Chapter 24—Conducting the Health Examination

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

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

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

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

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

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

A. Operations/Management
B. Complaint Handling
C. Marketing and Sales
D. Producer Licensing
E. Policyholder Service
F. Underwriting and Rating
G. Claims
H. Grievance Procedures
I. Network Adequacy
J. Provider Credentialing
K. Quality Assessment and Improvement
L. Utilization Review
M. External Review
N. Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation

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

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

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

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

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

Exempt Benefit Plans

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

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

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

HIPAA—Federal Minimum Requirements

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

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

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

Federally Mandated Benefits

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

Federally mandated benefits include:

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

IIPRC-Approved Products

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

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A. Operations/Management

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

B. Complaint Handling

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

C. Marketing and Sales

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

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STANDARDS
MARKETING AND SALES

Standard 1
Regulated entity rules on replacement are in compliance with applicable statutes, rules and regulations.

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

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Replacement register

_____ Underwriting file

_____ Replacement comparison form (if external replacement)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

Review replacement forms for compliance.

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

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

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STANDARDS
MARKETING AND SALES

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

Apply to: All health products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Actuarial records

_____ Underwriting file

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Small Employer and Individual Health Insurance Availability Model Act (#35)
Individual Health Insurance Portability Model Act (#37), Section 5

Review Procedures and Criteria

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

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

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

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

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

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

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

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

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STANDARDS
MARKETING AND SALES

Standard 3
The regulated entity has suitability standards for its products, when required by applicable statutes, rules and regulations.

Apply to: All health products

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Producer records

_____ Training materials

_____ Procedure manuals

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

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

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

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

Determine if negative enrollment practices are permitted and used.

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

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D. Producer Licensing

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

E. Policyholder Service

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

STANDARDS
POLICYHOLDER SERVICE

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

Apply to: All health products
Disability income products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Notice of reinstatement

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine that notice was sent in a timely manner.

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

Verify that reinstatement was applied per policy provisions.

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STANDARDS
POLICYHOLDER SERVICE

Standard 2
Evidence of creditable coverage is provided in accordance with the requirements of HIPAA and/or applicable statutes, rules and regulations.

Apply to: All health plans

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy history file

_____ Regulated entity procedures manual

Others Reviewed

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

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

"Creditable coverage" includes most health coverage, including prior coverage under:

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

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

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

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

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

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

Certificates should automatically be issued to:

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

Creditable coverage certificates should include:

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

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

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

Duplicate certificates should be provided free of charge.

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F. Underwriting and Rating

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

STANDARDS
UNDERWRITING AND RATING

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

Apply to: All health products
Disability income products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy contract

_____ Underwriter's file or notes on a system log

_____ Insured's request (if applicable)

_____ Regulated entity cancellation/nonrenewal guidelines

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

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

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

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

STANDARDS
UNDERWRITING AND RATING

Standard 2
Pertinent information on applications that form a part of the policy is complete and accurate.

Apply to: All health products
Disability income products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ All applications

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Group Health Insurance Standards Model Act (#100)

Review Procedures and Criteria

Determine if the coverage is issued as applied for.

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

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

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

Verify that supplemental applications are used, where appropriate.

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STANDARDS
UNDERWRITING AND RATING

Standard 3
The regulated entity complies with the provisions of COBRA and/or continuation of benefits procedures contained in policy forms, statutes, rules and regulations.

Apply to: All health products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy forms

_____ Regulated entity guidelines

_____ Regulated entity marketing materials dealing with continuation of benefits

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Individual Health Insurance Portability Model Act (#37), Section 10
Group Health Insurance Mandatory Conversion Privilege Model Act (#105)

Review Procedures and Criteria

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

Review continuation of benefit files.

Review declinations/cancellations of continuation of benefits insureds.

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

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

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

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STANDARDS
UNDERWRITING AND RATING

Standard 4
The regulated entity complies with the Genetic Information Nondiscrimination Act of 2008.

Apply to: All group health products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting guidelines and producer guidelines related to group health insurance

_____ Rating guidelines related to group health insurance

Others Reviewed

Genetic Information Nondiscrimination Act of 2008 (GINA)

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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STANDARDS
UNDERWRITING AND RATING

Standard 5
The regulated entity complies with proper use and protection of health information in accordance with statutes, rules and regulations.

Apply to: All health products
Disability income products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Written policies, standards and procedures

_____ Regulated entity guidelines

_____ Rights of individual applicant to access and amend health information

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

Review the regulated entity's procedures for proper use of protected health information.

Review medical/lifestyle questions and underwriting guidelines for AIDS.

Review guidelines for use of notice and consent form for AIDS.

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STANDARDS
UNDERWRITING AND RATING

Standard 6
The regulated entity complies with the provisions of HIPAA and state laws regarding limits on the use of preexisting exclusions.

Apply to: All group health products
Disability income products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy forms and endorsements

_____ Regulated entity guidelines

_____ Regulated entity materials dealing with HIPAA

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Individual Health Insurance Portability Model Act (#37), Section 7
Newborn and Adopted Children Coverage Model Act (#155)
Group Health Insurance Standards Model Act (#100)
Small Employer and Individual Health Insurance Availability Model Act (#35)

Review Procedures and Criteria

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

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

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Continuous coverage is required as follows:

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

Waiting periods:

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

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

Individual Market

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

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STANDARDS
UNDERWRITING AND RATING

Standard 7
The regulated entity does not improperly deny coverage or discriminate based on health status in the group market or against eligible individuals in the individual market in conflict with the requirements of HIPAA or state law.

Apply to: All health products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files of denied policies

_____ Regulated entity guidelines

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Individual Health Insurance Portability Model Act (#37), Section 7
Nondiscrimination in Health Insurance Coverage in the Group Market Model Regulation (#107)
Group Health Insurance Standards Model Act (#100)
Small Employer and Individual Health Insurance Availability Model Act (#35)

Review Procedures and Criteria

For group coverage:

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

For individual coverage:

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

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"Eligible individual" includes a person that:

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

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

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

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

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

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STANDARDS
UNDERWRITING AND RATING

Standard 8
The regulated entity issues coverage that complies with guaranteed-issue requirements of HIPAA and related state laws for groups of 2 to 50.

Apply to: All small group health products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files of denied policies

_____ Regulated entity guidelines

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

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STANDARDS
UNDERWRITING AND RATING

Standard 9
The regulated entity issues individual insurance coverage to eligible individuals entitled to portability under the provisions of HIPAA and in compliance with applicable statutes, rules and regulations.

Apply to: All health products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files of denied policies

_____ Regulated entity guidelines

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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STANDARDS
UNDERWRITING AND RATING

Standard 10
The regulated entity does not administer self-funded benefit plans for entities subject to state regulation (e.g., MEWAs) or provide insurance coverage to entities not entitled to such coverage under state or federal law.

Apply to: All group health plans

Priority: Essential

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

_____ Applicable statutes, rules and regulations

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

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

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

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

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

_____ Applicable statutes, rules and regulations

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

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

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Prevention of Illegal Multiple Employer Welfare Arrangements (MEWAs) and Other Illegal Health Insurers Model Regulation (#220)
Group Health Insurance Standards Model Act (#100)

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

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

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

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

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

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G. Claims

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

STANDARDS
CLAIMS

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

Apply to: All health products
Disability income products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations, including the Unfair Trade Practices Acts, Unfair Claims Settlement Practices Act and Unfair Discrimination Act

_____ Company claim procedure manuals

_____ Claim training manuals

_____ Internal company claim audit reports

_____ Claim bulletins, UCR guidelines and procedure manuals

_____ Company claim forms manual

_____ Claim files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

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

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

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

Determine if claim files are handled according to policy provisions.

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

Determine if claim handling includes proper referral of suspicious claims.

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

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

For disability income insurance claims:

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

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

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

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

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STANDARDS
CLAIMS

Standard 2
The company complies with the requirements of the federal Newborns' and Mothers' Health Protection Act of 1996.

Apply to: All health lines offering maternity coverage

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Company claim procedure manuals

Others Reviewed

Newborns' and Mothers' Health Protection Act of 1996

_____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

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

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

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

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STANDARDS
CLAIMS

Standard 3
The group health plan complies with the requirements of the federal Mental Health Parity Act of 1996 (MHPA) and the revisions made in the Mental Health Parity and Addiction Equity Act of 2008.

Apply to: Certain group health plans offering mental health coverage

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Company claim procedure manuals

_____ Claim training manuals

_____ Internal company claim audit reports

_____ Claim bulletins, UCR guidelines and procedure manuals

_____ Company claim forms manual

_____ Claim files

Others Reviewed

Mental Health Parity Act of 1996

Mental Health Parity and Addiction Equity Act of 2008

_____ _____

NAIC Model References

Review Procedures and Criteria

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

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

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

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STANDARDS
CLAIMS

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

Apply to: Certain group health plans offering mastectomy coverage

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Company claim procedure manuals

_____ Claim training manuals

_____ Internal company claim audit reports

_____ Claim bulletins and procedure manuals

_____ Company claim forms manual

_____ Claim files

Others Reviewed

Women's Health and Cancer Rights Act of 1998

_____ _____

NAIC Model References

Review Procedures and Criteria

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

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

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

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STANDARDS
CLAIMS

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

Apply to: Replacement or replaced group health plans

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Company claim procedure manuals

_____ Claim files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Group Coverage Discontinuance and Replacement Model Regulation (#110)

Review Procedures and Criteria

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

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

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

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

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H. Grievance Procedures

1. Purpose

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

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

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

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

2. Techniques

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

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

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

3. Tests and Standards

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

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STANDARDS
GRIEVANCE PROCEDURES

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

Apply to: All health carriers offering a health benefit plan

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Sample documents and files (including electronic correspondence)

_____ Member evidence of coverage

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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STANDARDS
GRIEVANCE PROCEDURES

Standard 2
The health carrier documents, maintains and reports grievances and establishes and maintains grievance procedures in compliance with applicable statutes, rules and regulations.

Apply to: All health carriers offering a health benefit plan

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Company's grievance handling policies and procedures

_____ Sample of grievances

_____ Member evidence of coverage

_____ Company's grievance register

_____ Company's annual grievance report to the insurance department

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

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

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

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

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

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

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

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

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

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STANDARDS
GRIEVANCE PROCEDURES

Standard 3
A health carrier has implemented grievance procedures, disclosed the procedures to covered persons, in compliance with applicable statutes, rules and regulations, and files with the commissioner a copy of its grievance procedures, including all forms used to process a grievance.

Apply to: All health carriers offering a health benefit plan

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Grievance procedures

_____ All forms used to process a grievance

_____ Company approval register

_____ Grievance procedure filings filed with the insurance department

_____ Certificates of compliance filed with the insurance department

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

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

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

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

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STANDARDS
GRIEVANCE PROCEDURES

Standard 4
The health carrier has procedures for and conducts first level reviews of grievances involving an adverse determination in compliance with applicable statutes, rules and regulations.

Apply to: All health carriers offering a health benefit plan

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Sample of first level reviews of grievances involving an adverse determination

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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STANDARDS
GRIEVANCE PROCEDURES

Standard 5
The health carrier has procedures for and conducts standard reviews of grievances not involving an adverse determination in compliance with applicable statutes, rules and regulations.

Apply to: All health carriers offering a health benefit plan

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Sample of grievances

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

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

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

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

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

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

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

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

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STANDARDS
GRIEVANCE PROCEDURES

Standard 6
The health carrier has procedures for voluntary reviews of grievances and conducts voluntary reviews of grievances in compliance with applicable statutes, rules and regulations.

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

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Sample of voluntary review grievances

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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STANDARDS
GRIEVANCE PROCEDURES

Standard 7
The health carrier has procedures for and conducts expedited reviews of urgent care requests of grievances involving an adverse determination in compliance with applicable statutes, rules and regulations.

Apply to: All health carriers offering a health benefit plan

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Sample of expedited appeals

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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I. Network Adequacy

1. Purpose

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

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

2. Techniques

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

3. Tests and Standards

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

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STANDARDS
NETWORK ADEQUACY

Standard 1
The health carrier demonstrates, using reasonable criteria, that it maintains a network that is sufficient in number and types of providers to ensure that all services to covered persons will be accessible without unreasonable delay.

Apply to: Health carriers with network plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Selection criteria

_____ Documents related to physician recruitment

_____ Provider directory

_____ Reports of out-of-network service denials

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

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

_____ List of providers by specialty

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

_____ Computer tools used to assess the network's adequacy; e.g., GeoAccess®

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

Reasonable criteria include, but are not limited to:

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

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

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

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

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

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

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STANDARDS
NETWORK ADEQUACY

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

Apply to: Health carriers with network plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

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

_____ Member materials referencing access plans

_____ Provider manual

_____ Provider contract

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

The access plan shall describe or contain the following:

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

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

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STANDARDS
NETWORK ADEQUACY

Standard 3
The health carrier files with the insurance commissioner all required contract forms and any material changes to a contract proposed for use with its participating providers and intermediaries.

Apply to: Health carriers with network plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Sample of provider contracts

_____ Credentialing file

_____ Directory of providers

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

Determine if the forms and endorsements have been filed.

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

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STANDARDS
NETWORK ADEQUACY

Standard 4
The health carrier ensures covered persons have access to emergency services 24 hours per day, 7 days per week within its network and provides coverage for emergency services outside of its network, pursuant to the appropriate section of state law that corresponds to the *Utilization Review and Benefit Determination Model Act* (#73) and/or the *Health Benefit Plan Network Access and Adequacy Model Act* (#74).

Apply to: Health carriers with network plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Provider manual

_____ Provider contracts

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Benefit Plan Network Access and Network Adequacy Model Act (#74), Section 5
Utilization Review and Benefit Determination Model Act (#73)
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

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

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

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

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STANDARDS
NETWORK ADEQUACY

Standard 5
The health carrier executes written agreements with each participating provider that are in compliance with applicable statutes, rules and regulations.

Apply to: Health carriers with network plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Provider contracts

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Benefit Plan Network Access and Network Adequacy Model Act (#74), Sections 6B and 6C
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

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

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

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STANDARDS
NETWORK ADEQUACY

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

Apply to: Health carriers with network plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Intermediary contracts

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

STANDARDS
NETWORK ADEQUACY

Standard 7
The health carrier's arrangements with participating providers comply with applicable statutes, rules and regulations.

Apply to: Health carriers with network plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Provider contracts

_____ Provider manuals

_____ Complaints made by providers

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

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

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

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

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

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

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

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

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

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

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

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STANDARDS
NETWORK ADEQUACY

Standard 8
The health carrier provides at enrollment a provider directory that lists all providers who participate in its network. It also makes available, on a timely and reasonable basis, updates to its directory.

Apply to: Health carriers with network plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Provider directory and updates

_____ Provider contracts

_____ Credentialing documentation

_____ Internet directory

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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J. Provider Credentialing

1. Purpose

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

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

2. Techniques

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

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

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

3. Tests and Standards

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

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STANDARDS
PROVIDER CREDENTIALING

Standard 1
The health carrier establishes and maintains a program for credentialing and re-credentialing in compliance with applicable statutes, rules and regulations.

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Credentialing policies and procedures

_____ Credentialing plan

_____ Minutes of the credentialing committee

_____ Credentialing plan evaluation reports (if any)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

The health carrier shall make all application and credentialing verification policies and procedures available for review by the applying health care professional upon written request.
The health carrier shall keep confidential all information obtained in the credentialing verification process, except as otherwise provided by law.

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

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

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STANDARDS
PROVIDER CREDENTIALING

Standard 2
The health carrier verifies the credentials of a health care professional before entering into a contract with that health care professional.

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Provider directory

_____ Provider credentialing files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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STANDARDS
PROVIDER CREDENTIALING

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

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Checklist for credentialing

_____ Checklist and forms for site visits (if any)

_____ Reports made from site visits (if any)

_____ Sample of credentialing files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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STANDARDS
PROVIDER CREDENTIALING

Standard 4
The health carrier obtains, through either a primary or secondary credentialing verification process, the information required by applicable state provisions equivalent to the *Health Care Professional Credentialing Verification Model Act* (#70) and accompanying regulations.

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Checklist for credentialing

_____ Checklist and forms for site visits (if any)

_____ Reports made from site visits (if any)

_____ Sample of credentialing files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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STANDARDS
PROVIDER CREDENTIALING

Standard 5
The health carrier obtains, at least every 3 years, primary verification of the information required by applicable state provisions equivalent to the *Health Care Professional Credentialing Verification Model Act* (#70) and accompanying regulations.

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Checklist for credentialing

_____ Checklist and forms for site visits (if any)

_____ Reports made from site visits (if any)

_____ Sample of credentialing files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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STANDARDS
PROVIDER CREDENTIALING

Standard 6
The health carrier requires all participating providers to notify the health carrier's designated individual of changes in the status of any information that is required to be verified by the health carrier.

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Credentialing policies and procedures

_____ Provider contracts

_____ Credentialing files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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STANDARDS
PROVIDER CREDENTIALING

Standard 7
The health carrier provides a health care professional the opportunity to review and correct information submitted in support of that health care professional's credentialing verification.

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Credentialing policies and procedures

_____ Provider manual

_____ Listing of providers (active and terminated)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

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STANDARDS
PROVIDER CREDENTIALING

Standard 8
The health carrier monitors the activities of the entity with which it contracts to perform credentialing functions and ensures the requirements of applicable state provisions equivalent to the *Health Care Professional Credentialing Verification Model Act* (#70) and accompanying regulations are met.

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

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Credentialing policies and procedures

_____ Intermediary contracts

_____ Periodic reports from intermediaries

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

_____ Minutes of the health carrier's credentialing committee

_____ Minutes of the health carrier's board of directors

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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K. Quality Assessment and Improvement

1. Purpose

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

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

2. Techniques

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

3. Tests and Standards

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

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STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 1
The health carrier develops and maintains a quality assessment program in compliance with applicable statutes, rules and regulations.

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Quality assessment policies and procedures

_____ Quality assessment plan (if any)

_____ Minutes of the health carrier's quality assessment committee

_____ Minutes of the health carrier's board of directors

_____ Evaluations of the quality assessment program

_____ Job descriptions for the chief medical officer or clinical director

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

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

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

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

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

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

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STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 2
The health carrier files a written description of the quality assessment program with the insurance commissioner in the prescribed format, which shall include a signed certification by a corporate officer of the health carrier that the filing meets applicable statutes, rules and regulations.

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Written description of the quality assessment program

_____ Signed certification by a corporate officer

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

Determine if the forms have been filed.

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STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 3
The health carrier develops and maintains a quality improvement program, in compliance with applicable statutes, rules and regulations.

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

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Quality improvement policies and procedures

_____ Quality improvement plan

_____ Minutes of the health carrier's quality improvement committee

_____ Minutes of the health carrier's board of directors

_____ Evaluations of the quality improvement program

_____ Job descriptions for the chief medical officer or clinical director

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

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

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

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

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

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

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

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

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

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

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

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STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 4
The health carrier reports to the appropriate licensing authority any persistent pattern of problematic care provided by a provider that is sufficient to cause the health carrier to terminate or suspend contractual arrangements with the provider.

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Quality assessment and improvement policies and procedures

_____ Reports made to the licensing authority

_____ Terminated and suspended provider contract files

_____ Quality of Care complaints

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

Determine that policies and procedures address reporting requirements.

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

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STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

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

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Quality assessment and improvement policies and procedures

_____ Member materials (e.g., member newsletters, advertisements, etc.)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

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STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 6
The health carrier annually certifies to the insurance commissioner that its quality assessment and quality improvement program, along with the materials provided to providers and consumers, meets applicable statutes, rules and regulations.

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Certification filings

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

The health carrier shall make the certified materials available for review by the public upon request, subject to a reasonable fee (except for those materials subject to confidentiality requirements and materials that are proprietary to the health plan).

The health carrier shall retain all certified materials for at least 3 years from the date the material has been used or until the material has been examined as part of a market conduct examination, whichever is longer.

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STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 7
The health carrier monitors the activities of the entity with which it contracts to perform quality assessment or quality improvement functions and ensures that the requirements of applicable state provisions equivalent to the *Quality Assessment and Improvement Model Act* (#71) and accompanying regulations are met.

Apply to: All health carriers with managed care plans that contract to have another entity perform quality assessment or quality improvement activities

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Quality assessment and improvement policies and procedures

_____ Contracts with entities

_____ Reports of entity reviews and audits (if any) by health carrier

_____ Periodic reports from the entity

_____ Minutes from the health carrier's board of directors

_____ Minutes from the health carrier's quality assessment committee and quality improvement committee

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Quality Assessment and Improvement Model Act (#71), Section 10
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

The health carrier has established, implemented and enforces a policy to address effective methods of accomplishing oversight of each delegated activity.

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L. Utilization Review

1. Purpose

The utilization review portion of the examination is designed to verify that companies and their designees that provide or perform utilization review services comply with standards and criteria for the structure and operation of utilization review processes. In the *Utilization Review and Benefit Determination Model Act* (#73), the NAIC defines utilization review as a set of formal techniques designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.

The areas to be considered in this kind of review include the company's written utilization review policies and procedures, annual summary reports, timeliness in making utilization review decisions and handling appeals, communications with members about the program and oversight of delegated utilization review functions.

2. Techniques

The review of utilization review activities should include an overview of the health plan's written utilization review policies, procedures and scripts, in addition to an overview of how utilization review activities are applied to individual cases. Utilization review issues may also surface during the examiners' review of claims, complaints and grievance procedures.

a. Examiners should request a written overview of the insurer's utilization review program. The overview should include the names and positions of individuals responsible for overseeing the program, along with the qualifications of the utilization review director and staff. Examiners may request an interview of appropriate personnel, to supplement information obtained in the written overview. During this process, examiners should also determine how the insurer maintains corporate oversight of the utilization review process. Where applicable, the examiner should obtain copies of any required utilization review licenses or certifications. Review the scope of the utilization review program. Utilization review functions for some specialized services are occasionally delegated to other entities. Examiners should request copies of applicable reports required for regulatory purposes.

b. Examiners should also obtain the program materials and scripts to ascertain the source of guidelines used, how frequently the materials are updated and whether they are supported by reliable sources of data and medical protocol. In addition, obtain standards used by applicable accreditation entities, if any. A review of the time guidelines for responding to utilization review and reconsideration requests should be conducted. An evaluation of the methods used to communicate utilization review decisions to medical providers, subscribers and other applicable divisions within the company should be completed.

c. Evaluate the availability of, and access to, the utilization review program to plan members or subscribers. Review adequacy of staffing and hours of operation.

d. Ascertain whether utilization review requirements are consistent with and supported by language in the policy, certificate of coverage and marketing materials.

e. Obtain listings of utilization review approvals or certifications, denials and requests for reconsideration. Use sampling techniques to review specific cases. Evaluate handling for adherence to written guidelines and standards.

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3. Tests and Standards

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

STANDARDS
UTILIZATION REVIEW

Standard 1
The health carrier establishes and maintains a utilization review program in compliance with applicable statutes, rules and regulations.

Apply to: Health carriers offering a health benefit plan providing or performing utilization review services

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations, including those related to mandated benefits and services

_____ Utilization review policies and procedures

_____ Utilization review program or plan documentation

_____ Medical criteria used to make utilization review determinations

_____ Job description of the staff position functionally responsible for day-to-day management

_____ Minutes of the health carrier's board of directors

_____ Minutes of the health carrier's utilization review committee

_____ Documentation of clinical staff credentialing maintenance and education requirements

_____ Program assessment reports

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Utilization Review and Benefit Determination Model Act (#73), Sections 5, 7 & 12

Review Procedures and Criteria

Verify that the health carrier implements procedures to ensure effective corporate oversight of its utilization review program.

Verify that a health carrier that requires a request for benefits under the covered person's health benefit plan to be subjected to utilization review, implements a written utilization review program that describes all review activities, both delegated and nondelegated for:

- The filing of benefit requests;
- The notification of utilization review and benefit determinations; and
- The review of adverse determinations in accordance with applicable state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72).

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Verify that the health carrier's written utilization review program document describes all of the following:

- Procedures to evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services;
- Data sources and clinical review criteria used in decision-making;
- Mechanisms to ensure consistent application of clinical review criteria and compatible decisions;
- Data collection processes and analytical methods used in assessing utilization of health care services;
- Provisions for ensuring confidentiality of clinical and proprietary information;
- The organizational structure (e.g., utilization review committee, quality assurance or other committee) that periodically assesses utilization review activities and reports to the health carrier's governing body; and
- The staff position functionally responsible for day-to-day program management.

Verify that the health carrier ensures that appropriate personnel have operational responsibility for conducting the carrier's utilization review program.

The health carrier shall annually certify in writing to the commissioner that the utilization review program of the health carrier complies with all applicable state and federal laws establishing confidentiality and reporting requirements.

The health carrier shall comply with all applicable state provisions equivalent to the *Utilization Review and Benefit Determination Model Act* (#73) and accompanying regulations not expressly covered by any other of these standards.

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STANDARDS
UTILIZATION REVIEW

Standard 2
The health carrier operates its utilization review program in accordance with applicable state statutes, rules and regulations.

Apply to: Health carriers offering a health benefit plan providing or performing utilization review services

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Utilization review policies and procedures

_____ Form letters

_____ Activity reports

_____ Provider manual

_____ Files with utilization review requests (Verify that all levels of authorized, appealed and disapproved requests are reviewed)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Utilization Review and Benefit Determination Model Act (#73), Section 8

Review Procedures and Criteria

Verify that the health carrier's utilization review program uses documented clinical review criteria that are based on sound clinical evidence and evaluated periodically to assure ongoing efficacy.

Note: The health carrier may develop its own clinical review criteria or may purchase or license clinical review criteria from qualified vendors.

Verify that the health carrier makes its clinical review criteria available upon request to authorized government agencies.

Verify that the health carrier ensures that qualified health care professionals administer the utilization review program and oversee review decisions. Verify that the health carrier has appointed clinical peers to evaluate the clinical appropriateness of adverse determinations.

Verify that the health carrier issues utilization review decisions and benefit determinations in a timely and efficient manner pursuant to the requirements set forth in applicable state statutes, rules and regulations.

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Verify that the health carrier has a process to ensure that utilization reviewers apply clinical review criteria in conducting utilization review consistently.

Verify that the health carrier conducts routine assessments of the effectiveness and efficiency of its utilization review program.

Verify that the health carrier's data systems are sufficient to support utilization review program activities and to generate management reports to enable the health carrier to monitor and manage health care services effectively.

If a health carrier delegates any utilization review activities to a utilization review organization, verify that the health carrier maintains adequate oversight, to include all of the following:

- A written description of the utilization review organization's activities and responsibilities, including reporting requirements;
- Evidence of formal approval of the utilization review organization program by the health carrier; and
- A process by which the health carrier evaluates the performance of the utilization review organization.

Verify that the health carrier coordinates its utilization review program activities with other medical management activity conducted by the health carrier—such as quality assurance, credentialing, provider contracting, data reporting, grievance procedures, claims adjudication, processes for assessing member satisfaction and risk management.

Verify that the health carrier provides covered persons, or, if applicable, the covered person's authorized representatives and participating providers with access to its utilization review staff via a toll-free number or collect call telephone line.

Verify that the health carrier, when conducting utilization review, collects only the information necessary, including pertinent clinical information, to make the utilization review or benefit determination.

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STANDARDS
UTILIZATION REVIEW

Standard 3
The health carrier discloses information about its utilization review and benefit determination procedures to covered persons, or, if applicable, the covered person's authorized representative, in compliance with applicable statutes, rules and regulations.

Apply to: Health carriers offering a health benefit plan providing or performing utilization review services

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Member materials

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Utilization Review and Benefit Determination Model Act (#73), Section 13

Review Procedures and Criteria

Verify that the health carrier provides a clear and accurate summary of its utilization review and benefit determination procedures to prospective covered persons, or, if applicable, to the covered person's authorized representative.

Verify that the health carrier provides a clear and comprehensive description of its utilization review procedures, including the procedures for obtaining adverse review determinations, and a statement of rights and responsibilities of covered persons, or, if applicable, the covered person's authorized representative, with respect to those procedures, in the certificate of coverage or member handbook provided to covered persons.

Verify that the health carrier prints on its membership cards a toll-free telephone number to call for utilization review and benefit determination decisions.

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STANDARDS
UTILIZATION REVIEW

Standard 4
The health carrier makes standard utilization review and benefit determinations in a timely manner and as required by applicable state statutes, rules and regulations, as well as the provisions of HIPAA.

Apply to: Health carriers offering a health benefit plan providing or performing utilization review services

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Utilization review policies and procedures

_____ Form letters

_____ Activity reports

_____ Provider manual

_____ Files with utilization review requests (Verify that all levels of authorized, appealed and disapproved requests are reviewed)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Utilization Review and Benefit Determination Model Act (#73), Section 9

Review Procedures and Criteria

Verify that the health carrier maintains written procedures, pursuant to applicable state statutes, rules and regulations, for making standard utilization review and benefit determinations on requests submitted to the health carrier by the covered person, or, if applicable, the covered person's authorized representative, for benefits and for notifying the covered person, and, if applicable, the covered person's authorized representative, of its determinations with respect to these requests within the specified time frames required pursuant to applicable state statutes, rules and regulations.

For prospective review determinations, verify that the health carrier makes the determination and notifies the covered person, or, if applicable, the covered person's authorized representative, of the determination, whether the carrier certifies the provision of the benefit or not, within a reasonable period of time appropriate to the covered person's medical condition, but in no event later than 15 days after the date the health carrier receives the request.

Whenever the determination is an adverse determination, verify that the health carrier makes the notification of the adverse determination in accordance with state statutes, rules and regulations regarding procedures for standard utilization review and benefit determination.

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Verify that if the health carrier extends the time period for making a determination and notifying the covered person, or, if applicable, the covered person's authorized representative, of the determination one time for up to 15 days pursuant to applicable state statutes, rules and regulations, the health carrier has:

- Determined that the extension was necessary due to matters beyond the health carrier's control; and
- Notified the covered person, or, if applicable, the covered person's authorized representative, prior to the expiration of the initial 15-day time period, of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.

If the extension referenced above is necessary due to the failure of the covered person, or, if applicable, the covered person's authorized representative, to submit information necessary to reach a determination on the request, verify that the health carrier issues a notice of extension that:

- Specifically describes the required information necessary to complete the request; and
- Gives the covered person, or, if applicable, the covered person's authorized representative, at least 45 days from the date of receipt of the notice to provide the specified information.

Whenever the health carrier receives a prospective review request from a covered person, or, if applicable, the covered person's authorized representative, that fails to meet the health carrier's filing procedures, verify that the health carrier notifies the covered person, or, if applicable, the covered person's authorized representative, of this failure and provides in the notice information on the proper procedures to be followed for filing a request.

Verify that the notice referenced in the previous paragraph is provided by the health carrier as soon as possible, but in no event later than five days following the date of the failure.

Verify that the health carrier provides the notice orally or, if requested by the covered person, or, if applicable, the covered person's authorized representative, in writing.

Note: The provisions regarding the covered person's, or, if applicable, the covered person's authorized representative's, failure to meet the health carrier's filing procedures apply only in the case of a failure that:

- Is a communication by a covered person, or, if applicable, the covered person's authorized representative, that is received by a person or organizational unit of the health carrier responsible for handling benefit matters; and
- Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment or provider for which certification is being requested.

For concurrent review determinations, if a health carrier has certified an ongoing course of treatment to be provided over a period of time or number of treatments, examiners need to be aware that:

- Any reduction or termination by the health carrier during the course of treatment before the end of the period or number of treatments, other than by health benefit plan amendment or termination of the health benefit plan, constitutes an adverse determination; and
- The health carrier shall notify the covered person, or, applicable, the covered person's authorized representative, of the adverse determination in accordance with applicable state statutes, rules and regulations regarding procedures for standard utilization review and benefit determination at a time sufficiently in advance of the reduction or termination to allow the covered person, or, if applicable, the covered person's authorized representative, to file a grievance to:
    - Request a review of the adverse determination pursuant to state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72); and
    - Obtain a determination with respect to that review of the adverse determination before the benefit is reduced or terminated.

Verify that the health care service or treatment that is the subject of the adverse determination is continued by the health carrier without liability to the covered person with respect to the internal review request made pursuant to state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72).

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For retrospective review determinations, verify that the health carrier makes the determination within a reasonable period of time, but in no event later than 30 working days after the date of receiving the benefit request.

If the retrospective review determination is an adverse determination, verify that the health carrier provides notice of the adverse determination to the covered person, or, if applicable, the covered person's authorized representative, in accordance with applicable state statutes regarding procedures for standard utilization review and benefit determination.

Verify that if the health carrier extends the time period for making a determination and notifying the covered person, or, if applicable, the covered person's authorized representative, of the determination one time for up to 15 days pursuant to applicable state statutes, rules and regulations, the health carrier has:

- Determined that the extension was necessary due to matters beyond the health carrier's control; and
- Notified the covered person, or, if applicable, the covered person's authorized representative, prior to the expiration of the initial 30 day time period, of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.

If the extension referenced above is necessary due to the failure of the covered person, or, if applicable, the covered person's authorized representative, to submit information necessary to reach a determination on the request, verify that the health carrier issues a notice of extension that:

- Specifically describes the required information necessary to complete the request; and
- Gives the covered person, or, if applicable, the covered person's authorized representative, at least 45 days from the date of receipt of the notice to provide the specified information.

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

If the time period for making a prospective or retrospective determination is extended due to the covered person's, or, if applicable, the covered person's authorized representative's, failure to submit the information necessary to make the determination, verify that the health carrier calculates the time period for making the determination to begin on the date on which the health carrier sends the notification of the extension to the covered person, or, if applicable, the covered person's authorized representative, until the earlier of:

- The date on which the covered person, or, if applicable, the covered person's authorized representative, responds to the request for additional information; or
- The date on which the specified information was to have been submitted.

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

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

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STANDARDS
UTILIZATION REVIEW

Standard 5
The health carrier provides written notice of an adverse determination of standard utilization review and benefit determinations in compliance with applicable statutes, rules and regulations.

Apply to: Health carriers offering a health benefit plan providing or performing utilization review services

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Utilization review policies and procedures

_____ Form letters

_____ Utilization review files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Utilization Review and Benefit Determination Model Act (#73), Section 9F

Review Procedures and Criteria

Verify that the health carrier issues notification of an adverse determination, in a manner calculated to be understood by the covered person, to include all of the following:

- The specific reason or reasons for the adverse determination;
- Reference to the specific plan provisions on which the determination is based;
- A description of any additional material or information necessary for the covered person, or, if applicable, the covered person's authorized representative, to perfect the benefit request, including an explanation of why the material or information is necessary to perfect the request;
- A description of the health carrier's grievance procedures established pursuant to applicable state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72), including any time limits applicable to those procedures;
- If the health carrier relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion, or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person, or, if applicable, the covered person's authorized representative, upon request;
- If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person, or, if applicable, the covered person's authorized representative, free of charge upon request;

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- A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination;
- The written statement of the scientific or clinical rationale for the adverse determination; and
- A statement explaining the availability of and the right of the covered person, or, if applicable, the covered person's authorized representative, as appropriate, to contact the insurance commissioner's office at any time for assistance or, upon completion of the health carrier's grievance procedure process as provided under state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72), to file a civil suit in a court of competent jurisdiction. The statement shall include contact information for the insurance commissioner's office.

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

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STANDARDS
UTILIZATION REVIEW

Standard 6
The health carrier conducts expedited utilization review and benefit determinations in a timely manner and in compliance with applicable statutes, rules and regulations.

Apply to: Health carriers offering a health benefit plan providing or performing utilization review services

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Utilization review policies and procedures

_____ Form letters

_____ Utilization review files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Utilization Review and Benefit Determination Model Act (#73), Section 10

Review Procedures and Criteria

Verify that the health carrier has established written procedures pursuant to applicable state statutes, rules and regulations for receiving benefit requests from covered persons, or, if applicable, their authorized representatives, and for making and notifying the covered person, or, if applicable, the covered person's authorized representative, of expedited utilization review and benefit determinations with respect to urgent care requests and concurrent review urgent care requests.

Verify that the health carrier, in the case of a failure by a covered person, or, if applicable, the covered person's authorized representative, to follow the health carrier's procedures for filing an urgent care request, notifies the covered person, or, if applicable, the covered person's authorized representative, of the failure and the proper procedures to be followed for filing the request.

Verify that the health carrier's notice regarding a covered person's, or, if applicable, the covered person's authorized representative's, failure to follow the health carrier's procedures for filing an urgent care request:

- Is provided to the covered person, or, if applicable, the covered person's authorized representative, as appropriate, as soon as possible, but not later than 24 hours after receipt of the request; and
- May be oral, unless the covered person, or, if applicable, the covered person's authorized representative, requests the notice in writing.

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Note: The provisions regarding the covered person's, or, if applicable, the covered person's authorized representative's, failure to follow the health carrier's procedures for filing an urgent care request apply only in the case of a failure that:

- Is a communication by a covered person, or, if applicable, the covered person's authorized representative, that is received by a person or organizational unit of the health carrier responsible for handling benefit matters; and
- Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment or provider for which approval is being requested.

For an urgent care request, unless the covered person, or, if applicable, the covered person's authorized representative, has failed to provide sufficient information for the health carrier to determine whether, or to what extent, the benefits requested are covered benefits or payable under the health carrier's health benefit plan, verify that the health carrier notifies the covered person, or, if applicable, the covered person's authorized representative, of the health carrier's determination with respect to the request, whether or not the determination is an adverse determination, as soon as possible, taking into account the medical condition of the covered person, but in no event later than 72 hours after the receipt of the request by the health carrier.

If the health carrier's determination is an adverse determination, verify that the health carrier provides notice of the adverse determination in accordance with applicable state statutes, rules and regulations regarding procedures for expedited utilization review and benefit determination.

If the covered person, or, if applicable, the covered person's authorized representative, has failed to provide sufficient information for the health carrier to make a determination, verify that the health carrier notifies the covered person, or, if applicable, the covered person's authorized representative, either orally or, if requested by the covered person, or, if applicable, the covered person's authorized representative, in writing of this failure and states what specific information is needed as soon as possible, but in no event later than 24 hours after receipt of the request.

Verify that the health carrier provides the covered person, or, if applicable, the covered person's authorized representative, a reasonable period of time to submit the necessary information, taking into account the circumstances, but in no event less than 48 hours after notifying the covered person, or, if applicable, the covered person's authorized representative, of the failure to submit sufficient information, pursuant to applicable state statutes, rules and regulations.

Verify that the health carrier notifies the covered person, or, if applicable, the covered person's authorized representative, of its determination with respect to the urgent care request as soon as possible, but in no event more than 48 hours after the earlier of:

- The health carrier's receipt of the requested specified information; or
- The end of the period provided for the covered person, or, if applicable, the covered person's authorized representative, to submit the requested specified information.

If the health carrier's determination is an adverse determination, verify that the health carrier provides notice of the adverse determination accordance with applicable state statutes, rules and regulations regarding procedures for expedited utilization review and benefit determination.

For concurrent review urgent care requests involving a request by the covered person, or, if applicable, the covered person's authorized representative, to extend the course of treatment beyond the initial period of time or the number of treatments, if the request is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, verify that the health carrier makes a determination with respect to the request and notifies the covered person, or, if applicable, the covered person's authorized representative, of the determination, whether it is an adverse determination or not, as soon as possible, taking into account the covered person's medical condition, but in no event more than 24 hours after the health carrier's receipt of the request.

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If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with applicable state statutes, rules and regulations regarding procedures for expedited utilization review and benefit determination.

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

Verify that the health carrier's notification of an adverse determination pursuant to an expedited utilization review and benefit determination is set forth in a manner calculated to be understood by the covered person, or, if applicable, the covered person's authorized representative, to include all of the following:

- The specific reason or reasons for the adverse determination;
- Reference to the specific plan provisions on which the determination is based;
- A description of any additional material or information necessary for the covered person, or, if applicable, the covered person's authorized representative, to complete the request, including an explanation of why the material or information is necessary to complete the request;
- A description of the health carrier's internal review procedures established pursuant to applicable state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72), including any time limits applicable to those procedures;
- A description of the health carrier's expedited review procedures established pursuant to applicable state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72);
- If the health carrier relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion, or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person, or, if applicable, the covered person's authorized representative upon request;
- If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person, or, if applicable, the covered person's authorized representative, free of charge upon request;
- If applicable, instructions for requesting:
    - A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination, as set forth in applicable state statutes, rules and regulations; or
    - The written statement of the scientific or clinical rationale for the adverse determination, as set forth in applicable state statutes, rules and regulations; and
- A statement explaining the availability of and the right of the covered person, or, if applicable, the covered person's authorized representative, as appropriate, to contact the insurance commissioner's office at any time for assistance or, upon completion of the health carrier's grievance procedure process as provided under applicable state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72), to file a civil suit in a court of competent jurisdiction. The statement shall include contact information for the insurance commissioner's office.

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

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

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STANDARDS
UTILIZATION REVIEW

Standard 7
The health carrier monitors the activities of the utilization review organization or entity with which the carrier contracts and ensures that the contracting organization complies with applicable state provisions equivalent to the *Utilization Review and Benefit Determination Model Act* (#73) and accompanying regulations.

Apply to: Health carriers offering a health benefit plan contracting out utilization review services

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Utilization review policies and procedures

_____ Contracts with organizations or entities

_____ Reports of entity reviews and audits (if any) by health carrier

_____ Periodic reports from the organization or entity

_____ Minutes of the health carrier's board of directors

_____ Minutes of the health carrier's utilization review committee

_____ Policies and procedures for oversight

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Utilization Review and Benefit Determination Model Act (#73), Sections 6 & 12

Review Procedures and Criteria

Whenever a health carrier contracts to have a utilization review organization or other entity perform the utilization review functions required by the *Utilization Review and Benefit Determination Model Act* (#73) or applicable state statutes, rules and regulations, the health carrier is responsible for monitoring the activities of the utilization review organization or entity with which the health carrier contracts and for ensuring that the requirements of the *Utilization Review and Benefit Determination Model Act* (#73) and applicable state statutes, rules and regulations are met.

Verify that the health carrier has policies and procedures in place that ensure the utilization review programs of designees comply with all applicable state and federal laws establishing confidentiality and reporting requirements.

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The health carrier shall annually certify in writing to the commissioner that the utilization review program of its designee complies with all applicable state and federal laws establishing confidentiality and reporting requirements.

M. External Review

Use the standards set forth below.

STANDARDS
EXTERNAL REVIEW

Standard 1
Companies covered under the *Health Carrier External Review Model Act* (#75) will be in compliance with the following procedures and criteria, as well as with other applicable statutes, rules and regulations.

Apply to: Health insurance carriers under the *Health Carrier External Review Model Act* (#75)

Priority: Essential

Documents to be Reviewed

_____ Certificates, policies and company procedures

_____ Applicable statutes, rules and regulations

_____ Reports on external review requests

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Carrier External Review Model Act (#75), Section 4
Health Maintenance Organization Model Act (#430)
Issues Involving External Review Procedures White Paper

Review Procedures and Criteria

The *Health Carrier External Review Model Act* (#75) shall apply to all health carriers that provide or perform utilization review, except for the following:

> "The provisions of this Act shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, as defined by [insert the reference to state law that defines long-term care insurance], vision care or any other limited supplemental benefit or to a Medicare supplement policy of insurance, as defined by the commissioner by regulation, coverage under a plan through Medicare, Medicaid or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis."

The health carrier shall notify covered persons in writing of the right to request an external review and shall:

- Include in the notice what circumstances constitute sufficient grounds for a standard, expedited or experimental/investigational review, and what procedures must be followed to request a review;
- Include an authorization form that allows the health carrier to disclose protected health information;
- Pay the cost of the independent review to the organization conducting the external review; and
- Include the telephone number and address of the insurance commissioner.

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The health carrier shall include a description of the external review procedures in or attached to the policy, certificate, membership booklet, an outline of coverage or other evidence of coverage it provides to covered persons.

The health carrier shall maintain written records in the aggregate and for each type of health benefit plan offered by the health carrier on all requests for external review. This information must be submitted to the insurance commissioner, at least annually, via a report in a format specified by the insurance commissioner.

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STANDARDS
EXTERNAL REVIEW

Standard 2
In jurisdictions that choose Option 1 or Option 2 under the *Health Carrier External Review Model Act* (#75) for providing an external review process, companies will be in compliance with the following requirements, whether the request for the review is for a standard, expedited or experimental/investigational review.

Apply to: Health insurance carriers in jurisdictions where the *Health Carrier External Review Model Act* (#75) has been adopted

Priority: Essential

Documents to be Reviewed

_____ Certificates, policies and company procedures

_____ Applicable statutes, rules and regulations

_____ Reports on external review requests

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Carrier External Review Model Act (#75), Section 4
Health Maintenance Organization Model Act (#430)
Issues Involving External Review Procedures White Paper

Review Procedures and Criteria (Option 1, Option 2)

The *Health Carrier External Review Model Act* (#75) shall apply to all health carriers that provide or perform utilization review, except for the following:

> "The provisions of this Act shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, as defined by [insert the reference to state law that defines long-term care insurance], vision care or any other limited supplemental benefit or to a Medicare supplement policy of insurance, as defined by the commissioner by regulation, coverage under a plan through Medicare, Medicaid or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis."

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External Review Process, Option 1
The external review process resides in the office of the insurance commissioner and requires that covered persons file all requests for external review with the commissioner. This option also provides that the commissioner will conduct a preliminary review of the request for external review to ensure that it meets all of the requirements to be eligible for external review. If the request for external review is determined to be eligible for external review, the commissioner is required to assign an independent review organization to conduct the external review. This option requires the assigned independent review organization to provide the commissioner with a written recommendation on whether to uphold or reverse the adverse determination or final adverse determination. After reviewing the recommendation, the commissioner is required to notify the covered person, if applicable, the covered person's authorized representative and the health carrier of the external review decision.

External Review Process, Option 2
This alternative is the same as Option 1, except the independent review organization assigned to conduct the review makes the determination, if the company's decision is to be reversed.

Standard Review Procedures
Provide within 7 days the documents and any information considered in making the adverse determination or the final adverse determination to the assigned independent review organization.

Notify the covered person, if applicable, the covered person's authorized representative, the assigned independent review organization and the commissioner in writing of its decision upon making the decision to reverse its adverse determination or final adverse determination.

Approve the coverage that was the subject of the adverse determination or final adverse determination upon receipt of a notice of a decision reversing the adverse determination or final adverse determination.

Expedited External Review Procedures
Provide in an expeditious manner all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization upon receipt of notice that the case has been accepted for an expedited external review.

Approve the coverage that was the subject of the adverse determination or final adverse determination upon receipt of the notice of a decision reversing the original determination.

Experimental or Investigational Treatment Procedures
Provide or transmit in an expeditious manner all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization.

Provide within 7 days the documents and any information considered in making the adverse determination or the final adverse determination to the assigned independent review organization.

Approve the coverage that was the subject of the adverse determination or final adverse determination upon receipt of the notice of a decision reversing the original determination.

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STANDARDS
EXTERNAL REVIEW

Standard 3
In states that choose Option 3 under the *Health Carrier External Review Model Act* (#75) for providing an external review process, companies will be in compliance with the following requirements, whether the request for the review is a standard, expedited or experimental/investigational review.

Apply to: Health insurance carriers in jurisdictions where the *Health Carrier External Review Model Act* (#75) has been adopted

Priority: Essential

Documents to be Reviewed

_____ Certificates, policies and company procedures

_____ Applicable statutes, rules and regulations

_____ Reports on external review requests

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Carrier External Review Model Act (#75)
Health Maintenance Organization Model Act (#430)
Issues Involving External Review Procedures White Paper

Review Procedures and Criteria

The *Health Carrier External Review Model Act* (#75) shall apply to all health carriers that provide or perform utilization review, except for the following:

> "The provisions of this Act shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, as defined by [insert the reference to state law that defines long-term care insurance], vision care or any other limited supplemental benefit or to a Medicare supplement policy of insurance, as defined by the commissioner by regulation, coverage under a plan through Medicare, Medicaid or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis."

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External Review Process, Option 3
This option makes it the responsibility of the health carrier to provide for an external review process and requires that covered persons file requests for external review with the health carrier. The health carrier must also assign an independent review organization, from the list of approved independent review organizations compiled by the insurance commissioner, to conduct a preliminary review of the request and conduct an external review of the request, if the request has satisfied specified requirements to be eligible for external review.

Standard Review Procedures
Send a copy of the request for an external review to the insurance commissioner.

Assign an independent review organization, upon receiving a request for an expedited external review, from the list compiled and maintained pursuant to Section 13 of this Act, to determine whether the request meets the reviewability requirements set forth in Section 8B of this Act and conduct the external review, if the request meets the reviewability requirements of Section 8B of this Act.

Provide within 7 days the documents considered in making the adverse determination or the final adverse determination to the assigned independent review organization.

Notify the covered person, if applicable, the covered person's authorized representative, the assigned independent review organization and the commissioner in writing of its decision upon making the decision to reverse its adverse determination or final adverse determination before a determination by the independent review organization.

Approve the coverage that was the subject of original adverse determination or final adverse determination upon receipt of a notice of a decision reversing the original determination.

Expedited External Review
Assign an independent review organization, from the list compiled and maintained pursuant to Section 13 of the Act, to determine whether the request meets the reviewability requirements set forth in the Act and conduct the external review if the request meets the reviewability requirements of the Act; and send a copy of the request to the commissioner.

Send a copy of the request for an external review to the commissioner.

Provide or transmit in an expeditious manner all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization.

Approve the coverage that was the subject of original adverse determination or final adverse determination upon receipt of a notice of a decision reversing the original determination.

Expedited Experimental or Investigational Review
Assign an independent review organization from the list of approved independent review organizations to determine whether the request meets the reviewability requirements and, if the request meets those requirements, conduct the review.

Provide or transmit in an expeditious manner all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization.

Standard Experimental or Investigational Review
Send a copy of the request for an external review to the commissioner.

Assign an independent review organization, from the list of approved independent review organizations compiled and maintained by the insurance commissioner pursuant to the Act, to conduct a preliminary review of the request to determine whether:

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Note: The independent review organization can deny the request for an external review.

Not choose or control the choice of the physicians or other health care professionals to be selected to conduct the external review.

Approve the coverage that was the subject of original adverse determination or final adverse determination upon receipt of a notice of a decision reversing the original determination.

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N. Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (#40)

Applies to State?	Review Criteria	Pass	Fail	N/A
	This regulation shall apply to individual and group accident and sickness insurance (except Medicare supplement insurance or any other insurance that is covered by a separate state statute) "advertisement," as that term is defined in Section 3B, G, H and I, unless otherwise specified in this regulation. **(Section 2A)**			
	Every insurer shall establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All of the insurer's advertisements, regardless of by whom written, created, designed or presented, shall be the responsibility of the insurer whose policies are advertised. **(Section 2B)**			
	Advertising materials that are reproduced in quantity shall be identified by form numbers or other identifying means. The identification shall be sufficient to distinguish an advertisement from any other advertising materials, policies, applications or other materials used by the insurer. **(Section 2C)**			
	All information, exceptions, limitations, reductions and other restrictions required to be disclosed by this regulation shall be set out conspicuously and in close conjunction to the statements to which the information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisements so as to be confusing or misleading. This regulation permits, but is not limited to, the use of either of two methods of disclosure listed in this Section. **(Section 4)**			
	The format and content of an advertisement of an accident or sickness insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Format means the arrangement of the text and the captions. **(Section 5A)**			

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Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	Distinctly different advertisements are required for publication in different media, such as newspapers or magazines of general circulation as compared to scholarly, technical or business journals and newspapers. Where an advertisement consists of more than one piece of material, each piece of material must, independent of all other pieces of material, conform to the disclosure requirements of this regulation. **(Section 5B)**			
	Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the commissioner from the overall impression that the advertisement may be reasonably expected to create within the segment of the public to which it is directed. **(Section 5C)**			
	Advertisements shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology, shall not be used. **(Section 5D)**			
	An insurer shall clearly identify its accident and sickness insurance policy as an insurance policy. A policy trade name shall be followed by the words "insurance policy" or similar words clearly identifying the fact that an insurance policy or health benefits product (in the case of health maintenance organizations, prepaid health plans and other direct service organizations) is being offered. **(Section 5E)**			
	An advertisement that is an invitation to contract[30] shall disclose the provisions relating to renewability, cancellability and termination and any modification of benefits, losses covered, or premiums because of age or for other reasons, in a manner that shall not minimize or render obscure the qualifying conditions. **(Section 7A)**			

[30] An advertisement providing details about specific products and intended to promote consumer purchase of insurance. An advertisement that includes an application is generally considered an invitation to contract. Such an advertisement would be regarded as an offer to contract if it contains some language of commitment or some invitation to take action without further communication.

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Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	Advertisements of cancelable accident and sickness insurance policies shall state that the contract is cancelable or renewable at the option of the company, as the case may be, in language substantially similar to the following: A policy that is renewable at the option of the insurance company shall be advertised in a manner similar to, "This policy is renewable at the option of the company," "The company has the right to refuse renewal of this policy," "Renewable at the option of the insurer" or "This policy can be cancelled by the company at any time." **(Section 7B)**			
	Advertisements of insurance policies that are guaranteed renewable, cancelable or renewable at the option of the company shall disclose that the insurer has the right to increase premium rates, if the policy so provides. **(Section 7C)**			
	Qualifying conditions that constitute limitations on the permanent nature of the coverage shall be disclosed in advertisements of insurance policies that are guaranteed renewable, cancelable or renewable at the option of the company. Examples of qualifying conditions are (1) age limits, (2) reservation of a right to increase premiums and (3) the establishment of aggregate limits. (1) Provisions for reduction of benefits at stated ages shall be set forth. For example, a policy may contain a provision that reduces benefits 50 percent after age 60, although it is renewable to age 65. Such a reduction shall be set forth. Also, a provision for the elimination of certain hazards at any specific ages or after the policy has been in force for a specified time shall be set forth. (2) An advertisement for a policy that provides for step-rated premium rates based upon the policy year or the insured's attained age shall disclose the rate increases and the times or ages at which the premiums increase. **(Section 7D)**			

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Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	An insurer, directly or through its agents or brokers, shall: (1) Establish marketing procedures to assure that any comparison of policies by its agents or brokers will be fair and accurate; (2) Establish marketing procedures assuring excessive insurance is not sold or issued, except this requirement does not apply to group major medical expense coverage and disability income coverage; and (3) Establish auditable procedures for verifying compliance with this subsection. **(Section 8A)**			
	In addition to the practices prohibited in [insert reference to state law equivalent to the *Unfair Trade Practices Act* (#880)], the following acts and practices are prohibited: (1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of insurance policies or insurers for the purpose of inducing, or intending to induce, a person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert an insurance policy, or to take out a policy of insurance with another insurer; (2) High Pressure Tactics. Employing a method of marketing that has the effect of inducing the purchase of insurance, or tends to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance; and (3) Cold Lead Advertising. Making use directly or indirectly of any method of marketing that fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company. **(Section 8B)**			
	Testimonials and endorsements used in advertisements shall be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced. The insurer, in using a testimonial or endorsement, makes as its own all of the statements contained in it, and the advertisement, including the statement, is subject to all the provisions of this regulation. When a testimonial or endorsement is used more than one year after it was originally given, a confirmation must be obtained. **(Section 9A)**			

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Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	A person shall be deemed a "spokesperson" if the person making the testimonial or endorsement: (1) Has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee or otherwise; (2) Has been formed by the insurer, is owned or controlled by the insurer, its employees or the person or persons who own or control the insurer; (3) Has any person in a policy-making position who is affiliated with the insurer in any of the above described capacities; or (4) Is in any way directly or indirectly compensated for making a testimonial or endorsement. **(Section 9B)**			
	The fact of a financial interest or the proprietary or representative capacity of a spokesperson shall be disclosed in an advertisement and shall be accomplished in the introductory portion of the testimonial or endorsement in the same form and with equal prominence. If a spokesperson is directly or indirectly compensated for making a testimonial or endorsement, the fact shall be disclosed in the advertisement by language substantially as follows: "Paid Endorsement." The requirement of this disclosure may be fulfilled by use of the phrase "Paid Endorsement" or words of similar import in a type style and size at least equal to that used for the spokesperson's name or the body of the testimonial or endorsement, whichever is larger. In the case of television or radio advertising, the required disclosure shall be accomplished in the introductory portion of the advertisement and shall be given prominence. **(Section 9C)**			
	The source of any statistics used in an advertisement shall be identified in the advertisement. **(Section 10C)**			
	When a choice of the amount of benefits is referred to, an advertisement that is an invitation to contract shall disclose that the amount of benefits provided depends upon the plan selected, and that the premium will vary with the amount of the benefits selected. **(Section 11B)**			

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Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	When an advertisement that is an invitation to contract refers to various benefits that may be contained in two (2) or more policies, other than group master policies, the advertisement shall disclose that the benefits are provided only though a combination of policies. **(Section 11C)**			
	The name of the actual insurer shall be stated in all of its advertisements. The form number or numbers of the policy advertised shall be stated in an advertisement that is an invitation to contract. An advertisement shall not use a trade name, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device that without disclosing the name of the actual insurer, would have the capacity and tendency to mislead or deceive as to the true identity of the insurer. **(Section 14A)**			
	Advertisements used by agents, producers, brokers or solicitors of an insurer shall have prior written approval of the insurer before they may be used. **(Section 14L)**			
	An agent who makes contact with a consumer, as a result of acquiring that consumer's name from a lead-generating device, shall disclose that fact in the initial contact with the consumer. An agent or insurer may not use names produced from lead-generating devices that do not comply with the requirements of this regulation. **(Section 14M)**			
	An advertisement to join an association, trust or discretionary group that is also an invitation to contract for insurance coverage shall clearly disclose that the applicant will be purchasing both membership in the association, trust or discretionary group and insurance coverage. The insurer shall solicit insurance coverage on a separate and distinct application that requires a separate signature. The separate and distinct applications required need not be on separate documents or contained in a separate mailing. The insurance program shall be presented so as not to conceal the fact that the prospective members are purchasing insurance as well as applying for membership, if that is the case. Similarly, it is prohibited to use terms such as "enroll" or "join" to imply group or blanket insurance coverage, when that is not the fact. **(Section 15D)**			

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Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	Advertising File. Each insurer shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of its individual policies and typical printed, published or prepared advertisements of its blanket, franchise and group policies hereafter disseminated in this or any other state, whether or not licensed in an other state, with a notation attached to each advertisement that indicates the manner and extent of distribution and the form number of any policy advertised. The file shall be subject to regular and periodical inspection by the commissioner. All of these advertisements shall be maintained in a file for a period of either 4 years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time. **(Section 18A)**			
	Certificate of Compliance. Each insurer required to file an annual statement shall file with the commissioner, with its annual statement, a certificate of compliance executed by an authorized officer of the insurer that states that, to the best of the officer's knowledge, information and belief, the advertisements that were disseminated by the insurer during the preceding statement year complied or were made to comply in all respects with the provisions of this regulation and the insurance laws of this state as implemented and interpreted by this regulation. **(Section 18B)**			
	An insurer, agent, broker, producer, solicitor or other person shall not solicit a resident of this state for the purchase of accident and sickness insurance in connection with or as the result of the use of advertisement by the person or any other persons, where the advertisement: (1) Contains any misleading representations or misrepresentations, or is otherwise untrue, deceptive or misleading with regard to the information imparted, the status, character or representative capacity of the person or the true purpose of the advertisement; or (2) Otherwise violates the provisions of this regulation. **(Section 5F)**			

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Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	An insurer, agent, broker, producer, solicitor or other person shall not solicit residents of this state for the purchase of accident and sickness insurance through the use of a true or fictitious name that is deceptive or misleading with regard to the status, character or proprietary or representative capacity of the person or the true purpose of the advertisement. **(Section 5G)**			
	Covered Benefits. (1) The use of deceptive words, phrases or illustrations in advertisements of accident and sickness insurance is prohibited. **(Section 6A)**			
	(2) An advertisement that fails to state clearly the type of insurance coverage being offered is prohibited. **(Section 6A)**			
	(3) An advertisement shall not omit information or use words, phrases, statements, references or illustrations if the omission of information or use of words, phrases, statements, references or illustrations has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements. **(Section 6A)**			
	(4) An advertisement shall not contain or use words or phrases such as "all," "full," "complete" "comprehensive," "unlimited," "up to," "as high as," "this policy will help fill some of the gaps that Medicare and your present insurance leave out," "the policy will help to replace your income" (when used to express loss of time benefits) or similar words and phrases, in a manner that exaggerates a benefit beyond the terms of the policy. **(Section 6A)**			

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Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	(5) An advertisement of a hospital or other similar facility confinement benefit that makes reference to the benefit being paid directly to the policyholder is prohibited unless, in making the reference, the advertisement includes a statement that the benefits may be paid directly to the hospital or other health care facility, if an assignment of benefits is made by the policyholder. An advertisement of medical and surgical expense benefits shall comply with this regulation in regard to the disclosure of assignments of benefits to providers of services. Phrases such as "you collect," "you get paid," "pays you" or other words or phrases of similar import may be used so long as the advertisement indicates that it is payable to the insured or someone designated by the insured. **(Section 6A)**			
	(6)(a) An advertisement for basic hospital expense coverage, basic medical-surgical expense coverage, basic hospital/medical-surgical expense coverage, hospital confinement indemnity coverage, accident only coverage, specified disease coverage, specified accident coverage or limited benefit health coverage or for coverage that covers only a certain type of loss is prohibited, if: (i) The advertisement refers to a total benefit maximum limit payable under the policy in any headline, lead-in or caption without also in the same headline, lead-in or caption specifying the applicable daily limits and other internal limits; (ii) The advertisement states a total benefit limit without stating the periodic benefit payment, if any, and the length of time the periodic benefit would be payable to reach the total benefit limit; or (iii) The advertisement prominently displays a total benefit limit that would not, as a general rule, be payable under an average claim. (b) This paragraph does not apply to individual major medical expense coverage, individual basic medical expense coverage or disability income insurance. **(Section 6A)**			
	(7) Advertisements that emphasize total amounts payable under hospital, medical or surgical accident and sickness insurance coverage or other benefits in a policy, such as benefits for private duty nursing, are prohibited, unless the actual amounts payable per day for the indemnity or benefits are stated. **(Section 6A)**			

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Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	(8) Advertisements that include examples of benefits payable under a policy shall not use examples in a way that implies that the maximum payable benefit payable under the policy will be paid, when less than maximum benefits are paid in an average claim. **(Section 6A)**			
	(9) When a range of benefit levels is set forth in an advertisement, it shall be clear that the insured will receive only the benefit level written or printed in the policy selected and issued. Language that implies that the insured may select the benefit level at the time of filing claims is prohibited. **(Section 6A)**			
	(10) Language in an advertisement that implies that the amount of benefits payable under a loss-of-time policy may be increased at the time of claim or disability according to the needs of the insured is prohibited. **(Section 6A)**			
	(11) Advertisements for policies with premiums that are modest because of their limited coverage or limited amount of benefits shall not describe premiums as "low," "low cost," "budget" or use qualifying words of similar import. The use of words such as "only" and "just" in conjunction with statements of premium amounts when used to imply a bargain is prohibited. **(Section 6A)**			
	(12) Advertisements that state or imply that premiums will not be changed in the future are prohibited, unless the advertised policies expressly provide that the premiums will not be changed in the future. **(Section 6A)**			
	(13) An advertisement for a policy that does not require the premium to accompany the application shall not overemphasize that fact and shall clearly indicate under what circumstances coverage will become effective. **(Section 6A)**			
	(14) An advertisement that exaggerates the effects of statutorily-mandated benefits or required policy provisions or that implies that the provisions are unique to the advertised policy is prohibited. **(Section 6A)**			
	(15) An advertisement that implies that a common type of policy or a combination of common benefits is "new," "unique," "a bonus," "a breakthrough" or is otherwise unusual is prohibited. The addition of a novel method of premium payment to an otherwise common plan of insurance does not render it new. **(Section 6A)**			

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Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	(16) Language in an advertisement that states or implies that each member under a family contract is covered as to the maximum benefits advertised, where that is not the fact, is prohibited. **(Section 6A)**			
	(17) An advertisement that contains statements such as "anyone can apply" or "anyone can join," other than with respect to a guaranteed-issue policy, for which administrative procedures exist to assure that the policy is issued within a reasonable period of time after the application is received by the insurer, is prohibited. **(Section 6A)**			
	(18) An advertisement that states or implies immediate coverage of a policy is prohibited, unless administrative procedures exist so that the policy is issued within 15 working days after the insurer receives the completed application. **(Section 6A)**			
	(19) An advertisement that contains statements such as "here is all you do to apply," "simply" or "merely" to refer to the act of applying for a policy that is not a guaranteed- issue policy is prohibited, unless it refers to the fact that the application is subject to acceptance or approval by the insurer. **(Section 6A)**			
	(20) An advertisement of accident and sickness insurance sold by direct response shall not state or imply that because no insurance agent will call and no commissions will be paid to agents that it is a low cost plan, or use other similar words or phrases because the cost of advertising and servicing the policies is a substantial cost in the marketing by direct response. **(Section 6A)**			
	(21) Applications, request forms for additional information and similar related materials are prohibited if they resemble paper currency, bonds, stock certificates, etc., or use any name, service mark, slogan, symbol or device in a manner that implies that the insurer or the policy advertised is connected with a government agency, such as the Social Security Administration or the Department of Health and Human Services. **(Section 6A)**			
	(22) An advertisement that implies in any manner that the prospective insured may realize a profit from obtaining hospital, medical or surgical insurance coverage is prohibited. **(Section 6A)**			

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Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	(23) An advertisement that uses words such as "extra," "special" or "added" to describe a benefit in the policy is prohibited. No advertisement of a benefit for which payment is conditioned upon confinement in a hospital or similar facility shall use words or phrases such as "tax-free," "extra cash," "extra income," "extra pay" or substantially similar words or phrases, because these words and phrases have the capacity, tendency or effect of misleading the public into believing that the policy advertised will, in some way, enable them to make a profit from being hospitalized. **(Section 6A)**			
	(24) An advertisement of a hospital or other similar facility confinement benefit shall not advertise that the amount of the benefit is payable on a monthly or weekly basis when, in fact, the amount of the benefit payable is based upon a daily pro rata basis relating to the number of days of confinement, unless the statements of the monthly or weekly benefit amounts are in juxtaposition with equally prominent statements of the benefit payable on a daily basis. The term "juxtaposition" means side by side or immediately above or below. When the policy contains a limit on the number of days of coverage provided, the limit shall appear in the advertisement. **(Section 6A)**			
	(25) An advertisement of a policy covering only one disease or a list of specified diseases shall not imply coverage beyond the terms of the policy. Synonymous terms shall not be used to refer to any disease so as to imply broader coverage than is the fact. **(Section 6A)**			
	(26) An advertisement that is an invitation to contract for a specified disease policy that provides lesser benefit amounts for a particular subtype of disease, shall clearly disclose the subtype and its benefits. This provision shall not apply to institutional advertisements.[31] **(Section 6A)**			

[31] An advertisement that is intended to provide general information about an insurer or company that does not include detailed product or policy specific information. Such an advertisement may, for example, be intended to promote company name recognition or to generate good will.

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	(27) An advertisement of a specified disease policy providing expense benefits shall not use the term "actual" when the policy only pays up to a limited amount for expenses. Instead, the term "charges" or substantially similar language should be used that does not create the misleading impression that there is full coverage for expenses. **(Section 6A)**			
	(28) An advertisement that describes any benefits that vary by age shall disclose that fact. **(Section 6A)**			
	(29) An advertisement that uses a phrase such as "no age limit," if benefits or premiums vary by age or if age is an underwriting factor, shall disclose that fact. **(Section 6A)**			
	(30) A television, radio, mail or newspaper advertisement or lead-generating device that is designed to produce leads either by use of a coupon, a request to write or to call the company or a subsequent advertisement prior to contact shall include information disclosing that an agent may contact the applicant. **(Section 6A)**			
	(31) Advertisements, applications, requests for additional information and similar materials are prohibited if they state or imply that the recipient has been individually selected to be offered insurance or has had his or her eligibility for the insurance individually determined in advance when the advertisement is directed to all persons in a group or to all persons whose names appear on a mailing list. **(Section 6A)**			

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Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	(32) An advertisement, including invitations to inquire[32] or invitations to contract, shall not employ devices that are designed to create undue fear or anxiety in the minds of those to whom they are directed. Examples of prohibited devices are: (a) The use of phrases such as "cancer kills somebody every two minutes" and "total number of accidents," without reference to the total population from which the statistics are drawn; (b) The exaggeration of the importance of diseases rarely or seldom found in the class of persons to whom the policy is offered; (c) The use of phrases such as "the finest kind of treatment," implying that the treatment would be unavailable without insurance; (d) The reproduction of newspaper articles, magazine articles, information from the Internet or other similar published material containing irrelevant facts and figures; (e) The use of images that unduly emphasize automobile accidents, disabled persons or persons confined in beds who are in obvious distress, persons receiving hospital or medical bills or persons being evicted from their homes due to their medical bills; (f) The use of phrases such as "financial disaster," "financial distress," "financial shock" or another phrase implying that financial ruin is likely without insurance is only permissible in an advertisement for major medical expense coverage, individual basic medical expense coverage or disability income coverage, and only if the phrase does not dominate the advertisement; (g) The use of phrases or devices that unduly excite fear of dependence upon relatives or charity; and (h) The use of phrases or devices that imply that long sicknesses or hospital stays are common among the elderly. **(Section 6A)**			

[32] An advertisement intended to promote inquiries to the insurer or its producers about a specific product or line of products. Such an advertisement would not be intended to induce an express undertaking to contract without further information, comparison or inquiry. Such advertisement may be an invitation to enter into negotiations, which may subsequently result in an offer and acceptance.

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Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	Exceptions, Reductions and Limitations (1) An advertisement shall not contain descriptions of policy limitations, exceptions or reductions, worded in a positive manner to imply that it is a benefit, such as describing a waiting period as a "benefit builder" or stating, "even preexisting conditions are covered after two years." Words and phrases used in an advertisement to describe the policy limitations, exceptions and reductions shall fairly and accurately describe the negative features of the limitations, exceptions and reductions of the policy offered. **(Section 6B)**			
	(2) An advertisement that is an invitation to contract shall disclose those exceptions, reductions and limitations affecting the basic provisions of the policy. **(Section 6B)**			
	(3) When a policy contains a waiting, elimination, probationary or similar time period between the effective date of the policy and the effective date of coverage under the policy or at a time period between the date a loss occurs and the date benefits begin to accrue for the loss, an advertisement that is subject to the requirements of the preceding paragraph shall prominently disclose the existence of the periods. **(Section 6B)**			
	(4) An advertisement shall not use the words "only," "just," "merely," "minimum," "necessary" or similar words or phrases to describe the applicability of any exceptions, reductions, limitations or exclusions such as: "This policy is subject to the following minimum exceptions and reductions." **(Section 6B)**			
	(5) An advertisement that is an invitation to contract that fails to disclose the amount of any deductible or the percentage of any coinsurance factor is prohibited. **(Section 6B)**			
	(6) An advertisement for loss-of-time coverage that is an invitation to contract that sets forth a range of amounts of benefit levels is prohibited unless it also states that eligibility for the benefits is based upon condition of health, income or other economic conditions, or other underwriting standards of the insurer if that is the fact. **(Section 6B)**			

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Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	(7) An advertisement that refers to "hospitalization for injury or sickness" omitting the word "covered" when the policy excludes certain sicknesses or injuries, or that refers to "whenever you are hospitalized," "when you go to the hospital" or "while you are confined in the hospital" omitting the phrase "for covered injury or sickness." if the policy excludes certain injuries or sickness, is prohibited. Continued reference to "covered injury or sickness" is not necessary where this fact has been prominently disclosed in the advertisement, and where the description of sicknesses or injuries not covered is prominently set forth. **(Section 6B)**			
	(8) An advertisement that fails to disclose that the definition of "hospital" does not include certain facilities that provide institutional care such as a nursing home, convalescent home or extended care facility, when the facilities are excluded under the definition of hospital in the policy, is prohibited. **(Section 6B)**			
	(9) The term "confining sickness" shall be explained in an advertisement containing the term. The explanation might be as follows: "Benefits are payable for total disability due to confining sickness only so long as the insured is necessarily confined indoors." Captions such as "Lifetime Sickness Benefits" or "Five-Year Sickness Benefits" are incomplete, if the benefits are subject to confinement requirements. When sickness benefits are subject to confinement requirements, captions such as "Lifetime House Confining Sickness Benefits" or "Five-Year House Confining Sickness Benefits" would be permissible. **(Section 6B)**			
	(10) An advertisement that fails to disclose any waiting or elimination periods for specific benefits is prohibited. **(Section 6B)**			
	(11) An advertisement for a policy providing benefits for specified illnesses only, such as cancer, or for specified accidents only, such as automobile accidents, or other policies providing benefits that are limited in nature, shall clearly and conspicuously in prominent type state the limited nature of the policy. The statement shall be worded in language identical to or substantially similar to the following: "This Is A Limited Policy," "This Policy Provides Limited Benefits," "This Is A Cancer Only Policy" or "This Is An Automobile Accident Only Policy." **(Section 6B)**			

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Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	Preexisting Conditions (1) An advertisement that is an invitation to contract shall, in negative terms, disclose the extent to which any loss is not covered, if the cause of the loss is traceable to a condition existing prior to the effective date of the policy. The use of the term "preexisting condition" without an appropriate definition or description shall not be used. **(Section 6C)**			
	(2) When an accident and sickness insurance policy does not cover losses resulting from preexisting conditions, an advertisement of the policy shall not state or imply that the applicant's physical condition or medical history will not affect the issuance of the policy or payment of a claim under the policy. This regulation prohibits the use of the phrase "no medical examination required" and phrases of similar import, but does not prohibit explaining "automatic issue." If an insurer requires a medical examination for a specified policy, the advertisement, if it is an invitation to contract, shall disclose that a medical examination is required. **(Section 6C)**			
	(3) When an advertisement contains an application form to be completed by the applicant and returned by mail, the application form shall contain a question or statement that reflects the preexisting condition provisions of the policy immediately preceding the blank space for the applicant's signature. For example, the application form shall contain a question or statement substantially as follows: "Do you understand that this policy will not pay benefits during the first [insert number] [years, months] after the issue date for a disease or physical condition that you now have or have had in the past? YES" Or substantially the following statement: "I understand that the policy applied for will not pay benefits for any loss incurred during the first [insert number] [years, months] after the issue date on account of disease or physical condition that I now have or have had in the past." **(Section 6C)**			

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Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	The disclosure requirements of this regulation shall not apply where the sole financial interest or compensation of a spokesperson, for all testimonials or endorsements made on behalf of the insurer, consists of the payment of union scale wages required by union rules, and if the payment is actually the scale for TV or radio performances. **(Section 9D)**			
	An advertisement shall not state or imply that an insurer or an accident and sickness insurance policy has been approved or endorsed by any individual, group of individuals, society, association or other organizations, unless that is the fact, and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial has been formed by the insurer or is owned or controlled by the insurer or the person or persons who own or control the insurer, the fact shall be disclosed in the advertisement. If the insurer or an officer of the insurer formed or controls the association, or holds any policy-making position in the association, that fact must be disclosed. **(Section 9E)**			
	When a testimonial refers to benefits received under an accident and sickness insurance policy, the specific claim data, including claim number, date of loss and other pertinent information shall be retained by the insurer for inspection for a period of 4 years or until the filing of the next regular report of examination of the insurer, whichever is the longer period of time. The use of testimonials that do not correctly reflect the present practices of the insurer or that are not applicable to the policy or benefit being advertised is not permissible. **(Section 9F)**			

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Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	An advertisement relating to the dollar amounts of claims paid, the number of people insured, or similar statistical information relating to an insurer or policy shall not use irrelevant facts, and shall not be used, unless it accurately reflects all of the current and relevant facts. The advertisement shall not imply that the statistics are derived from the policy advertised, unless that is the fact, and when applicable to other policies or plans shall specifically so state. (1) An advertisement shall specifically identify the accident and sickness insurance policy to which statistics relate and where statistics are given that are applicable to a different policy, it shall be stated clearly that the data do not relate to the policy being advertised. (2) An advertisement using statistics that describe an insurer, such as assets, corporate structure, financial standing, age, product lines or relative position in the insurance business, may be irrelevant and, if used at all, shall be used with extreme caution because of the potential for misleading the public. As a specific example, an advertisement for accident and sickness insurance that refers to the amount of life insurance which the company has in force or the amounts paid out in life insurance benefits is not permissible, unless the advertisement clearly indicates the amount paid out for each line of insurance. **(Section 10A)**			
	An advertisement shall not represent or imply that claim settlements by the insurer are "liberal," "generous" or use words of similar import, or that claim settlements are or will be beyond the actual terms of the contract. An unusual amount paid for a unique claim for the policy advertised is misleading and shall not be used. **(Section 10B)**			
	An advertisement that uses the word "plan" without prominently identifying it as an accident and sickness insurance policy is prohibited. **(Section 11A)**			

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Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	An advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits or comparisons of non-comparable policies of other insurers, shall not disparage competitors, their policies, services or business methods and shall not disparage or unfairly minimize competing methods of marketing insurance. An advertisement shall not contain statements such as "no red tape" or "here is all you do to receive benefits." **(Section 12A)**			
	Advertisements that state or imply that competing insurance coverages customarily contain certain exceptions, reductions or limitations not contained in the advertised policies are prohibited, unless the exceptions, reductions or limitations are contained in a substantial majority of the competing coverages. **(Section 12B)**			
	Advertisements that state or imply that an insurer's premiums are lower or that its loss ratios are higher because its organizational structure differs from that of competing insurers are prohibited. **(Section 12C)**			
	An advertisement that is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits. **(Section 13A)**			
	An advertisement shall not create the impression directly or indirectly that the insurer, its financial condition or status, or the payment of its claims, or the merits, desirability, or advisability of its policy forms or kinds or plans of insurance are approved, endorsed or accredited by any division or agency of this state or the federal government. Terms such as "official" or words of similar import, used to describe any policy or application form are prohibited because of the potential for deceiving or misleading the public. **(Section 13B)**			
	An advertisement shall not imply that approval, endorsement or accreditation of policy forms or advertising has been granted by any division or agency of the state or federal government. Approval of either policy forms or advertising shall not be used by an insurer to imply or state that a governmental agency has endorsed or recommended the insurer, its policies, advertising or its financial condition. **(Section 13C)**			

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Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	An advertisement shall not use any combination of words, symbols, or physical materials that by their content, phraseology, shape, color or other characteristics are so similar to combination of words, symbols or physical materials used by agencies of the federal government or of this state, or otherwise appear to be of such a nature that it tends to confuse or mislead prospective insureds into believing that the solicitation is in some manner connected with an agency of the municipal, state or federal government. **(Section 14B)**			
	Advertisements, envelopes or stationery that employ words, letters, initials, symbols or other devices that are similar to those used in governmental agencies or by other insurers are not permitted, if they may lead the public to believe: (1) That the advertised coverages are somehow provided by or are endorsed by the governmental agencies or the other insurers; (2) That the advertiser is the same, connected with or is endorsed by the governmental agencies or the other insurers. **(Section 14C)**			
	An advertisement shall not use the name of a state or political subdivision of a state in a policy name or description. **(Section 14D)**			
	An advertisement in the form of envelopes or stationery of any kind may not use any name, service mark, slogan, symbol or any device in a manner that implies that the insurer or the policy advertised, or that any agent who may call upon the consumer in response to the advertisement, is connected with a governmental agency, such as the Social Security Administration. **(Section 14E)**			
	An advertisement may not incorporate the word "Medicare" in the title of the plan or policy being advertised unless, wherever it appears, the word is qualified by language differentiating it from Medicare. The advertisement, however, shall not use the phrase "[…] Medicare Department of the […] Insurance Company" or language of similar import. **(Section 14F)**			
	An advertisement may not imply that the reader may lose a right or privilege or benefit under federal, state or local law if he or she fails to respond to the advertisement. **(Section 14G)**			

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Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	The use of letters, initials or symbols of the corporate name or trademark that would have the tendency or capacity to mislead or deceive the public as to the true identity of the insurer is prohibited, unless the true, correct and complete name of the insurer is in close conjunction and in the same size type as the letters, initials or symbols of the corporate name or trademark. **(Section 14H)**			
	The use of the name of an agency or "[ ] Underwriters" or "[ ] Plan" in type, size and location, so as to have the capacity and tendency to mislead or deceive as to the true identity of the insurer, is prohibited. **(Section 14I)**			
	The use of an address so as to mislead or deceive as to the true identity of the insurer, its location or licensing status is prohibited. **(Section 14J)**			
	An insurer shall not use, in the trade name of its insurance policy, any terminology or words so similar to the name of a governmental agency or governmental program as to have the tendency to confuse, deceive or mislead the prospective purchaser. **(Section 14K)**			
	An advertisement of a particular policy shall not state or imply that prospective insureds become group or quasi-group members covered under a group policy and as members, enjoy special rates or underwriting privileges, unless that is the fact. **(Section 15A)**			
	This regulation prohibits the solicitations of a particular class, such as governmental employees, by use of advertisements which state or imply that their occupational status entitles them to reduced rates on a group or other basis when, in fact, the policy being advertised is sold only on an individual basis at regular rates. **(Section 15B)**			
	Advertisements that indicate that a particular coverage or policy is exclusively for "preferred risks" or a particular segment of the population or that a particular segment of the population is an acceptable risk, when the distinctions are not maintained in the issuance of policies, are prohibited. **(Section 15C)**			

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Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	An advertisement to join an association, trust or discretionary group that is also an invitation to contract for insurance coverage shall clearly disclose that the applicant will be purchasing both membership in the association, trust or discretionary group and insurance coverage. The insurer shall solicit insurance coverage on a separate and distinct application that requires a separate signature. The separate and distinct applications required need not be on separate documents or contained in a separate mailing. The insurance program shall be presented so as not to conceal the fact that the prospective members are purchasing insurance as well as applying for membership, if that is the case. Similarly, it is prohibited to use terms such as "enroll" or "join" to imply group or blanket insurance coverage, when that is not the fact. **(Section 15D)**			
	Advertisements for group or franchise group plans that provide a common benefit or a common combination of benefits shall not imply that the insurance coverage is tailored or designed specifically for that group, unless that is the fact. **(Section 15E)**			
	(1) An advertisement of an individual policy shall not directly or by implication represent that a contract or combination of contracts is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless that is the fact. An advertisement shall not contain phrases describing an enrollment period as "special," "limited" or similar words or phrases when the insurer uses the enrollment periods as the usual method of marketing accident and sickness insurance. **(Section 16A)**			

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Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	(2) An enrollment period during which a particular insurance product may be purchased on an individual basis shall not be offered within this state, unless there has been a lapse of not less than [insert number] months between the close of the immediately preceding enrollment period for the same product and the opening of the new enrollment period. The advertisement shall indicate the date by which the applicant must mail the application, which shall be not less than 10 days and not more than 40 days from the date that the enrollment period is advertised for the first time. This regulation applies to all advertising media, i.e., mail, newspapers, the Internet, radio, television, magazines and periodicals, by any one insurer. It is inapplicable to solicitations of employees or members of a particular group or association that otherwise would be eligible under specific provisions of the insurance code for group, blanket or franchise insurance. The phrase "any one insurer" includes all the affiliated companies of a group of insurance companies under common management or control. **(Section 16A)**			
	(3) This regulation prohibits any statement or implication to the effect that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy, unless that is the fact. **(Section 16A)**			
	The phrase "a particular insurance product" in Paragraph (2) of this subsection means an insurance policy that provides substantially different benefits than those contained in any other policy. Different terms of renewability; an increase or decrease in the dollar amounts of benefits; an increase or decrease in any elimination period or waiting period from those available during an enrollment period for another policy shall not be sufficient to constitute the product being offered as a different product eligible for concurrent or overlapping enrollment periods. **(Section 16A)**			

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Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	B. An advertisement shall not offer a policy that utilizes a reduced initial premium rate in a manner that overemphasizes the availability and the amount of the initial reduced premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, the advertisement shall not display the amount of the reduced initial premium either more frequently or more prominently than the renewal premium, and both the initial reduced premium and the renewal premium must be stated in juxtaposition in each portion of the advertisement where the initial reduced premium appears. **(Section 16B)**			
	C. Special awards, such as a "safe driver's award," shall not be used in connection with advertisements of accident and sickness insurance. **(Section 16C)**			
	An advertisement shall not contain statements that are untrue in fact, or by implication misleading, with respect to the assets, corporate structure, financial standing, age or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system, unless it clearly indicates the purpose of the recommendation and the limitations of the scope and extent of the recommendations. **(Section 17)**			

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