

Date: 5/9/17

Market Conduct Examination Standards (D) Working Group
Conference Call
April 27, 2017

The Market Conduct Examination Standards (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call April 27, 2017. The following Working Group members participated: Bruce R. Ramage, Chair, Rhonda Ahrens, Martin Swanson and Cindy Williamson (NE); Jim Mealer, Vice Chair (MO); Bruce Glaser (CO); Kurt Swan (CT); Debra Peirce (GA); Russ Hamblen (KY); Rich Bradley (MA); Sherri Mortensen-Brown (MN); Maureen Belanger (NH); Peggy Willard-Ross (NV); Robert McLaughlin (NY); Amanda Baird, Rodney Beetch and Angela Dingus (OH); Cuc Nguyen and Joel Sander (OK); Constance Arnold and Robert Woronko (PA); Julie Fairbanks (VA); Christina Rouleau (VT); Jeanette Plitt (WA); Diane Dambach, John Kitslaar, Jo LeDuc, Cari Lee, Darcy Paskey and Rebecca Rebholz (WI); and Mark Hooker (WV). Also participating was: Pam O'Connell (CA).

1. Received a Report of Potential Inclusion of Content from Recently Adopted Non-ACA Models in the *Market Regulation Handbook*

On the Working Group's March 3 call, Director Ramage asked for volunteers to review the changes made to recently-adopted NAIC models not related to the federal Affordable Care Act (ACA) and to report to the Working Group as to whether corresponding updates to applicable *Market Regulation Handbook* (Handbook) market conduct examination standards should be made.

Mr. McLaughlin said the Working Group will need to update the Conducting the Long-Term Care Examination chapter (Chapter 22) of the Handbook with regard to recently adopted updates made to the *Long-Term Care Insurance Model Act* (#640) and the *Long-Term Care Insurance Model Regulation* (#641). Mr. McLaughlin presented to the Working Group his written comments outlining the specific topics and areas in the models that should be incorporated into examiner guidance in Chapter 22 of the Handbook.

Marty Mitchell (America's Health Insurance Plans—AHIP) said updated long-term care (LTC) guidance placed in the Handbook should refer to state laws and regulations, not to models. Birny Birnbaum (Center for Economic Justice—CEJ) said examiners already know to tailor the guidance in the Handbook to individual state laws and regulations. Director Ramage said the Handbook already contains this provision and said he would locate language in the Handbook that describes how examiners modify Handbook guidance to align with state statutes and regulations for the next Working Group call. Mr. Mealer made a motion, seconded by Ms. Plitt, to begin making LTC revisions to the *Market Regulation Handbook*. The motion passed unanimously.

Mr. Mealer and Ms. Plitt said they had reviewed the recently-revised *Advertisements of Life Insurance and Annuities Model Regulation* (#570). They said no updates are needed to the Handbook with regard to Model #570. Mr. Mealer said updates are also not needed to the Handbook with regard to recent revisions to the *Life Insurance and Annuities Replacement Model Regulation* (#613).

Ms. Ahrens said guidance should be added to the Conducting the Life and Annuity Examination chapter regarding the recently-revised *Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest* (AG 49). Ms. Ahrens said the actuarial guideline corresponds to the *Life Insurance Illustrations Model Regulation* (#582), which has been adopted in most jurisdictions. Ms. Ahrens said the guideline provides uniform guidance regarding illustrations calculated after the policy inception date for policies with index-based interest. Specifically, the guideline: 1) provides guidance in determining the maximum crediting rate for the illustrated scale and the earned interest rate for the disciplined current scale; 2) limits the policy loan leverage shown in an illustration; and 3) requires additional consumer information (side-by-side illustration and additional disclosures) that will increase consumer understanding. Mr. McLaughlin made a motion, seconded by Mr. Mealer, to begin making revisions pertaining to AG 49 to the Handbook. The motion passed unanimously. Director Ramage said he, Reva Vandevoorde (NE) and Ms. Ahrens would provide an exposure draft for distribution to the Working Group, interested state insurance regulators and interested parties.

Director Ramege said the Working Group should continue to monitor the progress of the *Annuity Disclosure Model Regulation* (#245), the *Suitability in Annuity Transactions Model Regulation* (#275), and the *Model Regulation on the Use of Senior-Specific Certifications and Professional Designations in the Sale of Life Insurance and Annuities* (#278) as these models are scheduled to be reopened in 2017 for further review, update and comment. Director Ramege said he is also monitoring the progress of the proposed draft Insurance Data Security Model Law. When the Insurance Data Security Model Law model is adopted, the Working Group will consider making corresponding updates to relevant sections of the Handbook.

Director Ramege asked the Working Group to identify and send any other models to him for consideration of inclusion in Handbook market conduct examination standards.

2. Reviewed and Discussed Revisions to Chapter 21—Conducting the Medicare Supplement Examination, April 25 Draft, for Inclusion in the Handbook

Mr. Swanson reviewed the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651) and suggested revisions be made to Operations/Management Standard 2 of Chapter 21—Conducting the Medicare Supplement Examination. The updates made to Model #651 were in regard to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which set forth standards outlining benefit requirements applicable to all Medicare Supplement policies on individuals newly eligible for Medicare on or after Jan. 1, 2020. Director Ramege asked for comments to be submitted on the draft by May 29 to Petra Wallace (NAIC).

3. Discussed Proposed New Content Regarding Closing Continuum Actions, March 1 Draft, for Inclusion in the Handbook

On the Working Group's March 23 call, Director Ramege said the Working Group identified issues in the closing continuum actions exposure draft in regard to: 1) possible duplication of content in the draft with content in existing Handbook chapters; 2) the need for descriptive language in the draft allowing deference to state statutes and regulations; and 3) suggestions from state insurance regulators that the language may be better suited as a reference document to the Handbook.

Ms. O'Connell presented her April 20 comments, suggesting that if the language from the exposure draft is added to the Handbook, that the language be consistent with language in other areas, specifically in Chapter 2—Continuum of Regulatory Responses. Ms. O'Connell said in her review of consistency in language, she found certain areas in Chapter 2 should be updated to reflect current guidance on continuum actions and content of the chapter should be arranged to reflect current state practices (e.g., placing the section regarding enforcement in Section C. Closure). Mr. Mealer suggested the Working Group consider making the closing continuum actions document a reference document and open Chapter 2 for review, comment and revision at an upcoming call. Director Ramege said he would re-review the closing continuum actions draft, taking into consideration the comments received to date, and provide revised language for consideration at the next call. Director Ramege asked for additional comments on the closing continuum actions draft to be submitted to Ms. Wallace by May 29.

4. Discussed an April 26 Proposed Compliance Risk Assessment Methodology Outline

Kirk Yeager (INS Regulatory Insurance Services Inc.) presented an outline addressing compliance risk assessment to the Working Group. Mr. Yeager said the approach in the outline is a review and analysis of information and data about a regulated entity to determine key issues or areas of concern that can result in potential compliance deficiencies and to prioritize examiner and examination resources for review of identified areas. Mr. Yeager said the methodology includes: 1) analysis of a regulated entity's compliance efforts, self-audits and compliance history; 2) information gathering; 3) interviews with regulated entity executive management personnel and process managers; 4) review of regulated entity processes and procedures (to include identification of inadequate and/or missing processes and procedures); 5) analysis of collected data; 6) development of a detailed work plan tailored to the identified areas and scope of the regulated entity's compliance risk; and 7) performing a market conduct examination following the methodology outlined in the Handbook.

Mr. Hooker said the methodology might be better suited for examinations performed as part of routine market conduct surveillance activities, rather than examinations of regulated entities for cause. Mr. Yeager said the methodology is not typically used in examinations with a narrow scope or focus. In response to Ms. Plitt's question regarding how the methodology differs from targeted continuum actions, Mr. Yeager said some duplication would occur. However, he said if "robust" market analysis were performed prior to an examination, then some portions of the methodology could be eliminated from the examination process.

Mr. Birnbaum asked what type of situation or issues would trigger a state's use of this type of methodology when initiating an examination of a regulated entity. Mr. Birnbaum said this methodology could be a tool state insurance regulators use as part of the continuum of regulatory options, in response to negative consumer-related outcomes as a result of regulated entity marketplace activity; or, to proactively assist in identifying problematic market-related issues that are affecting, or have the potential to affect, insurance consumers. Mr. Birnbaum said if a regulated entity's marketplace activities result in good consumer outcomes, there would be no need for examiners to use this methodology.

5. Discussed a Revised Proposal Regarding Process Review Methodology. Dated March 29

Director Ramage said the Working Group began reviewing a process review methodology proposal received in the fall of 2016 from Don Koch (NorthStarExams LLC). Director Ramage said Mr. Koch had recently prepared a revised proposal for the Working Group's review and discussion. Director Ramage asked that comments on the proposal be submitted by May 29 to Ms. Wallace.

Director Ramage said NAIC staff will provide advance email notice of the next Working Group call, to occur in June.

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

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**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 2

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

Apply to: All Medicare supplement carriers

Priority: Essential

Documents to be Reviewed

_____ Reporting Medicare supplement policies form

_____ Records of issued Medicare supplement policies/certificates

_____ Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

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

Review Procedures and Criteria

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

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

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

Review whether or not that plans, after January 1, 2020 are in compliance with Section 9.2 of the model.

Review whether or not the Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020 is correct pursuant to the model regulation.

Review whether or not the information provided by the carrier on Plan F or High Deductible F is correct pursuant to the model regulation for plans issued on or after January 1, 2020.

Review whether or not the information provided by the carrier on Plan G or High Deductible G is correct pursuant to the model regulation for plans issued on or after January 1, 2020.

Chapter X—Closing Continuum Actions

The process for continuum actions from inception to closing may be divided into four phases: (1) a “Fact Finding Phase” in which insurance department personnel are gathering facts¹ from the regulated entity and other sources²; (2) a “Violation Analysis Phase” in which the insurance department is applying the law to the facts in an effort to determine if any violations of the law have occurred; (3) a “Remedial Phase” in which the insurance department seeks appropriate remedies for any violations of the law; and (4) a “Reporting Phase” in which the insurance department reports the resolution of the continuum action to interested parties.

A. The Fact Finding Phase

Continuum actions involving the gathering of information from regulated entities regarding their activities can be divided into continuum actions that are undertaken pursuant to the insurance department’s investigation authority and those that are undertaken pursuant to the insurance department’s examination authority.

1. Continuum Actions under Investigation Authority

Chapter 2—Continuum of Regulatory Responses of this handbook lists a number of actions in the section titled “Contact with the Regulated Entity” that may be undertaken by an insurance department under its investigation authority³. Continuum actions under the investigation authority may be initiated on an informal basis (e.g., writing a letter to a company requesting information about an activity) or they may be part of a formal market regulation investigation as described in Chapter 7—Market Regulation Investigation Guidelines of this handbook. Regardless of whether the investigation is informal or formal, the end product of the Fact Finding Phase is generally a summary of findings from which a determination may be made in the next phase of the continuum action process. Depending upon the type of continuum action, the summary of findings may be as informal as a verbal discussion with a supervisor or may involve a more formal written memorandum or investigation report.

2. Continuum Actions under Examination Authority

Market conduct examinations are the continuum actions undertaken pursuant to an insurance department’s examination authority. The types of market conduct examinations and the procedures used are discussed in great detail in other chapters of this handbook, so they will not be described in detail here. While variations in the market conduct examination process may occur due to variations in state law, the Fact Finding Phase generally concludes with a draft examination report being filed with the insurance department by the exam team conducting the examination along with a response to the draft examination report being filed by the entity examined.

¹ Facts may be gathered through the entire continuum process beginning with market analysis and extending to examinations.

² Some states may also utilize market regulation continuum actions to investigate entities operating illegally in a state. In such cases, fact finding may also extend to such illegally operating entities.

³ Some states may take the position that all continuum activities from market analysis through examinations are conducted under their examination authority. For such states, the discussion of “Continuum Actions under Investigation Authority” in this chapter is intended to describe any continuum actions that these states may initiate under their examination authority other than actual market conduct examinations.

B. The Violation Analysis Phase

Once the Fact Finding Phase is completed, the results are referred to insurance department personnel with the requisite authority to determine whether violations have occurred⁴, which may vary depending upon the department's organizational structure. These insurance department personnel review the facts and apply the relevant laws to those facts in an effort to analyze whether or not the facts demonstrate a violation of the insurance laws. In performing this analysis, the insurance department personnel must apply the standards imposed by the language of the state's laws.

1. Laws Requiring Intent vs. Laws without Intent Language

In a legal context, "intent" is "[a] state of mind in which a person seeks to accomplish a given result through a course of action." *Black's Law Dictionary, Sixth Edition*, p. 810 (1990). Some laws have as a component of the violation that the prohibited action must be done with some level of intent. Laws that describe the prohibited action as being done "knowingly," "willfully" or "in conscious disregard" are laws that require the facts to demonstrate some intent on the part of the regulated entity in order for the entity's action to be considered a violation. Intent "can seldom be proved by direct evidence, but must ordinarily be proved by circumstances from which it may be inferred." *Id.* For example, evidence that behavior contrary to the law had previously been brought to the regulated entity's attention but it had done nothing to change its behavior would be circumstantial evidence that it acted with intent. Where intent is a necessary element of the prohibited conduct in the law, there is no violation if no evidence is found indicating intent on the part of the regulated entity.

By contrast, some laws contain no language indicating a requirement for intent on the part of the violator. In applying such laws to the facts, all that need be shown in order to show a violation of the law is that the regulated entity engaged in the prohibited conduct.

2. Frequency Based Violations vs. Non-Frequency Based Violations

For some insurance laws, the question of whether a violation has occurred is dependent upon whether the regulated entity committed the prohibited conduct with sufficient frequency. Two examples of this type of law are the *Unfair Trade Practices Act* (#880) and the *Unfair Claims Settlement Practices Act* (#900). Both of these model laws indicate that a violation may be found if the regulated entity commits any of the actions defined in the laws "with such frequency to indicate a general business practice to engage in that type of conduct." When conducting compliance testing for activities regulated by these two model laws, states frequently utilize benchmark error rates. The presumption of a business practice violation is created when the ratio of errors to the total number of files tested exceeds these benchmark error rates. States vary in the benchmark error rates they use.

When analyzing the facts for the existence of a business practice, however, the reviewer should be careful not to slavishly rely upon the benchmark error rates. A business practice may be shown by other evidence. For example, a test for claims practices may uncover only one error out of a field of 100. The resulting error rate of 1% may be less than the state's benchmark error rate for claims practices, but a review of the company's claims processing manual shows that all claims of the type that was noted as an error will be processed in this way. Therefore, the combination of the claims processing manual and the single found error demonstrate that it is the company's business practice to incorrectly process all claims of that type in violation of the law despite the test error rate of only 1%.

⁴ Some states will initiate a continuum action where a substantive error occurs even though a statute or regulation does not actually address the conduct. In such cases, the analysis phase may only involve a consideration of what actions, if any, the insurance department may be able to take.

Many other insurance laws are not based upon the frequency of committing the prohibited conduct. For these laws, a single instance of the prohibited conduct would constitute a violation. Such laws are the type of laws with which the average person is most familiar. For example, the laws against exceeding the speed limit do not say that one must exceed the speed limit a certain number of times before the law is violated; you will receive a ticket for a violation each time a policeman catches you speeding.

Similarly, some states have not included the “business practice” language when enacting the *Unfair Trade Practices Act* (#880) and/or the *Unfair Claims Settlement Practices Act* (#900). In these states, a violation occurs each time the regulated entity commits any of the acts prohibited by the statute regardless of whether it occurred once or one hundred times.

3. Violations of Prior Orders or Agreements

Some state laws make it a separate violation to fail to comply with an order or agreement not to behave in a certain way. For example, an insurance company may have entered into a settlement agreement with an insurance department not to process claims in a way that violated insurance law due to a finding of such violations in a market conduct examination. In a subsequent market conduct examination, it was discovered that the insurance company had continued to process claims in this way despite its agreement not to do so. If the state has a law making the company's failure to comply with the settlement agreement a violation, the company in this instance would be guilty of violating both the claims practices law it had previously violated as well as the law against failing to comply with a settlement agreement.

C. The Remedial Phase

The actions taken in this phase of the process are a function of what was determined in the Violation Analysis Phase.

1. No Violations Found

Where no violations are found, there is nothing to remedy, and the continuum action is usually closed without further action. How this occurs is a function of the type of continuum action. Actions under the investigation authority may or may not have prescribed processes under the state's laws, so closing may or may not involve communication of the resolution to the regulated entity. The market conduct examination process is usually more formalized. While the exact process depends upon a state's law, it usually involves something similar to the *Model Law on Examinations* (#390): (1) finalizing the exam report; (2) adoption of the exam report; and (3) forwarding of the adoption order and finalized exam report to the regulated entity examined.

Alternatively, if the regulator conducting the Violation Analysis Phase determines there is insufficient evidence of a violation, but there is reason to believe that it would be appropriate to gather additional facts, he or she could reopen the Fact Finding Phase. The degree of formality with which the Fact Finding Phase is reopened is a function of the state's law and the insurance department's procedures. The *Model Law on Examinations* (#390) specifically provides two options for reopening the Fact Finding Phase for market conduct examinations by authorizing the insurance commissioner to (1) reject the examination report with instructions to the examiners to reopen the examination to gather additional information or (2) call for an investigatory hearing for the same purpose.

2. Violations Found

Actions taken when violations are found depend upon the nature of the violations and the circumstances of the continuum action.

a. Resolution with Instructions to Cure any Violations Found

If violations are found that do not rise to a level requiring disciplinary action, a continuum action may be closed with instructions to the regulated entity to take action to bring itself into compliance with the law. Depending upon a state's laws, this directive to comply for continuum actions under an insurance department's investigation authority could be as informal as a verbal instruction or letter or as formal as a department order. Market conduct examinations usually have more formal procedures that may vary by state. For example, the *Model Law on Examinations* (#390) provides that "the commissioner may order the company to take any action the commissioner considers necessary and appropriate to cure the violation" in those states that have enacted it.

b. Voluntary Settlement

The majority of continuum actions where violations are found and disciplinary action is deemed appropriate are resolved through a voluntary settlement. Voluntary settlements allow the insurance department and the regulated entity to avoid the time, trouble and expense of litigation. While state laws may vary as to the process, voluntary settlements usually involve a negotiated settlement agreement and/or appropriate departmental orders, such as consent orders, encompassing one or more of the following remedial measures.

(1) Retrospective Remediation

To address past violations, a voluntary settlement may require the regulated entity to take steps to remedy its past practices, including the payment of restitution where appropriate. For example, a company that had been improperly denying claims may be required to reprocess and pay previously denied claims, including applicable interest, in order to make affected consumers whole.

(2) Prospective Remediation

To ensure that violations do not continue to occur, a voluntary settlement may require the regulated entity to cease and desist from engaging in the prohibited conduct and to develop a plan to ensure future compliance. The voluntary settlement may also require the regulated entity to perform self-audits of its compliance measures.

(3) Monetary Fines

A voluntary settlement may include a requirement for the regulated entity to pay a fine for the violations of law. The calculation of a fine should be based upon the provisions of state law, which may allow for the consideration of various aggravating and mitigating circumstances.

- (a) Intent as an aggravating or mitigating factor: While intent may be an element of determining whether or not a violation has occurred for some laws, other laws may utilize intent as a mechanism to enhance or reduce the fine. In such instances, evidence showing that the regulated entity acted with intent (e.g. "knowingly," "willfully" or "in conscious disregard") would involve the imposition of a higher fine and lack of a showing of intent would lead to a lesser fine.
- (b) Business practice violations: For laws that are not frequency based, the fining provision of state laws usually regard each instance of conduct contrary to the law as being subject to a separate fine. Frequency based business practice laws, however, may vary in how a fine is calculated. Some state laws may regard the business practice as a single violation subject to a single fine. Other state laws may regard the business practice standard as merely a threshold. Once a

business practice is established under this threshold view, each act making up the business practice is considered a separate violation subject to a separate fine.

- (c) Violation of prior agreements or orders as an aggravating factor: As noted above, a regulated entity's failure to comply with a prior agreement or order may be regarded as a separate violation subject to a separate fine under some state's laws. Additionally, this failure to comply may also be regarded as evidence of intent and an aggravating factor leading to increased fines for the underlying conduct that is contrary to the prior agreement or order.
- (d) Behavior of the regulated entity as a mitigating or aggravating factor: Where the insurance department has some discretion to calculate fines within a range, the behavior of the regulated entity both before and during the continuum action may act as either a mitigating or aggravating factor. Cooperation with the continuum action, efforts to identify and correct problems prior to the continuum action being initiated or self-reporting of a violation are examples of behavior that may justify a lower fine within the range. Lack of cooperation, obstruction or evasion by the regulated entity are types of behavior that may justify increases of the fine within the range.
- (e) Level of harm as an aggravating factor: The severity of financial or other harm to affected persons caused by the violations may act as an aggravating factor in calculating a fine, as opposed to technical violations that cause no apparent harm. Some state laws specifically recognize the amount or type of harm as an aggravating factor allowing an enhancement to the amount of fine imposed.

(4) Suspension or Revocation of License

Where violations are particularly egregious, a voluntary settlement may include the suspension or revocation of the regulated entity's license. Some state laws may allow a voluntary settlement to include a period of probation in lieu of a suspension or revocation of the license.

(5) Monitoring and Reporting

A voluntary settlement will likely include a requirement that the regulated entity provide the insurance department with reports on its retrospective and prospective remedial activities. Such reports may be at the completion of the remediation or may be required periodically if the voluntary settlement includes a monitoring period. After remedial measures are completed and any monitoring period has ended, the insurance department may determine that a follow-up investigation or examination is appropriate to audit compliance with the terms of the voluntary settlement.

c. Initiate an Administrative or Court Proceeding

Where the insurance department and the regulated entity cannot resolve a continuum action through a voluntary settlement, the insurance department may decide to initiate a formal proceeding. This may be either an administrative proceeding or a court proceeding depending upon the state's laws. In either case, it is important to realize the Fact Finding Phase starts anew given that either side may seek to do discovery (e.g., depositions, interrogatories or requests for production of documents) and the administrative hearing officer or judge will make his or her own findings of fact based upon the evidence presented at a hearing. After the hearing, the administrative hearing officer or judge will enter an order setting forth findings of fact and conclusions of law as to whether violations exist. This order may also impose some of the same kinds of disciplinary actions discussed above for voluntary settlements if the administrative hearing officer or judge agrees that violations exist, but if the administrative hearing officer or judge does not agree that violations exist, no discipline will be imposed. Either party may appeal the order through the court system if they are not happy with the result. This may lead to a protracted period before the continuum action is resolved unless the parties decide to negotiate a voluntary settlement at some point during the process.

d. Referral to the Market Actions (D) Working Group

If the findings of the continuum action indicate issues affecting multiple states, the insurance department may wish to refer the matter to the Market Actions (D) Working Group for collaborative action. A detailed discussion of this process may be found in Chapter 6—Collaborative Actions.

D. The Reporting Phase

Where appropriate, the results of a continuum action should be reported in accordance with the state's law and in the applicable NAIC database.

1. Publication of the Resolution as Authorized by State Law

The extent to which the resolution of a continuum action becomes a public record under a state's law may be dependent upon the type of continuum action.

a. Continuum Actions under Investigation Authority

Continuum actions under the investigation authority may not be considered public records under many state's laws unless some form of disciplinary action is imposed. Where disciplinary action is imposed, the settlement agreement and/or order for a voluntary settlement or the order entered pursuant to an administrative or court proceeding are frequently considered public documents⁵. Many insurance departments may wish to increase the dissemination of this information by posting the information on its website and issuing press releases.

b. Continuum Actions under Examination Authority

Finalized market conduct examination reports are generally considered public documents under state examination laws regardless of whether any violations were found or any disciplinary action was imposed. The "Continuum Core Competencies" for market conduct examinations in Appendix D of this handbook indicate that the publication of the final examination report should include the regulated entity's response to the examination report where allowed by state law. If disciplinary action is imposed, this will also likely include the settlement agreement and/or order for a voluntary settlement or the order entered pursuant to an administrative or court proceeding. As discussed above, dissemination of the final examination report and related documents to the public may occur through posting the information on the insurance department's website and the issuance of press releases.

2. Report the Resolution in the Market Actions Tracking System

The Market Actions Tracking System (MATS) was developed by the NAIC for tracking and reporting information regarding continuum actions to the other states. The resolution of any continuum action recorded in MATS should be entered into the system to share with other states.

3. Report any Disciplinary Action in the Regulatory Information Retrieval System

The Regulatory Information Retrieval System (RIRS) was developed by the NAIC to document and share information regarding disciplinary actions taken against regulated entities. If a continuum action results in disciplinary action, this information should be recorded in RIRS to share with the other states.

⁵ While settlement agreements and orders may be considered public documents, any other information in the continuum action file (e.g., work papers, information received, communications, etc.) may still be accorded confidential status under the laws of many states. In particular, this is likely to be the case where a state conducts all of its continuum activities under its examination authority.

4. Other Reporting Activities

The section titled “Closure” of Chapter 2—Continuum of Regulatory Responses of this handbook mentions other means of reporting on issues uncovered in a continuum action to interested parties, such as insurance department bulletins, consumer outreach and referrals to other law enforcement agencies. Where appropriate, these may be considered and implemented.

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TEXAS DEPARTMENT OF INSURANCE

Enforcement Section (110-1A)

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Attachment 3

May 19, 2017

Director Bruce R. Ramege, Chair
NAIC Market Conduct Examination Standards (D) Working Group
Attn: Petra Wallace
1100 Walnut St, Suite 1500
Kansas City, MO 64106

VIA EMAIL ONLY: pwallace@naic.org

RE: Proposed Chapter X – Closing Continuum Actions, and Chapter 2, NAIC’s Market Regulation Handbook 2016

Dear Director Ramege, Ms. Wallace, and working group members:

Thank you for this opportunity to comment on both proposed Chapter X, and possible improvements to the existing Chapter 2 in the NAIC’s Market Regulation Handbook, 2016.

First, the Texas Department of Insurance (TDI) agrees with California’s April 20, 2017 written comments recommending the movement of section “3. Enforcements” as it appears in the existing 2016 handbook to appear under heading “C. Closure” in Chapter 2. In Texas, the items listed as methods of taking enforcement action chronologically occur as a regulatory response after the conclusion of the market conduct examination.

Second, TDI agrees with Iowa’s March 16, 2017 comments and California’s December 29, 2016 comments on Chapter X suggesting that proposed section “B. The Violation Analysis Phase” should not be included. Proposed section B. provides legal discussion on: laws requiring and not requiring intent; the frequency versus non-frequency of violations; and violations of prior orders and agreements. Such topics delve into what individual state laws require and how individual states interpret their own laws. Section B. goes far beyond the handbook’s own purpose as a tool “to assist states in optimizing the use of insurance department resources, eliminating duplicative inquiries and investigations and coordinating efforts with other states.” *NAIC’s Market Regulation Handbook, 2016* at 1.

Third, TDI also recommends exclusion of proposed section B. because it appears to encroach upon the provision of legal advice and analysis. Section B. fails to suggest that department personnel consult with their own legal counsel. Competent legal counsel acting on the behalf of an individual state are in the best position to provide legal guidance and advice on the topics included under proposed section B, as well as to counsel department personnel on any other factual and legal considerations pertinent to an individual state’s decision on whether or not a violation has occurred.

Fourth, TDI notes that the following statement in section B.3. “Violations of Prior Orders or Agreements” is simply erroneous:

If the state has a law making the company's failure to comply with the settlement agreement a violation, the company in this instance *would be guilty* of violating both the claims practices law it had previously violated as well as the law against failing to comply with a settlement agreement.

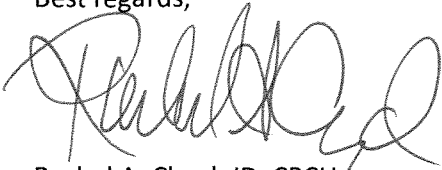
(emphasis added). This sentence applies criminal guilt to a civil disciplinary matter. Guilt is a criminal term, a state of responsibility assigned by a judge or jury for a criminal offense. In the civil enforcement context, “guilt” and “innocence” are not assigned by a hearing officer or administrative law judge. Rather, generally speaking, the department’s personnel or staff have the burden to prove by a preponderance of the evidence that a violation has occurred. The civil “punishment” is a sanction or discipline, which may include a monetary penalty, restitution, suspension, probation, revocation, or

imposition of a cease and desist order. Further, the sentence fails to account for the company's right to due process, including notice and a hearing.

Finally, proposed Section "C. The Remedial Phase" in Chapter X appears repetitive of the existing section "3. Enforcements" in the 2016 handbook, and thus may not be necessary. However, if included, TDI again has concerns that the entirety of section "C.2. Violations Found" borders on the provision of legal advice, and fails to contemplate that department personnel should consult with their own legal counsel when violations are found to discuss what method of resolution or remediation is appropriate.

Thank you for your time and consideration.

Best regards,

A handwritten signature in black ink, appearing to read "Rachel A. Cloyd". The signature is fluid and cursive, with the first name being the most prominent.

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cc: Ignatius Wheeler, Associate Commissioner - Chief Examiner

Chapter X—Closing Continuum Actions

The following discussion provides one example of how one jurisdiction approaches the closing of continuum actions. For every jurisdiction, the appropriate guidance for closing an action should ultimately be applicable state law such as insurer examination acts and administrative procedures acts along with established department policies. Individual state guidance may vary on mechanics, reporting requirements and timing for closing such actions. For example, some examination acts may require a period for “rebuttal” prior to issuing a final report. Some jurisdictions may have different requirements for investigations versus examinations. Jurisdictions may also have varying philosophies relative to resolution steps in the event of determinations of non-compliance. Guidance from the insurance Department’s legal counsel or division is often helpful in determining appropriate closing steps.

The process for continuum actions from inception to closing may be divided into four phases: (1) a “Fact Finding Phase” in which insurance department personnel are gathering facts¹ from the regulated entity and other sources²; (2) a ~~“Violation Analysis Phase”~~ “Compliance Evaluation and Documentation” phase in which the insurance department is applying the law to the facts in an effort to determine if ~~any violations of the law have occurred~~ company treatment of consumers is consistent with applicable laws, regulations and policy contract provisions; (3) a “Remedial Phase”, if applicable or necessary, in which the insurance department seeks appropriate remedies for ~~any violations of the law~~ material findings of non-compliance; and (4) a “Reporting Phase” in which the insurance department reports the resolution of the continuum action ~~to interested parties in accordance with state law~~. In some jurisdictions, steps 3 and 4 may be in opposite order. In other words, some states may issue a final report of findings prior to determination if any formal remedial action is necessary. Formal action may be in the form of an administrative order. Informal action may consist of corrective recommendations within the report.

A. The Fact Finding Phase

Continuum actions involving the gathering of information from regulated entities regarding their activities can be divided into continuum actions that are undertaken pursuant to the insurance department’s investigation authority and those that are undertaken pursuant to the insurance department’s examination authority.

1. Continuum Actions under Investigation Authority

Chapter 2—Continuum of Regulatory Responses of this handbook lists a number of actions in the section titled “Contact with the Regulated Entity” that may be undertaken by an insurance department under its investigation authority³. Continuum actions under the investigation authority may be initiated on an informal basis (e.g., writing a letter to a company requesting information about an activity) or they may be part of a formal market regulation investigation as described in Chapter 7—Market Regulation Investigation Guidelines of this handbook. Regardless of whether the investigation is informal or formal, the end product of the Fact Finding Phase is generally a summary of findings from which a

¹ Facts may be gathered through the entire continuum process beginning with market analysis and extending to examinations.

² Some states may also utilize market regulation continuum actions to investigate entities operating illegally in a state. In such cases, fact finding may also extend to such illegally operating entities.

³ Some states may take the position that all continuum activities from market analysis through examinations are conducted under their examination authority. For such states, the discussion of “Continuum Actions under Investigation Authority” in this chapter is intended to describe any continuum actions that these states may initiate under their examination authority other than actual market conduct examinations.

determination may be made in the next phase of the continuum action process. Depending upon the type of continuum action, the summary of findings may be as informal as a verbal discussion with a supervisor or may involve a more formal written memorandum or investigation report.

2. Continuum Actions under Examination Authority

Market conduct examinations are the continuum actions undertaken pursuant to an insurance department's examination authority. The types of market conduct examinations and the procedures used are discussed in great detail in ~~other~~ chapters of ~~this the~~ *NAIC Market Regulation Handbook*, so they will not be described in detail here. While variations in the market conduct examination process may occur due to variations in state law, the Fact Finding Phase generally concludes with a draft examination report being filed with the insurance department by the exam team conducting the examination along with a response to the draft examination report being filed by the entity examined.

B. The ~~Violation Analysis~~ Compliance Evaluation and Documentation Phase

Once the Fact Finding Phase is completed, evaluation and documentation of items demonstrating potential non-compliance ~~the results~~ are referred to insurance department personnel with the requisite authority to determine whether violations have actually occurred⁴. Applicable personnel, which may vary depending upon the department's organizational structure. These insurance department personnel review the facts and apply the relevant laws to those facts in an effort to analyze whether or not the facts demonstrate compliance or non-compliance with ~~a violation of~~ the insurance laws for items in question. In performing this analysis, the insurance department personnel must apply the standards imposed by the language of the state's laws.

1. Laws Requiring Intent vs. Laws without Intent Language

In a legal context, "intent" is "[a] state of mind in which a person seeks to accomplish a given result through a course of action." *Black's Law Dictionary, Sixth Edition*, p. 810 (1990). Some laws have as a component of the violation that the prohibited action must be done with some level of intent. Laws that describe the prohibited action as being done "knowingly," "willfully" or "in conscious disregard" are laws that require the facts to demonstrate some intent on the part of the regulated entity in order for the entity's action to be considered a violation. Intent "can seldom be proved by direct evidence, but must ordinarily be proved by circumstances from which it may be inferred." *Id.* ~~For example, evidence that behavior contrary to the law had previously been brought to the regulated entity's attention but it had done nothing to change its behavior would be circumstantial evidence that it acted with intent. Where intent is a necessary element of the prohibited conduct in the law, there is no violation if no evidence is found indicating intent on the part of the regulated entity.~~

By contrast, some laws contain no language indicating a requirement for intent on the part of the violator. In applying such laws to the facts, all that need be shown in order to show a violation of the law is that the regulated entity engaged in the prohibited conduct.

2. Frequency Based Violations vs. Non-Frequency Based Violations

For some insurance laws, the question of whether a violation has occurred is dependent upon whether the regulated entity committed the prohibited conduct with sufficient frequency. Two examples of this type of law are the *Unfair Trade Practices Act* (#880) and the *Unfair Claims Settlement Practices Act*

⁴ Some states will initiate a continuum action where a substantive error occurs even though a statute or regulation does not actually address the conduct. In such cases, the analysis phase may only involve a consideration of what actions, if any, the insurance department may be able to take.

(#900). Both of these model laws indicate that a violation may be found if the regulated entity commits any of the actions defined in the laws “with such frequency to indicate a general business practice to engage in that type of conduct.” When conducting compliance testing for activities regulated by these two model laws, states frequently utilize benchmark error rates. The presumption of a business practice violation is created when the ratio of errors to the total number of files tested exceeds these benchmark error rates. States vary in the benchmark error rates they use.

When analyzing the facts for the existence of a business practice, however, the reviewer should be careful not to slavishly rely upon the benchmark error rates. A business practice may be shown by other evidence. For example, a test for claims practices may uncover only one error out of a field of 100. The resulting error rate of 1% may be less than the state’s benchmark error rate for claims practices, but a review of the company’s claims processing manual shows that all claims of the type that was noted as an error will be processed in this way. Therefore, the combination of the claims processing manual and the single found error demonstrate that it is the company’s business practice to incorrectly process all claims of that type in violation of the law despite the test error rate of only 1%.

Many other insurance laws are not based upon the frequency of committing the prohibited conduct. For these laws, a single instance of the prohibited conduct would constitute a violation. Such laws are the type of laws with which the average person is most familiar. For example, the laws against exceeding the speed limit do not say that one must exceed the speed limit a certain number of times before the law is violated; you will receive a ticket for a violation each time a policeman catches you speeding.

Similarly, some states have not included the “business practice” language when enacting the *Unfair Trade Practices Act* (#880) and/or the *Unfair Claims Settlement Practices Act* (#900). In these states, a violation occurs each time the regulated entity commits any of the acts prohibited by the statute regardless of whether it occurred once or one hundred times.

3. Violations of Prior Orders or Agreements

Some state laws make it a separate violation to fail to comply with an order or agreement not to behave in a certain way. For example, an insurance company may have entered into a settlement agreement with an insurance department not to process claims in a way that violated insurance law due to a finding of such violations in a market conduct examination. In a subsequent market conduct examination, it was discovered that the insurance company had continued to process claims in this way despite its agreement not to do so. If the state has a law making the company's failure to comply with the settlement agreement a violation, the company in this instance would be guilty of violating both the claims practices law it had previously violated as well as the law against failing to comply with a settlement agreement.

C. The Remedial Phase

The actions taken in this phase of the process are a function of what was determined in the Violation Analysis Phase.

1. No Violations Found

Where no violations are found, there is nothing to remedy, and the continuum action is usually closed without further action. How this occurs is a function of the type of continuum action. Actions under the investigation authority may or may not have prescribed processes under the state’s laws, so closing may or may not involve communication of the resolution to the regulated entity. The market conduct examination process is usually more formalized. While the exact process depends upon a state’s law, it

usually involves something similar to the *Model Law on Examinations* (#390): (1) finalizing the exam report; (2) adoption of the exam report; and (3) forwarding of the adoption order and finalized exam report to the regulated entity examined.

~~Alternatively, if the regulator conducting the Violation Analysis Phase determines there is insufficient evidence of a violation, but there is reason to believe that it would be appropriate to gather additional facts, he or she could reopen the Fact Finding Phase. The degree of formality with which the Fact Finding Phase is reopened is a function of the state's law and the insurance department's procedures. The *Model Law on Examinations* (#390) specifically provides two options for reopening the Fact Finding Phase for market conduct examinations by authorizing the insurance commissioner to (1) reject the examination report with instructions to the examiners to reopen the examination to gather additional information or (2) call for an investigatory hearing for the same purpose.~~

2. Violations Found

Actions taken when violations are found depend upon the nature of the violations and the circumstances of the continuum action.

a. Resolution with Instructions to Cure any Violations Found

If violations are found that do not rise to a level requiring disciplinary action, a continuum action may be closed with instructions to the regulated entity to take action to bring itself into compliance with the law. Depending upon a state's laws, this directive to comply for continuum actions under an insurance department's investigation authority could be as informal as a verbal instruction or letter or as formal as a department order. Market conduct examinations usually have more formal procedures that may vary by state. For example, the *Model Law on Examinations* (#390) provides that "the commissioner may order the company to take any action the commissioner considers necessary and appropriate to cure the violation" in those states that have enacted it.

b. Voluntary Settlement

~~The majority~~Some of continuum actions where ~~violations noncompliance is~~are found and disciplinary action is deemed appropriate are resolved through a voluntary settlement. Voluntary settlements allow the insurance department and the regulated entity to avoid the time, trouble and expense of litigation. While state laws may vary as to the process, voluntary settlements usually involve a negotiated settlement agreement and/or appropriate departmental orders, such as consent orders, encompassing one or more of the following remedial measures.

(1) Retrospective Remediation

To address past violations, a voluntary settlement may require the regulated entity to take steps to remedy its past practices, including the payment of restitution where appropriate. For example, a company that had been improperly denying claims may be required to reprocess and pay previously denied claims, including applicable interest, in order to make affected consumers whole.

(2) Prospective Remediation

To ensure that violations do not continue to occur, a voluntary settlement may require the regulated entity to cease and desist from engaging in the prohibited conduct and to develop a plan to ensure future compliance. The voluntary settlement may also require the regulated entity to perform self-audits of its compliance measures.

(3) Monetary Fines

A voluntary settlement may include a requirement for the regulated entity to pay a fine for the violations of law. The calculation of a fine should be based upon the provisions of state law, which may allow for the consideration of various aggravating and mitigating circumstances.

- (a) Intent as an aggravating or mitigating factor: While intent may be an element of determining whether or not a violation has occurred for some laws, other laws may utilize intent as a mechanism to enhance or reduce the fine. In such instances, evidence showing that the regulated entity acted with intent (e.g. “knowingly,” “willfully” or “in conscious disregard”) would involve the imposition of a higher fine and lack of a showing of intent would lead to a lesser fine. An example of conscious disregard might be failure to comply with a cease and desist order.
- (b) Business practice violations: For laws that are not frequency based, the fining provision of state laws usually regard each instance of conduct contrary to the law as being subject to a separate fine. Frequency based business practice laws, however, may vary in how a fine is calculated. Some state laws may regard the business practice as a single violation subject to a single fine. Other state laws may regard the business practice standard as merely a threshold. Once a business practice is established under this threshold view, each act making up the business practice is considered a separate violation subject to a separate fine.
- (c) Violation of prior agreements or orders as an aggravating factor: As noted above, a regulated entity’s failure to comply with a prior agreement or order may be regarded as a separate violation subject to a separate fine under some state’s laws. Additionally, this failure to comply may also be regarded as evidence of intent and an aggravating factor leading to increased fines for the underlying conduct that is contrary to the prior agreement or order.
- (d) Behavior of the regulated entity as a mitigating or aggravating factor: Where the insurance department has some discretion to calculate fines within a range, the behavior of the regulated entity both before and during the continuum action may act as either a mitigating or aggravating factor. Cooperation with the continuum action, efforts to identify and correct problems prior to the continuum action being initiated or self-reporting of a violation are examples of behavior that may justify a lower fine within the range. Lack of cooperation, obstruction or evasion by the regulated entity are types of behavior that may justify increases of the fine within the range.
- (e) Level of harm as an aggravating factor: The severity of financial or other harm to affected persons caused by the violations may act as an aggravating factor in calculating a fine, as opposed to technical violations that cause no apparent harm. Some state laws specifically recognize the amount or type of harm as an aggravating factor allowing an enhancement to the amount of fine imposed.

(4) Suspension or Revocation of License

Where violations are particularly egregious, a voluntary settlement may include the suspension or revocation of the regulated entity’s license. Some state laws may allow a voluntary settlement to include a period of probation in lieu of a suspension or revocation of the license.

(5) Monitoring and Reporting

A voluntary settlement will likely include a requirement that the regulated entity provide the insurance department with reports on its retrospective and prospective remedial activities. Such reports may be at the completion of the remediation or may be required periodically if the voluntary settlement includes a monitoring period. After remedial measures are completed and any monitoring period has ended, the insurance department may determine that a follow-up investigation or examination is appropriate to audit compliance with the terms of the voluntary settlement.

c. Initiate an Administrative Action or Court Proceeding

Where the insurance department and the regulated entity cannot resolve a continuum action through a voluntary settlement, the insurance department may decide to initiate a formal proceeding. This may be either an administrative proceeding or a court proceeding depending upon the state's laws. In either case, it is important to realize the Fact Finding Phase starts anew given that either side may seek to do discovery (e.g., depositions, interrogatories or requests for production of documents) and the administrative hearing officer or judge will make his or her own findings of fact based upon the evidence presented at a hearing. After the hearing, the administrative hearing officer or judge will enter an order setting forth findings of fact and conclusions of law as to whether violations exist. This order may also impose some of the same kinds of disciplinary actions discussed above for voluntary settlements if the administrative hearing officer or judge agrees that violations exist, but if the administrative hearing officer or judge does not agree that violations exist, no discipline will be imposed. Either party may appeal the order through the court system if they are not happy with the result. This may lead to a protracted period before the continuum action is resolved unless the parties decide to negotiate a voluntary settlement at some point during the process.

d. Referral to the Market Actions (D) Working Group

If the findings of the continuum action indicate issues affecting multiple states, the insurance department may wish to refer the matter to the Market Actions (D) Working Group for collaborative action. A detailed discussion of this process may be found in Chapter 6—Collaborative Actions.

D. The Reporting Phase

Where appropriate, the results of a continuum action should be reported in accordance with the state's law and in the applicable NAIC database.

1. Publication-Entering of the Resolution as a Public Record as Authorized by State Law

The extent to which the resolution of a continuum action becomes a public record under a state's law may be dependent upon the type of continuum action.

a. Continuum Actions under Investigation Authority

Continuum actions under the investigation authority may not be considered public records under many state's laws unless some form of disciplinary action is imposed. Where disciplinary action is imposed, the settlement agreement and/or order for a voluntary settlement or the order entered pursuant to an administrative or court proceeding are frequently considered public documents⁵. Many insurance departments may wish to increase the dissemination of this information by posting the information on its website and issuing press releases.

b. Continuum Actions under Examination Authority

Finalized market conduct examination reports are generally considered public documents under state examination laws regardless of whether any violations were found or any disciplinary action was imposed. The "Continuum Core Competencies" for market conduct examinations in Appendix D of this handbook indicate that the publication of the final examination report should include the regulated entity's response to the examination report where allowed by state law. If disciplinary action is imposed,

⁵ While settlement agreements and orders may be considered public documents, any other information in the continuum action file (e.g., work papers, information received, communications, etc.) may still be accorded confidential status under the laws of many states. In particular, this is likely to be the case where a state conducts all of its continuum activities under its examination authority.

this will also likely include the settlement agreement and/or order for a voluntary settlement or the order entered pursuant to an administrative or court proceeding. As discussed above, dissemination of the final examination report and related documents to the public may occur through posting the information on the insurance department's website and the issuance of press releases.

2. Report the Resolution in the Market Actions Tracking System

The Market Actions Tracking System (MATS) was developed by the NAIC for tracking and reporting information regarding continuum actions to the other states. The resolution of any continuum action recorded in MATS, and any subsequent updates to a resolution, should be entered into the system to share with other states.

3. Report any Disciplinary Action in the Regulatory Information Retrieval System

The Regulatory Information Retrieval System (RIRS) was developed by the NAIC to document and share information regarding disciplinary actions taken against regulated entities. If a continuum action results in disciplinary action, this information should be recorded in RIRS to share with the other states.

4. Other Reporting Activities

The section titled "Closure" of Chapter 2—Continuum of Regulatory Responses of this handbook mentions other means of reporting on issues uncovered in a continuum action to interested parties, such as insurance department bulletins, consumer outreach and referrals to other law enforcement agencies. Where appropriate, these may be considered and implemented.

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CLAIMS STANDARDIZED DATA REQUEST
Life Line of Business

Contents: This file should be downloaded from company system(s) and contain one record for any and all claims which were submitted, reviewed or processed during the examination period. This data should be presented by claimant.

Uses: Data will be used to determine if the company follows appropriate procedures with respect to the adjudication of claims by the company during the scope of examination:

- Cross-reference to annual statement claims data (amount) to ensure completeness of exam data submitted;
- Cross-reference to MCAS claims data (record count) to ensure completeness of exam data submitted;
- Cross-reference to replacement data to ensure compliance with applicable incontestability period statutes; and
- Cross-reference to state(s) licensing information (if applicable) to ensure proper adjuster licensure.

Field Name	Start	Length	Type	Decimals	Description
CoCode	1	5	A		NAIC company code
ClmNo	6	15	A		Claim number
PolPre	21	3	A		Policy prefix (Blank if NONE)
PolNo	24	20	A		Policy number
PolSuf	44	3	A		Policy suffix (Blank if NONE)
CertNo	47	10	A		Certificate number, if applicable
GroupInd	57	1	A		Group or individual (G/I)
GroupNo	58	5	A		Group number, if applicable
LOB	63	3	A		Line of business according to annual financial statement Please provide a list to explain LOB codes
PolForm	66	10	A		Policy form number as filed with the insurance department
PlanCode	76	6	A		System plan code Please provide a list of system plan codes and their descriptions
InsFirst	82	15	A		First name of insured
InsMid	97	15	A		Middle name of insured
InsLast	112	20	A		Last name of insured
InsDOB	132	10	D		Date of birth of insured [MM/DD/YYYY]
InsAddr	142	100	A		Insured street address
InsCity	242	20	A		Insured city
InsSt	262	2	A		Insured state
InsZip	264	5	A		Insured ZIP code
IssSt	269	2	A		State abbreviation where policy was issued
CmtFirst	271	15	A		First name of claimant

CmtMid	286	15	A		Middle name of claimant
CmtLast	301	20	A		Last name of claimant (Entity filing proof of loss)
BeneFirst	321	15	A		First name of beneficiary If multiple beneficiaries are designated, repeat field as necessary
BeneMid	336	15	A		Middle name of beneficiary If multiple beneficiaries are designated, repeat field as necessary
BeneLast	351	20	A		Last name of beneficiary or name of non-living entity named as beneficiary (e.g. trust, organization, etc.) If multiple beneficiaries are designated, repeat field as necessary
BeneSt	371	2	A		Resident state of beneficiary at the date of death
StlmtOpt	373	5	A		Settlement option code Please provide a list to explain settlement option codes
ClmTyp	378	64	A		Type of claim Please provide a list of claim type codes along with their meanings. Example: death claim, accelerated death benefit, life, accident, waiver of premium, etc.
ClmStat	442	1	A		Claim status code as of the end of the exam period Please provide a list of claim status codes along with their meanings. Example: Paid, denied, pending, etc.
ClmIncDt	443	10	D		Claim incurred date [MM/DD/YYYY]
ClmNtDt	453	10	D		Date the company or producer received notification of claim [MM/DD/YYYY]
ClmAckDt	463	10	D		Date company or its producer acknowledged the claim [MM/DD/YYYY]
ClmPrfDt	473	10	D		Date proof of death received [MM/DD/YYYY]
FaceAmt	483	11	N	2	Face amount at claim incurred date
CashVal	494	11	N	2	Cash value at claim incurred date
ClmPdDt	505	10	D		Claim paid date [MM/DD/YYYY]
TtlPrcd	515	11	N	2	Total policy proceeds (excluding interest amount to credit) paid to claimant For claims other than death claims, total amount paid as of the end of the review period
Interest	526	1	A		Is interest payable on death proceeds? (Y/N)
IntRate	527	6	N	4	Interest rate, expressed as a decimal applied to policy proceeds, if applicable (4% = 0.0400)
IntAmt	533	11	N	2	Interest amount credited to policy proceeds, if applicable
ClmDnyDt	544	10	D		Claim denial date [MM/DD/YYYY]
ClmDenRsn	554	3	A		Reason for claim denial Please provide a list to explain any codes used
ClmPendRsn	557	3	A		Reason for claim pending Please provide a list to explain any codes used
DlyRsn	560	3	A		Reason for claim delay Please provide a list to explain any codes used
DlyLtrDt	563	10	D		Date when delay letter was sent [MM/DD/YYYY]
EndRec	573	1	A		End of record marker. Please place an asterisk in this field to indicate the end of the record. This must be in the same character position for every record in this table.

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DECLINATIONS STANDARDIZED DATA REQUEST
Life Line of Business

Contents: This file should be downloaded from company system(s) and contain one record for each policy or contract that was declined in the examination state(s) during the examination period.

Uses: Data will be used to determine if the company follows appropriate procedures with respect to refusal of the company to issue a life policy or contract, or add additional coverage within defined (and approved) company underwriting rules:

- Cross-reference to in force data file to test if declined applicants subsequently written;
- Cross-reference to producer data file to test for producers with declination rates that are significantly higher than or lower than the average;
- Test for unfair discrimination in declinations; and
- Test for compliance with declination notice requirements.

“Declination” means refusal of an insurer to issue a policy or add additional coverage from an application or written request from a producer or applicant.

Field Name	Start	Length	Type	Decimals	Description
CoCode	1	5	A		NAIC company code
AppNo	6	10	A		Application number, if applicable
GroupInd	16	1	A		Group or individual (G/I)
LOB	17	3	A		Line of business according to annual financial statement Please provide a list to explain LOB codes
PolForm	20	10	A		Policy form number applied for as filed with insurance department
PlanCode	30	6	A		System plan code Please provide a list of system plan codes and their descriptions
PolType	36	20	A		Type of policy (i.e. whole life, universal life, etc) Please provide a list of all policy type codes and their meaning
PrCode	56	9	A		Company internal producer, CSR or business entity producer identification code Please provide a list to explain any codes used
NPN	65	6	A		National producer number
Rep	71	1	A		Does this policy replace an existing policy regardless of who wrote the previous policy? (Y/N)
AppFirst	72	15	A		First name of applicant
AppMid	87	15	A		Middle name of applicant
AppLast	102	20	A		Last name of applicant (or name of business)
AppAddr	122	100	A		Applicant street address
AppCity	222	20	A		Applicant city
AppSt	242	2	A		State in which policy was applied for
AppZip	247	5	A		Applicant ZIP code
InsFirst	252	15	A		First name of proposed insured
InsMid	267	15	A		Middle name of proposed insured

InsLast	282	20	A		Last name of proposed insured
InsDOB	302	10	D		Date of birth of proposed insured [MM/DD/YYYY]
InsAddr	312	100	A		Proposed insured street address
InsCity	412	20	A		Proposed insured city
InsSt	432	2	A		Proposed insured state
InsZip	434	5	A		Proposed insured ZIP code
InsSx	439	1	A		Proposed insured's sex (M/F)
InsOcc	440	50	A		Proposed insured occupation
AppProDt	490	10	D		Date application processed [MM/DD/YYYY]
AppRecDt	500	10	D		Date application received [MM/DD/YYYY]
FaceAmt	510	11	N	2	Face amount of policy as applied for
PremAmt	521	11	N	2	Premium amount received with application
DeclDt	532	10	D		Date of declination [MM/DD/YYYY]
DeclRsn	542	20	A		Reason for declining application If declination codes are used, please provide a list of codes and their description
NoticeDt	562	10	D		Date notice of declination sent to applicant [MM/DD/YYYY]
RefAmt	572	11	N	2	Amount of refund, if applicable
RefDt	583	10	D		Date refund mailed, if applicable [MM/DD/YYYY]
RefToFst	593	15	A		First name of person who received refund, if applicable
RefToMd	608	15	A		Middle name of person who received refund, if applicable
RefToLst	623	20	A		Last name of person who received refund, (or name of business), if applicable
EndRec	643	1	A		End of record marker. Please place an asterisk in this field to indicate the end of the record. This must be in the same character position for every record in this table.

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POLICY IN FORCE STANDARDIZED DATA REQUEST
Life Line of Business

Contents: This file should be downloaded from company system(s) and contain one record for each policy or contract that the company issued to or insuring the lives of [applicable state] residents at any time during the examination period. Information submitted pursuant to this standardized data request should also include cancellations, terminations and nonforfeitures.

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

- Cross-reference to annual statement claims data (amount) to ensure completeness of exam data submitted;
- Cross-reference with the company's MCAS data to validate MCAS reporting and review the exam data for completeness;
- Cross-reference with the claims data file to validate the completeness of the in force file; and
- Cross-reference to state (s) licensing information to ensure proper producer licensure.

Field Name	Start	Length	Type	Decimals	Description
CoCode	1	5	A		NAIC company code
PolPre	6	3	A		Policy prefix (Blank if NONE)
PolNo	9	20	A		Policy number
PolSuf	29	3	A		Policy suffix (Blank if NONE)
CertNo	32	10	A		Certificate number, if applicable
GroupNo	42	5	A		Group number, if applicable
LOB	47	3	A		Line of business according to annual financial statement Please provide a list to explain LOB codes
PolSt	50	2	A		State abbreviation of insured as of the end of the exam period
IssSt	52	2	A		State abbreviation where policy was issued
PolStat	54	3	A		Policy status as of the end of the exam period Please provide a list to explain any codes used
PolForm	57	10	A		Policy form number as filed with the insurance department
PlanCode	67	6	A		System plan code Please provide a list of system plan codes and their descriptions
PrCode	73	9	A		Company internal producer, CSR, or business entity producer identification code Please provide a list to explain any codes used
NPN	82	6	A		National producer number
Rep	88	1	A		Does policy replace an existing policy regardless of who wrote the previous policy? (Y/N)
Conv	89	1	A		Is policy the result of a conversion or continuation? (Y/N)
T1035	90	1	A		Is a T1035 required to be completed in the event of a termination or replacement? (Y/N)
POFirst	91	15	A		First name of policyowner responsible for premium payment of policy
POMid	106	15	A		Middle name of policyowner responsible for premium payment of policy
POLast	121	20	A		Last name of policyowner responsible for premium payment of policy
POAddr	141	25	A		Policyowner street address

POCity	166	20	A		Policyowner city
POSt	186	2	A		State abbreviation of policyowner as of the end of the examination period
POZip	188	9	A		Policyowner ZIP code
BeneFirst	197	15	A		First name of beneficiary If multiple beneficiaries are designated, repeat field as necessary
BeneMid	212	15	A		Middle name of beneficiary If multiple beneficiaries are designated repeat field as necessary
BeneLast	227	20	A		Last name of beneficiary or name of non-living entity named as beneficiary (e.g. trust, organization, etc.) If multiple beneficiaries are designated, repeat field as necessary
BeneRel	247	20	A		Beneficiary relationship to insured If multiple beneficiaries are designated, repeat field as necessary for each beneficiary
InsFirst	267	15	A		First name of insured
InsMid	282	15	A		Middle name of insured
InsLast	297	20	A		Last name of insured
InsAddr	317	25	A		Insured street address
InsCity	342	20	A		Insured city
InsSt	362	2	A		Insured state
InsZip	364	9	A		Insured ZIP code
IssAge	373	2	A		Age of insured on policy effective date
InsDOB	375	10	D		Insured date of birth [MM/DD/YYYY]
InsOcc	385	50	A		Insured occupation
InsSx	435	1	A		Insured's sex (M/F)
PaySt	436	2	A		State where premium is reported in annual statement, as of the end of the exam period
AppRecDt	438	10	D		Date application received [MM/DD/YYYY]
AppProDt	448	10	D		Date application processed [MM/DD/YYYY]
CWAAmt	458	11	N	2	Consideration amount received with the application
IssDt	469	10	D		Policy or certificate issue date [MM/DD/YYYY]
EffDt	479	10	D		Policy or certificate effective date [MM/DD/YYYY]
FaceAmt	489	11	N	2	Face amount of policy
APL	500	1	A		Does automatic payment loan apply to this policy? (Y or N)
Amrden	501	30	A		All applicable amendments, riders, and endorsements added Please provide a list to explain any codes used
AmrdenDt	531	10	D		Effective date of applicable amendment, rider or endorsement [MM/DD/YYYY] If multiple amendment, rider or endorsements, repeat fields as necessary
UWClass	541	40	A		Underwriting class applicable to insured Please provide a list of all underwriting classes and their meanings
TabAmt	581	11	N	2	Table rating amount applied, if applicable
TabNo	592	5	A		Number of table rating applied, if applicable

AnnPrem	597	11	N	2	Annual policy premium including any additional amounts for table rating, flat extras, riders, endorsements, and amendments
ModalFac	608	5	A		Modal factor
PaidDt	613	10	D		Date to which the policy is paid [MM/DD/YYYY]
CurAmt	623	11	N	2	Current amount of insurance as of the end of the exam period
CurCash	634	11	N	2	Current cash value of the policy, if applicable
CurCashT	645	11	N	2	Cash value of policy as of the termination date
CanReqDt	656	10	D		Date cancellation requested, if applicable [MM/DD/YYYY]
CanTerRs	666	64	A		Reason for cancellation/termination of coverage Example: Lapse, individual requested cancellation, company cancellation, death, cash surrender, etc. If codes are used, provide a list of all cancellation codes along with their meanings
CanTer	730	1	A		Who cancelled the coverage C=Consumer and I=Insurer
CanTerNt	731	10	D		Date notice (cancellation, nonrenewal, lapse in coverage) was mailed [MM/DD/YYYY]
CanTerDt	741	10	D		Date policy cancelled/terminated [MM/DD/YYYY]
NonType	751	15	A		Type of nonforfeiture Example: cash surrender, automatic premium loan, policy loan, extended term, reduced paid up, return of premium, etc. If codes are used, provide a list of all nonforfeiture codes along with their meanings
NonRecDt	766	10	D		Date company received request for nonforfeiture action [MM/DD/YYYY]
NonProDt	776	10	D		Date company processed nonforfeiture request or took nonforfeiture action [MM/DD/YYYY]
NonAPL	786	11	N	2	Automatic premium loan amount
APLDate	797	10	D		Date of most recent APL transaction [MM/DD/YYYY]
NonETIAm	807	11	N	2	Amount of extended term
NonETIDt	818	10	D		Date extended term will cease [MM/DD/YYYY]
RefAmt	828	11	N	2	Amount of refund, if applicable
RefDt	839	10	D		Date refund mailed, if applicable [MM/DD/YYYY]
RefTo	849	15	A		Person who received refund, if applicable
EndRec	864	1	A		End of record marker. Please place an asterisk in this field to indicate the end of the record. This must be in the same character position for every record in this table.

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REPLACEMENT STANDARDIZED DATA REQUEST
Life Line of Business

Contents: This file should be downloaded from company system(s) and contain one record for each policy or contract that the company replaced in the examination state(s) during the examination period. The data should reflect only records that the company replaced, and not include policies or contracts that were issued by the company, and replaced by other companies.

Uses: Data will be used to determine if the company follows appropriate procedures with respect to the issuance of life policies or contracts that replaced existing policies or contracts in force from other companies:

- Cross-reference to in force data file to review persistency;
- Cross-reference to in force data file to determine whether producers are coding replacements properly;
- Cross-reference to producer data file to test producer licensure and replacement rates by producer; and
- Test for compliance with replacement notice requirements.

Field Name	Start	Length	Type	Decimals	Description
CoCode	1	5	A		NAIC company code
PolPre	6	3	A		Policy prefix (Blank if none)
PolNo	9	20	A		Policy number
PolSuf	29	3	A		Policy suffix (Blank if none)
CertNo	32	10	A		Certificate number, if applicable
GroupInd	42	1			Group or individual (G/I)
GroupNo	43	5	A		Group number, if applicable
LOB	48	3	A		Line of business according to annual financial statement Please provide a list to explain LOB codes
PolForm	51	10	A		Policy form number as filed with the insurance department
PlanCode	61	10	A		System plan code Please provide a list of system plan codes and their descriptions
PolType	71	20	A		Type of policy (i.e. whole life, universal life, etc) Please provide a list of all policy type codes and their meaning
AnnPrem	91	11	N		Total annualized policy premium
PrCode	102	9	A		Company internal producer, CSR, or business entity producer identification code Please provide a list to explain any codes used
NPN	111	6	A		National producer number
POFirst	117	15	A		First name of policyowner responsible for premium payment of policy
POMid	132	15	A		Middle name of policyowner responsible for premium payment of policy
POLast	147	20	A		Last name of policyowner (or name of business) responsible for premium payment of policy
POSt	167	2	A		State abbreviation of policyowner as of the end of the examination period
InsFirst	169	15	A		First name of insured
InsMid	184	15	A		Middle name of insured

InsLast	199	20	A		Last name of insured
InsDOB	219	10	D		Insured date of birth [MM/DD/YYYY]
InsSt	229	2	A		State abbreviation of insured as of the end of the examination period
IssSt	231	2	A		State abbreviation where policy was issued
IssAge	233	2	A		Age of insured on policy effective date
IssDt	235	10	D		Policy issue date [MM/DD/YYYY]
FaceAmt	245	11	N	2	Face amount of policy as issued
EffDt	256	10	D		Policy effective date [MM/DD/YYYY]
AppDt	266	10	D		Date application was signed [MM/DD/YYYY]
AppRecDt	276	10	D		Date application received by the company [MM/DD/YYYY]
RepNtcDt	286	10	D		Date replacement notice sent [MM/DD/YYYY]
RepType	296	1	A		Type of replacement (Internal = I or External = E)
RepNtcCo	297	50	A		Name of replaced company
T1035	347	1	A		Is a T1035 required to be completed in the event of a termination of replacement? (Y/N)
EndRec	348	1	A		End of record marker. Please place an asterisk in this field to indicate the end of the record. This must be in the same character position for every record in this table.

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Chapter 13—Standardized Data Requests

This chapter provides guidance to market conduct examiners and promotes the use of standardized data requests during market conduct examinations. Examiners should also consult the [guidance offered standards](#) in the Market Conduct Uniform Examination Outline, which is located in Chapter 12.

The intent is to establish a set of standardized data requests that all ~~the~~ states can use for uniform examinations. ~~Each type of~~The standardized data request ~~layouts and the fields contained within are subject matter and/or line of business specific.~~contains two parts: (1) a master field list, and (2) a data request layout. ~~They include a brief description of the data the standardized data request intends to gather and a list of possible uses for the data submitted. The master field list is composed of the majority of fields that could be requested in the examination request. The fields are sorted alphabetically and include the desired format and a description of each field. The actual data request layouts are for each data table that could be requested in a data request. Each table layout includes a brief description of the data to be included in the table, along with possible uses for the data submitted.~~The type and scope of examination ~~would will~~ determine which ~~tables standardized data requests~~ and ~~data~~ fields ~~would need to should~~ be requested.

The following parameters were taken into consideration during the development of standardized data requests:

- An examiner can add fields that are specific to business in their state ~~or cover areas that have not been covered in the master list.~~ The examiner should inform the company of additional requests and give the company a longer time period to provide ~~those files~~the data;
- The companies are not required to maintain each field ~~named in the standardized data requests.~~ ~~The master list is just an example of the types of data that might be requested.~~ The examiner should review the actual data request with the company prior to the creation of any ~~data files in order to determine which field the company can or cannot provide.~~ ~~The discussion should determine which fields the company can or cannot provide.~~ For fields that cannot be provided, the company and examiner need to determine the best way for the examiners to obtain the information needed;
- The fields are designed to mirror information normally kept in specific fields on the company's computer system. They were not meant to ~~gather be for~~ information that is kept in "memo" fields. For example, a company may keep the amount of the claim payment in a numeric field specifically marked for that purpose, but would keep all of the adjuster's notes on how the adjuster arrived at that amount in a memo or notes field. ~~Because information contained in memo fields These~~ cannot be easily provided and can be quite large, ~~so they would need to this data should~~ be reviewed during the actual examination and not requested in the initial data request;
- The fields selected ~~were are~~ intended to enable the examiner to break down the file for sampling or perform 100 percent compliance tests. For example, a file of paid claims would include the claim feature code so that it would be broken down into the different feature code populations (e.g., first-party vs. third-party) and sampled; or a file of commissions paid would be reviewed directly for 100 percent licensed and appointed compliance testing; and
- The fields may also be used for completeness testing. Completeness testing for market conduct examinations differs from ~~that testing~~ conducted for financial examinations. The market conduct examiner will normally try to compare to the financial State Pages. Since State Pages are not usually audited, results of these tests can be inconclusive. Other fields must be placed into the data request to help the examiner feel comfortable that the file is accurate and complete. These types of fields would include the NAIC company code, state, policy effective date or policy inception date.

Standardized data requests were developed to help a less experienced examiner get started. At the top of each sample data request is an explanation of what the request is and how/when to use it.

The NAIC updates standardized data requests periodically. Please review the *Market Regulation Handbook* web page on StateNet in order to obtain the most current standardized data requests adopted by the NAIC.

~~Each master list is laid out in the basic structure of a typical mainframe file definition and contains the following information:~~

- ~~• **Field Name**—This is an eight spaced abbreviation of what the field is. The name is limited to eight spaces because some types of software, such as dBase, will not work properly if the field name is longer than eight spaces. A large portion of the industry supplies examiners with dBase files because dBase files can be downloaded from most mainframe computers. Also, when using programs like ACL and Microsoft Access, it is best to have short field names when programming queries;~~
- ~~• **Length**—This field tells the company how long the field should be. The actual field length may vary from company to company, but it is good to give the company a starting point. The examiner should allow the company to change the length, if necessary, but ask that the company inform the examiner if such a change is made. This instruction is also included at the top of each of the sample data requests that follow the master list. Having a standard length can save time for the examiner. If the same request is used from company to company, the format in ACL and Microsoft Access can easily be copied and reused from one examination to the next;~~
- ~~• **Type**—This tells the company whether to format the information in a given field as an alphanumeric field (both letters and numbers possible) or as a numeric field (only numbers possible). This is especially important for fields such as ZIP codes that could start with a zero. If a ZIP code field is formatted as a numeric field, any leading zeros will be removed. A ZIP code that should be “01742” will show up as “1742” in a numeric field;~~
- ~~• **Decimals**—This is only used with numeric fields and tells the company how many decimal places should be in the number. If decimal places are not specified, the examiner will not be able to distinguish between \$100 and \$1;~~
- ~~• **Description**—This explains what the field is and if specific layouts are needed. For example, it may specify whether a particular field should contain “yes” or “no,” or a description might specify a date format of “MM/DD/YY”; and~~
- ~~• **Suggestions for possible data requests**—Helps examiners who may not be very familiar with some of these fields; the master list contains suggestions for what kind of request would contain each field.~~

~~Included within each standardized data request file are sample data requests to help demonstrate how fields are picked from the master list and used in an actual data request. Standardized data requests were also developed to help a less experienced examiner get started. At the top of each sample data request is an explanation of what the request is and how/when to use it.~~

~~Further lines of business and directions will be available on the *Market Regulation Handbook* web page on StateNet as additional standardized data requests are adopted by the NAIC.~~

A. Standardized Data Requests (SDR)

What is an SDR?

~~The SDR is a “wish list” list of possible fields that could be asked for during an examination can be used to obtain data from a company for regulatory purposes. The data fields contained in the SDRs are not “mandatory” fields. Rather, they are suggested fields to enable regulators to gather information uniformly. It includes field names and descriptions, along with suggestions for possible data requests to help an examiner get started. Examiners can deviate from this list by informing the company in writing.~~

The SDR:

- ~~• Provides a list of suggested individual fields from which an examiner can pick and choose to give an examiner a starting point for requesting data for an examination;~~
- ~~• Assists with uniformity of requesting data from companies;~~
- ~~• Is not an “end-all, be-all” list. It does not cover all areas (especially topics such as privacy or medical malpractice, where electronic data requests are a new arena). An SDR is a standardized data request should be considered a working document; and~~

- Is not intended to replace a file review. Due to the limitations of SDRs and the data files produced in response to SDRs, policy, claim or complaint files may need to be reviewed to adequately assess a company's compliance with a state(s) laws and regulations.
- ~~Is not a mandatory list of what companies have to maintain electronically. An examiner needs to be prepared to be flexible and willing to accept paper documents; and~~
- ~~Is not intended to replace on-site portions of examinations. Some information that is mandatory to check for compliance can only be found by reviewing actual hardcopy files and may not be feasibly retrieved electronically.~~

How Do I Use A Standardized Data Request (SDR)?

The following is a step-by-step guide to using an SDR, once a company has been selected for examination.

- ~~What type of examination is needed?~~
 - ~~Annuity;~~
 - ~~Life;~~
 - ~~Health, long term care or Medicare supplement;~~
 - ~~Credit life and accident/health;~~
 - ~~Title;~~
 - ~~Property and casualty; and/or~~
 - ~~Personal or commercial;~~
 - ~~All areas (producer, commissions, complaints);~~
 - ~~Advertising; and/or~~
 - ~~Privacy.~~
- ~~What areas will be reviewed?~~
 - ~~New business;~~
 - ~~Terminations, cancellations, nonrenewals, territory rating;~~
 - ~~Claims;~~
 - ~~Advertising;~~
 - ~~Producer licensing;~~
 - ~~Replacements (life and annuity); and/or~~
 - ~~Underwriting.~~
- ~~What is the time frame and scheduling?~~
 - ~~Examination period;~~
 - ~~When to send the data request;~~
 - ~~When to have the data due; and~~
 - ~~When the on-site portion of the examination will commence.~~
- ~~What standards and tests can be used?~~
 - ~~Market Regulation Handbook;~~
 - ~~Determine which standards and tests apply; and~~
 - ~~Consider the type of examination and any indicators that triggered a targeted examination.~~
- ~~What are the applicable rules and statutes of the examining state?~~
 - ~~Individual state;~~
 - ~~Multiple states; and~~
 - ~~Language and provisions in company forms may require a higher standard than the applicable state's rules and statutes. For example:~~
 - ~~A life and annuity company may have a higher minimum/guaranteed interest rate than required; and~~
 - ~~A property/casualty company may have a longer grace period or window for accepting past due premiums than required.~~
- Identify the line of business to be reviewed;

- Define the areas to be reviewed;
- Determine the examination period and the scheduling time frame;
- Designate the standards and tests that will be utilized; and
- Review applicable rules and statutes:
 - Individual state;
 - Multiple states; and
 - Language and provisions in company forms may require a higher standard than the applicable state's rules and statutes, (e.g., a life and annuity company may have a higher minimum/guaranteed interest rate than required, and a property/casualty company may have a longer grace period or window for accepting past due premiums than required);
- ~~What types of records are needed?~~
 - ~~Policies issued or applications taken; and~~
 - ~~Paid claims or denied claims.~~
- Determine the records from which the data will be derived:
 - Policies issued or applications taken; and
 - Reported/Paid claims or denied claims;
- ~~What Identify~~ fields ~~are~~ needed to determine populations and samples or 100 percent compliance?
 - ~~Required fields;~~
 - Policy number ~~or claim number~~ (for identification purposes);
 - Application, effective, paid or denied date (to determine if items are within the examination period);
 - State (also used to verify that correct data was provided);
 - ~~Plan code (used to determine business type and/or relevant policy form(s));~~
 - Producer ~~code number~~ (used to quantify results by producer or look for patterns of practice by producers); ~~and~~
 - ~~Plan code (used to determine business type and/or relevant policy form); and~~
 - Reason code (for determining populations);
- Optional additional fields; ~~and~~
 - Names (to easily verify that correct sample files are provided);
 - Insured; and
 - Beneficiary;
 - Interest rates;
 - ~~Rates; and~~
 - Amount paid;
 - Underwriting; and
 - Riders; and
 - Endorsements;
 - Claims;
 - Insured/Claimant name;
 - Date of loss; and
 - Claim payment amount.
- Fields needed to cross-reference or join tables:
 - Policy number ~~on claims lists~~ (to join the claim record with the policy record);
 - ~~Social Security number or tax~~ Insured ID (to search for unreported replacements and producers with multiple producer codes to verify completeness of data files); ~~and~~
 - Producer ~~code on business and claims lists~~ number or department of insurance ID on business and claims lists (to determine producer identity);
 - ~~Plan code on business and claims lists (to determine business type and/or policy form); and~~
 - ~~Insured name, when SSN or tax ID not available (can also be used to look for unreported replacements).~~
- ~~How should the data request be organized?~~ Determine the layout of the data request:

- Customize the ~~standardized~~ data request to the company;
 - Separate data requests by company systems; and
 - ~~Producer licensing;~~
 - ~~Life;~~
 - ~~Annuity;~~
 - ~~Homeowners;~~
 - ~~Auto; and~~
 - ~~Health;~~
 - Separate requests by various areas to test, ~~including, but not limited to:~~
 - ~~Auto; and~~
 - ~~Claims paid (this file may include total losses, partial losses, first and third party cases);~~
 - ~~Claims not paid;~~
 - ~~Cancellations;~~
 - ~~New business; and~~
 - ~~Unfair discrimination;~~
 - ~~Homeowners;~~
 - ~~Claims paid; and~~
 - ~~Claims not paid;~~
- Provide the company with specific instructions or parameters for each ~~table-SDR or file~~ and field requested:
 - ~~Do not be surprised if the company interprets something differently than a previously examined company. Be aware that a company may interpret the SDR or its fields differently than a previously examined company; and~~
 - ~~Replacements—Determine whether the examiner wants to review. Be clear about what data the examiner is specifically seeking. For example, if the examiner is gathering information on replacements, clearly specify whether the company should provide data on replacements where the company is the existing insurer, the replacing insurer or both (an internal replacement);~~
 - Provide the company with ~~guidelines data specifications on how each table will work; and. Each data request is laid out in a basic structure containing:~~
 - ~~Field Name—Eight character or less identifier for field being requested. This field offers an abbreviated descriptor of the type of data being requested in eight characters or less;~~
 - ~~Start—This field indicates the placement of where each field begins in the order of the data request. This is a suggested number that can vary depending on whether the data is provided. If the company does not capture a field, they will move on to the next one;~~
 - ~~Length—Number of characters examiner has provided for this field's data. This field suggests to the company how long the field should be. This is a suggested number that can vary depending on the data provided. This field can be altered, but should be adjusted only after discussion and agreement with the company;~~
 - Be sure the company knows to adjust the field lengths as needed and not to just cut off data because the company runs out of room;
 - ~~Type—The SDR uses only alphanumeric because companies are familiar with these types and not the more detailed options listed in ACL. This suggests to the company the proper format for the information in a given field, i.e., alphanumeric (both letters and numbers), numeric (numbers only), or date [MM/DD/YYYY]. Generally, data fields should only be numeric if a calculation is to be performed on them;~~
 - ~~Decimals—This is only used with numeric fields and tells the company how many decimal places should be in the number;~~
 - ~~Description—Brief. This field provides a brief explanation of what each field should contain; and if specific layouts are needed. For example, it may specify whether a~~

- particular field should contain a “yes or no” response or specify a date format of [MM/DD/YYYY]; and
 - End of record indicator—This field should contain a value for each record in a table ~~so~~ that the examiner will always know to indicate where the record ends;
- Provide a cover page with instructions relevant to the entire examination:
 - Company to be examined;
 - Examination period;
 - Applicable state(s);
 - Data submission protocol;
 - Data submission format;
 - Contact person at the insurance department; and
 - Due date for data requested;:-
- ~~How can the~~Determine how the right information can be obtained;?:
 - Maintain communication with the company;
 - Compliance contact (person responsible for coordinating examination);
 - ~~Person responsible for coordinating examination;~~
 - Systems contact (person responsible for pulling electronic data); and
 - ~~Person responsible for pulling electronic data;~~
 - Financial contact (person responsible for completing annual financial statement);
 - ~~Person responsible for completing annual financial statement;~~
 - Schedule meeting or conference call to discuss; and
 - Definition and submission guidelines;
 - Fields and workarounds; and
 - Supporting documentation;
 - Code lists; and
 - Paper documents;
 - Determine How to present questions (critique forms).

Where Are the NAIC Standardized Data Requests Found?

Regulators may access the NAIC standardized data requests via myNAIC at the Market Regulation Handbook link on the StateNet home page. The standardized data requests are located in the Market Regulation Handbook Reference Documents section of the web page. Non-regulators may access the standardized data requests on the Market Conduct Examination Standards (D) Working Group web page which is found at www.naic.org >> **Committees >> Committees, Task Forces & Working Groups >> Market Regulation and Consumer Affairs (D) Committee >> Market Conduct Examination Standards (D) Working Group >> Market Regulation Handbook Updates and Reference Documents**. When accessing the Market Regulation Handbook Updates and Reference Documents link, please use the user ID and password located at the front of the most recently published *Market Regulation Handbook*.

Revisions to the Producer, Commission and Complaint SDR, Property and Casualty Personal Lines SDR, Life and Annuity Insurance SDR and the Property and Casualty Commercial SDR were adopted in 2006 by the Market Regulation Handbook (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee. The Credit Life and Accident and Health SDR was also adopted by the Market Regulation Handbook (D) Working Group in 2006. The Title Insurance SDR and Sample Letter were adopted by the Market Regulation Handbook (D) Working Group in 2008. In 2009, revisions to the Commercial Property and Casualty SDR were adopted by the Market Conduct Examination Standards (D) Working Group. A health reform-related SDR and corresponding definitions were adopted at the NAIC 2015 Spring National Meeting.

Updated stand-alone NAIC Producer, Marketing and Sales, Commission and Complaint standardized data requests (which replace the combined Producer, Commission and Complaint standardized data request adopted in 2006) were adopted by the NAIC Executive (EX) Committee and Plenary in 2017. There are therefore eleven standardized data requests currently available, including:

1. Producer Data Request;*
2. Marketing and Sales Data Request;*
3. Commission Data Request;*
4. Complaint Data Request;*
5. Property and Casualty Personal Lines Data Request;
6. Life and Annuity Insurance Data Request;
7. Property and Casualty Commercial Standard Data Request;
8. Health, Long-Term Care and Medicare Supplement Data Request;
9. Credit Life and Accident and Health Data Request;
10. Title Data Request and Sample Letter; and
11. Health Reform-Related Data Request and Definitions.

*Regulators may access the updated NAIC Producer, Marketing and Sales, Commission and Complaint standardized data requests via myNAIC at the Market Regulation Handbook link on the StateNet home page. The standardized data requests are located in the Market Regulation Handbook Updates section of the web page.

Non-regulators may access the updated Producer, Marketing and Sales, Commission and Complaint standardized data requests via the Market Conduct Examination Standards (D) Working Group web page which is found at www.naic.org >> **Committees** >> **Committees, Task Forces & Working Groups** >> **Market Regulation and Consumer Affairs (D) Committee** >> **Market Conduct Examination Standards (D) Working Group** >> **Market Regulation Handbook Updates and Reference Documents**. When accessing the Market Regulation Handbook Updates and Reference Documents link, please use the user ID and password located at the front of the most recently published *Market Regulation Handbook*.

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**Proposed Outline for NAIC Market Regulation Handbook
Compliance Risk Assessment
April 26, 2017**

Compliance Risk Assessment is the review and analysis of information and data about a company to determine areas of potential compliance deficiencies and to prioritize examination resources for review of those areas.

A proposed outline for development of guidelines for performing a compliance risk assessment in the market conduct examination (risk focused examination) is as follows:

Information Gathering

- Compliance Materials
 - Documents and data identified in the NAIC Market Regulation Handbook for each applicable standard
 - Complaint data and trends from Company, DOI and NAIC (Include Grievances and Appeals for Health)
 - Compliance history (NAIC data bases and DOI)
 - Prior Market Conduct Examination Reports
 - Level I and Level II Market Analysis Summaries
 - Internal and Independent Audits
 - NCQA or URAC reports
 - Policies and Procedures related to NAIC Handbook Standards
 - Litigation logs
- Financial Information
 - Annual and Quarterly Financial Statements
 - Financial Examination Reports
 - Annual Financial Audit
 - Credit Rating Service Summaries (A.M. Best, Standard and Poor's, Moody's)
- Other
 - Company website
 - DOI Website
 - Social Media
- Issue interrogatories to:
 - Obtain statements from the company regarding business practices and processes that are not documented in other materials
 - Obtain information that is unique to the examination
 - Obtain statements to clarify conflicting information that has been received
- Perform interviews focusing on governance and controls related to NAIC Market Regulation Handbook Standards
 - "C Level" managers, as needed
 - Process managers, for key areas:
 - Company Operations and Management
 - Complaint Handling
 - Producer Licensing
 - Policyholder Services

- Marketing and Sales
- Underwriting and Rating
- Claims
- (Additional Standards for Health)

Data Analysis

- Is the data requested complete? If something is missing or incomplete, why?
- Does it provide evidence of compliance with NAIC Handbook Standards?
- Are there indications of compliance concerns? (Examples)
 - Policies and procedures don't exist
 - Policies and procedures that aren't compliant
 - Adverse complaint trends
 - Inconsistencies between policies and procedures, and interview statements
 - Disclosed information from interviews
 - Disclosed information from interrogatories
 - Prior audit or exam findings that have not been addressed
 - Adverse findings in Level I and Level II reviews
 - Adverse compliance history

Development of the Detailed Workplan

- Rank the areas of compliance risk
- Define scope of additional review
- Define additional in-depth testing
- Define alternative approaches such as IT Forensics, investigations, or self –audits
- Create a detailed workplan

Performing the Examination

At this point, the market conduct examination follows traditional NAIC Market Regulation Handbook Methodology.

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CHAPTER 29 PROCESS REVIEW METHODOLOGY

This chapter describes a process review methodology that may be utilized in a market conduct examination as an alternative process or as a supplement to the methodology described in other chapters. It is focused on a review of the process and controls utilized by an examinee in the management of its operations. Each of the standards described in Chapters 16 through 24 of this *Handbook* are applicable under either methodology. The methodology described in those chapters will be referred to as conventional market conduct examination methodology.

The Sections in this chapter describe the process review approach and include interrogatories, process testing and suggestions for reviews conducted utilizing this methodology. The contents of this chapter include:

- A. General
- B. Enabling Statutes
- C. Review Considerations
- D. Application of the Process Review Methodology
- E. Uses of the Process Review Methodology
- F. Requests for Information
- G. Testing of Processes
- H. Evaluation of Process

A. General

The material that follows is a substantial departure from what is viewed as a conventional market conduct examination methodology as described in Chapters 16 through 24 of this *Handbook*. Several states have acted as laboratories to develop these concepts. The methodology discussed in this chapter requires the increased use of an examiner's analytical skills. The testing suggested here does not necessarily result in a pass or fail, yes or no, or black or white response. Nevertheless, it represents a potential for the acquisition of better information pertinent to a regulated entity's operations and the management of those operations than does a conventional market conduct examination. This methodology utilizes a qualitative review as opposed to the quantitative review found in the conventional methodology. This methodology should not be limited to Company Operations/Management (Section A in most examination chapters), but also to each of the other areas of interest during an examination.

Briefly stated, this approach is the review of the directions provided by a regulated entity's management in the form of written procedures, directives, processes, strategies, etc., (collectively, processes). This review reveals how a regulated entity manages and controls the various processes it implements to operate its business and to comply with insurance statutes. This approach is an effective means to determine whether regulated entity management in an area or areas under review is proactive or reactive. A proactive process generally results in a minimal level of error or violation. A reactive process has an increased propensity for error and violation. If the process is flawed, compliance is usually compromised.

The conventional method of examination as described in this *Handbook* typically reviews the results of a regulated entity operation for error or violation of statute and reacts to that result. It is generally quantitative and microscopic in nature. This approach is reasonably effective at identifying violations of state law that have already occurred. It uses sampling methodology to select files for review and then applies standards and tests to determine whether the files reviewed comply with the applied test. This results in considerable duplication when multiple states have similar concerns and conduct separate examinations. The conventional method of examination is usually cumbersome when applied on a multi-state basis unless the subject of the examination is sufficiently targeted and the state laws for the examining states are sufficiently similar. It is not particularly effective at determining causation of file failure. The principal regulatory interest in developing new tools for review is not the quantification of violation or error, but rather the qualification of the management structure and its ability to provide effective compliance. It is also particularly useful in structuring corrective action.

The conventional market conduct examination utilizes a review of events at the operational level of an insurer. These results have already occurred so the review is historical. A process review approach looks to all levels with emphasis on the management and control of those processes of interest to market regulation.

In an effort to avoid the criticism of duplication in regulation, states revisited the role of market analysis. Market analysis has existed in states actively engaging in market conduct examinations in some form or another for years. However, it did not possess the refinements that have been developed in recent years. In its current configuration, market analysis is being used to determine which of a variety of regulatory responses are appropriate to a particular set of circumstances. See chapters 1 through 5 of this *Handbook*. As this process becomes more refined, and as the states collaborate in their regulatory efforts, much of the duplication can be expected to dissipate. The challenge is to recognize more effectively and efficiently the indicators that should lead to some form of regulatory interaction.

When a state conducts a review, finds violations or errors and tells a regulated entity to fix it, a difficult condition may be established particularly in those instances where causation is not clear. The regulated entity may have no more of an idea of what has caused a violation or error than does the regulator. For that determination a qualitative review is needed, not a quantitative one. The only way to arrive at a qualitative utility is to adopt reviews that look more intensively at the process and controls affecting the process of interest. Like the reviews to which financial examiners have moved, the overall techniques are similar but rely on very different experience bases. The Financial Examiner reviews process from the viewpoint of the reviewer's background in accounting, investment and/or financial management experience. The market conduct examiner reviews process from the viewpoint of the reviewer's background in underwriting, claims, consumer services, complaint handling and/or contract review experience.

The methodology discussed in this chapter is a review of management structures and controls of areas impacting market related issues. This approach is very effective at identifying *causes* for violations of statute. The process review market conduct examination utilizes a review of the processes and controls developed for the operations of an insurer.

The use of process review methodology has several advantages including the following:

- It can be used on a targeted or routine basis.
- It requires less time to conduct such a review.
- A considerable amount of the review work can be conducted off-site.
- The review conducted tends to be corporate-wide rather than state-specific, thus increasing the multi-state utility of the process.
- It is readily able to identify causation and potential areas of regulatory slippage.
- It tends to be less confrontational since development of violations is not the primary function.
- It is highly predictive of where violations have occurred or are likely to occur thus allowing for proactive correction activity.
- It provides an opportunity for objective regulator/regulated entity dialogue.
- It provides value for the examination costs to the regulated entity.
- It can be used as a stand-alone examination or as a supplement to a conventional examination.
- It is responsive to domestic deference concerns.
- It offers the regulated entity the opportunity to improve compliance.

In its' September 30, 2003 report, GAO-03-433 Insurance Regulation, the Government Accounting Office recognized the need to include corporate governance (process review) elements in the examination approach with the following statement in its' conclusions: "In addition, existing computerized audit tools could allow regulators to substantially change the way examinations are done by shifting the focus from file review to a review of controls, systems, and processes and possibly by shortening the time needed for the examination."

B. Enabling Statute

The statute enabling a process review review is already found in state examination statutes and to some extent, in the admissions statutes. The language in the examination statutes is generally similar from state to state and provides broad authority to examine matters of regulatory interest to the states.

The provision of interest in the admissions statutes is that related to competent management. An enabling statute reads something similar to the following:

“The Commissioner shall not grant or continue authority to transact insurance in this State as to any insurer or proposed insurer the management of which is found by the Commissioner after investigation or upon reliable information to be incompetent or dishonest or untrustworthy or of unfavorable business repute or so lacking in insurance company managerial experience in operations of the kind proposed in this State as to make such operation, currently or prospectively, hazardous to or contrary to the best interests of, the insurance-buying or investing public of this State, or which the Commissioner has good reason to believe is affiliated directly or indirectly through ownership, control, reinsurance transactions or other business relations with any person or persons of unfavorable business repute or whose business operations are or have been marked, to the injury of insurers, stockholders, policyholders, creditors, or the public, by illegality, or by manipulation of assets or of accounts or of reinsurance or by bad faith.”

In some cases the reference is somewhat less direct. For example:

“It is the duty of the commissioner to examine all requests and applications for licenses to be issued under the authority of this title, and the commissioner is authorized to refuse to issue any such licenses until the commissioner is satisfied of the qualifications and general fitness of the applicant in accordance with the requirements of the insurance laws.”

In fewer cases the reference appears only in the Commissioners authority to revoke or suspend the regulated entity’s license. For example:

“The certificate of authority of an insurance company to do business in this state may be revoked or suspended by the commissioner for any reason specified in this title. Specifically, the certificate may be suspended or revoked by the commissioner for reasons that include, but are not limited to use of methods that, although not otherwise specifically proscribed by law, nevertheless render its operation hazardous, or its condition unsound, to the public or to its policyholders.”

C. Review Considerations

An examination that utilizes the process review approach should be based on an understanding of the considerations that contribute to the efficacy of its processes. If the considerations and the logic that support the approach are not thoroughly understood, it is not likely that the method can be used effectively. This usually means that the examiner will be focusing on the written processes in use by the regulated entity.

1. Management Cycle

The management of a well-run regulated entity adopts processes that are similar in structure to ensure compliance. An absence or ineffective application of such processes in a regulated entity often results in an inconsistent application of the intended process. Ineffective processes are typically revealed by adverse findings in samples tested during the course of a market conduct examination. The processes include the following components:

- A planning function where direction, policy, objectives, and goals are formulated
- An execution or implementation of the planning function elements
- A measurement and control function that considers the results of the planning and execution, such as an internal audit function that looks to test and refine the effectiveness of the control or process
- A reaction function that utilizes the results of measurement to take corrective action or to modify the process to develop more efficient and effective management of the regulated entity's operations.

(a). Planning

The planning function in the management cycle is where direction, policy, objectives, and goals are formulated. The function is often predicated on a risk assessment and mitigation review. This function is found most often in the written policies and procedures of the regulated entity. These may also be called processes, strategies, or directives, and are tested for clarity, currency, functionality, and conflict with existing statutes. A proactive process that results in reduced error or violation is one that is clearly stated, up-to-date, fits its intended purpose, and complies with state laws. A reactive process generally results in observable errors and violations that the regulated entity can not avoid, because it is not structured to do so. Absences of policies suggest areas that need to be tested. Findings from this review are predictive of areas where an examiner's review of a sample will yield criticisms and errors. They also provide the examiner with data that helps identify whether problems found are systemic, intended, unintended, or true error. Finally, review findings aid the planners of the examination in determining what business areas may need further examiner attention.

(b). Implementation

When management-directed policies and written processes are disseminated throughout the regulated entity to appropriate and affected persons, implementation of the planning function in the management cycle occurs. Review of the implementation process is useful in determining whether the regulated entity is effectively distributing its directives. Testing the implementation of the planning function involves answering many questions including:

- What are your processes to ensure compliance?
- Are the processes in writing?
- Are the written processes coherent, readable, and on point?
- Are the written processes functional; that is, do they fit their intended purposes?
- Do the written processes comport with statutes and contain state exceptions where applicable?
- Are the written processes up-to-date?
- Are the written processes readily available to affected persons?
- Are the written processes utilized?
- Are affected persons trained in the use of the written processes?
- If the written processes are computerized, is the documentation for the resultant process adequate and does the process accomplish management's intent?
- If the written processes are not computerized, is the documentation for the resultant process adequate and does the process accomplish management's intent?
- Is the process periodically tested and updated?

(c). Measurement

The measurement function in the management cycle evaluates the results of planning and implementation. Measurements can be found in internal audits, management reports, supervisory reports, Board meeting minutes, minutes of the Compliance Committee, minutes of the Quality Review Committee, Market Conduct Examination reports, etc. The measurement function is concerned with the quality of information developed to inform the management and the Board of the results and the effectiveness of its directives. This function must develop information that confirms or refutes that the intended process is utilized, functioning and working. Without measurement, management cannot know whether its directions are being implemented effectively. The measurement process must be written, formal, and documented, and must occur with sufficient frequency to function as a reasonable tool. Without the measurement function in place, the process used is passive or reactive, and the regulated entity will not

have an effective means for knowing that errors or violations are occurring and be in a position to prevent them. This is where the regulated entity exercises the control over the intended process and is critical to the effectiveness of that process.

(d). Reaction

The reaction function in the management cycle is where a regulated entity has the opportunity to insert into the process what it learned through the measurement of its written processes. The process requires a means of utilizing the information arising from internal audits, management reports, and complaint systems. This is reflected in the responses to internal audits, management reports, supervisory reports, Board of Directors and Committee minutes, Market Conduct Examinations, and errors detected through the regulated entity's complaint system analysis.

This information needs to flow back directly to management so that it can use these findings to modify policies and written processes. The regulated entity should also resolve, through documented remediation, any errors that resulted in harm to policyholders and/or the public.

This information represents data that a regulated entity should know about itself. In some cases federal law insists on it. The Sarbanes-Oxley Act (SOX) essentially requires documentation that certain levels of corporate governance are in place and operating.

2. The Cycle as a Whole

The cycle of preparing instructions (policies and written processes), disseminating them, testing their results, and making modifications should be a continuous and ongoing cycle. A continuous and ongoing cycle is indicative of proactive management. Of course, not every regulated entity is fully proactive or fully reactive. A regulated entity can be at both ends of the proactive/reactive spectrum depending on the business area being reviewed. For example, a regulated entity with a proactive claims environment may have a reactive underwriting environment. In some cases a specific process may have components of the proactive/reactive scale. Section I describes a method to evaluate where, on a comparative scale, a particular process is located. The levels resulting from such an evaluation are described with key characteristics in Section I. The levels are:

- 0 Lack of any recognizable processes / practices.
- 1 Processes are ad hoc and disorganized.
- 2 Processes follow a regular pattern.
- 3 Processes are documented and communicated.
- 4 Processes are monitored, measured and controls are in place.
- 5 Good practices are followed and automated.

3. Policies and Procedures

Policies and procedures are two terms heard with some frequency, but they do not tend to evoke an image of how they might be used in a regulatory application. These terms in fact denote two different things.

(a). Definitions

“Policies” are the high-level general principles by which an entity guides the management of its affairs. It is not critical for the regulator to be concerned with policy statements except to the extent that they represent management's direction to proceed in a particular manner. Policies may be the basis for procedures. Policies are generally too vague to require any regulatory interaction unless they are obviously in conflict with a statute.

“Procedures” are the specific methods or courses of action used to implement a policy or corporate directive. Many companies have processes in place that do not derive from policy and do not really constitute procedures. In this chapter, a written procedure is referred to as a written process. How a regulated entity structures and documents its written processes tells the regulator a considerable amount about the regulated entity. Written processes indicate whether a regulated entity is proactive or reactive in the management of its operations; whether the corporate compliance activities are a cause for concern; and whether particular areas of concern to the regulator are managed in a way to avoid the need for regulatory interaction.

(b). Procedure Review

Throughout the *Handbook*, there are suggestions in the review criteria for the various standards to review a particular procedure. For example, Standard 2 for Operations/Management in Chapter 16 states, “Review regulated entity records, central recovery and backup procedures.” It then adds, “Review computer security procedures.” Standard 3 of the same section adds, “Determine if the regulated entity has procedures in place to prevent persons convicted of a felony involving dishonesty or breach of trust from participating in the business of insurance.” It also adds another, “Determine if the regulated entity has procedures in place to provide information regarding fraudulent insurance acts to the insurance commissioner and in a manner prescribed by the commissioner.” There are many other examples of a procedural or process review indicated in the *Handbook*. Unfortunately, the *Handbook* is silent concerning what constitutes such a review. The review of a procedure should determine whether the management cycle relating to the process at interest adequately considers each of the elements noted in the discussion of the management cycle.

(c). Testing the Process

Management analysis of written processes is a top-down look at how a regulated entity operates. It can be thought of as a vertical view of a regulated entity's operation. It represents a somewhat different skill set than typically used in the conventional market conduct examination that is more focused on a “bottom of the ladder” view or horizontal view of a regulated entity operation. Both methods are valid and may be used in conjunction with each other. To test the validity of

the use of this approach, laboratory states have conducted examinations utilizing both methods, process review and conventional including sampling. The examiners have then compared the results of the samples impacted by particular written processes with the management analysis performed relating to that process and the findings have been striking.

Since most examinations conducted during the testing phase have been comprehensive examinations with reasonable levels of sampling, the samples support the notion that the proactive/reactive analysis is a valid tool. The samplings of business areas for companies with proactive tendencies generally yield fairly “clean” results. Where the analysis indicated that there was a passive or reactive process in place or no process in place, the samples revealed considerable human error, systemic error, and certainly more deliberate errors than are seen with proactive management.

(d). Processes to Review

The written processes to review vary depending on the lines of business written by a regulated entity, the reason for examination (target or “baseline”), and a variety of other considerations. Each of the standards appearing in chapters 16 through 24 of the *Handbook* is a potential review subject.

(e). Additional Considerations- The Case for Ethical Management

In addition to the considerations noted above, ethical management, management attitude, and confirmation of management processes are appropriate.

A critical element in any scheme to develop allocation of examiner resources is ethical management. Ethical management is not a direct standard currently in the *Handbook* nor is it a statutory requirement of the regulation of the business of insurance. However, the need for ethical management is strongly implied through the structure of those statutes. For example, a pattern of misrepresentations will raise strong doubts about an insurer’s ethical base. The standards and tests found in the *Handbook* are generally objective indicators that can measure this behavior. Factors such as regulated entity attitude and negative, confrontational, or resistive reaction by regulated entity management may be more subjective, but no less apparent, to the regulator. Likewise, a regulated entity with a reputation for being a “good corporate citizen” typically demonstrates a willingness and structure that is responsive to its customers.

D. Application of the Process Review Methodology

The application of a process review methodology consists of several steps with variations depending upon the particular process under review. The steps are as follows:

- Determine which processes to review
- Provide an information request to the regulated entity.
- Consider the quality and completeness of responses
- Test the structure of the process
- Test the content of the particular process
- Confirm the process is as represented
- Document the review
- Determine the maturity level of the particular process reviewed
- Determine whether issues that arise merit reporting in a report or in a management letter

1. Determination of Processes to Review

The most likely use of this approach will be to apply a combination of the examination standards already outlined in the *Handbook* or state specific handbook and a process review of selected processes. The approach will be generally driven by the reasons for conducting the examination. The examination supervisor will need to evaluate, given the information derived from market analysis, which standards in the *Handbook* require a conventional approach or quantification and which standards require a process review approach. In some cases, both methods will seem useful. In such cases, the decision to apply process review methodology should be deferred until sample results suggest a need.

2. The Information Request

Reasonable structure to the information request is critical to a timely and thorough understanding of a particular process. There are a series of requests that should be made for any process reviewed. Some of these are generic to all processes while others are specific to the particular process.

(a). Risk Assessment and Mitigation Document

The examiner will want to know what led the regulated entity down a particular path in its development of a process. For this reason, the first item requested should be a copy of the risk assessment and mitigation document that formed the starting point for the process. This document should identify and enumerate the operational and regulatory risks to which the regulated entity is exposed and what it needs to do to control or mitigate that risk. In many cases this document will not exist and that will make the examiners effort a bit more difficult. This situation may be partially overcome with interviews of mid and upper management.

(b). Written Process

The examiner should request a complete description of the process including the applicable written procedure used to operate and control the process. The regulated entity should also describe how errors are detected and corrected in the process. The regulated entity should note if the process is contained within a computerized application. If the process is computerized, the documentation for the process and how it works should be described along with any exception reports.

(c). Process Communication and Training

The examiner should request a description to indicate how the process is conveyed to persons affected by it and how those persons are trained in its use. The response should include how the process is accessed; describe training related to the process and how management confirms that the process is being utilized.

(d). Monitoring the Process

The examiner should request a description of the methods used to monitor compliance with the process to ensure it is performing as intended. The response should include a description of the frequency of measurement. Also request copies of any management reports or forms used for this purpose.

(e). History of the Process

The examiner should request a five-year history and description of changes to the process.

(f). Person Responsible for the Process

The examiner should request the name, position and title of the person in the regulated entity responsible for the effective operation of the process under review.

Additional requests should be designed for the specific process under review. The examiner should tailor additional questions to the specific area of interest. For some processes the added questions will be extensive while in others none will be necessary. The best source for additional information requests related to a specific process is the “Review Procedures and Criteria” for a related standard in the *Handbook*.

3. Quality of Information Request Responses

The examiner, where possible, should receive a number of process responses prior to arriving on-site. This provides an opportunity to determine if the regulated entity has provided complete responses of sufficient quality to be useful. The examiner should assume a lack of understanding initially as to process review generally by the Insurer. The Examiner-in-Charge might want to arrange a test of a process selected jointly with the regulated entity to assure that the level of understanding of expectations is reasonable. Since the information contained in the responses is generally sensitive, additional caution to maintain confidentiality is necessary.

4. Testing the Structure of the Process Generally

The first level of testing a process is focused on the quality of the process as a process. These are tests that apply to all processes reviewed using process review methodology. They are generic tests. The items that follow are expressed as questions that should be posed to gain an understanding of review of the process. The examiner should provide responses to these questions in the documentation of his or her review.

(a). Policy Statement

This is a broad statement intended for adoption by management of a regulated entity. It is the basis on which procedures, standards and processes are developed for the operation of the various parts of the regulated entity.

Is there a policy statement that generally provides the overall direction is expected to take on compliance matters?

(b). Risk Assessment and Identification

A Risk Identification is a statement describing an element of risk that is inherent in the performance of some operation of the regulated entity. Risks may be operational, environmental, reputational or the effect of a contract provision, applicable statute, rule, regulation or court precedent. In each case failure to manage the risk identified can result in a violation of a contract provision, applicable statute, rule, regulation or a court precedent. The Review Criteria associated with a Standard are the principle source for Risk Identifications.

Has a risk assessment been conducted? Are all the risks associated with a particular function adequately identified? Does the risk assessment address compliance issues?

(c). Mitigation Potential

For each risk identified, there are potential mitigations available that provide the means for a regulated entity to, mitigate, reduce or avoid the risk outlined. The categories of mitigation can be used singly or more effectively in combination. Management of a regulated entity must determine which combination best achieves the result desired within the framework of their particular operations and circumstances. While a particular mitigation potential category may not be necessary for every Risk Description, it should be evaluated for applicability and potential impact. Listed below are the mitigation categories with descriptions:

- *Process* – Process is the written instruction provided to guide the affected party or parties in applying the mitigation.
- *Intent* – Intent is usually in a written form and is the basis for establishing a consistent measurement or baseline for periodic oversight and review. It can be viewed as a policy statement specific to the risk identified.
- *Structure* – Structure refers to the standards or guides that are established, monitored, tracked and enforced as they relate to mitigation of the Risk Identification.

- *Research-Internal* – Research-Internal refers to research or compilations related to the risk arising from noncompliance with the Company’s contract provisions or Company policies.
- *Research-External* – Research-External refers to research or compilations related to the risk arising from noncompliance with applicable statutes, rules, regulations or court precedent.
- *Reference* – Reference refers to the tools created for affected persons in the Company resulting from Research-Internal and Research-External.
- *Timeframe* – Timeframe refers to a mitigation that has an associated amount of time in which an activity must occur. These are frequently stated in contract provisions, and applicable statutes, rules or regulations.
- *Access* – A mitigation process cannot be effective if it is not circulated or accessible to persons expected to effect change on the process.
- *Feedback* – The effectiveness of a mitigation process is enhanced if there is a well-structured feedback mechanism at the operational level to ensure that flaws inherent in the process are identified and corrected. The same is true for errors arising from operation of the process. Flaws and errors must be corrected or remedied in order to improve the process.
- *Review* – Periodic review of the process should occur at the departmental level to assure that the mitigations designed for a particular Risk Identification are effective and working as intended.
- *Modification* – Mitigations must remain dynamic and reflect continuous improvement in order to remain effective and valid. Improvements learned from the operation, feedback and review of a mitigation process must be utilized to revise the process.
- *Training* – Personnel must be trained in the use, expectations and operation of the process if it is to be applied appropriately, consistently and effectively.

Do the mitigations provided adequately address the risk noted? Are any obvious mitigation elements missing?

(d). Process in Writing

A written structured process is important to consistently meet regulatory requirements; avoid violation of statute; as well as improve service quality to policyholders. These statements describe a component of a process or procedure used to address a risk identified and its accompanying mitigation. Notice that the mitigation potential described above is frequently a procedure or process component.

Is a written procedure or process in place? The absence of a written policy or procedure potentially allows for inconsistent application of the process. If not in writing, how does the regulated entity assure consistent application of the process? Exceptions should be minimal for the process to be effective.

(e). Clarity of Description

Is the procedure or process unambiguous, clear and readable? Does the examiner understand the process or procedure described? Would employees understand the process or procedure? Examiner should explain analysis.

(f). Accessibility

Is the procedure or process accessible and provided to persons subject to its provisions? How the procedure or process is made accessible to those persons? How are they made aware of the existence of the procedure?

(g). Training

Does the Regulated entity provide adequate training to persons affected by the procedure or process? What training is provided? How does the Regulated entity ensure those affected by the process receive training? How are employees re-trained if a problem is found? Are steps to avoid bias adequate?

(h). Measurement and Control

Measurement is the effort applied by the regulated entity to determine that a process is conducted in the manner expected and is working. Control is the management feature in place to guide the process in the direction intended. Most controls make deviation from the intended path difficult if not impossible. Some provide for correction of performance in order to make sure that enterprise objectives and the plans devised to attain them are accomplished. This is the method by which management assures that a process or procedure it has adopted as their mitigation to an identified risk is working as intended. The control provides the opportunity to address defects or flaws in a process and achieve continuous improvement. There are three categories of controls that a Company should utilize: feedback controls, concurrent controls and pre-controls. The difference among the categories of controls is when they occur: feedback controls focus on past performance and concurrent controls occur while work is being performed. A pre-control is a control effort made to prevent an undesirable outcome and may include setting policies, rules and procedures. Relying solely on feedback controls is a reactionary stance that may not uncover defects or flaws in a process until after they have occurred. Delayed feedback increases an organization's operational, regulatory and reputation risk. In order to obtain assurance that a process or procedure is working as intended, a Company should incorporate all three categories of controls. Some of the types of measurement and control that an examiner should expect to see include:

- Internal or external Audit;
- Checklists;
- Computer Anomaly or Error Reports (including Expert Systems Use);
- Intervention by Supervisor or Manager;
- Regular Management Reports;
- Periodic Sampling;
- Employee evaluations; and/or,
- Training or retraining.

Are appropriate measurements or controls in place to test the functioning and efficacy of the procedure or process? How often is the procedure or process reviewed, tested or audited? How does management exercise oversight and control of the process? How is the procedure or process reviewed, tested or audited?

(i). Use of Measurement

How does management utilize the results of its measurement structures? Explain and provide examples, how the results of measurement structures are utilized.

(j). Performing as Intended

Is the procedure or process performing as intended? How does the regulated entity know the procedure or process is performing as intended? If it is not, where is it deficient? Is it possible to know if the procedure or process is performing as intended?

(k). Currency of Process

Is the procedure or process current? When was process last modified? Have events suggested a need for update such as legislation or product line change? Revisions and their reasoning if provided should be explained. Were revisions proactive? Reactive? Are any changes the result of an examination?

5. Testing the Content of the Specific Process

The second level of testing a process is focused on the content of the specific process. These are tests that apply only to the specific process reviewed using process review methodology. A good source for tests applicable to a specific process is the testing criteria for a related standard in the *Handbook*. The examiner should provide responses to these questions in the documentation of his or her review.

6. Process Confirmation

The third level of testing a process is focused on the confirmation that the process is in operation. Often a regulated entity claims to maintain a process or procedure, but in fact it does not. In using this methodology it is important that the examiner confirm the existence **and use of** the processes a regulated entity purports to utilize. This can be accomplished in several different ways:

(a). Walk Through

The first exercise is conducting a “walk-through”. It provides the examiner with the opportunity to question how the process actually functions. The examiner should have questions prepared so he or she can achieve a thorough understanding of what the regulated entity does.

(b). Interview

The next method is the use of interviews of upper and mid-level managers and persons using the purported written process. Some companies may use an

informal or undocumented process. The efficacy of such processes should also be considered. The challenge with an undocumented process is that it is frequently without measurement, meaning that the regulated entity really does not know how that process is working. It also means that there is an increased likelihood of inconsistent application, posing potential unfair discrimination issues.

(c). Sampling

The final method is to actually test a sample of files to determine that the process has been applied as described.

7. Documenting the Review

The process review methodology can be more subjective than application of a standard that has only a pass or fail option. It is therefore especially important that examiner work be carefully documented. Worksheets are recommended to assure that consistency of application is maintained.

8. Determine Maturity Level of the Process

The review of procedures and processes is intended to aid in the understanding of the regulated entity efforts to comply with regulatory requirements and to manage its regulatory risks. This is done through a review of the procedures, processes and controls utilized by a Company to manage its exposure to regulatory risk and to mitigate the effects of that exposure. To be useful, a means to place processes on a comparative scale is needed. This is described in Section I.

9. Report or Management Letter

The discovery of flawed process may not result in a violation of statute or regulation. It may not be an actual violation but may represent a potential for violation. The risk for such an event may be low and not warrant inclusion in an examination report. Some states utilize a management letter for low risk situations when it is desirable to provide the regulated entity with an opportunity to correct or repair a system flaw. A management letter is less threatening to the regulated entity and provides an opportunity for more cordial communication and resolution.

E. Uses of the Process review Methodology

The use of process review methodology has a wide range of utility for insurance organizations. It can be used as a stand-alone form of examination or it can help to narrow a focused review of an area of the regulated entity's operations. It can be useful to augment a conventional examination.

1. Domestic Baseline

The phrase "baseline examination", as used here, contemplates an initial examination of a regulated entity conducted by a state. It is expected to provide a "baseline" of information on which to base future regulatory oversight or absence thereof.

The advantage in this instance is that the state of domicile possesses the authority to look at business areas that other states cannot. This is true whether the domestic regulated entity is a large writer in the domestic state or writes no business at all in the state. The written processes a regulated entity utilizes are generally corporate-wide. The domicile state has the opportunity to look at how the regulated entity treats compliance on a scale that is broader than its own immediate interests and to provide other states with information of strong interest to them. This is a meaningful way to address a state's interest in achieving domestic deference. It also happens to enhance efficiency.

Typical baseline examinations are conducted on a state's domestic insurers. The examinations look at a regulated entity's total complaint population to determine if there are any detectable patterns that may suggest a need for regulatory interaction. The reviews should not be limited to a single line of business or to a single jurisdiction, but they can easily consider all jurisdictions in which the regulated entity operates. Examiners conducting the baseline examination consider complaints directed at the regulated entity, its producers, its vendors, etc. The object is to look for developing patterns anywhere and to determine if the regulated entity maintains processes to correct or repair the issues driving the patterns.

In a full scope base line, examiners will review 40 or more written processes for each regulated entity examined, unless the examination is for a group of companies using the same written processes and controls. The process should take approximately three to five days for each process in the examination scope assuming all requested materials are available and examiners are appropriately trained in the review process. Generally, half of the work can be conducted off-site, resulting in travel-related expense savings. This review also replaces the market conduct work performed as part of a financial examination. The expectation is that this will provide considerable information about each of the state's domestic companies, thereby allowing better future allocation of a state's regulatory resources. For example, this type of examination can identify companies with reactive or passive management styles and, consequently, allow a state to focus greater attention upon those companies. Data developed in this process should be incorporated into a state's market analysis efforts, thus providing a true baseline for future efforts.

It is not unusual to find a regulated entity with few, or no, written processes. Even more commonplace is finding a regulated entity that has no way to tell whether its written processes are working since measurements are non-existent. If the regulated entity writes a line of business that does not generate consumer complaints, there may be few other valid indicators of regulatory concern. Maintenance of the data in the baseline, once acquired, is easy to accomplish with minimal effort.

The baseline examination departs substantially from the definition of a conventional market conduct examination. However, in view of recent NAIC discussions, experience in proactive/reactive analysis, and the need for states to accomplish their examinations with minimal resources, states might well consider a baseline examination. Examinations that focus on the regulated entity operations and management, proactive vs. reactive analysis of each business area, and a detailed review of patterns that arise from complaint systems provide an insurance commissioner with the necessary data to determine when and where a more limited-scope, targeted examination is appropriate in addition to enhancing data derived from market analysis.

2. Target Examination

The analysis completed in the process review examination is exceptionally predictive; it lends itself to a more precise application of Department resources. Other indicators used in market analysis may suggest that a specific review of a particular process is warranted. This next level of review may be accomplished using the process review methodology as a stand-alone process or combined with a conventional market conduct examination.

3. Identification of Causation

When a trade practice or repeat violation of statute is found through market analysis, a conventional examination or complaint review, using a focused application of process review methodology is useful in identifying causation. Once the cause of the violation is determined, the regulator is able to develop recommendations to repair the issue or structure remediation with precision.

4. Market Analysis Supplement

Users of market analysis are seeking ways to gather and review data that are valid indicators that can be used to demonstrate the need for regulatory interaction. Process review methodology is a valuable tool that provides a means of achieving this goal. However, because the process is relatively new, it will be some time before there is an adequate database of findings from the application of process review methodology upon which states can rely.

F. Requests for Information

This section addresses the Requests for Information made by the examiner(s). Please note that the listed requests for a procedure are not fixed or absolute. These requests do not limit the examiner from posing additional questions, when warranted, in efforts to enhance the understanding of the Regulated Entity's response(s). If no response is provided, the fact should be part of the examiners documentation. A discussion and explanation of the first ten Requests for Information is found in Section D(4).

1. Does the regulated entity have a (name of process) in place?
2. Please provide a copy of the most recent risk assessment and mitigation document for the regulated entity's (name of process) process.
3. Please provide a copy of the written (name of process) process or procedure. If a written procedure does not exist, so state, and describe the process the company uses in the absence of a written procedure.
4. Please provide a complete description of the controls utilized to ensure proper operation of the regulated entity's (name of process) process. Please provide documentation.
5. Please provide a copy of policy statement or statement of intent related to the process.
6. Please describe how errors are detected and corrected in the process. If the process is contained within a computerized application, please describe the process and how it works. Please provide documentation.
7. Please describe in detail how <ul style="list-style-type: none"> (a). the process is conveyed to persons affected by it. (b). persons utilizing the process are trained in its use and the content of the training. (c). the process is accessed. (d). the Company confirms that the process is being utilized.
8. Please <ul style="list-style-type: none"> (a). describe the methods used to monitor compliance with the process to ensure it is performing as intended. (b). describe the frequency of measurement and exercise of control. (c). provide copies of any forms used for this process. (d). provide copies of any management reports arising from this process. (e). describe what management does with measurements and reports arising from this process. (f). describe how bias within the process is detected and avoided.
9. Please provide a five-year history and description of changes to the process.
10. Please identify the person and position in the Company responsible for the effective

operation of this process. Include Name, title, phone contact and email address.

In addition to the first ten Requests for Information common to all processes, there are requests to be considered that apply to a specific process. These are listed by process showing source chapter, section and number. For example, Ch16§A01 indicates chapter 16, section A, standard number 1. The examiner may add additional requests for information based on differences in state law, regulations, or observed practice and tailor additional questions to specific area of interest. In addition, many of the Review Procedures and Criteria for the Standards in the *Handbook* are a source for additional Requests for Information.

The following Requests for Information are listed by the Chapter in the *Handbook* affected. These requests are intended as a guide as to the kind of questions that may be posed and are not intended to limit the examiners review of the Standard under review. In some instances, the subject matter in a Standard is so extensive that it makes little sense to attempt to itemize the possible questions here.

This chapter has not considered inclusion of

- Chapter 25 – Conducting the Advisory Organization Examination;
- Chapter 27 – Conducting the Examination of a Viatical Settlement Provider; or,
- Chapter 28 – Conducting the Premium Finance Company Examination.

However, placeholders for those chapters are included in this section for future use.

**(1) Chapter 16 - General Examination Standards
Requests for Information**

Process Ch16§A01 – The regulated entity has an up-to-date, valid internal or external audit program.

<p>Note: The focus is on the internal or external audit process utilized to verify appropriate function and to perform analysis of market conduct issues including the various business areas considered in a market conduct examination. A regulated entity that has no internal or external audit function lacks the ready means to detect structural problems until after problems have occurred.</p>
<p>11. Please provide a description of the frequency of application and triggering events for audit.</p>
<p>12. Please provide access to reports generated by the audit process during the Examination Period. This request encompasses audits conducted by or for the regulated entity's internal audit department as well as other operational audits conducted by affected departments. Indicate location for access.</p>
<p>Note: The State and the examiners are aware that these documents may be viewed as proprietary and sensitive. The reports will be viewed on the company premises after commencement of the on-site portion of the examination. The examiners, based on the results of audit findings for which the company has taken appropriate corrective action and remediation, will not recommend administrative action. The purpose for viewing these documents is to determine that management directives are in compliance with statute and that errors found through the audit process are corrected. It is not used as a device to discover and quantify violations, rather it is used for qualitative purposes. Any special needs or concerns should be discussed with the Examiner in Charge.</p>
<p>13. Please describe how recommendations made in audits are tracked until implemented or resolved. Cross reference to appropriate location in the written procedure.</p>
<p>14. Does the audit function include edit and audit procedures to screen and to check data submitted by the regulated entity's statistical agent.</p>
<p>15. Does the regulated entity conduct periodic reviews of creditors with respect to its credit insurance business with such creditors?</p>

Process Ch16§A02 – The regulated entity has appropriate controls, safeguards and procedures for protecting the integrity of computer information.

<p>Note: The focus is on the existence of sufficient protection to the regulated entity systems. Examiners should avoid requiring information that itself poses a threat to</p>
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that protection.
11. If changes to contracts can be made electronically or verbally, please describe process for the change and who has authority to make such changes.
12. How does the regulated entity detect and respond to attempts at unauthorized access to computer data? How does the regulated entity respond to successful unauthorized access? Has the regulated entity experienced inappropriate intrusions?
13. What steps are taken to ensure there is adequate security of applicant/insured data during electronic transfer of data? Please address the security of both data "at rest" and data "in motion". Are security audits conducted and if so with what frequency.

Process Ch16§A03 – The regulated entity has antifraud initiatives in place that are reasonably calculated to detect, prosecute and prevent fraudulent insurance acts.

Note: Examiners are interested in internal as well as external fraud response and detection mechanisms.
11. Please provide a copy of the fraud warning notice provided with claims processing.
12. Please describe how the regulated entity determines that its anti-fraud efforts are adequate.
13. Please describe staffing for the program and number of suspected fraud cases referred to the Commissioner during the examination period.
14. Please describe procedures in place to prevent persons convicted of a felony involving dishonesty or breach of trust from participating in the business of insurance.
15. Does the regulated entity utilize a reporting mechanism to provide information regarding fraudulent insurance acts to the insurance commissioner?

Process Ch16§A04 – The regulated entity has a valid disaster recovery plan.

11. Please describe any use of the regulated entity disaster recovery plan during the period of the examination.
12. Please describe how often elements of the disaster recovery plan are tested and the methods used to critique results.
13. Please describe the regulated entity's off-site backup for its data and the frequency of update. Is the backup site sufficiently distant geographically so as not to expose primary and backup sites to a common disaster?

Process Ch16§A05 – Contracts between the regulated entity and entities assuming a business function or acting on behalf of the regulated entity, such as, but not limited to, managing general agents (MGAs), general agents (GAs), third-party administrators (TPAs) and management agreements, must comply with applicable licensing requirements, statutes, rules and regulations.

Note: “Vendor” refers to a third party provider of services including but not limited to MGA’s, GA’s, and TPA’s related to one or more of the following functions:

- **Complaint handling**
- **Marketing and Sales**
- **Producer Licensing**
- **Policyholder Service**
- **Underwriting and Rating**
- **Claims Handling**
- **Grievance Handling**
- **Network Adequacy**
- **Provider Credentialing**
- **Utilization Review**

It does not include supply vendors or vendors providing equipment such as computers, maintenance, landscaping, communications, etc.

11. Provide a list of any vendors including but not limited to MGA’s, GA’s and TPA’s used by the regulated entity to perform functions in the complaint handling, sales and marketing, producer licensing, policyholder services, underwriting and rating, claims handling grievance handling, network adequacy, provider credentialing and utilization review areas, and describe the scope of authority extended. If license for the vendor is required, indicate the type of license held.

12. Provide a copy of the contract(s) used by the regulated entity for vendors.

13. Does contract specify the responsibilities of the subcontractor regarding recordkeeping and audit.

Process Ch16§A06 – The regulated entity is adequately monitoring the activities of any entity that contractually assumes a business function or is acting on behalf of the regulated entity.

Note: “Vendor” refers to a third party provider of services including but not limited to MGA’s, GA’s, and TPA’s related to one or more of the following functions:

- **Complaint handling**
- **Marketing and Sales**
- **Producer Licensing**
- **Policyholder Service**

<ul style="list-style-type: none"> • Underwriting and Rating • Claims Handling • Grievance Handling • Network Adequacy • Provider Credentialing • Utilization Review <p>It does not include supply vendors or vendors providing equipment such as computers, maintenance, landscaping, communications, etc.</p>
11. Provide a list of any vendors including but not limited to MGA's, GA's and TPA's used by the regulated entity to perform functions in the complaint handling, sales and marketing, producer licensing, policyholder services, underwriting and rating, claims handling grievance handling, network adequacy, provider credentialing and utilization review areas, and describe the scope of authority extended. If license for the vendor is required, indicate the type of license held.
12. Provide a copy of the contract(s) used by the regulated entity for vendors.
13. Does contract specify the responsibilities of the subcontractor regarding recordkeeping and audit.
14. Please describe oversight and control by regulated entity of a vendor.
15. Provide a copy of each vendor audit completed during the Examination Period.
16. Describe how performance standards for vendors are established, monitored and documented.
17. If for credit insurance, describe periodic review of creditors. Provide access to written records of the reviews maintained by the insurer.

Process Ch16§A07 – Records are adequate, accessible, consistent and orderly and comply with state record retention requirements.

<p>Note: The records of interest include records for complaint handling, sales and marketing, producer licensing, policyholder services, underwriting and claims handling. For Health records this also include grievance procedures, network adequacy, provider credentialing, quality assessment and utilization review functions.</p>
11. Please describe the various media used for records affected by market regulation concerns.
12. Please describe step taken to maintain orderly organization, legibility and structure of files.
13. Please provide a copy of the regulated entity record retention schedule.

14. Please describe any failed recoveries.

15. Please describe record backup process.

Process Ch16§A08 – The regulated entity is licensed for the lines of business that are being written.

11. Please describe how the regulated entity avoids writing business not authorized by its certificate of authority.

Process Ch16§A09 – The regulated entity cooperates on a timely basis with examiners performing the examinations.

11. Please describe how the regulated entity monitors its interaction with examiners to assure timely delivery of requested data.

Note: “Assertions of Privilege” refers to the process whereby the company asserts some form of privilege to deny access to certain documents. The primary privilege of this type is the attorney-client privilege. The privilege is asserted to protect communications between an Attorney and a client. The party asserting the privilege bears the burden of demonstrating its existence and applicability of the privilege is determined on a case-by-case basis. The regulated entity should have a written policy regarding the use of attorney-client privilege, as state or federal law governs the protection afforded by the privilege. “Assertions of Privilege” may also be attempted for self-evaluative or self-critical analysis privilege and privilege may be claimed for proprietary documents, however, these forms of privilege may not be recognized by the examining state.

12. If a document for which a privilege is claimed is critical to examiner review of an issue, to whom in the Company can an appeal be made and what is the process for appeal?

13. Please describe the various Assertion of Privilege types used by the regulated entity and the logic for each type.

Process Ch16§A10 – The regulated entity has procedures for the collection, use and disclosure of information gathered in connection with insurance transactions so as to minimize any improper intrusion into the privacy of applicants and policyholders.

11. Please provide a copy of all “Notice of Information Practices” used by the regulated entity.

12. Describe how the regulated entity utilizes investigative reports and the privacy protections in use for investigative reports.

13. Describe how the regulated entity limits access to personal information and the controls in place to assure that personal information is not inappropriately released.
14. Describe the reasons the regulated entity utilizes for adverse underwriting decisions.
15. Please describe how the regulated entity provides adverse underwriting decisions to prospective insureds and the detail provided.
16. Please describe regulated entity's system for allowing production of all disclosures made, routine or otherwise.
17. Please provide the identity of any vendors holding and/or using personal information concerning insureds or prospective insureds of the regulated entity and their reasons for doing so. The list should also contain a contact name, phone number and email address.

Process Ch16§A11 – The regulated entity has developed and implemented written policies, standards and procedures for the management of insurance information.

Note: This process applicable for states that have adopted the NAIC Insurance Information and Privacy Protection Model Act referred to as the 1982 Model Act.
11. Please provide training manuals and bulletins that address the management of insurance information including handling, disclosing, storing or disposing of insurance information.
12. Please describe the regulated entity's standards and security to safeguard insurance information. Please describe the factors considered in developing these safeguards.
13. Please provide a copy of the contract used by the regulated entity to share information shared with a contractor of the regulated entity.
14. Please describe all contractual agreements between the regulated entity and other persons and indicate how they address privacy procedures and standards for the person with whom the regulated entity is contracting.
15. Please describe the process used by the regulated entity before disclosure of information held.
16. Describe how the regulated entity ensures proper authorization before disclosing insurance information.
17. Describe how the regulated entity handles, discloses, stores and disposes of insurance information.
18. Please provide the identity of any vendors holding and/or using personal information concerning insureds or prospective insureds of the regulated entity and their reasons for

doing so. The list should also contain a contact name, phone number and email address.
19. Describe the training process, time required and frequency for employees handling insurance information.
20. Describe the process utilized when the regulated entity discovers an inappropriate release of insurance information.
21. Please provide a copy of the “Notice of Information Practices” provided to all applicants or policyholders for the protection of consumer information and privacy. If this responsibility has been delegated to the producer, please provide the contractual language that supports the delegation and a discussion of the controls utilized to assure that the delivery has occurred.
22. Please specify those questions posed by the regulated entity designed to obtain information solely for marketing or research purposes.
23. Please describe the regulated entity's use of investigative consumer reports including personal interviews and how reports are initiated.
24. Please describe the process for correcting, amending, or deleting personal information held by the regulated entity including recorded personal information.
25. Please describe the controls used by the regulated entity for information or data held by vendors or producers.

Process Ch16§A12 – The regulated entity has policies and procedures to protect the privacy of nonpublic personal information relating to its customers, former customers and consumers that are not customers.

11. Please describe the regulated entity's standards and security to safeguard nonpublic customer information. Please describe the factors considered in developing these safeguards.
12. Please provide communications by the regulated entity to employees and producers subject to the regulated entity’s privacy policies.
13. Please provide a copy of all notices and disclosures provided to customers, former customers and consumers who are not customers, for the protection of consumer information and privacy including but not limited to “Notice of Information Practices”, disclosure of nonpublic personal financial information, and disclosure of nonpublic personal health information.
14. Please furnish verification that the regulated entity has provided a copy of its privacy notice to its producers. Indicate frequency.

15. Please provide a copy of the opt-out form used by the regulated entity with any instructions for its use.
16. Please describe efforts to prevent unfair discrimination against customers and consumers who are not customers who have opted out from the disclosure of nonpublic personal financial information to nonaffiliated third parties or who have not authorized disclosure of nonpublic personal health information.
17. Please provide all privacy-related consumer complaints and inquiries.

Process Ch16§A13 – The regulated entity provides privacy notices to its customers and, if applicable, to its consumers who are not customers regarding treatment of nonpublic personal financial information.

11. Please describe the regulated entity's standards and security to safeguard nonpublic customer information. Please describe the factors considered in developing these safeguards.
12. Please provide a copy of all notices and disclosures provided to customers, former customers and consumers who are not customers, for the protection of consumer information and privacy including but not limited to “Notice of Information Practices”, disclosure of nonpublic personal financial information, and disclosure of nonpublic personal health information. This includes initial (standard and short-form) notices, annual and revised notices.
13. Please describe the categories of nonpublic personal information that the regulated entity collects and why.
14. Please describe all entities to whom the regulated entity discloses nonpublic personal information.
15. Please describe all nonaffiliated third parties to whom the regulated entity discloses information and explain the reasons for the disclosures.

Process Ch16§A14 – If the regulated entity discloses information subject to an opt-out right, the regulated entity has policies and procedures in place so that nonpublic personal financial information will not be disclosed when a consumer who is not a customer has opted out, and the regulated entity provides opt-out notices to its customers and other affected consumers.

11. Please describe the controls used by the regulated entity to ensure that information subject to an opt out right will not be disclosed when a consumer who is not a customer has opted out.

12. Please describe the capability of the regulated entity to keep nonpublic personal financial information from being unlawfully disclosed to a non-affiliated third-party when a consumer has opted out.
13. Please provide a copy of the opt-out form used by the regulated entity with any instructions for its use.

Process Ch16§A15 – The regulated entity’s collection, use and disclosure of nonpublic personal financial information are in compliance with applicable statutes, rules and regulations.

11. Please describe the regulated entity's standards and security to safeguard nonpublic personal financial information. Please describe the factors considered in developing these safeguards.
12. Identify vendors holding and/or using nonpublic personal financial information concerning insureds or prospective insureds of the regulated entity and their reasons for doing so.
13. Please provide a copy of all notices and disclosures provided to customers and consumers for the protection of nonpublic personal financial information.

Process Ch16§A16 –In states promulgating the health information provisions of the Privacy of Consumer Financial and Health Information Model Regulation (#672), or providing equivalent protection through other substantially similar laws under the jurisdiction of the insurance department, the regulated entity has policies and procedures in place so that nonpublic personal health information will not be disclosed, except as permitted by law, unless a customer or a consumer who is not a customer has authorized the disclosure.

11. Please describe the regulated entity's standards and security to safeguard nonpublic personal health information of customers and consumers who are not customers. Please describe the factors considered in developing these safeguards.
12. Please provide a copy of all notices and disclosures provided to customers, former customers and consumers who are not customers, for the protection of nonpublic personal health information.
13. Please describe the authorization process for release of nonpublic personal health information, provide any forms utilized in connection with the authorization and all instructions for their use.

Process Ch16§A17 – Each licensee shall implement a comprehensive written information security program for the protection of nonpublic customer information.

11. Please describe the regulated entity's standards and security to safeguard nonpublic customer information. Does the security include administrative, technical and physical safeguards? Please describe the factors considered in developing these safeguards.
12. How do the safeguards implemented consider the size and complexity of the regulated entity? How do the safeguards implemented consider the nature and scope of the regulated entity's activities? In responding to this request, consider such factors as: (1) the products and services offered by the regulated entity; (2) the methods of distribution for the products and services; (3) the types of information maintained by the regulated entity; (4) the size of the regulated entity (which may include the number of employees and the volume of business, etc.); (5) the marketing arrangements; and (6) the extent to which, or methods by which, the regulated entity communicates electronically with customers, producers and other third parties.
13. Describe how the regulated entity ensures proper authorization before disclosing insurance information.
14. How frequently is the security program reviewed and updated?

Process Ch16§A18 – All data required to be reported to departments of insurance is complete and accurate.

Note: This process impacts loss statistical reports, medical professional liability loss reports, MCAS data, state specific data calls, etc.
11. Please describe the process for detecting, resolving and correcting data errors.
12. Please explain the reconciliation process utilized before data is submitted.
13. Please explain how the regulated entity assures timely reporting.

Process Ch16§B01 – All complaints are recorded in the required format on the regulated entity's complaint register.

11. Please provide a copy of the Consumer Complaint Register.
12. Please describe the media used for the complaint register and how it is accessed.
13. Describe limitations to access.

Process Ch16§B02 – The regulated entity has adequate complaint handling procedures in place and communicates such procedures to policyholders.

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| 11. Please describe information provided to policyholders to communicate procedures for complaint handling. |
| 12. Please describe steps taken by regulated entity to ensure that correspondence and email received expressing a complaint or grievance is handled as a complaint and is logged and processed accordingly. |

Process Ch16§B03 – The regulated entity takes adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules and regulations and contract language.

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| 11. Please describe the regulated entity's reporting mechanism and frequency for reporting the findings on its review of complaints to senior management.. |
| 12. Please describe how the regulated entity assures that all issues raised in a complaint or grievance are fully addressed by its responses. |
| 13. Please describe the regulated entity's standards for logging, dating and documentation of all complaint/grievance activities. Please describe the controls in place to assure that the standards are met. |
| 14. Provide a listing of all complaints filed with the company during the examination period including grievances filed. |

Process Ch16§B04 – The timeframe within which the regulated entity responds to complaints is in accordance with applicable statutes, rules and regulations.

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| Source: |
| 11. Please describe the regulated entity's standards for timely and accurate response and disposition of a complaint. Please describe the controls in place to assure that the standards are met. |

Process Ch16§C01 – All advertising and sales materials are in compliance with applicable statutes, rules and regulations.

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| 11. Provide a copy of the regulated entity's advertising objectives statement. |
| 12. Provide a copy of the regulated entity's producer marketing materials or solicitation kits. |

13. Provide a copy of the regulated entity's advertising materials and associated policy forms used during the Examination Period.
14. Describe the regulated entity's internet marketing efforts.
15. Provide a copy of the regulated entity's telemarketing scripts.
16. Describe methods of communication with producers. Is electronic media used to train, inform, communicate with producers?
17. Provide a copy of any buyer's guide in use by the regulated entity.
18. Please describe any use of social media by the regulated entity.

Process Ch16§C02 – Regulated entity internal producer training materials are in compliance with applicable statutes, rules and regulations.

Note: For purposes of this process, this includes, agent, broker, solicitor, surplus lines broker, general agent, managing general agent, etc.
11. Please describe the specialized product training provided to producers and the frequency of the training.
12. Please describe the regulated entity efforts to avoid producer misrepresentation.
13. Please provide all producer training material utilized by the regulated entity.

Process Ch16§C03 – Regulated entity communications to producers are in compliance with applicable statutes, rules and regulations.

11. Please describe the media used for communications with producers.
12. Please provide all general communications, bulletins, notices, etc. sent to producers during the examination period.

Process Ch16§D01 – Regulated entity records of licensed and appointed (if applicable) producers and in jurisdictions where applicable, licensed company or contracted independent adjusters agree with insurance department records.

Tailor additional questions to specific area of interest.

Process Ch16§D02 – The producers are properly licensed and appointed and have appropriate continuing education (if required by state law) in the jurisdiction where the application was taken.

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| 11. Please describe steps aimed at assuring that producers is licensed before submission of business and appointed within 15 days of submission. |
| 12. Please provide a sample producer contract and commission schedule. |
| 13. Please describe controls in place to assure that the producer is acting within the scope of his/her authority. |

Process Ch16§D03 – Termination of producers complies with applicable standards, rules and regulations regarding notification to the producer and notification to the state, if applicable.

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| 11. Please provide a listing of acceptable reasons for termination of a producer contract. |
| 12. Are terminations and reasons for the termination provided to the state? |

Process Ch16§D04 – The regulated entity’s policy of producer appointments and terminations does not result in unfair discrimination against policyholders.

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| 11. Please describe the steps taken to prevent unfair discrimination when considering a termination. |
| 12. Please describe the documentation required for a termination. |
| 13. Provide a listing of all producers that were terminated during the examination period. List reasons. |

Process Ch16§D05 – Records of terminated producers adequately document reasons for terminations.

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| 11. Please provide a listing of acceptable reasons for termination of a producer contract. |
| 12. Please describe the documentation required for a termination. |
| 13. Provide a listing of all producers that were terminated during the examination period. List reasons. |

Process Ch16§D06 – Producer account balances are in accordance with the producer’s contract with the insurer.

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| 11. Are criminal reports made when a defalcation occurs? |
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12. Does the producer contract used by the regulated entity require that premiums be held in a fiduciary capacity?
13. Provide a listing of producer accounts current where the remittance of premiums due has not been made according to contract.

Process Ch16§E01 – Premium notices and billing notices are sent out with an adequate amount of advance notice.

11. Please provide sample copy of billing notice.
12. Please provide a description of the timing of billings.

Process Ch16§E02 – Policy issuance and insured-requested cancellations are timely.

11. Please describe the regulated entity standards for timely policy issuance.
12. Please describe the regulated entity standards for timely insured requested cancellations.

Process Ch16§E03 – All correspondence directed to the regulated entity is answered in a timely and responsive manner by the appropriate department.

11. Please describe the regulated entity's standards for identifying and directing incoming correspondence.
12. Please describe the regulated entity's standard for timely response to correspondence.

Process Ch16§E04 – Whenever the regulated entity transfers the obligation of its contracts to another regulated entity pursuant to an assumption reinsurance agreement, the regulated entity has gained prior approval of the insurance department, and the regulated entity has sent the required notices to affected policyholders.

<p>Note: According to the model act, “assumption reinsurance agreement” means any contract which both;</p> <ul style="list-style-type: none">• transfers insurance obligations and/or risks of existing or enforce contracts of insurance from a transferring insurer to and assuming reinsurer; and• is intended to affect a novation of the transferred contract of insurance with the result that the assuming insurer becomes directly liable to the policyholders of the transferring insurer.
11. Does the regulated entity enter into assumption reinsurance agreements?

12. What notifications are provided to affected policyholders?
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Process Ch16§E05 – Policy transactions are processed accurately and completely.

11. Please describe the regulated entity’ standards for timeliness and accuracy of all transactions.
12. Please describe the regulated entity’s standards for documentation of all transactions including but not limited to Cash surrenders; Policy loans; Bank draft acceptance and clearance; and Beneficiary changes.
13. Please describe the regulated entity’ standards for processing of mature endowments when due.
Life Products 14. Please describe the regulated entity’ standards for processing premium refunds for modifying the guaranteed life products. Special requirements may exist, under policy provisions or state law, for calculation of refunds involving “10 day day right to return” periods for life products, which include a separate account.
Credit Insurance 14. Please describe the regulated entity’ standards for handling of credit insurance where the debt is refinanced prior to the scheduled maturity date.

Process Ch16§E06 – Reasonable attempts to locate missing policyholders or beneficiaries are made.

11. Please describe the steps taken and tools utilized to locate beneficiaries, policyholders and recipients of unclaimed properties.

Process Ch16§E07 – Unearned premiums are correctly calculated and returned to the appropriate party in a timely manner and in accordance with applicable statutes, rules and regulations.

11. Does the Company have a process to return unearned premium?
12. Please describe how the regulated entity verifies that refunds provided to a producer are properly distributed.
13. Please describe how the regulated entity verify adherence to “free look” periods?
14. Please describe how credit insurance refunds are calculated and refunded.

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Process Ch16§F01 – The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the regulated entity’s rating plan.

11. Please provide a copy of all rating manuals in use during the Examination Period.
12. Please describe method of rating policies. Indicate if rating is done manually, electronically, or a combination of both. If different systems used for new business versus renewal business, describe differences.
13. Please describe steps taken by regulated entity to determine that the basis of premium is correct.
14. Please describe how the regulated entity assures that correct rating factors are used.

Process Ch16§F02 – All mandated disclosures are documented and in accordance with applicable statutes, rules and regulations.

11. Please provide a copy of all disclosures made to policyholders during the examination period. Describe how disclosures made are documented.
12. How does the regulated entity determine what disclosures are required and what controls are in place to assure that required disclosures are made?
13. Is notice of the existence of pools provided where required?
14. Are help phone numbers provided to policyholders?
15. Does the regulated entity utilize <i>Buyers Guides</i> and if so for what lines of business?

Process Ch16§F03 – The regulated entity does not permit illegal rebating, commission-cutting or inducements.

11. Please provide a copy of all rating manuals in use during the Examination Period.
12. Please describe method of rating policies. Indicate if rating is done manually, electronically, or a combination of both. If different systems used for new business versus renewal business, describe differences.
13. Please describe steps taken by regulated entity to detect and prevent illegal rebating, commission-cutting or inducements.
14. Please describe steps taken by regulated entity to determine that the basis of premium is

correct.

Process Ch16§F04 – The regulated entity’s underwriting practices are not unfairly discriminatory. The regulated entity adheres to applicable statutes, rules and regulations and regulated entity guidelines in the selection of risks.

11. Please provide a copy of all underwriting manuals and guidelines in use during the Examination Period.
12. Do applications form a part of the contract of coverage in all cases? Specify.
13. Provide a copy of each policy form and rider used by the regulated entity during the Examination Period.
14. Describe process for handling adverse underwriting decisions. Include copies of form letters used.
15. Provide a copy of all bulletins, notices, orders, and newsletters, etc. provided to or accessible by underwriters to guide them in their selection of business. If materials are voluminous, please provide an index.
16. Describe latitude given to underwriters to deviate from selection or rating criteria and circumstances under which it may be exercised. Describe the documentation required in such instances and controls utilized to avoid abuse.
17. Describe commission structure including any variances permitted on an individual agent basis. Does the regulated entity use multilevel commission schedule and if so describe conditions under which variances are used and how are they applied?
18. Describe verification process used by the regulated entity to determine accuracy of application information.
19. Describe process used by Company to assure that underwriting, rating and classification efforts on auditable policies is developed at or near inception of the coverage rather than near or after expiration or following a claim.
20. Please provide a copy of each application for coverage used by the Company.
21. Describe controls in place to monitor declination/rejection by underwriters.

Process Ch16§F05 – All forms, including policies, contracts, riders, amendments, endorsement forms and certificates are filed with the insurance department, if applicable.

11. Please provide a list of forms filed during the examination period. If any were

disapproved, so indicate.
12. Please provide a copy of any form certifications made during the Examination Period.

Process Ch16§F06 – Policies, contracts, riders, amendments and endorsements are issued or renewed accurately, timely and completely.

11. Please describe the regulated entity standards for timely policy issuance.
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Process Ch16§F07 – Rejections and declinations are not unfairly discriminatory.

11. Please provide a list of reasons used by the regulated entity for rejection or declinations.
12. Please provide an explanation of conditions that allow a producer to terminate coverage and the specific controls the company has in place to assure that such terminations are appropriate and not unfairly discriminatory.
13. Please explain the Company standards for materiality utilized before exercising a decision to rescind coverage.

Process Ch17§F08 – Cancellation/nonrenewal, discontinuance and declination notices comply with policy and contract provisions, state laws and the regulated entity’s guidelines.

11. Please provide a list of reasons used by the regulated entity for cancellation/nonrenewal, discontinuance or declination.
12. Please provide samples of cancellation/nonrenewal, discontinuance or declination notices.
13. Please describe controls in place to assure that cancellation/nonrenewal, discontinuance or declinations by underwriters comport with statutes rules and regulations including unfairly discriminatory practices.
14. Please describe controls in place to assure that cancellation/nonrenewal, discontinuance or declinations by producers or managing general agents comport with statutes rules and regulations including unfairly discriminatory practices.
15. Describe process for handling adverse underwriting decisions. Include copies of form letters used.

Process Ch16§F09 – Rescissions are not made for non-material misrepresentation.

11. Please explain the Company standards for materiality utilized before exercising a decision
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to rescind coverage.
12. Please describe the controls in place to assure standard is consistently applied.

Process Ch16§G01 – The initial contact by the regulated entity with the claimant is within the required timeframe.

11. What timeframes are utilized by the regulated entity for initial contact?
12. Please describe the controls in place to assure timeframe is consistently applied.

Process Ch16§G02 – Timely investigations are conducted.

11. What timeframes are utilized by the regulated entity for timely investigation?
12. Please describe the controls in place to assure timeframe is consistently applied.

Process Ch16§G03 – Claims are resolved in a timely manner.

11. What timeframes are utilized by the regulated entity for resolution?
12. Describe regulated entity standards for use of claim releases, if any. Are releases used? If so provide a sample of each type of release used.
13. Please describe the controls in place to assure timeframe is consistently applied.
14. Please describe differences in the claim handling process necessitated by a catastrophic event.
15. Describe source of adequate claim adjustment or claim adjudication resources needed to address loss arising from a catastrophic event.

Process Ch16§G04 – The regulated entity responds to claims correspondence in a timely manner.

11. What timeframes are utilized by the regulated entity for response to claim correspondence?
12. Please describe the controls in place to assure timeframe is consistently applied.

Process Ch16§G05 – Claim files are adequately documented.

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| 11. Please describe the regulated entity claim file documentation requirements. |
| 12. Please describe the regulated entity claim file retention/destruction requirements. |
| 13. Please describe the regulated entity controls to assure that documentation is complete and sufficient. |

Process Ch16§G06 – Claims are properly handled in accordance with policy provisions and applicable statutes (including HIPAA), rules and regulations.

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| 11. How does regulated entity assure that claim is settled in accord with policy provisions? |
| 12. Does the regulated entity utilize fraud detection measures in its review of claims? |

Process Ch16§G07 – Regulated entity claim forms are appropriate for the type of product.

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| 11. Please provide a copy of each claim form in use by the regulated entity. |
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Process Ch16§G08 – Claim files are reserved in accordance with the regulated entity’s established procedures.

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| 11. Please provide a copy of the claims guidelines used by the adjuster or claim processor to establish reserves. |
| 12. Please provide a copy of all bulletins, notices, orders, and newsletters, etc. provided to or accessible by adjusters to guide them in their adjustment of claims. |
| 13. Please describe controls in place to detect reserve inadequacies or redundancies and to make adjustments. |

Process Ch16§G09 – Denied and closed without payment claims are handled in accordance with policy provisions and state law.

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| 11. Please describe the regulated entity’s standard of explanation for a denied and closed without payment claims. |
| 12. Does the regulated entity provide claimants with instructions for having rebuttals to denials reviewed by the Insurance Department or the regulated entity? |

Process Ch16§G10 – Canceled benefit checks and drafts reflect appropriate claim handling practices.

11. Indicate whether claims are paid by check or by draft. If by draft describe clearance process.
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Process Ch16§G11 – Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than is due under the policy.

11. Please describe the regulated entity controls utilized to properly assess the recoverable amounts under a policy and avoid litigation due to insufficient offers.	Ch16§G11
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**(2) Chapter 17 – Conducting the Property and Casualty Examination
Requests for Information**

Process Ch17§C01 – The regulated entity’s mass marketing of property/casualty insurance is in compliance with applicable statutes, rules and regulations.

11. Please describe how a legitimate basis for a group is determined.

Process Ch17§E01 – Claims history and loss information is provided to the insured in a timely manner.

11. Please provide the regulated entity standards for providing claim history and loss information in a timely manner when requested?

Process Ch17§F01 – Credits, debits and deviations are consistently applied on a non-discriminatory basis.

11. Please explain how the regulated entity assures consistent application of its credits, debits and deviations.

Process Ch17§F02 – Schedule rating or individual risk premium modification plans, where permitted, are based on objective criteria with usage supported by appropriate documentation.

11. Please explain how the regulated entity assures consistent application of its schedule rating plan.

12. Please explain how the regulated entity documents its use of the schedule rating plan and describe what constitutes adequate support for the various categories of credit and debit.

Process Ch17§F03 – Verification of use of the filed expense multipliers; the regulated entity should be using a combination of loss costs and expense multipliers filed with the insurance department.

11. Please provide the regulated entity’s filed (and approved if applicable) expense multipliers during the examination period.

12. Please explain how the expense multiplier is developed for each line of business affected.

Process Ch17§F04 – Verification of premium audit accuracy and the proper application of rating factors.

11. Please describe the regulated entity's standard for timely premium audit.
12. Please explain under what circumstances and conditions are premium audits waived.
13. Please describe the process utilized when the auditor finds a significant difference in the classifications used or the estimated premium basis.
14. How does the Company assure that premium audit data is accurately reflected in the unit statistical report. (Workers Compensation)

Process Ch17§F05 – Verification of experience modification factors.

11. Does the regulated entity reconcile experience modification to the unit statistical reports made to NCCI?
12. Does the regulated entity insist on timely development of experience modifications and what is the process when modifications are not applied within the first thirty days of the policy period affected?
13. How does the Company assure that the correct experience modification is applied accurately and timely?

Process Ch17§F06 – Verification of loss reporting.

11. How does the regulated entity assure timely and accurate reporting of the unit statistical reports made to NCCI?
12. How does the regulated entity assure timely and accurate reporting of data calls made by NCCI?

Process Ch17§F07 – Verification of the regulated entity's data provided in response to the NCCI call on deductibles.

11 Please describe verification process for data submitted on deductible calls.

Process Ch17§F08 – Underwriting, rating and classification are based on adequate information developed at or near inception of the coverage rather than near expiration, or following a claim.

Note: Underwriting decisions should be based on information that reasonably should have been developed at the inception of the policy or during initial underwriting and

not, through audit or other means, after the policy has expired or after a claim has occurred.
11 Please describe the controls the regulated entity has implemented to avoid post-claims underwriting.
12. Please describe the minimum information required for the regulated entity to accept business offered to it.

Process Ch17§F09 – Audits, when required, are conducted accurately and timely.

11. Please describe the regulated entity’s standard for timely premium audit.
12. Please explain under what circumstances and conditions are premium audits waived.
13. Please describe the process utilized when the auditor finds a significant difference in the classifications used or the estimated premium basis.

Process Ch17§F10 – The regulated entity’s underwriting practices are not unfairly discriminatory. The regulated entity adheres to applicable statutes, rules and regulations and the regulated entity’s guidelines in the selection of risks.

11. Please provide a copy of all underwriting manuals and guidelines in use during the Examination Period.
12. Do applications form a part of the contract of coverage in all cases? Specify.
13. Provide a copy of each policy form and rider used by the regulated entity during the Examination Period.
14. Describe process for handling adverse underwriting decisions. Include copies of form letters used.
15. Provide a copy of all bulletins, notices, orders, and newsletters, etc. provided to or accessible by underwriters to guide them in their selection of business. If materials are voluminous, please provide an index.
16. Describe latitude given to underwriters to deviate from selection or rating criteria and circumstances under which it may be exercised.
17. Describe commission structure including any variances permitted on an individual agent basis. Does the regulated entity use multilevel commission schedule and if so describe conditions under which variances are used and how are they applied?

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| 18. Describe verification process used by the regulated entity to determine accuracy of application information. |
| 19. Describe process used by Company to assure that underwriting, rating and classification efforts on auditable policies are developed at or near inception of the coverage rather than near or after expiration or following a claim. |
| 20. Please provide a copy of each application for coverage used by the Company. |
| 21. Describe controls in place to monitor declination/rejection by underwriters. |

Process Ch17§F11 – All forms and endorsements forming a part of the contract are listed on the declaration page and should be filed with the insurance department (if applicable).

Note: All forms and endorsements forming a part of a contract must be listed on the declaration page unless added after inception in which case the attaching clause must be completed.

11. Does the regulated entity conduct a control review before a policy is released to assure that all forms and endorsements forming part of the contract are itemized on the declaration page?

Process Ch17§F12 – Regulated entity verifies that the VIN number submitted with the application is valid and that the correct symbol is utilized.

11. Does the regulated entity utilize a third party to test the VIN numbers of the vehicles it insures for validity?
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12. Describe how the regulated entity verifies the physical damage symbols it uses.

Process Ch17§F13 – The regulated entity does not engage in collusive or anti-competitive underwriting practices.

Note: Examiners are instructed to refer any practice suggesting anti-competitive behavior to the Insurance Department legal counsel. This includes engaging in collusive underwriting practices that may inhibit competition.

Tailor additional questions to specific area of interest.

Process Ch17§F14 – The regulated entity’s underwriting practices are not unfairly discriminatory. The regulated entity adheres to applicable statutes, rules and regulations in its application of mass marketing plans.

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| 11. Please explain the differences between the underwriting guidelines for mass-marketed business and individually marketed business. |
| 12. Please explain the regulated entity’s treatment of nonpayment of premium for mass marketed business. |
| 13. Please describe the method used to disclose the right to continue for members of the group who leave employment or the group. |

Process Ch17§F15 – All group personal lines property and casualty policies and programs meet minimum requirements.

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| 11. Please describe the conversion options when an individual terminates coverage. |
| 12. What are the differences between the group coverage written and the coverage offered under a conversion option? |
| 13. What are the conditions or rules for participation in a group program? |
| 14. Is group coverage contingent on the purchase of any other insurance, product or service? |
| 15. How are experience refunds or dividends distributed? |

Process Ch17§F16 – Cancellation/nonrenewal notices comply with policy provisions and state laws, including the amount of advance notice provided to the insured and other parties to the contract.

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| 11. Please provide a copy of the Notice of Cancellation and the Notice of Nonrenewal used by the regulated entity. |
| 12. Are reasons for cancellation or nonrenewal given with the notice? |

Process Ch17§F17 – All policies are correctly coded.

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| 11. How does the regulated entity assure that codes are current? |
| 12. How does the regulated entity assure that codes provided by producers are correct and current? |

Process Ch17§F18 – Application or enrollment forms are properly, accurately and fully completed, including any required signatures, and file documentation adequately supports decisions made.

11. Are applications maintained in the underwriting file?
12. When and under what conditions does the regulated entity require a physical inspection, a motor vehicle report (MVR), an inspection report, a credit report or other underwriting information to confirm exposure or premium basis?
13. When a policy is issued on a basis other than applied for, does the regulated entity provide an adverse underwriting decision? If not, please explain.

Process Ch17§G01 – Regulated entity uses the reservation of rights and excess of loss letters, when appropriate.

11. Who makes the determination to send a reservation of rights letter or an excess of loss letter and under what conditions?

Process Ch17§G02 – Deductible reimbursement to insureds upon subrogation recovery is made in a timely and accurate manner.

11. What methods are used to refund recovered deductible amounts to insureds?
12. For long term subrogation cases, describe refund methodology.

Process Ch17§G03 – Loss statistical coding is complete and accurate.

11. How does the regulated entity assure that codes are current?
12. Does the regulated entity assure that loss amounts are separated from expense amounts?

**(3) Chapter 18 Conducting the Title Insurance Company Examination
Requests for Information**

Process Ch18§A01– The title insurance company acts within the scope of its license.

11. Please describe how the regulated entity avoids writing business not authorized by its certificate of authority.

Process Ch18§A02– No member of the board of directors of the title insurance company may be a title insurance agent who wrote 1 percent or more of the direct premiums for the previous calendar year.

11. Explain how the regulated entity assures that no member of its board of directors may be a title agent who wrote more than 1% of its direct writings for the previous year.

Process Ch18§A03– The agency and all applicable employees have in place an errors and omissions policy, fidelity coverage, and/or a surety bond (or alternative financial arrangement, where permitted), if required by statutes, rules and regulations.

11. Please describe the errors and omissions policy and fidelity coverage (or alternative financial arrangement, where permitted) requirements to which the regulated entity is subject.

Process Ch18§A04– Business is diversified as required by statutes, rules and regulations.

11. Please describe all business diversification requirements to which the regulated entity is subject.

Process Ch18§A05 – There is a periodic review and testing of the title plant built, owned, controlled or maintained by a title agent.

11. Describe frequency of title plant update and testing for accuracy,

Process Ch18§C01 – Controlled business is handled in accordance with statutes, rules and regulations.

11. Please describe all controlled business arrangements used by the regulated entity.

Process Ch18§C02 – Inducements are not provided, directly or indirectly, in consideration of referral of title insurance business, escrow or other services provided by a title insurance agent.

11. Please describe process utilized to prevent inappropriate or illegal inducements related to referrals of business.

Process Ch18§C03 – Affiliated business arrangements are organized and operated in compliance with statutes, rules and regulations.

11. Please describe all affiliated business arrangements and their relationship to the regulated entity.

Process Ch18§F01– Re-issue and refinance credits are applied consistently in compliance with statutes, rules and regulations.

11. Please describe the how credits work and under what conditions for re-issue and refinance situations.

Process Ch18§F02 – The title insurance company does not engage in collusive or anti-competitive underwriting practices.

11. Please describe relationships with banks, realtors, attorneys and builders that generate referrals for title insurance.

Process Ch18§F03 – Charges or fees other than premium for providing coverage are in compliance with statutes, rules and regulations.

11. Please describe all charges or fees other than premium made for services and demonstrate that such fees are not subsidized by the title policy premiums.

Process Ch18§F04 – Other than closing or settlement protection, the title insurance company does not provide any other coverage which purports to indemnify against improper acts or omissions of a person with regard to escrow, settlement or closing services.

11. Please describe any coverages or indemnifications made other than those in the title insurance policy.

Process Ch18§F05 – The closing or settlement protection conforms to the terms of coverage and form of instrument as required by statutes, rules and regulations.

Tailor additional questions to specific area of interest.

Process Ch18§F06 – Reports and disclosures are made in accordance with statutes, rules and regulations.

11. Please describe the process used when the report is not delivered prior to closing.

12. Please provide the notice given to the parties to the title transaction prior to closing.

Process Ch18§F07 – The title insurance company complies with statutes, rules and regulations regarding the recording, reporting and validation of revenue, loss and expense experience.

11. Please describe the validations required and who performs them.

Process Ch18§F08 – All policies are correctly coded.

Tailor additional questions to specific area of interest.

Process Ch18§G01 – Indemnification of a proposed insured solely against the loss of settlement funds may only be made for events as authorized by statutes, rules or regulations.

11. Please describe controls utilized to avoid theft of settlement funds by an agent.

12. Please describe controls utilized to address failure to comply with written closing instructions by the proposed insured when agreed to by the title insurance agent relating to title insurance coverage.

Process Ch18§G02 – Loss statistical coding is complete and accurate.

Tailor additional questions to specific area of interest.

Process Ch18§H01 – All escrow, settlement, closing or security deposit funds are submitted for collection to or deposited in a separate fiduciary trust account in a qualified financial institution promptly and in accordance with statutes, rules and regulations.

Tailor additional questions to specific area of interest.

Process Ch18§H02 – Interest received on funds deposited in connection with any escrow, settlement, security deposit or closing shall be paid in accordance with applicable statutes, rules and regulations.

Tailor additional questions to specific area of interest.

Process Ch18§H03 – Disbursements made from an escrow, settlement or closing account are done in accordance with statutes, rules and regulations.

Tailor additional questions to specific area of interest.

Process Ch18§I01 – Written underwriting contracts, which include required provisions, are in place between title insurance agencies and all applicable title companies, and business is not placed without a contract.

11. Please provide a copy of each underwriting contract used with a title insurance agency.

Process Ch18§I02 – Policies and premiums are reported and remitted on a timely basis.

11. Please describe the content of reports required of a title insurance agent for policies on property that has closed but for which the insurer has not received premium.

Process Ch18§I03 – The title insurance company maintains a record of financial stability for each title insurance agent under contract with the title insurance company.

11. Please describe the insurance coverages required by the title insurer of its agents.

Process Ch18§I04 – The title insurance company conducts a review of underwriting, claims and escrow practices of the title insurance agent in accordance with statutes, rules and regulations.

11. Please describe the frequency and structure of title insurance agency reviews by the title insurer.

Process Ch18§I05 – The title insurance company maintains an inventory of all policy forms or policy numbers allocated to each title insurance agent.

Tailor additional questions to specific area of interest.

Process Ch18§J – Special Considerations for Title Insurance Companies and Title Insurance Agents

Note: Title Insurance varies greatly from state to state. Some of these differences are explored in Chapter 18, Section J.

Section K discusses Affiliated Business Arrangements

Section L provides an example Title Interrogatory that contains numerous questions that may serve to make questions in this chapter redundant or provide a source of questions to pose when preparing a process review examination.

Section M provides a good preliminary list for either a conventional examination or a process review examination.

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**(4) Chapter 19 – Conducting the Life and Annuity Examination
Requests for Information**

Process Ch19§A01 – The regulated entity files all certifications with the insurance department, as required by statutes, rules and regulations.

11. Please describe the controls in place to assure that all illustrations and certifications are completed, accurate and filed timely.

Process Ch19§C01 – All advertising and sales materials are in compliance with applicable statutes, rules and regulations.

Note: The extensive Review Procedures and Criteria for Standard Ch19§C01 is a source for additional questions related to this Process. In addition, Section H provides a supplemental checklist for this Standard from which “Requests for Information” can be specifically tailored.

Tailor additional questions to specific area of interest.

Process Ch19§C02 – The insurer’s rules pertaining to producer requirements in connection with replacements are in compliance with applicable statutes, rules and regulations.

Note: The extensive Review Procedures and Criteria for Standard Ch19§C02 is a source for additional questions related to this Process.

11. Please describe oversight and controls of producers aimed at prevention of inappropriate producer replacements.

Process Ch19§C03 – The insurer’s rules pertaining to replacements are in compliance with applicable statutes, rules and regulations.

Note: The extensive Review Procedures and Criteria for Standard Ch19§C03 is a source for additional questions related to this Process. In addition, Section I provides a supplemental checklist for this Standard from which “Requests for Information” can be specifically tailored.

11. Please describe controls aimed at prevention of inappropriate replacements.

Process Ch19§C04 – An illustration used in the sale of a policy contains all required information and is delivered in accordance with statutes, rules and regulations.

Note: The extensive Review Procedures and Criteria for Standard Ch19§C04 is a source

for additional questions related to this Process.

11. Please describe quality control used to assure that life illustrations are accurate and complete. Describe process when they are not.

Process Ch19§C05 – The insurer has suitability standards for its products, when required by applicable statutes, rules and regulations.

11. Please describe steps taken to assure product suitability.

12. Does the regulated entity allow multiple issue of policies to the same insured? If so, under what conditions or limitations.

Process Ch19§C06 – Preneed funeral contracts or prearrangement disclosures and advertisements are in compliance with statutes, rules and regulations.

Tailor additional questions to specific area of interest.

Process Ch19§C07 – The regulated entity’s policy forms provide required disclosure material regarding accelerated benefit provisions.

11. Please provide a copy of the disclosure made to an insured upon request for an accelerated benefit.

Process Ch19§C08 – Policy and contract application forms used by depository institutions provide required disclosure material regarding insurance sales.

Note: The Review Procedures and Criteria for Standard Ch19§C08 is a source for additional questions related to this Process. In addition, Section J provides a supplemental checklist for this Standard from which “Requests for Information” can be specifically tailored.

11. Please provide a copy of the notice provided and disclosures made to an insured that is related or unrelated to an extension of credit.

Process Ch19§C09 – Insurer rules pertaining to producer requirements with regard to suitability in annuity transactions are in compliance with applicable statutes, rules and regulations.

Note: The extensive Review Procedures and Criteria for Standard Ch19§C09 is a source for additional questions related to this Process.

11. Please describe steps taken to assure product suitability.
12. Please describe any remediation efforts during the examination period to correct any inappropriate annuity sales.

Process Ch19§C10 – Insurer rules pertaining to suitability in annuity transactions are in compliance with applicable statutes, rules and regulations.

Note: The extensive Review Procedures and Criteria for Standard Ch19§C10 is a source for additional questions related to this Process.
11. Please describe steps taken to assure product suitability.
12. Please describe any remediation efforts during the examination period to correct any inappropriate annuity sales..
13. Please describe oversight of producers aimed at suitability of sale of annuity products.

Process Ch19§C11 – The insurer has procedures in place to educate and monitor compliance with insurer-specific education and training requirements and with applicable statutes, rules and regulations regarding the solicitation, recommendation and sale of annuity products.

Note: The Review Procedures and Criteria for Standard Ch19§C11 is a source for additional questions related to this Process.
11. Please describe producers training regimen.

Process Ch19§C12 – The insurer has product-specific training standards and materials designed to provide producers with adequate knowledge of the annuity products recommended prior to soliciting the sale of annuity products. The insurer also must have reasonable procedures in place to require its producers to comply with applicable producer training requirements.

Note: The Review Procedures and Criteria for Standard Ch19§C12 is a source for additional questions related to this Process.
11. Please describe producers training regimen.

Process Ch19§C13 – The insurer has procedures in place to provide full disclosure to consumers regarding all sales of products involving fixed-index annuity products, and all sales are in compliance with applicable statutes, rules and regulations.

11. Please describe producer oversight and controls related to training.

Process Ch19§C14 – The insurer has procedures in place to provide full disclosure to consumers regarding all sales of products involving index life, and all sales are in compliance with applicable statutes, rules and regulations.

Tailor additional questions to specific area of interest.

Process Ch19§C15 – The insurer’s underwriting requirements and guidelines pertaining to travel are in compliance with applicable statutes, rules and regulations.

Tailor additional questions to specific area of interest.

Process Ch19§E01 – Reinstatement is applied consistently and in accordance with policy provisions.

11. Please provide sample copy of reinstatement notice.

12. Please describe under what circumstances would reinstatement be denied.

13. Please describe the regulated entity standard for timely reinstatement notice.

Process Ch19§E02 – Nonforfeiture options are communicated to the policyholder and contractholder and correctly applied in accordance with the policy contract.

Note: The Review Procedures and Criteria for Standard Ch19§E02 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch19§E03 – The regulated entity provides each policyowner with an annual report of policy values in accordance with statutes, rules and regulations and, upon request, an in force illustration or contract policy summary.

Note: The Review Procedures and Criteria for Standard Ch19§E03 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch19§E04 – Upon receipt of a request from a policyholder for accelerated benefit payment, the regulated entity must disclose to the policyholder the effect of the request on the policy’s cash value, accumulation account, death benefit, premium, policy loans and liens. The regulated entity must also advise that the request may adversely affect the recipient’s eligibility for Medicaid or other government benefits or entitlements.

11. Please provide a copy of the disclosure made to an insured upon request for an accelerated benefit.

Process Ch19§F01 – Pertinent information on applications that form a part of the policy and contract is complete and accurate.

Tailor additional questions to specific area of interest.

Process Ch19§F02 – The regulated entity complies with the specific requirements for Acquired Immune Deficiency Syndrome (AIDS)-related concerns in accordance with statutes, rules and regulations.

Note: The Review Procedures and Criteria for Standard Ch19§F02 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch19§G01 – The regulated entity provides the required disclosure material to policyholders at the time an accelerated benefit payment is requested.

Note: The Review Procedures and Criteria for Standard Ch19§G01 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch19§G02 – The regulated entity does not discriminate among insureds with differing qualifying events covered under the policy or among insureds with similar qualifying events covered under the policy.

Note: This process relates to a benefit provision or benefit rider for the payment of accelerated benefits.

11. Please describe how the regulated entity maintains consistent evaluation of criteria for approval of accelerated benefits payments.

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Process Ch19§G03 – The regulated entity provides the beneficiary, at the time a claim is made, written information describing the settlement options available under the policy and how to obtain specific details relevant to the settlement options.

Note: The Review Procedures and Criteria for Standard Ch19§G03 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

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**(5) Chapter 20 Conducting the Health Examination
Requests for Information**

Process Ch20§C01 – Regulated entity rules on replacement are in compliance with applicable statutes, rules and regulations.

11. Please provide a copy of your replacement register for the period covered by this Examination.
12. Please provide a copy of your application for individuals used during the period covered by this Examination.
Note: Section N of Chapter 20 provides a checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (#40). Use of this checklist can be used as a source to develop additional specifically tailored “Requests for Information” under this Process.

Process Ch20§C02 – Outline of coverages is in compliance with all applicable statutes, rules and regulations.

11. Please describe the authorization process used by the regulated entity for Outlines of Coverage it issues. List persons with approval authority within the regulated entity over Outlines of Coverage.
12. Provide copies of the Outlines of Coverage in use by the regulated entity.
13. Does the regulated entity require a receipt to affirm that the Outline of Coverage reflects the application and that it has been received?
Note: Section N of Chapter 20 provides a checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (#40). Use of this checklist can be used as a source to develop additional specifically tailored “Requests for Information” under this Process.

Process Ch20§C03 – The regulated entity has suitability standards for its products, when required by applicable statutes, rules and regulations.

11. Does the regulated entity allow the issue of multiple policies to a single individual and if so, under what circumstances?
Note: Section N of Chapter 20 provides a checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (#40). Use of this checklist can be used as a source to develop additional specifically tailored “Requests for Information” under this Process.

Process Ch20§E01 – Reinstatement is applied consistently and in accordance with policy provisions.

11. Please provide sample copy of reinstatement notice.

12. Please describe under what circumstances would reinstatement be denied.

13. Please describe the regulated entity standard for timely reinstatement notice.

Process Ch20§E02 – Evidence of creditable coverage is provided in accordance with the requirements of HIPAA and/or applicable statutes, rules and regulations.

Note: Title I of HIPAA regulates the availability and breadth of group health plans and certain individual health insurance policies. It amended the Employee Retirement Income Security Act, the Public Health Service Act, and the Internal Revenue Code.

Title I also limits restrictions that a group health plan can place on benefits for preexisting conditions. Group health plans may refuse to provide benefits relating to preexisting conditions for a period of 12 months after enrollment in the plan or 18 months in the case of late enrollment. (29 U.S.C. § 1181(a)(2))

However, individuals may reduce this exclusion period if they had group health plan coverage or health insurance prior to enrolling in the plan. Title I allows individuals to reduce the exclusion period by the amount of time that they had “creditable coverage” prior to enrolling in the plan and after any “significant breaks” in coverage. (29 U.S.C. § 1181(a)(3))

“Creditable coverage” is defined quite broadly and includes nearly all group and individual health plans, Medicare, and Medicaid. (29 U.S.C. § 1181(c)(1))

A “significant break” in coverage is defined as any 63 day period without any creditable coverage. (29 U.S.C. § 1181(c)(2)(A))

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**
- **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**
- **Other relevant documents that evidence periods of health coverage**

11. Please provide a sample Creditable Coverage certificate.

12. Does the regulated entity issue certificates upon request?

13. Please describe your processing of certificates received.

Process Ch20§F01 – Cancellation practices comply with policy provisions, HIPAA and state laws.

Tailor additional questions to specific area of interest.

Process Ch20§F02 – Pertinent information on applications that form a part of the policy is complete and accurate.

Tailor additional questions to specific area of interest.

Process Ch20§F03 – The regulated entity complies with the provisions of COBRA and/or continuation of benefits procedures contained in policy forms, statutes, rules and regulations.

Tailor additional questions to specific area of interest.

Process Ch20§F04 – The regulated entity complies with the Genetic Information Nondiscrimination Act of 2008.

Tailor additional questions to specific area of interest.

Process Ch20§F05 – The regulated entity complies with proper use and protection of health information in accordance with statutes, rules and regulations.

Tailor additional questions to specific area of interest.

Process Ch20§F06 – The regulated entity complies with the provisions of HIPAA and state laws regarding limits on the use of preexisting exclusions.

Note: The Review Procedures and Criteria for Standard Ch20§F06 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20§F07 – 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.

Note: The Review Procedures and Criteria for Standard Ch20§F07 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20§F08 – The regulated entity issues coverage that complies with guaranteed-issue requirements of HIPAA and related state laws for groups of 2 to 50.

Tailor additional questions to specific area of interest.

Process Ch20§F09 – 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.

Tailor additional questions to specific area of interest.

Process Ch20§F10 – 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.

Tailor additional questions to specific area of interest.

Process Ch20§G01 – Claim files are handled in accordance with policy provisions, HIPAA and state law.

Note: The Review Procedures and Criteria for Standard Ch20§G01 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20§G02 – The company complies with the requirements of the federal Newborns' and Mothers' Health Protection Act of 1996.

Tailor additional questions to specific area of interest.

Process Ch20§G03 – The group health plan complies with the requirements of the federal Mental Health Parity Act of 1996 (MHP A) and the revisions made in the Mental Health Parity and Addiction Equity Act of 2008.

Tailor additional questions to specific area of interest.

Process Ch20§G04 – The group health plan complies with the requirements of the federal Women's Health and Cancer Rights Act of 1998.

Tailor additional questions to specific area of interest.

Process Ch20§G05 – The company complies with applicable statutes, rules and regulations for group coverage replacements.

Tailor additional questions to specific area of interest.

Process Ch20§H01 – 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.

Tailor additional questions to specific area of interest.

Process Ch20§H02 – The health carrier documents, maintains and reports grievances and establishes and maintains grievance procedures in compliance with applicable statutes, rules and regulations.

Tailor additional questions to specific area of interest.

Process Ch20§H03 – 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.

Tailor additional questions to specific area of interest.

Process Ch20§H04 – 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.

Note: The Review Procedures and Criteria for Standard Ch20§H04 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20§H05 – 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.

Note: The Review Procedures and Criteria for Standard Ch20§H05 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20§H06 – The health carrier has procedures for voluntary reviews of grievances and conducts voluntary reviews of grievances in compliance with applicable statutes, rules and regulations.

Note: The Review Procedures and Criteria for Standard Ch20§H06 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20§H07 – 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.

Note: The Review Procedures and Criteria for Standard Ch20§H07 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20§I01 – 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.

Note: The Review Procedures and Criteria for Standard Ch20§I01 is a source for

additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20§I02 – The health carrier files an access plan with the insurance commissioner for each managed care plan that the carrier offers in the state, and files updates whenever it makes a material change to an existing managed care 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.

Tailor additional questions to specific area of interest.

Process Ch20§I03 – 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.

Tailor additional questions to specific area of interest.

Process Ch20§I04 – 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 Managed Care Plan Network Adequacy Model Act (#74).

Tailor additional questions to specific area of interest.

Process Ch20§I05 – The health carrier executes written agreements with each participating provider that are in compliance with applicable statutes, rules and regulations.

Tailor additional questions to specific area of interest.

Process Ch20§I06 – The health carrier's contracts with intermediaries are in compliance with applicable statutes, rules and regulations.

Note: The Review Procedures and Criteria for Standard Ch20§I06 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20§I07 – The health carrier's arrangements with participating providers comply with applicable statutes, rules and regulations.

Note: The Review Procedures and Criteria for Standard Ch20§I07 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20§I08 – 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.

Tailor additional questions to specific area of interest.

Process Ch20§J01 – The health carrier establishes and maintains a program for credentialing and re-credentialing in compliance with applicable statutes, rules and regulations.

Note: The Review Procedures and Criteria for Standard Ch20§J01 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20§J02 – The health carrier verifies the credentials of a health care professional before entering into a contract with that health care professional.

Tailor additional questions to specific area of interest.

Process Ch20§J03 – 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.

Tailor additional questions to specific area of interest.

Process Ch20§J04 – 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.

Tailor additional questions to specific area of interest.

Process Ch20§J05 – 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.

Tailor additional questions to specific area of interest.

Process Ch20§J06 – 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.

Tailor additional questions to specific area of interest.

Process Ch20§J07 – 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.

Tailor additional questions to specific area of interest.

Process Ch20§J08 – 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.

Tailor additional questions to specific area of interest.

Process Ch20§K01 – The health carrier develops and maintains a quality assessment program in compliance with applicable statutes, rules and regulations.

Note: The Review Procedures and Criteria for Standard Ch20§K01 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20§K02 – 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.

Tailor additional questions to specific area of interest.

Process Ch20§K03 – The health carrier develops and maintains a quality improvement program, in compliance with applicable statutes, rules and regulations.

Note: The Review Procedures and Criteria for Standard Ch20§K03 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20§K04 – 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.

Tailor additional questions to specific area of interest.

Process Ch20§K05 – The health carrier documents and communicates information about its quality assessment program and its quality improvement program to covered persons and providers.

Tailor additional questions to specific area of interest.

Process Ch20§K06 – 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.

Tailor additional questions to specific area of interest.

Process Ch20§K07 – 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.

Tailor additional questions to specific area of interest.

Process Ch20§L01 – The health carrier establishes and maintains a utilization review program in compliance with applicable statutes, rules and regulations.

Note: The Review Procedures and Criteria for Standard Ch20§L01 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20§L02 – The health carrier operates its utilization review program in accordance with applicable state statutes, rules and regulations.

Note: The Review Procedures and Criteria for Standard Ch20§L02 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20§L03 – 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.

Note: The Review Procedures and Criteria for Standard Ch20§L03 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20§L04 – 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.

Note: The Review Procedures and Criteria for Standard Ch20§L04 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20§L05 – 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.

Note: The Review Procedures and Criteria for Standard Ch20§L05 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20§L06 – The health carrier conducts expedited utilization review and benefit determinations in a timely manner and in compliance with applicable statutes, rules and regulations.

Note: The Review Procedures and Criteria for Standard Ch20§L06 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20§L07 – 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.

Note: The Review Procedures and Criteria for Standard Ch20§L07 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20§M01 – 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.

Note: The Review Procedures and Criteria for Standard Ch20§M01 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20§M02 – 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.

Note: The Review Procedures and Criteria for Standard Ch20§M02 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20§M03 – 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.

Note: The Review Procedures and Criteria for Standard Ch20§M03 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

(6) Chapter 20A Conducting the Affordable Care Act (ACA) Related Examination Requests for Information

Note: It is recommended that an examiner conducting a process review examination methodology, carefully review the introduction to Chapter 20A. Many of the elements needed will be found in Chapters 16 and 20. The Requests for Information should be drawn from Standards in those chapters and then focused by the indications for examination and supplemented by Review Procedures and Criteria from Chapter 20A.

Process Ch20A§2709-01 – A health carrier may not deny coverage or restrict coverage for qualified individuals, as defined in applicable statutes, rules and regulations, who participate in approved clinical trials.

Note: The Review Procedures and Criteria for Standard Ch20A§2709-01 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20A§2714-01 – A group health plan, or a health carrier offering group or individual health insurance coverage, that makes available dependent coverage of children shall make such coverage available for children until attainment of 26 years of age.

Note: The Review Procedures and Criteria for Standard Ch20A§2714-01 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20A§2719-01 – A health carrier offering individual health insurance coverage shall maintain records of all claims and notices associated with the internal claims and appeals process for the length of time specified in the final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Note: The Review Procedures and Criteria for Standard Ch20A§2719-01 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20A§2719-02 – The health carrier shall comply with grievance procedures requirements, in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Note: The Review Procedures and Criteria for Standard Ch20A§2719-02 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20A§2719-03 – The health carrier shall conduct first-level reviews of grievances involving an adverse determination in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Note: The Review Procedures and Criteria for Standard Ch20A§2719-03 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20A§2719-04 – The health carrier shall conduct first-level reviews of grievances involving an adverse determination in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Note: The Review Procedures and Criteria for Standard Ch20A§2719-04 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20A§2702-01 – A health carrier offering individual market health insurance coverage shall issue any applicable health benefit plan to any eligible individual who: 1) applies for the plan; 2) agrees to make the required premium payments; and 3) agrees to satisfy the other reasonable provisions of the health benefit plan that are not inconsistent with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Note: The Review Procedures and Criteria for Standard Ch20A§2702-01 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20A§2702-02 – A health carrier offering small group market health insurance coverage shall issue any applicable health benefit plan to any eligible small group employer that: 1) applies for the plan; 2) agrees to make the required premium payments; and 3) agrees to satisfy the other reasonable provisions of the health benefit plan that are not

inconsistent with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Note: The Review Procedures and Criteria for Standard Ch20A§2702-02 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20A§2703-01 – A health carrier offering individual market health insurance coverage shall renew or continue in force the coverage, at the option of the policyholder, subject to final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Note: The Review Procedures and Criteria for Standard Ch20A§2703-01 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20A§2703-02 – A health carrier offering small group market health insurance coverage shall renew or continue in force the coverage, at the option of the small employer subject to final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Note: The Review Procedures and Criteria for Standard Ch20A§2703-02 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20A§2711-01 – A health carrier shall not establish any lifetime or annual limit on the dollar amount of essential health benefits (EHB)s for any individual, in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Note: The Review Procedures and Criteria for Standard Ch20A§2711-01 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20A§2704-01 – A health carrier may not deny coverage to applicants/proposed insureds under the age of 19 years pursuant to the provisions of any preexisting condition exclusion or preexisting condition limitation.

Note: The Review Procedures and Criteria for Standard Ch20A§2704-01 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20A§2704-02 – A health carrier may not deny benefits under a policy to any insured under the age of 19 pursuant to the provisions of any preexisting condition exclusion or other preexisting condition limitation.

Note: The Review Procedures and Criteria for Standard Ch20A§2704-02 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20A§2704-03 – Policy language, enrollment materials, and marketing and sales materials may not directly or indirectly indicate that individuals under the age of 19 with a preexisting condition cannot enroll in coverage or receive benefits under a group health or individual health insurance policy.

Note: The Review Procedures and Criteria for Standard Ch20A§2704-02 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20A§2713-01 – A health carrier shall not impose cost sharing requirements upon preventive services, as defined in, and in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Note: The Review Procedures and Criteria for Standard Ch20A§2713-01 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20A§2712-01 – A health carrier may not retrospectively rescind individual or group coverage (including family coverage in which the individual is included) unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact.

Note: The Review Procedures and Criteria for Standard Ch20A§2712-01 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20A§2712-02 – A health carrier offering group or individual health insurance coverage shall provide at least 30 days' advance written notice to each plan enrollee (in the individual market, primary subscriber) who would be affected before coverage may be rescinded.

Note: The Review Procedures and Criteria for Standard Ch20A§2712-02 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20A§2715-01 – The appearance, language, form and content of a summary of benefits and coverage (SBC) and uniform glossary issued by a health carrier shall be in compliance with final regulations issued by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Note: The Review Procedures and Criteria for Standard Ch20A§2715-01 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20A§2715-02 – A health carrier shall make a summary of benefits and coverage (SBC) available in compliance with final regulations issued by the U.S. Department of Health and Human Services (HHS), U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Note: The Review Procedures and Criteria for Standard Ch20A§2715-02 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch20A§2719-01 – The health carrier shall operate its utilization review program in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Note: The Review Procedures and Criteria for Standard Ch20A§2719-01 is a source for

additional questions related to this Process.
Tailor additional questions to specific area of interest.

Process Ch20A§2719-02 – The health carrier shall provide written notice of an adverse determination of standard utilization review and benefit determinations, in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Note: The Review Procedures and Criteria for Standard Ch20A§2719-02 is a source for additional questions related to this Process.
Tailor additional questions to specific area of interest.

Process Ch20A§2719-03 – The health carrier shall conduct expedited utilization review and benefit determinations, in a timely manner and in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Note: The Review Procedures and Criteria for Standard Ch20A§2719-03 is a source for additional questions related to this Process.
Tailor additional questions to specific area of interest.

Process Ch20A§2719-04 – The health carrier shall conduct utilization reviews or makes benefit determinations for emergency services in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Note: The Review Procedures and Criteria for Standard Ch20A§2719-04 is a source for additional questions related to this Process.
Tailor additional questions to specific area of interest.

**(7) Conducting the Medicare Supplement Examination
Requests for Information**

Process Ch21§A01 – The Medicare Select carrier’s plan of operation complies with applicable statutes, rules and regulations.

11. Please provide a copy of the plan of operation.

Process Ch21§A02 – The entity reports to the insurance department on an annual basis, each resident of the state for whom the entity has more than one Medicare supplement policy or certificate in force.

11. Please provide copies of reports relating to each resident of the state for whom the entity has more than one Medicare supplement policy or certificate in force.

Process Ch21§A03 – The entity certifies compliance with standards for claims payments on the Medicare supplement insurance experience reporting form.

11. Provide a copy of the certification by the regulated entity that it is in compliance with standards for claims payments on the Medicare supplement insurance experience reporting form.

Process Ch21§A04 – The entity does not provide producer compensation that encourages replacement sales.

11. Please explain how the determination is made that the regulated entity does not provide producer compensation that encourages replacement sales.

Process Ch21§C01 – The entity does not provide producer compensation that encourages replacement sales.

11. Please explain how the determination is made that the regulated entity does not provide producer compensation that encourages replacement sales.

12. Please provide a copy of your replacement register for the period covered by this Examination.

Process Ch21§C02 – Outlines of coverage are in compliance with applicable statutes, rules and regulations.

11. Please describe the authorization process used by the regulated entity for Outlines of Coverage it issues. List persons with approval authority within the regulated entity over

Outlines of Coverage.
12. Provide copies of the Outlines of Coverage in use by the regulated entity.
13. Does the regulated entity require a receipt to affirm that the Outline of Coverage reflects the application and that it has been received?

Process Ch21§C03 – The entity obtains receipts from applicants verifying that the outline of coverage has been received and that it is the outline of the policy for which the applicant has applied.

11. Does the regulated entity require a receipt to affirm that the Outline of Coverage reflects the application and that it has been received?
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Process Ch21§C04 – Guide to Health Insurance for People with Medicare is provided to the applicant within the timeframe required by law and is in compliance with applicable statutes, rules and regulations.

Tailor additional questions to specific area of interest.

Process Ch21§C05 – The entity maintains a system of control over the content, form and method of dissemination of all of its Medicare supplement advertisements.

Tailor additional questions to specific area of interest.

Process Ch21§C06 – Each advertisement of a Medicare supplement product is identified by form number or other means unique to that product and is labeled “insurance policy.”

Tailor additional questions to specific area of interest.

Process Ch21§C07 – Advertisements that are invitations to join an association, trust or discretionary group—and that are also solicitations of insurance—contain a separate and distinct application for membership of the group and another for the insurance coverage.

11. Is a separate and distinct application for membership of the group and another for the insurance coverage required? Please explain.

Process Ch21§C08 – Advertisements truthfully represent the Medicare supplement coverage being marketed.

Tailor additional questions to specific area of interest.

Process Ch21§C09 – Testimonials comply with applicable statutes, rules and regulations.

Tailor additional questions to specific area of interest.

Process Ch21§C10 – Advertisements that employ statistics accurately represent all relevant facts.

Tailor additional questions to specific area of interest.

Process Ch21§C11 – Advertisements do not disparage competitors or their policies, services or business methods.

Tailor additional questions to specific area of interest.

Process Ch21§C12 – Advertisements do not imply licensing of the entity beyond the jurisdiction in which the entity is licensed or imply a status with any governmental entity.

Tailor additional questions to specific area of interest.

Process Ch21§C13 – Advertisements state the name of the insurer and all other pertinent information required by applicable statutes, rules and regulations.

Tailor additional questions to specific area of interest.

Process Ch21§C14 – Advertisements do not state or imply that prospective insureds become group or quasi-group members under a group policy and, as such, will enjoy special rates or underwriting privileges, unless it is a fact.

11. Please describe steps taken to assure that Advertisements do not state or imply that prospective insureds become group or quasi-group members under a group policy and, as such, will enjoy special rates or underwriting privileges, unless it is a fact.

Process Ch21§C15 – Advertisements should not use incentives to purchase that mislead the prospective insured.

Tailor additional questions to specific area of interest.

Process Ch21§C16 – Advertisements do not contain statements about the entity that are untrue or misleading.

Tailor additional questions to specific area of interest.

Process Ch21§H01 – The entity defines as a grievance any dissatisfaction expressed in writing with the administration, claims practices or provision of services concerning an issuer of a Medicare Select product or network.

Tailor additional questions to specific area of interest.

Process Ch21§H02 – The entity develops written grievance procedures that comply with applicable statutes, rules and regulations, and provides enrollees with a copy of its grievance procedures.

Tailor additional questions to specific area of interest.

Process Ch21§H03 – The entity documents, resolves and records grievances in compliance with applicable statutes, rules and regulations, and their contract language.

Tailor additional questions to specific area of interest.

Process Ch21§H04 – The company provides to any enrollee, who has filed a grievance, detailed information concerning its grievance and appeal procedures, how to use them and how to notify the insurance department, if applicable.

Tailor additional questions to specific area of interest.

Process Ch21§H05 – The company reports its grievance procedures to the insurance commissioner on an annual basis.

Tailor additional questions to specific area of interest.

Process Ch21§I01 – The company demonstrates, using reasonable criteria, that it maintains a network that is sufficient in number and types of providers to ensure that all services to enrollees will be accessible without unreasonable delay.

Note: The Review Procedures and Criteria for Standard Ch21§I01 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch21§I02 – The company has a plan of operation for each plan offered in the state, and files updates whenever it makes a material change to an existing plan.

Tailor additional questions to specific area of interest.

Process Ch21§I03 – The company ensures that enrollees have access to emergency services 24 hours per day, 7 days per week within its network and provides coverage for urgently needed services and emergency services outside of the service area.

Tailor additional questions to specific area of interest.

Process Ch21§I04 – The company files with the insurance commissioner all required contract forms and any material changes to a contract proposed for use with its participating providers and intermediaries.

Tailor additional questions to specific area of interest.

Process Ch21§I05 – The company executes with each participating provider written agreements that are in compliance with applicable statutes, rules and regulations.

Tailor additional questions to specific area of interest.

Process Ch21§I06 – The company’s arrangements with participating providers comply with applicable statutes, rules and regulations.

Note: The Review Procedures and Criteria for Standard Ch21§I06 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch21§I07 – The company provides at enrollment a directory of providers participating in its network. It also makes available, on a timely and reasonable basis, updates to its directory and files the directory with the insurance commissioner.

Tailor additional questions to specific area of interest.

Process Ch21§J01 – The company establishes and maintains a program for credentialing and re-credentialing of providers in compliance with applicable statutes, rules and regulations.

Note: The Review Procedures and Criteria for Standard Ch21§J01 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch21§J02 – The company verifies the credentials of a health care provider before entering into a contract with that health care provider.

Tailor additional questions to specific area of interest.

Process Ch21§J03 – The company obtains primary verification of the information required by state law relating to provider credentialing.

Tailor additional questions to specific area of interest.

Process Ch21§J04 – The company obtains at the interval provided for by state law, primary verification of the information required by state law relating to provider credentialing.

Tailor additional questions to specific area of interest.

Process Ch21§J05 – The company requires all participating providers to notify the individual designated by the company of changes in the status of any provider information that is required to be verified by the company.

Tailor additional questions to specific area of interest.

Process Ch21§J06 – The company provides the provider with the opportunity to review and correct information submitted in support of the provider’s credentialing verification.

Tailor additional questions to specific area of interest.

Process Ch21§J07 – The company monitors the activities of the providers and provider entities with which it contracts and ensures that the requirements of state law are met.

Tailor additional questions to specific area of interest.

Process Ch21§K01 – The company develops and maintains a quality assessment program that is in compliance with state law to evaluate, maintain and improve the quality of health services provided to enrollees.

Note: The Review Procedures and Criteria for Standard Ch21§K01 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch21§K02 – The company develops and maintains a quality improvement program that is in compliance with applicable statutes, rules and regulations to evaluate, maintain and improve the quality of health services provided to enrollees.

Note: The Review Procedures and Criteria for Standard Ch21§K02 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch21§K03 – The company files with the insurance commissioner a written description, in the prescribed format, of the quality assessment program, which includes a signed certification by a corporate officer of the company that the filing meets the requirements of applicable statutes, rules and regulations.

Tailor additional questions to specific area of interest.

Process Ch21§K04 – The company 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 statutes, rules and regulations are met.

Tailor additional questions to specific area of interest.

Process Ch21§K05 – The company reports to the appropriate licensing authority any persistent pattern of problematic care provided by a provider that is sufficient to cause the company to terminate or suspend contractual arrangements with the provider.

Tailor additional questions to specific area of interest.

Process Ch21§K06 – The company documents and communicates information about its quality assessment program and its quality improvement program to enrollees and providers.

Tailor additional questions to specific area of interest.

Process Ch21§K07 – The company 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.

Tailor additional questions to specific area of interest.

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Process Ch21§L – Utilization Review.

<p>Note: Check state-specific laws to determine if utilization review is applicable to Medicare supplement insurance within a state.</p>

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**(8) Conducting the Long-Term Care Examination
Requests for Information**

Process Ch22§A01 – The entity files all reports and certifications with the insurance department as required by applicable statutes, rules and regulations.

Note: The Review Procedures and Criteria for Standard Ch22§A01 is a source for additional questions related to this Process.

11. Provide a copy of any reports by the regulated entity in compliance applicable statutes rules or regulations for Long Term Care.

12. Provide a copy of any certifications by the regulated entity in compliance applicable statutes rules or regulations for Long Term Care.

Process Ch22§C01 – The entity has suitability standards for its products, when required by applicable statutes, rules and regulations.

Note: The Review Procedures and Criteria for Standard Ch22§C01 is a source for additional questions related to this Process.

11. Does the regulated entity allow the issue of multiple policies to a single individual and if so, under what circumstances?

Process Ch22§C02 – Policy forms provide required disclosure material regarding standards for benefit triggers.

Note: The Review Procedures and Criteria for Standard Ch22§C02 is a source for additional questions related to this Process.

11. Please describe how the regulated entity provides disclosures for the standards for benefit triggers to its insureds.

Process Ch22§C03 – Marketing for long-term care products complies with applicable statutes, rules and regulations.

Note: The Review Procedures and Criteria for Standard Ch22§C03 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch22§C04 – All advertising and sales materials are in compliance with applicable statutes, rules and regulations.

Note: The Review Procedures and Criteria for Standard Ch22§C04 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch22§C05 – Company rules pertaining to producer requirements in connection with replacements are in compliance with applicable statutes, rules and regulations.

11. Please describe oversight of producers aimed at prevention of inappropriate producer replacements.

Process Ch22§C06 – Company rules pertaining to company requirements in connection with replacements are in compliance with applicable statutes, rules and regulations.

Note: The Review Procedures and Criteria for Standard Ch22§C06 is a source for additional questions related to this Process.

11. Please describe steps aimed at prevention of inappropriate replacements.

12. Please provide a copy of your replacement register for the period covered by this Examination.

Process Ch22§E01 – Policy renewals are applied consistently and in accordance with policy provisions.

Note: The Review Procedures and Criteria for Standard Ch22§E01 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch22§E02 – Nonforfeiture upon lapse and reinstatement provisions is applied consistently and in accordance with policy provisions.

Note: The Review Procedures and Criteria for Standard Ch22§E02 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch22§E03 – Nonforfeiture options are communicated to the policyholder and correctly applied in accordance with the policy contract.

Note: The Review Procedures and Criteria for Standard Ch22§E03 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch22§E04 – Policyholder service for long-term care products complies with applicable statutes, rules and regulations.

Tailor additional questions to specific area of interest.

Process Ch22§F01 – Insurers shall be in compliance with applicable state statutes, rules and regulations regarding appeal of adverse benefit trigger determination.

Note: The Review Procedures and Criteria for Standard Ch22§F01 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch22§G01 – All mandated definitions and requirements for group long-term care insurance are followed in accordance with applicable statutes, rules and regulations.

Note: The Review Procedures and Criteria for Standard Ch22§G01 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch22§G02 – Pertinent information on applications that form a part of the policy is complete and accurate, and applications conform to applicable statutes, rules and regulations.

Note: The Review Procedures and Criteria for Standard Ch22§G02 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch22§G03 – The entity complies with specific requirements for AIDS-related concerns in accordance with applicable statutes, rules and regulations.

Note: The Review Procedures and Criteria for Standard Ch22§G03 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch22§G04 – Policies, riders, amendments, endorsements, applications and certificates of coverage contain required provisions, definitions and disclosures.

Note: The Review Procedures and Criteria for Standard Ch22§G04 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch22§G05 – Underwriting and rating for long-term care products complies with applicable statutes, rules and regulations.

Note: The Review Procedures and Criteria for Standard Ch22§G05 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch22§G06 – The company’s underwriting practices are not unfairly discriminatory. The company adheres to applicable statutes, rules and regulations and company guidelines in the selection of risks.

Note: The Review Procedures and Criteria for Standard Ch22§G06 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch22§H01 – Claim files are handled in accordance with policy provisions and applicable statutes, rules and regulations.

Note: The Review Procedures and Criteria for Standard Ch22§H01 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

**(9) Conducting the Consumer Credit Examination
Requests for Information**

Process Ch23§A01 – Claim files are handled in accordance with policy provisions and applicable statutes, rules and regulations.

Note: The Review Procedures and Criteria for Standard Ch23§A01 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch23§C01 – All mandated disclosures and advertisements are documented and in compliance with applicable statutes, rules and regulations.

Note: The Review Procedures and Criteria for Standard Ch23§C01 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch23§C02 – The amount of credit insurance sold is in compliance with the requirements of applicable statutes, rules and regulations.

Note: The Review Procedures and Criteria for Standard Ch23§C02 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch23§F01 – The effective dates and termination dates of coverage are in accordance with applicable statutes, rules and regulations.

Note: The Review Procedures and Criteria for Standard Ch23§F01 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch23§F02 – Group consumer credit insurance policies and certificates are terminated in accordance with applicable statutes, rules and regulations.

Note: The Review Procedures and Criteria for Standard Ch23§F02 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

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Process Ch23§F03 – The creditor submits premium to the insurer in accordance with applicable statutes, rules and regulations.

Tailor additional questions to specific area of interest.

Process Ch23§F04 – The insurer and creditor comply with requirements for the payment of compensation in accordance with applicable statutes, rules and regulations.

Note: The Review Procedures and Criteria for Standard Ch23§F04 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch23§F05 – The insurer does not engage in activities that constitute unfair methods of competition.

Note: The Review Procedures and Criteria for Standard Ch23§F05 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch23§G01 – Proof of payments reflect appropriate claim handling practices.

Tailor additional questions to specific area of interest.

Process Ch23§G01 – Claim files clearly establish pertinent events and the dates of such events.

Tailor additional questions to specific area of interest.

(10) Conducting the Surplus Lines Broker Examination Requests for Information

Process Ch24§A01 – All statutorily required bonds are in force.

11. Please provide a listing of all statutorily required bonds.

Process Ch24§A02 – All required reports have been filed with the insurance department or the appropriate authority.

11. Please provide a copy of any reports filed in compliance with applicable statutes rules or regulations.

Process Ch24§A03 – The applicable taxes are reported and are credited to the state.

Note: The Review Procedures and Criteria for Standard Ch24§A03 is a source for additional questions related to this Process.

11. Please describe methods used to properly allocate premium and taxes to appropriate state on a multistate placement.

Process Ch24§A04 – If the surplus lines broker is responsible for such calculations, then unearned premiums are correctly calculated and returned to the appropriate party in a timely manner and in accordance with applicable statutes, rules and regulations.

Note: The Review Procedures and Criteria for Standard Ch24§A04 is a source for additional questions related to this Process.

11. Please explain how determinations are made for unearned premiums and how refunds are made and tracked.

Process Ch24§H – Procedural Considerations.

Note: Although the focus of the surplus lines broker examination differs from that of the insurer examination, much of the material in Chapter 16 General Examination Standards also applies to the surplus lines examination.

Process Ch24§I01 – All required disclosures are made in accordance with applicable statutes, rules and regulations.

Note: The Review Procedures and Criteria for Standard Ch24§I01 is a source for

additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch24§I02 – When issued by the surplus lines broker, all forms and endorsements forming a part of the contract are listed on the declarations page.

Tailor additional questions to specific area of interest.

Process Ch24§I03 – The selected carrier was evaluated to ensure it complies with applicable statutes, rules and regulations regarding financial condition.

Tailor additional questions to specific area of interest.

Process Ch24§I04 – The authorization to bind was provided before the binder was extended to the insured.

Tailor additional questions to specific area of interest.

Process Ch24§I05 – All advertising and sales materials are in compliance with applicable statutes, rules and regulations.

Note: The Review Procedures and Criteria for Standard Ch24§I05 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch24§I06 – Diligent effort was made to place the risk with an admitted carrier in compliance with applicable statutes, rules and regulations.

Note: The Review Procedures and Criteria for Standard Ch24§I06 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

**(11) Conducting the Advisory Organization Examination
Requests for Information**

Not currently developed.

(Reserved for future Use.)

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(12) Conducting the Third Party Administrator Examination Requests for Information

Process Ch26§A01 – The TPA is in compliance with applicable statutes, rules and regulations regarding financial security.

Tailor additional questions to specific area of interest.

Process Ch26§H01 – Verify written agreement(s) are executed between the TPA and client, applicable insurer or other related entity.

Note: The Review Procedures and Criteria for Standard Ch26§H01 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch26§H02 – The written agreement includes a statement of duties the TPA is expected to perform on behalf of the insurer or regulated, risk-bearing entity subject to the jurisdiction of the insurance department and the lines, classes or types of insurance for which the TPA is authorized to administer.

Note: The Review Procedures and Criteria for Standard Ch26§H02 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch26§H03 – The written agreement between the TPA and the insurer provides for the TPA to periodically render an accounting to the client, applicable insurer or other related entity detailing all transactions performed by the TPA pertaining to the business underwritten by the client, applicable insurer or other related entity.

Tailor additional questions to specific area of interest.

Process Ch26§H04 – The written agreement defines specifics of the TPA’s authority to make withdrawals from financial institution accounts.

Note: The Review Procedures and Criteria for Standard Ch26§H04 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch26§H05 – If prohibited by applicable statutes, rules or regulations, the TPA does not enter into an agreement or understanding with the client, applicable insurer or other related entity to make the TPA’s commissions, fees or charges contingent upon savings effective in the adjustment, settlement or payment of losses on behalf of the client, applicable insurer or other related entity.

Tailor additional questions to specific area of interest.

Process Ch26§H06 – The TPA holds all insurance charges or premiums collected on behalf of the client, applicable insurer or other related entity in a fiduciary capacity.

Note: The Review Procedures and Criteria for Standard Ch26§H06 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch26§H07 – The TPA provides required written notices (approved by the client, applicable insurer or other related entity) to covered individuals in accordance with applicable statutes, rules and regulations.

Note: The Review Procedures and Criteria for Standard Ch26§H07 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch26§H08 – The TPA delivers materials and written communications in a timely manner.

Tailor additional questions to specific area of interest.

Process Ch26§H09 – Transactions are processed accurately and completely.

Tailor additional questions to specific area of interest.

Process Ch26§H10 – The TPA maintains and makes available to the client, applicable insurer or other related entity complete books and records of all transactions performed on behalf of the client, applicable insurer or other related entity.

Note: The Review Procedures and Criteria for Standard Ch26§H10 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

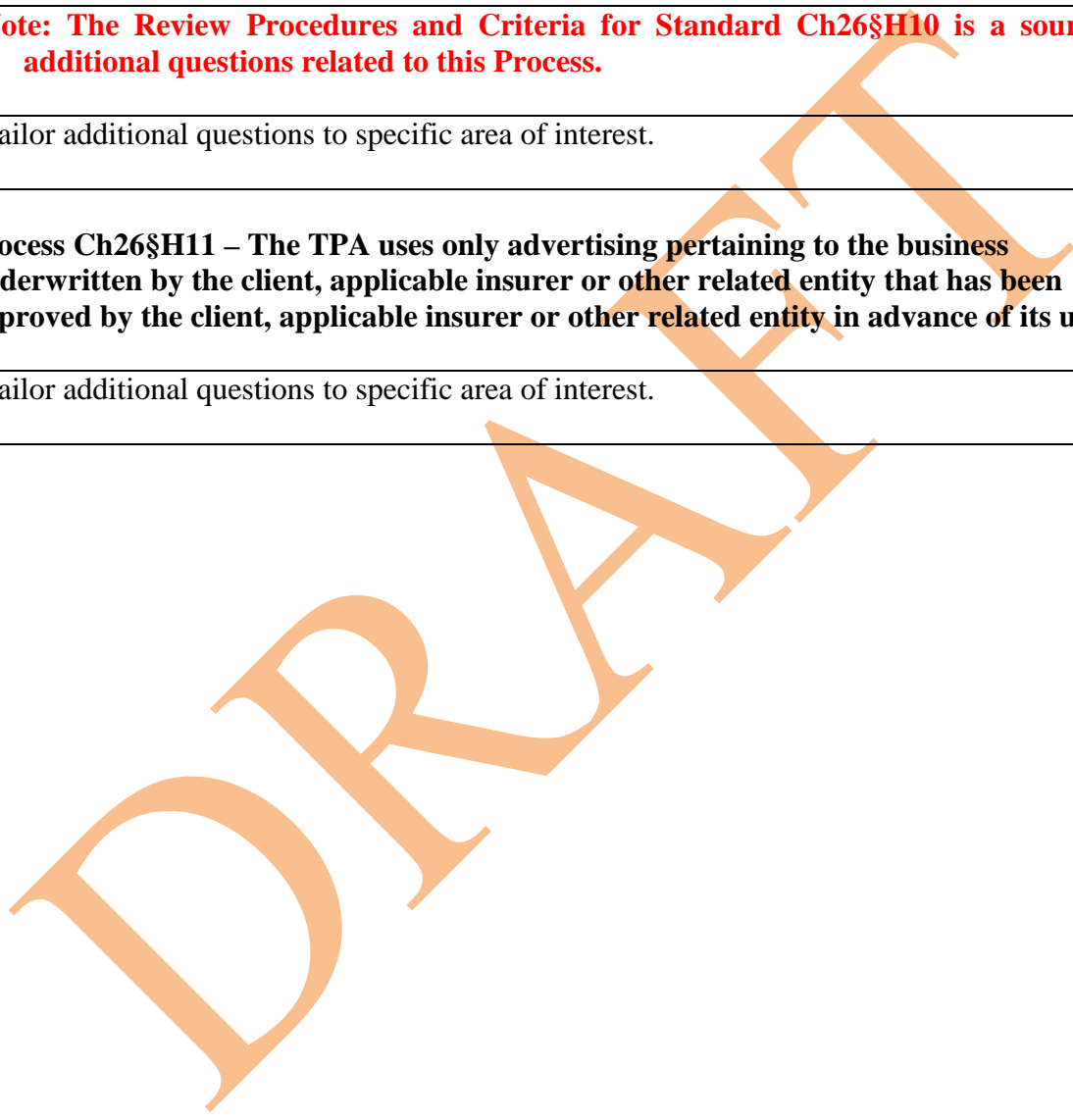
Process Ch26§H10 – The TPA maintains and makes available to the client, applicable insurer or other related entity complete books and records of all transactions performed on behalf of the client, applicable insurer or other related entity.

Note: The Review Procedures and Criteria for Standard Ch26§H10 is a source for additional questions related to this Process.

Tailor additional questions to specific area of interest.

Process Ch26§H11 – The TPA uses only advertising pertaining to the business underwritten by the client, applicable insurer or other related entity that has been approved by the client, applicable insurer or other related entity in advance of its use.

Tailor additional questions to specific area of interest.



**(13) Conducting the Examination of a Viatical Settlement Provider
Requests for Information**

Not currently developed.

(Reserved for future Use.)

**(14) Conducting the Premium Finance Company Examination
Requests for Information**

Not currently developed.

(Reserved for future Use.)

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G. Testing of Processes.

This section addresses the testing of the processes examined to determine that features common to all processes exist. The tests are phrased in question form. These tests are applicable to each process identified in Section F. Please note that the listed tests for a process are not fixed and absolute. They do not limit the examiner from posing additional questions, when warranted, in efforts to enhance the understanding of the Regulated Entity's response(s). If no response is provided, that fact should be part of the examiners documentation.

The first ten requests for information are the same for all Standards. The questions the examiner should consider for these common requests are:

<p>1. Is the process or procedure in written form? Is the process dated? When was it initially adopted? Refer to response for Section F.1</p>
<p>Note: The absence of a written policy or procedure potentially allows an inconsistent application of the process. If not in writing, how does the Company assure consistent application of the process? The complete lack of any recognizable process indicates Level 0 when evaluating the process under Section H.</p>
<p>2. Has a risk assessment and mitigation review been conducted? If so, does it address compliance issues? Are any obvious mitigation elements missing? Refer to response for Section F.2</p>
<p>Note: The absence of a risk assessment and mitigation document for the process may indicate that the regulated entity has not recognized that the issues exist or need to be addressed. This is a level 0 characteristic. If there is a document, the Level is likely to be Level 1 or higher. If appropriate mitigations are not reflected the maturity level should not exceed Level 1.</p>
<p>3. Is the procedure or process unambiguous, clear and readable? Refer to response for Section F.3.</p>
<p>Note: If there are no standardized processes, and ad hoc approaches that tend to be applied on an individual or cases by case basis, the maturity level can be no higher than Level 1. When the procedures themselves are not sophisticated but are the formalization of existing practices, the maturity level can be no higher than Level 3.</p>
<p>4. Are appropriate measurements or controls in place to test the functioning and efficacy of the procedure or process? How often is the procedure or process reviewed, tested or audited?</p>

<p>How does management exercise oversight and control of the process? Do the controls include a method to detect deviations? Refer to response for Section F.4 & F.8.</p>
<p>Note: If the overall approach to management is disorganized, the maturity level can be no higher than Level 1. Processes that have developed to the stage where similar procedures are followed by adherent people undertaking the same task indicate a Level 2 maturity. If there is a high degree of reliance on the knowledge of individuals then errors are likely and the maturity level is Level 2 or lower. It is a maturity Level 3 characteristic when it is mandated that these processes should be followed; however, it is unlikely that deviations will be detected.</p>
<p>5. Does the regulated entity have a policy statement or statement of intent for this process? Is the policy statement or statement of intent distributed? What is the frequency of distribution? Refer to response for Section F.5.</p>
<p>Note: The reasons for processes and procedures must be transmitted to staff and ingrained in the corporate culture if it is to be used. Failure to do so encourages a Level 1 or lower expectation.</p>
<p>6. How are errors in the process detected and corrected? Is the detection method timely? Is documentation sufficient? Refer to response for Section F.7.</p>
<p>Note: When management monitors and measures compliance with procedures and takes action where processes appear not to be working effectively, this is a Level 4 characteristic but not necessarily a Level 4 evaluation. When processes are under constant improvement and provide good practice, this is a Level 4 characteristic. When Automation and tools are used in a limited or fragmented way, the maturity level should not exceed Level 4 and may be Level 3.</p>
<p>7. How are persons subject to its provisions of the process or procedure made aware of its existence? How is the procedure or process made accessible to those persons subject to its provisions? Does the Company provide adequate training to persons affected by the procedure or process? Is the training for the process mandatory and sufficient? Is access to the process clear and intuitive? Do controls confirm usage of the process? Refer to response for Section F.7.</p>

Note: The absence of communication of the process is a characteristic of maturity Level 2 or lower. If learning of the process is left to individual responsibility, the maturity level is Level 2 or lower. When procedures have been standardized and documented, and communicated through training, the maturity level characteristic is Level 3.

8. Is the procedure or process performing as intended?
How do you know?
Are any deficiencies noted?
Do you understand how the controls work?
Are the controls on point?
Are the controls automated or is some other form of reporting utilized?
Are reports made to management relating to data gathered from the controls?
How does management utilize the results of its measurement structures?
Does the regulated entity take steps to avoid and detect inappropriate bias in the process?
Refer to response for Section F.8.

Note: When processes have been refined to a level of good practice, based on the results of continuous improvement and maturity modeling with other enterprises, this is a maturity Level 5 characteristic. When IT tools are used in an integrated way to automate the workflow, providing tools to improve quality and effectiveness, making the enterprise quick to adapt, this is a maturity Level 5 characteristic.

9. How does management track changes in the process and reasons for the changes?
How long has it done so?
Is the procedure or process current?
Refer to response for Section F.9.

Note: The history of changes can give clues to the maturity of the review process used by management and aid in the evaluation of the state of the process.

10. Has the person responsible for the process been interviewed to ascertain how the process is viewed and its efficacy?

Note: The examiner may be able to detect how the regulated entity views the process reviewed through interview of the responsible person. Determining who the person reports to may also be an indicator of the importance of the process by management.

In addition to the tests applied to all processes described above, Section F discusses tests for specific standards. The tests are phrased in question form. The examiner should determine what questions the examiner wishes to answer for each process reviewed and then determine if the Requests for Information responses have adequately answered those concerns. Testing of the

process to determine that those features specific to a particular process that should exist, do exist and are adequately addressed. The listed tests for a process are not fixed and absolute. They do not limit the examiner from posing additional questions, when warranted, in efforts to enhance the understanding of the Regulated Entity's response(s). Pertinent responses for the examined process should be reviewed and carefully considered as part of the evaluation of the process. If no response is provided, the fact should be part of the examiners documentation.

Poor results in any of the tests applied may suggest the need to run a review of a sample of files to confirm the existence of a flaw observed in the process. This will generally provide the examiner with a clear causation for errors found in a sample.

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H. Evaluation of Process.

This section considers how to evaluate the results of the testing done in section G. Based on the results of the testing done, the examiner should arrive at a determination concerning where on the matrix noted below, the process is generally described. This determination should be supported with the examiners evaluation of the process describing the reasons for the selection.

This review utilizes a maturity model to evaluate the efficacy of a procedure or process reviewed. Levels of maturity are generally not mandated by statute or regulation, but the evaluation does assist in identification of those areas where a procedure or process is non-existent, weak or insufficient. The maturity levels used in this report are identified numerically on a scale of 0 to 5, with 0 being the weakest and 5 the strongest. The definitions of these levels are:

Level	Description	Characteristics
0	Lack of any recognizable processes / practices.	<ul style="list-style-type: none"> - Complete lack of any recognizable processes. - The enterprise has not even recognized that there is an issue to be addressed.
1	Processes are ad hoc and disorganized.	<ul style="list-style-type: none"> - There is evidence that the enterprise has recognized that the issues exist and need to be addressed. - There are however, no standardized processes; instead, there are ad hoc approaches that tend to be applied on an individual or case by case basis. - The overall approach to management is disorganized.
2	Processes follow a regular pattern.	<ul style="list-style-type: none"> - Processes have developed to the stage where similar procedures are followed by adherent people undertaking the same task. - There is no formal training or communication of standard procedures, and responsibility is left to the individual. - There is a high degree of reliance on the knowledge of individuals and, therefore errors are likely.
3	Processes are documented and communicated.	<ul style="list-style-type: none"> - Procedures have been standardized and documented, and communicated through training. - It is mandated that these processes should be followed; however, it is unlikely that deviations will be detected. - The procedures themselves are not sophisticated but are the formalization of existing practices
4	Processes are monitored, measured and controls are in place.	<ul style="list-style-type: none"> - Management monitors and measures compliance with procedures and takes action where processes appear not to be working effectively. - Processes are under constant improvement and provide good practice. - Controls are in place and operating. - Automation and tools are used in a limited or fragmented way.

5	Good practices are followed and automated.	<ul style="list-style-type: none">- Processes have been refined to a level of good practice, based on the results of continuous improvement and maturity modeling with other enterprises.- Controls are operating efficiently.- IT tools are used in an integrated way to automate the workflow, providing tools to improve quality and effectiveness, making the enterprise quick to adapt.
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When applying this evaluation to examination results, the examiner should recognize that some processes and procedures will contain characteristics of a more advanced level of maturity but the characteristics as a whole do not necessarily rise to that level of maturity. For example, some ad hoc processes may contain more advanced IT functions than might otherwise be expected given the state of process development.

Also note that expectation for some areas of risk may not be as high as others.

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April 28, 2017

Revised Proposal for Process Review Methodology

Since last I joined you in a conference call, I have revisited the proposal submitted earlier. The revised proposal was distributed prior to the meeting on April 27, 2017. I realized following an exchange of emails with others that the effort to complete a chapter as I had laid it out was going to be an unnecessarily long and difficult process.

The chapter originally submitted had too much of its content “under construction” so I decided that my best focus would be to complete the project. I have gone back through the proposal and rewritten everything from Section F to the end. The chapter is now complete.

Sections A – E

There are minor tweaks in Sections A through E. Nothing particularly substantive. Spacing is a little different so it does not cover as many pages. blank pages have been removed.

Section F

I did a major rework of Section F. Rather than name each process used, I have referred directly to the standard from which it is drawn. I then went through each chapter in order and addressed each standard. I have not included the chapters on Advisory Organizations, Viatical Settlement Providers or Premium Finance Companies. I have made placeholders for those regulated entities but have not included them. My recommendation would be to remove them altogether.

Section F deals with the information the examiner needs to start the examination. This is where the information needed to perform a review is detailed. The first 10 questions are the same for all processes. Questions 11 and up are aimed at the specific standard tested. These questions are found on pages 20-97. More questions can be developed directly from the applicable standard, depending on the reason for targeting the examination.

Section G - H



Sections G and H have been combined into a Section G (Pages 98-101) and has been substantially reduced. Once you have the responses to the questions in Section F, you need to determine how the examiner will consider the information provided. What kinds of questions should the examiner be asking of the responses that have been provided? Section G provides some guidance. This is more on the order of a high-level approach that had been suggested to me. Sections G and H would have been subject to far too many variables to ever finish properly so it has been structured as a guideline so the examiner knows the approach to be used.

Section I

Old Section I has been re-lettered as Section H. This section has minor editorial changes. This is the maturity table that aids the examiner's evaluation of the process reviewed.

Section J

Old Section J has been removed as not necessary.

Comments

I have tried to make revisions that would enhance the utility of this methodology. If the level adopted is too high, I am concerned that its utility would be impaired. If the approach has insufficient content, frankly, I doubt it will be used.

I believe that the information that derive from examinations utilizing this tool would vastly improve the analytical capability of the NAIC of the regulated industry.

I know that the NAIC has been concerned with applying some form of accreditation to market conduct examinations sometime soon. I believe that adoption of this proposal will enhance your ability to accomplish that goal as well. If your examination process meshes the historic results of an examination with the identification of causation of error and the viability of a regulated entity's current compliance efforts, and this is done by a majority of examiners, you will have improved the examination process and provided an expectation for those doing examinations. Seems to me, that is where you want this process to go.

Sincerely,

Don Koch