting the disclosure of important market-related information, maintaining fair dealing and protecting consumers against fraud. The SEC website [www.sec.gov](http://www.sec.gov) provides information on publicly held companies, as well as on entities licensed to sell securities products. The SEC's Electronic Data Gathering, Analysis and Retrieval (EDGAR) database provides free public access to disclosure documents that public companies are required to file with the SEC, allowing the user to research a company's financial information and operations by reviewing registration statements, prospectuses and periodic reports.

### Other States

Many states require that insurance companies provide specific filings or reports in response to previously identified issues. An inventory of such filings may produce valuable information. It is helpful to state insurance regulators to have ongoing email and phone communications about companies and issues of common concern with state insurance regulators in other insurance departments. Regulators in neighboring states with specialized expertise on particular issues are especially helpful.

### Regulatory Meetings

NAIC meetings and training seminars provide valuable opportunities to share information. The same is true for other forums, such as meetings of the National Conference of Insurance Legislators (NCOIL), the Insurance Regulatory Examiners Society (IRES), the Society of Financial Examiners (SOFE) and insurance trade association meetings.

### Other Regulatory Agencies within a State Insurance Department

Regulators who oversee market conduct of insurance companies have areas of common concern with various other state agencies, including the agencies that regulate health care, workers' compensation and consumer protection. These agencies can be valuable sources of information and assistance.

## G. Industry Sources

### Financial Rating Agencies

There are five major financial rating agencies that review insurance companies. Each has its own unique methodology for assigning ratings. More information can be found for each rating agency at the links provided below.

**A.M. Best Company:** The A.M. Best Company has been rating insurance companies since 1900. The objective of A.M. Best's rating system is to evaluate the factors affecting the overall performance of an insurance company and to provide its opinion as to the company's relative financial strength and ability to meet its contractual obligations. Ratings are available at [www.ambest.com](http://www.ambest.com).

**Fitch Ratings:** Fitch Ratings was founded as the Fitch Publishing Company in 1913. Fitch’s rating evaluations are qualitative and quantitative and provide two basic types of ratings—insurer financial strength ratings and issuer and fixed income security ratings. Fitch Ratings are available at [www.fitchratings.com](http://www.fitchratings.com).

**Moody’s Investors Service:** Moody’s Investors Service was founded in 1900. Moody’s insurance financial strength ratings reflect its opinion as to an insurer’s ability to meet senior policyholder claims and obligations. Ratings are available at [www.moodys.com](http://www.moodys.com).

**Standard & Poor’s:** Standard & Poor’s (S&P) has been rating bonds since 1923 and insurance companies’ claims-paying ability since 1983. Standard & Poor’s claims-paying ability rating is an assessment of an operating insurance company’s financial capacity to meet its policyholder obligations in accordance with its terms. Ratings are available at [www.standardandpoors.com](http://www.standardandpoors.com).

**Weiss Ratings, LLC** (formerly TheStreet.com): In 2006, Weiss Group sold Weiss Ratings to TheStreet.com. In 2010, TheStreet.com sold the insurance and bank ratings back to the Weiss Group. Weiss’ financial strength rating indicates its opinion regarding an insurer’s ability to meet its commitments to its policyholders under current economic conditions. Ratings are available at [www.weissratings.com](http://www.weissratings.com).

## H. Public Information Sources

### Center for Economic Justice (CEJ) Data Guide

In 1999, the Center for Economic Justice, a consumer advocacy group based in Austin, Texas, published *A Consumer Advocate’s Guide to Getting, Understanding and Using Insurance Data*. As explained in the introduction to the guide: “This handbook provides an introduction to the topic of auto and homeowners insurance data and ratemaking. This handbook attempts to serve as a tool kit for consumer advocates working on insurance issues by discussing the sources, uses and misuses of insurance data.”

### Legal Actions

Monitoring of litigation may alert regulators to issues that the regulatory system has not yet addressed. There are many class action websites available on the Internet, such as Westlaw and Lexis/Nexis.

### Consumer and Community Groups

Regular communication with consumer and community groups can help regulators identify and address issues of consumer concern. Educating consumers on insurance matters and where to report concerns can increase complaints among groups, identifying possible trends.

### Trade Press/Research Papers

Trade publications and academic research papers inform regulators about emerging issues and other regulatory concerns.

### Consumer Advocacy Organizations

Consumer advocacy organizations represent consumer interests and address issues that impact the well-being of consumers. Some consumer advocacy organizations focus their efforts specifically on insurance-related issues and financial security of consumers. Consumer advocacy organizations typically conduct research, develop public education programs, and provide studies and reports to consumers.

## **I. Company Self-Audits**

Self-audits, when made available to regulators, can provide information about how particular market problems have been addressed by insurers on a voluntary basis. The growing use of self-audits and voluntary accreditation programs, such as the National Council on Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC) has the potential of providing regulators important information about companies. Many of these organizations require companies to actively monitor their compliance practices and take appropriate corrective actions when necessary. This information can provide useful insights regarding a company's commitment to establishing and maintaining a culture of compliance designed to continually improve their market conduct and compliance practices.

DRAFT

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

### **IMPORTANT NOTE:**

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

### **Introduction**

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

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

~~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 2021<sup>10</sup>) 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)).

**Classifications of benefits used for applying parity rules:**

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

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

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

**(3) Outpatient, In-network.** Benefits furnished on an outpatient basis and within a network of providers established or recognized under a plan or health insurance coverage. See special rules for office visits and plans with multiple network tiers in paragraph (c)(3)(iii) (C) and (c)(3)(iii)(B) of 45 CFR § 146.136 ~~(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 subclassification the reflect network tiers, if the tiering is based on reasonable factors determined in accordance with the rules for NQTLs (such as quality, performance, and market standards) and without regard to whether a provider provides services with respect to medical/surgical benefits or MH/SUD benefits. After the tiers are established the plan may not impose any financial requirements or treatment limitation on MH/SUD benefits in any tier that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the tier.

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

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

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

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

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

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

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

**Expected Plan Payments** are payments expected to be paid under the plan for the plan year (45 CFR § 146.136(c)(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 STANDARDS**  
**Mental Health and Substance Use Disorder Parity Compliance**

**Standard 1**

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

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

**Priority:** Recommended

**Documents to be Reviewed**

- \_\_\_\_\_ Applicable state and federal statutes, rules, regulations and published sub-regulatory guidance
- \_\_\_\_\_ Type of generally recognized independent standards of current medical practice, state law or guidance, used to define mental health conditions, substance use disorders and medical/surgical conditions (e.g., the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Statistical Classification of Diseases and Related Health Problems (ICD code), etc.)
- \_\_\_\_\_ List of specific mental health conditions or substance use disorders by diagnosis excluded from coverage as stated in the policy documents
- \_\_\_\_\_ Mental health and/or substance use disorder and medical/surgical claim files
- \_\_\_\_\_ Health carrier complaint/grievances/appeals records concerning mental health and/or substance use disorders (supporting documentation, including, but not limited to: written and phone records of inquiries, call center scripts, complaints, complainant correspondence and health carrier response)
- \_\_\_\_\_ Internal department appeals/grievance files
- \_\_\_\_\_ Applicable external appeals register/logs/files, external appeal resolution and associated documentation

**~~Others Reviewed~~ Other References**

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

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

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

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

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

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

## **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. 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.~~

~~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. 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.~~

~~The carrier shall identify excluded diagnoses and stipulate that such exclusions are not prohibited by state or federal law. 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 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). For services the health carrier has determined are both medical/surgical and mental health/substance use disorders, review the explanation of how they determine the correct expected dollar amount for these services (e.g., nutritional counseling, occupational therapy).~~

**Standards for STANDARDS**

**Mental Health and Substance Use Disorder Parity Compliance**

**Standard 2**

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

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

**Priority:** Recommended

**Documents to be Reviewed**

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

**~~Others Reviewed~~ Other References**

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

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

Mental Health Parity and Addiction Equity Act of 2008  
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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. Review the health carrier's list that specified the classification or sub-classification to which each benefit was assigned.~~

~~The health carrier shall identify which, if any, benefits were classified into sub-classifications. Determine whether the health carrier uses permissible sub-classifications for any benefits.~~

Please note that the only permissible sub-classifications are: multiple tiers for prescription drugs benefits that are based on reasonable factors<sup>1</sup> (45 CFR § 146.136(c)(3)(iii)(A)); multiple network tiers that are based on reasonable factors within the inpatient in-network and outpatient in-network classifications (45 CFR § 146.136(c)(3)(iii)(B)); outpatient office visits and outpatient other services within the outpatient in-network and outpatient out-of-network classifications (45 CFR § 146.136(c)(3)(iii)(C)). Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up (45 CFR § 146.136(c)(3)(iii)(A) Author note: the footnote #1 in the previous draft of this document has been incorporated within the text, instead of as a footnote.

~~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 t~~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.

~~The~~ Review the health carrier's documentation that shall demonstrate<sup>s</sup> that mental health or substance use disorder benefits are covered in each classification in which medical/surgical benefits are covered.

<sup>1</sup> Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up (45 CFR § 146.136(c)(3)(iii)(A) Author note, this footnote has been included within the text above and removed as a footnote.

~~Standards for~~ **STANDARDS**  
**Mental Health and Substance Use Disorder Parity Compliance**

**Standard 3**

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

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

**Priority:** Recommended

**Documents to be Reviewed**

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

~~Others Reviewed~~ Other References

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

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

Mental Health Parity and Addiction Equity Act of 2008  
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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)).

~~Review the~~ The health carrier's methodology for performing its analysis 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. 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 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).~~ Note: If the financial requirement applies to all medical/surgical benefits in the classification, no cost analysis is required. No financial requirements shall apply only to mental health or substance use disorder benefits.

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

**Standards for STANDARDS**

**Mental Health and Substance Use Disorder Parity Compliance**

**Standard 4**

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

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

**Priority:** Recommended

**Documents to be Reviewed**

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

**~~Others Reviewed~~ Other References**

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

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

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

Publication of summary plan description  
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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>

## 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 The health carrier shall demonstrate the reasonable method used methodology to for performing the-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 thatThe health carrier shall 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.~~

~~Determine whether The-the health carrier's documentation supports 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 (45 CFR § 146.136(c)(3)(i)(B)(2)). 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 STANDARDS****Mental Health and Substance Use Disorder Parity Compliance****Standard 5**

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

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

**Priority:** Recommended

**Documents to be Reviewed**

- \_\_\_\_\_ Applicable state and federal statutes, rules, regulations and published sub-regulatory guidance
- \_\_\_\_\_ A list of all NQTLs imposed upon mental health or substance use disorder benefits within each classification of benefits (or applicable sub-classification), including the methodology used to determine those NQTLs. A state may focus its review on a subset of NQTLs rather than all NQTLs. (See reference link to DOL Self-Compliance Tool for a non-exhaustive list) Note: Due to the significant number of potential NQTLs, it is advised that the examiner selects a targeted subset or sample of NQTLs based on examination resources, state specific concerns, company common practices, etc. to avoid the review of hundreds of service variations. Additional NQTLs can be phased into the review as appropriate.
- \_\_\_\_\_ Utilization management manuals and utilization review documents such as: utilization review criteria; criteria hierarchies for performing utilization review; case management referral criteria; initial screening scripts and algorithms; policies relating to reviewer discretion; processes for identifying and evaluating clinical issues and utilizing performance goals
- \_\_\_\_\_ Notes and/or logs kept during utilization review, such as those describing: peer clinical review; telephonic consultations with attending providers; consultations with expert reviewers; clinical rationale used in approving or denying benefits; the selection of information deemed reasonably necessary to make a medical necessity determination; adherence to utilization review criteria and criteria hierarchy; professional judgment used in lieu of utilization review criteria; actions taken when incomplete information is received from attending providers
- \_\_\_\_\_ Company claim procedure manuals and bulletins/communications
- \_\_\_\_\_ Claims processor and customer services MHPAEA training materials
- \_\_\_\_\_ Company fraud, waste, and abuse policies and procedures
- \_\_\_\_\_ Internal company claim audit reports
- \_\_\_\_\_ Prescription drug formulary for each product/plan design
- \_\_\_\_\_ Prescription drug utilization management documentation

- \_\_\_\_\_ Fail-first policies or step therapy protocols
- \_\_\_\_\_ Network development/contracting policies and procedures
- \_\_\_\_\_ Standards for provider admission to participate in a network, including credentialing requirements
- \_\_\_\_\_ Standards for determining provider reimbursement rates
- \_\_\_\_\_ Samples of provider/facility contracts in use during the exam period
- \_\_\_\_\_ Plan methods for determining usual, customary and reasonable charges for each product/plan design
- \_\_\_\_\_ Mental health and/or substance use disorder and medical/surgical claim files.
- \_\_\_\_\_ Mental health and/or substance use disorder and medical/surgical utilization review procedures
- \_\_\_\_\_ ~~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~~ Other References

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

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

Mental Health Parity and Addiction Equity Act of 2008  
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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**

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):

*Author's note: The above language shown in yellow (shown as stricken) is being added back to the above paragraph, the strike through has been retained so you can see what's being changed. With the above yellow highlighted language added back in, the paragraph would then read as follows:*

~~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.

**Standards for STANDARDS**

**Mental Health and Substance Use Disorder Parity Compliance**

**Standard 6**

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

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

**Priority:** Recommended

**Documents to be Reviewed**

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

**~~Others Reviewed~~ Other References**

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

**Review Procedures and Criteria**

Review theThe 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.~~

*Author's note: The above language shown in yellow (shown as stricken) is being added back to the above paragraph, the strike through has been retained so you can see what's being changed. With the above yellow highlighted language added back in, the paragraph would then read as follows:*

~~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~~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~~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 the comparative analysis required under (42 USC 300gg-26(a)(8)(A)), disclosures referenced above (45 CFR § 146.136(d)(3)) as referenced in ACA FAQ 45-Q6. ~~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.~~

*Author's note: The above language shown in yellow is being added to the above paragraph. With the above yellow highlighted language added in, the paragraph would then read as follows:*

~~Review the~~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 the comparative analysis required under (42 USC 300gg-26(a)(8)(A)), disclosures referenced above (45 CFR § 146.136(d)(3)) as referenced in ACA FAQ 45-Q6. ~~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~~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).

**Standards for STANDARDS**

**Mental Health and Substance Use Disorder Parity Compliance**

**Standard 7**

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

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

**Priority:** Recommended

**Documents to be Reviewed**

- \_\_\_\_\_ Contractual agreements between the carrier and vendors having administrative, claims and/or medical management responsibilities
- \_\_\_\_\_ Policies and procedures for ensuring availability of health carrier information needed for vendor analysis of compliance with MHPAEA
- \_\_\_\_\_ A narrative summary outlining how the vendor and the carrier coordinate benefit design and application to ensure compliance with MHPAEA
- \_\_\_\_\_ ~~Any-Select~~ written communications relevant to mental health and substance use disorder benefits between the carrier and the vendor ~~in regard to the administration of mental health and substance use disorder benefits~~

~~Others Reviewed~~ Other References

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

**Review Procedures and Criteria**

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

Review theThe 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.