

Date: 7/5/17

Market Conduct Examination Standards (D) Working Group
Conference Call
June 14, 2017

The Market Conduct Examination Standards (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call June 14, 2017. The following Working Group members participated: Bruce R. Ramage, Chair, and Martin Swanson (NE); Damion Hughes (CO); Stephen Deangelis and Kurt Swan (CT); Debra Peirce (GA); Shasta Pack (KY); Rich Bradley (MA); Paul Hanson and Maybeth Moses (MN); Brent Kabler (MO); Maureen Belanger (NH); Cliff Day (NJ); Peggy Willard-Ross (NV); Robert McLaughlin and Mark McLeod (NY); Rodney Beetch and Angela Dingus (OH); Joel Sander (OK); Julie Fairbanks and Laura Klanian (VA); Carla Bailey (WA); Diane Dambach, Sue Ezalarab, John Kitslaar and Rebecca Rebholz (WI); and Mark Hooker (WV). Also participating was: Rachel Cloyd (TX).

1. Adopted its April 27 Minutes

The Working Group met April 27 and took the following action: 1) received a report of potential inclusion of content from recently adopted models in the *Market Regulation Handbook* (Handbook); 2) reviewed and discussed revisions to Chapter 21—Conducting the Medicare Supplement Examination for inclusion in the Handbook; 3) discussed proposed new content regarding closing continuum actions for inclusion in the Handbook; 4) discussed an April 26 proposed compliance risk assessment methodology outline; and 5) discussed a revised proposal regarding process review methodology. Mr. McLaughlin made a motion, seconded by Ms. Peirce, to adopt the Working Group’s April 27 minutes (Attachment XXXXXXX). The motion passed unanimously.

2. Adopted Revisions to Operations/Management Standard 2 of Chapter 21—Conducting the Medicare Supplement Examination for Inclusion in the Handbook

Director Ramage said that Mr. Swanson reviewed the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651) and suggested that revisions be made to Operations/Management Standard 2 of Chapter 21—Conducting the Medicare Supplement Examination in the Handbook. 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 Ramage said comments were received from Ms. Bailey, which suggest replacing the phrase “review whether or not” with “verify” where it occurs in the draft. Mr. McLaughlin made a motion, seconded by Mr. Hooker, to adopt the revised Standard 2 to include Ms. Bailey’s changes (Attachment XXXXXXX). The motion passed unanimously.

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

Director Ramage said that proposed new content regarding closing continuum actions had been developed by Jim Mealer (MO) and other staff members at the Missouri Department of Insurance (DOI) for inclusion in the reference documents of the Handbook. Ms. Cloyd presented comments dated May 19 that suggested revisions to the draft and also to Chapter 2—Continuum of Regulatory Responses of the Handbook. Ms. Cloyd suggested the removal of Section B—The Violation Analysis Phase from the March 1 draft; she stated that the language of the Section B: 1) provides legal advice and analysis, which should instead be deferred to a state’s own legal counsel; and 2) does not allow deference to individual state statutes and regulations. Ms. Cloyd said the word “guilt” is used erroneously in Section B.3—Violations of Prior Orders or Agreements, as the concept of “guilt” is a criminal term, and the context of the chapter relates to civil law. Ms. Cloyd also suggested the removal of Section C—The Remedial Phase from the draft, as the language of the section is somewhat repetitive of Section 3—Enforcements in Chapter 2—Continuum of Regulatory Responses. Ms. Cloyd recommended that Section 3—Enforcements be removed from its current location in Section B—Regulatory Responses of Chapter 2 and added to Section C—Closure of Chapter 2. Director Ramage said that any proposed revisions to Chapter 2 can be subsequently drafted and posted for Working Group, interested state insurance regulator and interested party comment at the next scheduled call.

Director Ramage said that he had submitted revised language dated May 22 to address issues that had arisen in previous Working Group calls. Director Ramage said he had: 1) added introductory language to the draft; 2) replaced Section B—Violation Analysis with Section B—Compliance Evaluation and Documentation Phase; and 3) inserted language broadening the scope of the chapter to allow for deference to state statutes, regulations, etc. Ms. Cloyd said while the revised language in Director Ramage’s May 22 draft partially addressed her comments, the language referencing “guilt” and legal advice, such as

“... the reviewer should be careful not to slavishly rely upon the benchmark error rates ...” is still located within the document. Ms. Cloyd added that since Chapter 2—Continuum of Regulatory Responses adequately addresses enforcement, Section C—The Remedial Phase need not be included within the May 22 draft.

Director Ramage said that the May 22 draft will be rewritten with regard to the comments expressed during the call and forwarded to the Working Group, interested state insurance regulators and interested parties for discussion, comment and potential adoption at the next call. Director Ramage asked for additional comments on the draft to be submitted to Petra Wallace (NAIC) by July 10.

4. Discussion of Proposed New Standardized Data Requests, June 7 Draft, for Inclusion in the Reference Documents of the Handbook

Director Ramage said that four new life insurance-related draft standardized data requests had been developed for Working Group review, discussion and comment. The standardized data requests address claims, declinations, in force policies and replacement. Director Ramage said that the four new standardized data requests were originally combined together into one document, titled the “NAIC Life and Annuity Insurance Data Request.” The revisions to the standardized data requests are extensive, so redlines are not shown within the documents; they can be considered as brand new, and annuity standardized data requests will be developed separately at a later date.

Director Ramage said that each standardized data request was updated to add data elements where needed and delete items that are obsolete and redundant. The “contents” and “uses” sections within each standardized data request was edited to clarify its use and purpose, and the standardized data requests were edited for consistency in format and with common field names as that of previous standardized data requests adopted by the Working Group in the fall of 2016. The standardized data requests were created in Microsoft Word, for ease of showing redlined edits, while under review by the Working Group.

Birny Birnbaum (Center for Economic Justice—CEJ) said he supports the changes made in the context and uses sections of the standardized data requests. Mr. Birnbaum said that the life declinations, life in force policies and life replacement standardized data requests contain repetitive fields and that these three standardized data requests should instead be combined into one marketing and sales-related standardized data request to reduce redundant fields and to request data on policies declined, policies issued and policies replaced. Mr. Birnbaum asked why the three standardized data requests were developed as stand-alone data requests. Mr. Hooker said that he performs separate tests for policies that are not issued (declined), so that is an example of a reason to request data on declined policies separately.

Mr. Birnbaum asked why the data elements in the standardized data requests are not requested routinely from all companies that file the Market Conduct Annual Statement (MCAS). Mr. Birnbaum said that the baseline approach to market regulation should be routine collection and analysis of the type of transactional data that is set forth in the standardized data requests. Mr. Birnbaum said that the result of analysis of data collected, such as the data found in the standardized data requests, can provide empirical evidence of either: 1) consumer harm that has occurred; or 2) violation of state statute. Director Ramage asked Ms. Wallace to speak to the NAIC staff support for the Market Conduct Annual Statement (D) Working Group regarding the issue raised by Mr. Birnbaum. Director Ramage asked for comments on the draft standardized data requests to be submitted to Ms. Wallace by July 10.

5. Discussion of Revisions to Chapter 13—Standardized Data Requests, June 7 Draft, for Inclusion in the Handbook

Director Ramage said that Chapter 13—Standardized Data Requests has been updated to correspond to revisions made in the Handbook. Director Ramage asked for comments on the draft standardized data requests to be submitted to Ms. Wallace by July 10.

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

Director Ramage said that on its April 27 conference call, the Working Group began discussing an outline describing compliance risk assessment methodology, which was developed by Kirk Yeager (INS Regulatory Insurance Services —INS). Shelly Schuman (INS) and Tanya Sherman (INS) provided additional feedback on the outline during the conference call. Ms. Schuman said that the outline is used as a state insurance regulator tool to identify problems or areas of potential consumer harm, arising out of a breakdown in regulatory entity processes, or resulting from a lack of regulated entity processes or controls. Ms. Sherman said that Level 1 Analysis data and Level 2 Analysis data are both incorporated into the methodology. Mr. Birnbaum said that the methodology described in the outline is not a substitute for gathering relevant, transactional-level data. Mr. Birnbaum said that state insurance regulator collection of data and subsequent analysis of that data is a more effective market regulatory approach to identifying negative consumer outcomes and violation of state statutes, rules and

regulations than a prospective review of regulated entity processes, procedures and controls. Director Ramage requested that written comments be submitted by July 10 regarding: 1) the content of the outline; and 2) suggestions regarding how the outline can be incorporated into the Handbook.

7. Discussed a Proposal Revised March 29 for Process Review Methodology

Director Ramage said that the Working Group is continuing its review and discussion of a process review methodology draft proposed by Don Koch (NorthStarExams LLC) in the fall of 2016. Mr. Koch presented a revised draft dated March 29, into which he had inserted additional material. Ms. Bailey said that the language on page 21 of the draft in the second “Note” section referring to on-site examinations may not be applicable in all circumstances. Mr. Koch said he would submit revisions to address this issue.

Mr. Birnbaum asked whether a state insurance regulator would have any evidence-based data that demonstrates that processes and procedures modified by a regulated entity, as a result of a process review methodology-based exam, have resulted in good consumer outcomes. Mr. Koch stated that the only way a state insurance regulator would have that knowledge is if a traditional examination were to also take place, where an examiner would take a sample of historical data and, also, if that data (if current) would support that conclusion. Mr. Koch stated that process review methodology is not outcome-based, unless used in conjunction with a traditional examination, which typically uses historical data. Mr. Birnbaum said that a benefit of the process review methodology approach to state insurance regulators would be to assist in identifying problematic marketplace issues if a DOI is unable to precisely identify those issues through other means. Mr. Birnbaum asked: 1) how a state insurance regulator using this methodology determines whether the issues being reviewed in are, in fact, causing marketplace problems; and 2) how a state insurance regulator knows that if a regulated entity has fixed issues identified by state insurance regulators, if fewer marketplace problems occur as a result.

Director Ramage requested that written comments be submitted by July 10 regarding: 1) the content of methodology proposal; and 2) suggestions regarding how the methodology proposal can be incorporated into the Handbook.

8. Discussed Any Other Matters

In response to an issue expressed by interested parties on its April 27 conference call, where interested parties stated a concern that exam standards (not only long-term care [LTC] exam standards, but all exam standards) in the Handbook may not align with state-specific statutes, rules and regulations, Director Ramage provided an excerpt from Section E of How to Use This Handbook in Chapter 8 of the Handbook. The excerpt stated that “The handbook is only a guide and should be used by each jurisdiction as a tool for developing jurisdiction-specific procedures and guidelines. To effectively use this handbook, it is recommended that each jurisdiction closely review the handbook to determine those standards that reflect the statutes and regulations of the given jurisdiction and those that do not. Each jurisdiction should develop its own procedural manual reflecting audit procedures based on the standards and methodology set forth in this handbook and modified to meet the specific requirements of the laws of that jurisdiction. This handbook is designed solely to provide assistance to each jurisdiction in developing effective and consistent examination methodology. It is not intended that examiners apply any requirements to the examination process beyond the laws of their respective jurisdictions.”

Director Ramage said that Rhonda Ahrens (NE) will draft updates to the life chapter of the Handbook for review at the next conference call, which will address recent revisions to *Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest* (AG 49). Director Ramage said that he is aware that insurance regulators would like to have additional guidance regarding mental health parity in the Handbook, so review procedures and criteria will be developed to address this issue. Director Ramage said that draft LTC examination standards will be developed for review and discussion at a future scheduled Working Group call.

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

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

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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~~ *In the June 14 call, TX recommended removal of Section B from this draft*

~~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~~

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.~~

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%.

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*In the June 14 call, TX recommended removal of Section C from this draft, as it is repetitive of the existing Section B.3. Enforcements in Chapter 2—Continuum of Regulatory Responses*

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:~~

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(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.

e. 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.~~

BD. 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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Chapter 2—Continuum of Regulatory Responses

Insurance regulators can access a broad continuum of regulatory responses when determining the appropriate regulatory response to an identified issue or concern. The continuum can be used to guide the decision-making process when regulators move from analysis to a regulatory response. This chapter will provide considerations for selecting regulatory responses to specific situations, as well as provide lists and descriptions of the categories of continuum actions.

A. Considerations

The substantive nature of regulatory concerns may be clarified by evaluating responses to select questions. Answers to the questions categorized below may help set the stage for prioritizing regulatory projects and for then choosing the most appropriate response.

1. Questions to Evaluate

Consumers

- How immediate is the concern? What is the likelihood or severity of any potential consumer harm?
- What is the nature and potential scope of the harm to consumers?
- How extensive is the issue? Does the concern involve one regulated entity or multiple regulated entities?

Regulators

- Do other state, federal or self-regulating organizations also have responsibility over the concern or an interest in it? Is this an issue that should be resolved by the affected jurisdiction independently, with the combined efforts of a few or multiple affected jurisdictions, or should the concern be referred to another jurisdiction?
- Has the concern already been addressed by another jurisdiction? If so, can that resolution be applied to other impacted jurisdictions?

Regulated Entities

- How do company self-audit or best practices organization reviews speak to the concern?
- What is the regulated entity's history for proactive and responsive market conduct compliance?
- What types of market conduct actions have been effective with this or similar entities in the past?

Actions

- What type and volume of information is needed to evaluate the concern and recommend corrective action?
- If an analyst or examiner discovers information or activities that raise suspicions of fraudulent activity, what steps should be taken?
- Should the regulatory response include an enforcement action, restitution, or process and procedure changes?

2. Scale of Response

When deciding which response is most appropriate for the situation, it is also important to determine toward whom the response should be directed. One common target would be a single insurer, although addressing multiple insurers within a holding company group may be more efficient at times. Some groups are comprised of almost completely autonomous operations, while others function within the same operating system or location and under the same management.

Health groups may have a centralized holding company that dictates policies and practices, while connected with numerous small, state-admitted entities. An insurance company or group should be able to indicate how the specific entity is set up. In some cases, the response is best focused on a regulated entity other than an insurer, such as a third-party administrator or producer entity. Some issues may be industry-wide or nearly industry-wide, calling for an appropriate multi-jurisdictional response.

3. Goals of Response

When determining the most appropriate responses, pursue goals similar to the following:

- Stop practices that are harmful to consumers and prevent future harm to consumers;
- Address the issue as widely as possible, with minimal impact to regulated entities that have not contributed to the problem; and
- Remediate harm to impacted consumers. The form of remediation is generally determined through the administrative/legal process. In many cases, the regulated entity will voluntarily propose corrective measures once a noncompliant or incorrect process has been identified. Gathering information to show specific impact can assist the administrative resolution.

4. Measures of Success

When comparing several options that appear to meet the above goals, consider these measures of success to help guide the final decision. Determine if the response is:

- Appropriate: Does the response correspond appropriately to the identified problem?
- Cost-effective: Is the regulatory response cost-effective for both the department and the regulated entity? Does the regulatory response leverage regulatory resources?
- Timing: Does the proposed response accommodate deadlines or time requirements, if any?
- Least intrusive: Is the response the least intrusive way to effectively resolve the matter of regulatory concern?

5. Assigning Regulatory Staff

Who should be assigned to conduct continuum of regulatory responses such as those discussed below? The answer will differ among insurance departments. Individuals with market conduct examination or consumer affairs investigation backgrounds are among those individuals that would be appropriate.

Skills needed, in addition to an understanding of insurance practices to be reviewed, are good letter and report writing skills, good verbal communication skills, and an understanding of insurance department policies and procedures. Additionally, a thorough understanding of issues surrounding treatment of confidential versus publicly available information is important.

B. Regulatory Responses

The continuum of regulatory responses can be roughly divided into four categories: Contact, Examination, Enforcement and Market Actions (D) Working Group. The continuum is not a “ladder,” whereby one step must be taken prior to advancing to the next. Rather, it should be viewed as a range of decision-making options.

A brief discussion of each category follows. Examples are provided only for clarity and should not be considered the sole use for each type of response. Note: The principles outlined in Section D Confidentiality in Chapter 8—Examination Introduction of this handbook can also be applied to the continuum of regulatory responses.

1. Contact with the Regulated Entity

Contact with the regulated entity will include the following components:

- Statutory authority for making the request;
- A clear explanation of the concern, along with the specific insurance laws or regulations related to the matter;
- A clear expectation of what action is being requested;

- If requesting information, an explanation of how that information will be used and the statutory protections for confidential information;
- A date by which a reply is expected, along with to whom the response should be sent; and
- A clear explanation of how any billing of investigatory work will be addressed.

The continuum begins with the contact category, dealing with various opportunities to connect directly with the regulated entity, such as:

- Correspondence;
- Interrogatories;
- Interviews with the entity;
- Contact with other stakeholders;
- Targeted information gathering;
- Policy and procedure reviews;
- Review of self-audits and self-review documents; and
- Review of voluntary compliance programs.

This category of continuum actions would be recorded in the appropriate NAIC database to enable regulators to share information about regulatory responses other than examinations and enforcement actions.

Correspondence

Once a potential or fully identified problem has been detected, regardless of any other continuum options chosen, correspondence will typically be the initial response. For some issues, correspondence may be all that is needed. A letter or email may be used to discuss such issues as a perceived negative trend in complaints or a specific problem that needs immediate attention.

A distinct advantage of using correspondence is that the problem can be quickly reviewed and addressed by the insurer. In addition, having documentation of the discussion will also serve as a record in the event the problem is not corrected and is subsequently escalated to another continuum option. However, correspondence may not be the best response if a regulated entity has resisted regulatory communications in the past.

Practical examples of using correspondence include:

- Reminding the regulated entity of a specific regulatory requirement after insurance department consumer affairs staff notes cases of noncompliance; and
- Advising an insurer of increasing complaint ratios noted during the market analysis process.

If correspondence does not satisfactorily address the regulatory concern, further regulatory responses should be considered.

Interrogatories

An interrogatory is simply a set of questions used to evaluate an insurer's handling of compliance or processing issues, and can be tailored to a very specific need for information. Interrogatories are a good option when attempting to determine compliance with a particular rule or law. Surveys, certifications or questionnaires might be included in an interrogatory.

Practical examples of using interrogatories include questionnaires regarding:

- Claim handling practices related to automobile total loss valuation, reimbursement of sales tax and special costs, and branding of salvage titles;
- The company's plan of action to comply with a particular new statute; and
- Compliance with annuity suitability requirements.

Interviews with the Regulated Entity

In the form of a face-to-face meeting or conference call, interviews with the entity are useful when there is a need for open dialogue, discussion or clarification. It provides both the regulator and the regulated entity with an opportunity to ask questions, provide clarification and verbalize each point of view about compliance matters. Interviews with company personnel can be useful to obtain information about specific company divisions or functions.

The most formal method of interview would be taking a statement under oath. Before conducting a statement under oath, review the insurance department's policies and procedures or seek advice from insurance department counsel to become familiar with state-specific requirements. General standards may require that persons examined under oath be permitted representation by counsel and be permitted to have access to a transcript of the proceeding.

Interviews may also be advantageous when the state has determined that the insurer is conducting business outside its standard operating policies and procedures. This option may require specific knowledge of the regulated entity's policies and procedures to understand that the analysis results indicate a deviation from those policies and procedures.

Interviews might also be conducted to resolve questionable market analysis findings. That is, should market analysis findings indicate that the regulated entity might be engaged in problematic practices, interviews may be conducted to give a state a better understanding of these activities. As with the option to correspond with an entity, interviews may not be the best response if a regulated entity has resisted regulatory communications in the past.

Practical examples of performing an interview with the regulated entity include:

- Making a phone call to an insurance company compliance officer to discuss concerns relating to the company's change in marketing strategy;
- Requesting a meeting with a company underwriting manager to learn first-hand how the company uses loss history information; and
- Setting up a recorded statement under oath to ask a claims examiner about company instructions and procedures relating to the handling of problematic claims.

Contact with Other Stakeholders

There may be occasions when the state feels that input is necessary beyond what is gained from talking or corresponding with company officers and decides to contact specified members of the public. The state will need to obtain information from the company to contact its current or past policyholders and claimants, while most states will have current contact information for a company's producers. These contacts can be made by mail or by phone and should be intended to uncover very specific information about the company and the potentially harmful behavior under investigation.

Practical examples of contacting other stakeholders:

- Contacting producers to ask for their perspective about training provided by the company; and
- Contacting consumers who purchased a specific insurance product to ask how the product was presented and sold to them.

Targeted Information Gathering

Targeted information gathering may take the form of a survey or data request. A useful survey should include clear and understandable questions. Where possible, it will be helpful to limit the scope of a survey to one or two insurance company functional areas.

Should the state determine that additional data is required from the regulated entity, the NAIC uniform data requests should be followed. If there is a need to deviate from the uniform data requests to capture specialized information, the need for additional data should be explained and justified to the regulated entity.

Also, if possible, be mindful of time constraints faced by insurance companies. For example, requesting a response date that is near the Market Conduct Annual Statement (MCAS) due date may create an undue workload and unnecessary cost upon an insurer.

Practical examples of targeted information gathering include:

- Requesting a data file from a health insurer to analyze compliance with prompt-pay requirements; and
- Requesting producer mailing lists and mailed materials to assess the company's dissemination of state-required information to its producers.

Policy and Procedure Reviews

For some cases, policy and procedure reviews may be a workable alternative to the traditional market conduct practice of performing sampling and file reviews. A review of written policies and procedures may also be supplemented with a review of a minimal number of files to help ensure that policies and procedures have actually been implemented. Reliance on such a review is dependent upon the company's inclusion of the compliance issue within its written policies and procedures.

Practical examples of the use of policy and procedure reviews include:

- Review of a company's written guidelines relating to protecting privacy of consumer financial and health information; and
- Review of a company's written guidelines that address mandatory training of producers who sell policies under the National Flood Insurance Program (NFIP).

Reviews of Self-Audits and Self-Review Documents

One use of self-audits involves a review of an insurer's existing internal market conduct audit programs. Use of this technique will vary by state; if uncertain, regulators should consult their insurance department's legal counsel. Additional discussion may be found in the NAIC white paper *Regulatory Access to Insurer Information: The Issues of Confidentiality and Privilege*. An advantage to reviewing self-audit reports is to prevent duplication in the review of compliance issues already actively managed by the insurer.

A disadvantage to use of these documents is that scrutiny of an insurer's self-audit reports may place a damper on such self-audit practices because of fear that the insurer will be penalized for identifying mistakes and that such mistakes will ultimately subject the insurer to liability. One practice to consider is to learn the scope and structure of a company's self-audit program, rather than conduct a review of the resulting self-audit reports themselves.

Practical examples of the use of self-audits and self-review documents include:

- Requesting that an insurer identify all health claims with a specific medical procedure code to correct a systematic payment error for the preceding 12 months; and
- Determining which functional areas and subject matters have been evaluated by a company's self-audit program during the preceding 12 months to enable a regulator's market conduct review to focus on company-neglected issues and concerns.

Voluntary Compliance Programs Review

The review of reports from a regulated entity's compliance programs or reports produced by best practices organizations such as the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC) may be performed. These types of reviews might be helpful where the scope of the best practice organization's review is substantially similar to the scope of the issue, problem or concern that a state wishes to address. States are encouraged to familiarize themselves with the best practice organization's review processes and, particularly, whether the review process includes verification of compliance with documented policies and procedures.

Such organizations are generally willing to provide a list of participating entities and to share their review standards and methods with regulators. By comparing those review standards with examination review standards, regulators can make better decisions on how to focus the scope of a review. Regulators should also determine how their specific state laws apply to best practice organizations and accreditation services. It is possible that certain accreditation services are required for licensure purposes—for example, managed care utilization review and provider credentialing.

Practical examples of reviewing voluntary compliance program documents include:

- Reviewing the URAC documentation when researching an increase in health insurance-related complaints.

2. Examinations

The examinations category is possibly the most familiar of the continuum categories, and the bulk of the chapters in this handbook are devoted to addressing examination practices in great detail. Unless an examination is required by law in a state, there are often more efficient and cost-effective methods to respond to marketplace issues. However, at times an examination will be the best choice among the continuum options. As stated previously, states should enter any continuum actions into the appropriate NAIC database.

Even within examinations there are many levels and choices available. Decisions need to be made as to:

- Timing of examination;
- Penetration level of examination;
- Location of examination; and
- Participation level of examination.

Timing of Examination

Once the need for an examination has been decided, timing of the examination and notification of the entity will need to be determined. There are three general approaches to timing, and each fits a specific need:

- Statutory examination: Regularly scheduled examination based on state statute;
- Scheduled examination: An examination for cause, providing the entity with prior notice, typically 60-90 days, of when the examination will begin and all pertinent details about what will be reviewed; and
- No-knock examinations: An examination without prior notice being sent to the examined entity. This choice is used when a regulator feels that providing an entity with advance notice of an examination would result in the entity destroying evidence of violations, or creating false information to give the impression of compliance.

Examination Type

It will also need to be determined exactly what will be reviewed. Should the focus be narrow to only the issue that prompted the examination, or wide to encompass all entity functions? There are two recognized divisions:

- Targeted examinations: An examination of one or two areas of business (e.g., an examination of a company's marketing and sales practices); and
- Comprehensive examinations: A review of most, if not all, market conduct areas within an entity (e.g., a five-year statutorily required examination of a domestic insurer).

Location of Examination

Once the scope of the examination has been determined, the location of the examination will logically follow based on the examinations needs:

- Desk examinations: A review of specimen copies or electronic documents at a location other than the regulated entity's offices, e.g. a regulator uses the Internet and electronically provided samples to conduct a review of an entity's advertising materials; and
- On-site reviews: A review conducted in the regulated entity's offices, necessary for review of original documents and actual transactions, e.g. a review of mail processing practices or complaints logs.

Often examiners will utilize a combination of desk and on-site reviews to conduct an effective review while reducing the travel time and costs associated with having a regulatory team on-site for prolonged stays.

Participation Level of Examination

When analyzing the scope of an issue, the breadth of the concern across the company and the likelihood of the issue being found in other jurisdictions should also be evaluated. Collaboration with other jurisdictions is discussed in detail in its own chapter later in this handbook; however, it is worth mentioning here:

- Single State: A review of a regulated entity's actions limited to the jurisdiction conducting the review (e.g., a review of an entity's compliance with a statute enacted in the preceding year);
- Joint Effort: A review conducted by two or more jurisdictions of a single entity or issue (e.g., an examination of a small regional insurer by two bordering states into claims adjustments involving both states; and
- Multi-jurisdictional: An examination of one or more regulated entities by multiple jurisdictions (e.g., an investigation led by a few states for the benefit of all 56 jurisdictions into a large national insurer's practices related to sales of life insurance targeting specific ethnic groups).

Multi-jurisdictional examinations can be conducted in all of the different variations mentioned above. For example, a multistate examination might be conducted as a targeted desk examination or might be an on-site investigation. They are increasing in popularity with both regulated entities and regulators because of the resources saved. Due consideration should always be given to referring multijurisdictional endeavors to the Market Actions (D) Working Group. The Working Group is discussed later in this chapter and also in the chapter titled Collaborative Actions.

As mentioned earlier, this handbook has several chapters devoted to the details of how to conduct investigations and examinations. Please see the applicable chapters relating to investigations and examinations for an in-depth discussion of those types of reviews.

3. Enforcements *In the June 14 call, TX recommended moving Section B.3. Enforcements to Section C. Closure of this chapter, on page 10 of this document*

~~On occasion, an enforcement action will clearly be the most practical solution for addressing cases of noncompliance. The types and combinations of enforcement actions are virtually unlimited, although a few general types are captured in this list. Any action of this type should be recorded in the appropriate NAIC database:~~

- ~~• Informal agreements;~~
- ~~• Voluntary compliance plans;~~
- ~~• Administrative complaints;~~
- ~~• Cease and desist orders;~~
- ~~• Ongoing monitoring/self-audits;~~
- ~~• Remediation plans;~~
- ~~• Negotiated settlement agreements and consent orders;~~
- ~~• Restitution;~~
- ~~• Administrative fines/penalties;~~
- ~~• Post-investigation or follow-up examinations; and~~
- ~~• Probations/suspensions/revocations of license.~~

Informal Agreements

~~An informal agreement to change practices or implement procedures can be either written or verbal. Such an agreement would be most appropriate for situations involving noncompliance with technical regulatory issues and where no significant harm has occurred to consumers or other stakeholders. Such an agreement could include such things as amendment of business practices, forms or rating plans.~~

Voluntary Compliance Plans

An agreement with the regulated entity to establish a voluntary compliance plan would go beyond implementation of a single change in procedures or practices. Such an agreement may include self-monitoring, self-audits and possibly reporting back to the regulator after an agreed-upon period of time.

Administrative Complaints

An administrative complaint is filed when the insurance department has reason to believe that a regulated entity is engaging in noncompliant behavior. The document will allege that a violation of insurance law has occurred or may occur and provide for an administrative hearing where both parties are allowed to present evidence and testimony about the allegations.

Cease and Desist Orders

An order can be issued by the insurance department to a company to prohibit a person or business from continuing all operations or certain targeted operations or violations of law. Such an order would be issued when harm to consumers is considered imminent and quick action is perceived to be necessary. The insurance department then may bring the company in for an administrative hearing to determine future action.

Ongoing Monitoring/Self-Audit

After identification of a systematic compliance error being made by an insurer, regulators may request that the insurer conduct a targeted market conduct self-audit. This permits an insurer to take corrective action and to report its findings to the regulator. Additionally, as part of settlement agreements or after final examination reports, a company may be required to submit regular audits covering the areas of concern. The audits would be submitted to the regulator over a period of one or more years to help ensure continued compliance in the area of concern.

Remediation Plans

In cases where harm can be measured and corrected, remediation may take the form of such actions as premium refunds, supplemental claim payments, removal of unapproved, or incorrectly administered restrictive endorsements or policy change options. Obtaining remediation for policyholders, claimants and parties affected by an adverse situation should generally be a primary goal. Where possible, remediation should be undertaken for all affected jurisdictions. This will reduce or eliminate the need for duplicate regulatory responses.

Negotiated Settlement Agreements and Consent Orders

A negotiated settlement may be used to arrive at a mutually agreeable conclusion to a matter of concern. Such an agreement is typically negotiated and placed into a written consent order by the insurance department's legal counsel. The agreed-upon settlement may include such components as remediation, voluntary forfeitures (fines), agreements to cease and desist, agreements to implement action plans, self-reviews, and possibly reporting back to the regulator after an agreed-upon period of time. The settlement agreement may or may not lack an administrative determination that a specific violation has occurred and may or may not also indicate that the regulated entity neither affirms nor denies the specific allegations. The agreement is made as a means to resolve the conflict. Multiple states may also be involved in negotiated settlements, in which case those regulators involved may wish to consult the Market Actions (D) Working Group created document *Best Practices for Multistate Settlement Agreements*.

Restitution

When a company's actions or omissions have done harm to policyholders, claimants or the department of insurance, the state may require that compensation is made for that harm. The scope and extent of the harm may be determined through self-reporting, any of the continuum actions, or through single or multistate examinations. Compensation is made for actual loss or damage that was sustained.

Administrative Fines and Penalties

An administrative adjudication should follow insurance department or state guidelines. A typical action would follow the filing of a petition or formal complaint against the regulated entity, setting a time and place for an administrative hearing. The regulated entity would be provided an opportunity to offer testimony and evidence before a hearing officer, who would decide the outcome of the action. Likewise, the regulatory representative

~~would present evidence and request a finding or determination along with a request for resolution. Occasionally, a voluntary consent agreement may be reached prior to an administrative hearing. A regulated entity could be required to pay both restitution and a penalty so that actual financial harm is repaired and the entity is also punished for the violations that caused the financial harm.~~

~~Post-Investigation or Follow-Up Examinations~~

~~There may be instances when a regulated entity modifies procedures in order to respond to a state's determination of a violation through an investigation or examination. However, the state may not be assured that the change will stay in effect over a long period of time and is not comfortable with the company self-monitoring. In such cases, the state may elect to schedule a series of targeted examinations to monitor the issue over an extended period of time until a comfort level is reached.~~

~~Probations/Suspensions/Revocations of License~~

~~Depending on the severity and frequency of specific violations, or the variety of violations, a state may take action against a regulated entity's authority to operate in the state. Probation is often ordered for entities guilty of more minor violations or first offenses, which allows them to continue the business of insurance under supervision. For a more serious charge, the license may be suspended to prohibit any performance of the business of insurance, usually for a specified period of time. If the violations are severe or pervasive in nature, or if probation or suspension has not resulted in a remedy to the issues, the license or authority to conduct the business of insurance may be revoked.~~

43. Market Actions (D) Working Group

The Market Actions (D) Working Group was created to give regulators a forum for issues found that should be addressed on a national level. The Working Group meets at each NAIC meeting, as well as holds periodic conference calls and communicates as needed on issues. Membership is made up of a select number of regulators from across the country selected based on their skills, experience and ability to participate in national level activity.

Information Sharing

Each state commissioner appoints a Collaborative Action Designee (CAD) to handle or coordinate the communication to and from the Market Actions (D) Working Group and with other CADs about multistate issues. Most member jurisdictions of the NAIC have signed the Information Sharing and Confidentiality Agreement; the list of signatory jurisdictions may be found in StateNet. Generally, that agreement can be referenced in any exchange of information rather than requiring states to sign individual confidentiality agreements with each other.

Additionally, regulators should be familiar with their state insurance code provisions to determine the extent of materials that may be shared with other state insurance regulators, other state agencies and federal agencies, as some compliance issues may involve multiple jurisdictions or multiple agencies.

Practical applications of information sharing include:

- Entering into a confidentiality agreement and sharing information with banking regulators to evaluate a licensed agency that has sold unregistered investments to insurance clients; and
- Sharing information under the NAIC confidentiality agreement with another state when both states' market analysis processes have identified similar concerns about a licensed insurer.

Referral to the Market Actions (D) Working Group

Issues of concern that have been developed through market analysis or by other channels may be referred to the Market Actions (D) Working Group. When there is a likelihood that the issue affects multiple jurisdictions and cannot be readily or simply resolved to answer the concerns of all affected jurisdictions, a Request for Review (RFR) can be submitted to the Market Actions (D) Working Group. The RFR may be initiated by one or more states, by a commissioner or deputy commissioner, by a Collaborative Action Designee (CAD), by NAIC staff or self-reported by an entity. The RFR asks the referring state(s) not only for the particulars of the issue and the entity (ies), but also for recommendations for continuum-based regulatory responses.

Practical applications of submitting an RFR to the Market Actions (D) Working Group include:

- Several states identify a company with the same issue, and they believe a united request for voluntary compliance will resolve the issue for all impacted states; and
- One state has completed a continuum action with a company for an issue that potentially impacts many states and believes the same resolution can be applied to those states with an action initiated through the Market Actions (D) Working Group.

National Analysis

In addition to responding to issues brought before the group, the Market Actions (D) Working Group annually coordinates a national analysis project using Market Conduct Annual Statement Data that proactively looks at the country's insurers for signs of developing issues. When issues are found, a volunteer jurisdiction will investigate the concern and report back to the group, completing an official referral if necessary.

C. Closure

No matter which continuum of regulatory response option is used to address a situation, regulators will be faced with the decision of how to bring closure to an issue. **TX 7/10/17 comments recommended incorporating the following lead-in language:** Each jurisdiction has different considerations and methods for bringing closure to an issue. In some instances, taking enforcement or disciplinary action, or even initiating civil litigation, may be necessary to achieve compliance or resolve the issue. On other occasions, the following listed methods of closure may be appropriate:

A discussion of some of the most common methods of closure, listed below, follows:

- Determining that no further action is necessary;
- Communicating the insurance department's position;
- Providing information to producers;
- Referral to other agencies, fraud prevention divisions or law enforcement;
- Initiating consumer outreach or education initiatives;
- Ongoing, nonstructured monitoring; and
- Requesting legislative or regulatory rule changes.

Regulators should be aware of and abide by protocols established by their insurance department, commissioner and general counsel relating to the use of various closure outcomes. Insurance departments may have established procedures for communications with media or other governmental agencies and for the distribution of public information. Public information officers, governor liaisons, legislative liaisons, general counsels, deputies and commissioners are all possible sources of information regarding any such protocols within a state insurance department.

When deciding upon a method of closure or outcome, it is helpful to consider not only the nature of the issue and how it has affected consumers, but also the manner in which the issue was discovered and how it was addressed by the regulated entity. It would seldom be prudent to penalize a regulated entity that voluntarily communicated about a problem discovered by way of self-audit, if the regulated entity also took steps to rectify the problem and provided remediation as needed.

TX 7/10/17 comments recommended adding the following subheading in this location:

:1. Closure Without Initiating Action or Litigation**Determining That No Further Action Is Necessary**

Justification for taking no further action might include such reasons as: (1) determination that company actions were handled in accordance with insurance laws or statutes; (2) there was no violation of insurance law; or (3) that a single problematic issue resulting from a miscommunication was acknowledged and addressed. Additionally, a regulatory response could produce findings that ease concerns raised by market analysis. If an initiative was recorded in the appropriate NAIC database at the beginning of the issue, notes would be added to the entry, and it would then be closed.

Communicating the Insurance Department's Position

A written communication expressing the insurance department's position on a matter can serve not only as clarification, but also as a potential warning or admonishment. It can place the regulated entity on notice that future occurrences may be dealt with in a stricter fashion. This outcome would be finalized in the appropriate NAIC database, and the entry closed. Any such communication should be clear and specific to the issue at hand. For examinations, this generally takes place in the form of a report of examination. For other types of regulatory responses, a closing letter to management may be appropriate.

Alternatively, the issue may be of wider concern than a specific company, and the insurance department will want to convey its position more broadly. The use of targeted mailings, newsletter articles, bulletins and website notices may allow regulators to widely address a concern or provide information relative to new issues, interpretations, relevant case law, implementation policies for new laws, or discussion of new industry practices or technologies. Education is an effective regulatory tool that can be used to provide information to the insurance industry. Two primary forms of education are insurance department communication and proactive outreach.

Practical examples of insurance department communications include:

- Issuing a formal bulletin to clarify the insurance department's interpretation of a specific law;
- Posting an advisory letter to respond to multiple requests for information about a specific compliance issue;
- Providing access to insurance laws and regulations through the insurance department's website;
- Listing helpful suggestions for responding to insurance department inquiries on the insurance department's website; and
- Discussing specific regulatory concerns in an insurance department's quarterly newsletter.

Providing Information to Producers

The insurance department may also wish to convey information to producers, agencies and brokers. In addition to the possible use of mailings and notices, the department may choose a more proactive type of outreach. Outreach mediums include speaking engagements, insurance department-sponsored seminars and training events, press releases, interviews with the media, articles for publication, billboards and advertisements, brochures, and radio spots. Identifying the target audience and tailoring the delivery to that audience are keys to a successful outreach campaign.

Practical examples of producer outreach include:

- Sponsoring a seminar aimed at insurance compliance professionals to discuss changes to variable life insurance law;
- Participating in an industry or regulator-sponsored trade organization seminar to share information about a new rule affecting market regulation; and
- Requesting trade organizations place periodic reminders in their publications about the importance of flood insurance.

Referral to Other Agencies, Fraud Prevention Divisions or Law Enforcement

Occasionally, regulatory issues or concerns may cross agency boundaries within the state. Common examples include securities, banking, motor vehicle registration and financial responsibility, health and human services, consumer protection functions of attorneys general, and senior protection agencies. It is helpful to know who within the state insurance department may have established channels of communication with other applicable agencies. It is also helpful to have a general understanding of the functions within those agencies and how they might apply to insurance.

Any indication of insurance fraud, whether directed against an insurer by an outside person or implemented from within the insurance organization, should immediately be reported to the applicable fraud prevention division. Referrals to law enforcement may be warranted when infractions such as theft by deception or forgery are noted.

Initiating Consumer Outreach or Education

Insurance departments have a unique opportunity for determining which insurance-related issues are confusing or unclear to consumers. It is important to use the insurance department's established guidelines for media contact and generally best to coordinate any media outreach with the department's public information officer. Newspaper and magazine articles, press releases, outreach at public events, and speaking engagements can help provide consumers with tips on how to be more "savvy" about insurance. Publishing a brochure explaining a certain confusing insurance product and requiring its distribution at point of sale can help prevent abusive sales techniques and unsuitable sales.

Practical examples of consumer outreach or education initiatives include:

- Initiating a "Fight Fake Insurance" campaign to inform consumers about the danger of fraudulent and unauthorized health insurers;
- Developing media news releases to teach consumers how to best file insurance claims after a natural disaster; and
- Use of billboards to remind the public that insurance fraud is a crime.

Ongoing, Nonstructured Monitoring

Ongoing, nonstructured monitoring is often appropriate for issues with a high-dollar or high-volume impact. This is especially true if the regulator is not assured that the initial corrective action will be applied continuously and consistently. For example, a claims payment problem that was corrected by programming the correct reimbursement rate for a single medical procedure code into the computer system will probably not need further monitoring. A similar claims payment practice that involves numerous codes or repeated instances might warrant the planning of ongoing monitoring. Deliberate monitoring may also be appropriate when the regulatory response is not conclusive about the extent or nature of an identified problem.

Requesting Legislative or Regulatory Rule Changes

A market conduct issue may be discovered for which no regulatory authority exists to address the concern or when the law has not kept pace with changing market conditions. Sometimes a practice is identified that is perfectly legal, but is causing harm to consumers or disrupting the marketplace. If the issue is approached correctly, insurers are willing to change the practice in question as long as they can be assured of a level playing field. At other times, these situations are identified when new types of insurance, new marketing mechanisms or industry use of emerging technology and tools are introduced and problems need to be addressed on a broader basis through rulemaking, legislative changes and the development of NAIC model laws.

Most insurance departments will have an established protocol for discussion and proposal of new statutes and regulations, generally requiring that all such proposals be channeled directly to the insurance department commissioner. When evaluating the need for change, it is helpful to review existing NAIC model laws and regulations and to request feedback from other states to see if anyone has already addressed the concern. The NAIC, consumer advocacy groups and insurance trade organizations can also be valuable sources of information.

Practical examples of requesting legislative or regulatory rule changes include:

- Addressing the need for advertising regulations in Internet sales; and
- Addressing the need to amend existing insurance statutes to address new types of insurance or marketing arrangements.

TX 7/10/17 comments recommended adding the following subheading in this location:

2. Closure Through Enforcement Methods, Disciplinary Action or Litigation

In the June 14 call, TX recommended moving Section B.3. Enforcements to Section C. Closure of this chapter. CA also made this same recommendation in their April 20 comments.

On occasion, an enforcement action will clearly be the most practical solution for addressing cases of noncompliance. The types and combinations of enforcement actions are virtually unlimited, although a few general types are captured in this list. Any action of this type should be recorded in the appropriate NAIC database:

- Informal agreements;
- Voluntary compliance plans;
- Administrative complaints;
- Cease and desist orders;
- Ongoing monitoring/self-audits;
- Remediation plans;
- Negotiated settlement agreements and consent orders;
- Restitution;
- Administrative fines/penalties;
- Post-investigation or follow-up examinations; and
- Probations/suspensions/revocations of license.

Informal Agreements

An informal agreement to change practices or implement procedures can be either written or verbal. Such an agreement would be most appropriate for situations involving noncompliance with technical regulatory issues and where no significant harm has occurred to consumers or other stakeholders. Such an agreement could include such things as amendment of business practices, forms or rating plans.

Voluntary Compliance Plans

An agreement with the regulated entity to establish a voluntary compliance plan would go beyond implementation of a single change in procedures or practices. Such an agreement may include self-monitoring, self-audits and possibly reporting back to the regulator after an agreed-upon period of time.

Administrative Complaints

An administrative complaint is filed when the insurance department has reason to believe that a regulated entity is engaging in noncompliant behavior. The document will allege that a violation of insurance law has occurred or may occur and provide for an administrative hearing where both parties are allowed to present evidence and testimony about the allegations.

Cease and Desist Orders

An order can be issued by the insurance department to a company to prohibit a person or business from continuing all operations or certain targeted operations or violations of law. Such an order would be issued when harm to consumers is considered imminent and quick action is perceived to be necessary. The insurance department then may bring the company in for an administrative hearing to determine future action.

Ongoing Monitoring/Self-Audit

After identification of a systematic compliance error being made by an insurer, regulators may request that the insurer conduct a targeted market conduct self-audit. This permits an insurer to take corrective action and to report its findings to the regulator. Additionally, as part of settlement agreements or after final examination reports, a company may be required to submit regular audits covering the areas of concern. The audits would be submitted to the regulator over a period of one or more years to help ensure continued compliance in the area of concern.

Remediation Plans

In cases where harm can be measured and corrected, remediation may take the form of such actions as premium refunds, supplemental claim payments, removal of unapproved, or incorrectly administered restrictive endorsements or policy change options. Obtaining remediation for policyholders, claimants and parties affected by an adverse situation should generally be a primary goal. Where possible, remediation should be undertaken for all affected jurisdictions. This will reduce or eliminate the need for duplicate regulatory responses.

Negotiated Settlement Agreements and Consent Orders

A negotiated settlement may be used to arrive at a mutually agreeable conclusion to a matter of concern. Such an agreement is typically negotiated and placed into a written consent order by the insurance department's legal counsel. The agreed-upon settlement may include such components as remediation, voluntary forfeitures (fines), agreements to cease and desist, agreements to implement action plans, self-reviews, and possibly reporting back to the regulator after an agreed-upon period of time. The settlement agreement may or may not lack an administrative determination that a specific violation has occurred and may or may not also indicate that the regulated entity neither affirms nor denies the specific allegations. The agreement is made as a means to resolve the conflict. Multiple states may also be involved in negotiated settlements, in which case those regulators involved may wish to consult the Market Actions (D) Working Group-created document *Best Practices for Multistate Settlement Agreements*.

Restitution

When a company's actions or omissions have done harm to policyholders, claimants or the department of insurance, the state may require that compensation is made for that harm. The scope and extent of the harm may be determined through self-reporting, any of the continuum actions, or through single or multistate examinations. Compensation is made for actual loss or damage that was sustained.

Administrative Fines and Penalties

An administrative adjudication should follow insurance department or state guidelines. A typical action would follow the filing of a petition or formal complaint against the regulated entity, setting a time and place for an administrative hearing. The regulated entity would be provided an opportunity to offer testimony and evidence before a hearing officer, who would decide the outcome of the action. Likewise, the regulatory representative would present evidence and request a finding or determination along with a request for resolution. Occasionally, a voluntary consent agreement may be reached prior to an administrative hearing. A regulated entity could be required to pay both restitution and a penalty so that actual financial harm is repaired and the entity is also punished for the violations that caused the financial harm.

Post-Investigation or Follow-Up Examinations

There may be instances when a regulated entity modifies procedures in order to respond to a state's determination of a violation through an investigation or examination. However, the state may not be assured that the change will stay in effect over a long period of time and is not comfortable with the company self-monitoring. In such cases, the state may elect to schedule a series of targeted examinations to monitor the issue over an extended period of time until a comfort level is reached.

Probations/Suspensions/Revocations of License

Depending on the severity and frequency of specific violations, or the variety of violations, a state may take action against a regulated entity's authority to operate in the state. Probation is often ordered for entities guilty of more minor violations or first offenses, which allows them to continue the business of insurance under supervision. For a more serious charge, the license may be suspended to prohibit any performance of the business of insurance, usually for a specified period of time. If the violations are severe or pervasive in nature, or if probation or suspension has not resulted in a remedy to the issues, the license or authority to conduct the business of insurance may be revoked.

From: Rachel Cloyd [mailto:Rachel.Cloyd@tdi.texas.gov]
Sent: Monday, July 10, 2017 8:19 AM
To: Wallace, Petra
Cc: Wheeler, Ignatius
Subject: RE: Closing Continuum Actions and Chapter 2

Good morning Ms. Wallace,

For the group's consideration, I've added a transitional sentence and two subheadings to the Closure section to address the concern about awkwardness. Please let me know if you need any further assistance or additional feedback.

Thank you,

Rachel A. Cloyd, JD, CPCU
Director, Regulatory Analysis Office
Enforcement Section | Legal & Enforcement Division
DL: (512) 676-6349 | Fax: (512) 490-1020
rachel.cloyd@tdi.texas.gov

Texas Department of Insurance
333 Guadalupe Street | Austin, Texas 78701
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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.

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]
CWA Amt	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 fields~~ [WA 6/14/17 Comments recommend changing "Field" to "Fields"](#) 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 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 H](#)ow 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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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

Comment [BC(1): I believe this should be plural, "fields."

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Chapter 19—Conducting the Life and Annuity Examination

IMPORTANT NOTE:

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

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

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

- A. Operations/Management
- B. Complaint Handling
- C. Marketing and Sales
- D. Producer Licensing
- E. Policyholder Service
- F. Underwriting and Rating
- G. Claims (Several specialized checklists are available in Sections H–J of this chapter)
- H. Checklist for Marketing and Sales Standard #1
- I. Checklist for Marketing and Sales Standard #4
- J. Checklist for Marketing and Sales Standard #8

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

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

IIPRC-Approved Products

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

Comment [RA1]: Standard #3 is related to Marketing and Sales Replacements. Standard #4 is related to Marketing and Sales Illustrations. In my review of Section I, these checklists are related to illustrations. Possibly a standard was added at one time and the old Standard #3 became Standard #4.

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A. Operations/Management

Use the standards for this business area that are listed in Chapter 16—General Examination Standards and the standards set forth below.

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**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 1
The regulated entity files all certifications with the insurance department, as required by statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Insurance department records of certifications made by the regulated entity

Others Reviewed

NAIC Model References

Life Insurance Illustrations Model Regulation (#582)

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

Actuarial Guideline 49 – The Application of the Life Illustrations Model Regulation to Policies with Index Based Interest

Review Procedures and Criteria

The illustration actuary should file a certification with the insurance department annually for all policies for which illustrations are used (*Life Insurance Illustrations Model Regulation (#582)*, Section 11).

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

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

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

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Comment [RA2]: Illustration Actuary should be aware that AG49 goes with Model Regulation #582 and that the Illustrated Scale and the Disciplined Current Scale for IUL products according to AG49 are subject to this certification. I did not want to add the Model Reference above without explaining to the review group why I did not change any of the procedures.

B. Complaint Handling

Use the standards for this business area that are listed in Chapter 16—General Examination Standards.

C. Marketing and Sales

1. Purpose

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

2. Techniques

This area of review should include all advertising and sales material and all producer sales training materials to determine compliance with statutes, rules and regulations. Information from other jurisdictions may be reviewed, if appropriate. The examiner may contact policyholders, producers and others to verify the accuracy of information provided or to obtain additional information.

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

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

All advertisements are required to be truthful and not misleading in fact or by implication. The form and content of an advertisement of a policy shall be sufficiently clear so as to avoid deception. The advertisement shall not have the capacity or tendency to mislead or deceive. Whether an advertisement has the capacity or tendency to mislead or deceive shall be determined upon reviewing the overall impression that the advertisement reasonably may be expected to create upon a person of average education or intelligence within the segment of the public to which the advertisement is directed.

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

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

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

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

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

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

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

Market regulators should also be aware that sales of products, such as fixed-index annuities (formerly referred to as equity-indexed annuities) and index life insurance products (such as universal index life insurance) continue to increase. These products typically include features that require an understanding of bonuses, guaranteed elements and an array of interest-crediting methods. In some cases, existing NAIC model laws and regulations may not give specific guidance on all aspects of all products. In such instances, examiners may rely on general principles found in the *Unfair Trade Practices Act* (#880) and the *Annuity Disclosure Model Regulation* (#245). [Actuarial Guideline 49 – The Application of the Life Illustrations Model Regulation to Policies with Index Based Interest was adopted by the NAIC in 2015. It provides guidance and limitations for Indexed Universal Life illustrations with implementation of Sections 4 and 5 of the Actuarial Guideline required for new business and inforce illustrations beginning September 1, 2015 and with implementation of Sections 6 and 7 required for new business and inforce illustrations beginning March 1, 2016.](#)

Evaluation of compliance with annuity suitability may best be accomplished through a process and procedure review coupled with sampling. The process and procedure portion of the review is a good example of a function where states may wish to coordinate their reviews and share responsibilities. A continuum approach, such as use of a desk audit, may also be appropriate. Sampling enables examiners to evaluate whether the established processes have been clearly communicated and implemented rather than to function as a means to "second-guess" each individual suitability determination. Company programs

for reviewing suitability may vary widely and should not be considered a "once-size-fits-all" approach. Annuity products can be designed or tailored to serve a wide variety of clientele and customer objectives.

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

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

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

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

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

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

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

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

3. Tests and Standards

The marketing and sales review includes, but is not limited to, the following standards addressing various aspects of the marketing and sales function. The sequence of the standards listed here does not indicate priority of the standard.

**STANDARDS
MARKETING AND SALES**

Standard 1
All advertising and sales materials are in compliance with applicable statutes, rules and regulations.

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ All company advertising and sales materials, including radio and audiovisual items, such as television commercials, telemarketing scripts and pictorial materials
- _____ Policy forms, including any required buyers' guides as they coincide with advertising and sales materials
- _____ Producers' own advertising and sales materials

Others Reviewed

- _____
- _____

NAIC Model References

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

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Review Procedures and Criteria

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

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

Review advertising materials in conjunction with the appropriate policy form.

Materials should not:

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

- State or imply that prospective insureds are or become members of a special class, group or quasi-group and enjoy special rates, dividends or underwriting privileges, unless that is a fact;
- Contain an assertion, representation or statement with regard to the risk-based capital levels of any insurer or of any component derived in the calculation;
- Use the existence of the insurance guaranty association for the purpose of sales, solicitation or inducement to purchase any form of insurance covered by the association;
- Misrepresent the dividends or share of the surplus to be received on any policy;
- Make a false or misleading statement as to the dividends or share of surplus previously paid on a policy;
- Misrepresent any policy as being shares of stock; and
- Illustrations of benefits payable under any modified guaranteed life insurance³⁰ shall not include projections of past investment experience. Hypothetical assumed interest credits may only be used if it is made clear that such are hypothetical only.

Materials should:

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

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

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

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

³⁰ "Modified Guaranteed Life Insurance Policy" means an individual policy of life insurance, the underlying assets of which are held in a separate account, and the values of which are guaranteed if held for specified periods. It contains nonforfeiture values that are based upon a market value adjustment formula if held for shorter periods. The formula may, or may not, reflect the value of assets held in the separate account. The assets underlying the policy must be in a separate account during the period or periods when the policyholder can surrender the policy.

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

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

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

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

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

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

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

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

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

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

For the review of Internet advertisements:

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

A summary of special requirements is available for the following:

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

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

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

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

Index products

For advertising for interest-sensitive products, review explanations of the crediting methods and terms. Review the functioning of the crediting methods to determine that the explanations are understandable and accurate. Verify that accurate information is provided regarding the options available to the consumer and the methods by which the consumer is to exercise the options. For Indexed Universal Life, determine whether the explanations and information provided regarding the options available to the consumer are consistent with the requirements and limitations presented in Actuarial Guideline 49 – The Application of the Life Illustrations Model Regulation to Policies with Index Based Interest.

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

Comment [RA3]: It seems to be appropriate to add a reference here even though AG49 did not address “advertising.” The advertising should not be inconsistent with illustrations, so awareness that IUL should at least be consistent with a new standard for the illustration is good for the MC examiner to be aware of.

**STANDARDS
MARKETING AND SALES**

Standard 2
The insurer's rules pertaining to producer requirements in connection with replacements are in compliance with applicable statutes, rules and regulations.

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Replacement register/Data

_____ Policy/Underwriting files

_____ Loan and surrender files

Others Reviewed

NAIC Model References

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

Suitability in Annuity Transactions Model Regulation (#275)

Suitability of Sales of Life Insurance and Annuities White Paper

Military Sales Practices Model Regulation (#568)

Review Procedures and Criteria

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

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

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

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

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

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

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

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

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

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

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

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

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

**STANDARDS
MARKETING AND SALES**

Standard 3
The insurer's rules pertaining to replacements are in compliance with applicable statutes, rules and regulations.

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

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

Others Reviewed

- ___ _____
- ___ _____

NAIC Model References

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

Review Procedures and Criteria

- Determine if the regulated entity has advised its producers of its replacement policy.
- Determine if the regulated entity has provided timely notice to the existing insurer(s) of the replacement.
- Examine for effectiveness the regulated entity's system of identifying undisclosed replacements.
- Determine if the regulated entity has the capacity to produce data required by replacement regulation to assess producer replacement activity.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**STANDARDS
MARKETING AND SALES**

Standard 4

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

Apply to: All life products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Actuarial records

_____ Underwriting file

Others Reviewed

NAIC Model References

Life Insurance Illustrations Model Regulation (#582)

Universal Life Insurance Model Regulation (#585)

Variable Life Insurance Model Regulation (#270)

Life Insurance Disclosure Model Regulation (#580)

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

Actuarial Guideline 49 – The Application of the Life Illustrations Model Regulation to Policies with Index Based Interest

Review Procedures and Criteria

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

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

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

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

- Use the terms “vanish,” “vanishing premium” or a similar terms that imply that the policy becomes paid-up, to describe a plan for using non-guaranteed elements to pay a portion of future premiums;
- Except for policies that can never develop nonforfeiture values, use an illustration that is “lapse-supported”; or
- Use an illustration that is not “self-supporting.”

Ensure that the insurer has a documented, reasonable methodology for the manner in which it determines its index-crediting strategy. Verify that the insurer has a system which monitors the interest rates used by its insurance producers in illustrations for compliance with the insurer’s credited interest rates.

Review new business and inforce life illustrations on policies sold on or after September 1, 2015. Ensure the illustration is consistent with the requirements and limitations of Sections 4 and 5 of *Actuarial Guideline 49 – The Application of the Life Illustrations Model Regulation to Policies with Index Based Interest*.

Review new business and inforce life illustrations on policies sold on or after March 1, 2016. Ensure the illustration is consistent with the requirements and limitations of Sections 6 and 7 of *Actuarial Guideline 49 – The Application of the Life Illustrations Model Regulation to Policies with Index Based Interest*.

Comment [RA4]: See I. Supplemental Checklist for Illustrations Standard #4. (previously I. referred to “Marketing and Sales Standard #3 errantly)

- For new business and in force life insurance illustrations on policies sold on or after September 1, 2015, determine whether the credited rate for the Illustrated Scale has been limited according to the requirements of Section 4.
- For new business and in force life insurance illustrations on policies sold on or after September 1, 2015, determine whether the earned interest rate for the Disciplined Current Scale has been limited according to the requirements of Section 5.
- For new business and in force life insurance illustrations on policies sold on or after March 1, 2016, ensure that, if the illustration includes a loan, the illustrated rate credited as compared to the illustrated loan charge has been limited according to the requirements of Section 6.
- For new business and in force life insurance illustrations on policies sold on or after March 1, 2016, ensure that the basic illustration includes a ledger using the Alternate Scale shown alongside a ledger using the illustrated scale with equal prominence according to the requirements of Section 7.A.
- For new business and in force life insurance illustrations on policies sold on or after March 1, 2016, ensure that the basic illustration includes a table showing the minimum and maximum of the geometric average annual credited rates as referenced in Section 7.B.
- For new business and in force life insurance illustrations on policies sold on or after March 1, 2016, ensure that the basic illustration includes a table showing actual historical index changes and corresponding hypothetical interest rates using current index parameters for the most recent 20-year period for each Index Account illustrated, as required by Section 7.C.

Comment [RA5]: This bulleted list is only here to demonstrate the steps during review of the changes to the Handbook. Once the Checklist in Section I. is reviewed and approved by the group, this list can be removed so the document is consistent with how other review procedures are handled – basic attention to the applicable item here with a detailed checklist in Sections H-J.

Ensure that the insurer has established requirements for producers to provide universal life applicants with a “Statement of Policy Information.” The statement should substantially follow the format set forth in the *Universal Life Insurance Model Regulation* (#585). Insurers that use direct response solicitation of universal life insurance products should provide such a statement at the time of policy delivery.

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Ensure illustrations are retained in accordance with statutes, rules and regulations. A copy of the basic illustration and a revised basic illustration (if any) signed, as applicable, or a certification that either no illustration was used or that the policy was applied for other than as illustrated, should be retained until 3 years after the policy is no longer in force.

Determine if the illustration is submitted to the regulated entity as required.

- If a basic illustration is used by an insurance producer or other authorized representative of the insurer in the sale of a life insurance policy and the policy is applied for as illustrated, a copy of the illustration must be submitted to the insurer at the time of policy application. A copy must also be provided to the applicant.
- If the policy is issued other than as applied for:

- A revised basic illustration conforming to the policy as issued should be sent with the policy;
- The revised illustration should be labeled “Revised Illustration”;
- The illustration should be signed and dated by the applicant or policyowner and producer or other authorized representative of the insurer no later than the time the policy is delivered; and
- A copy must be provided to the insurer and the policyowner.
- If no illustration is used by an insurance producer or other authorized representative, or if the policy is applied for other than as illustrated:
 - The producer or representative must certify to that effect in writing on a form provided by the insurer;
 - The applicant should acknowledge (on the same form) that no illustration conforming to the policy applied for was provided and also acknowledge an understanding that an illustration conforming to the policy as issued will be provided no later than the time of policy delivery; and
 - The form must be submitted to the insurer at the time of application.
- If the basic or revised illustration is sent by mail from the insurer:
 - It should include instructions for the applicant/policyowner to sign the duplicate copy of the numeric summary page and return the signed copy; and
 - An insurer’s obligation will be satisfied if it demonstrates a diligent effort to obtain the signature. Diligent effort includes the mailing of a self-addressed postage-prepaid envelope with instructions for the return of the signed page.

Ensure a signed copy of the basic illustration and revised basic illustration, if any, or a certification that either no illustration was used or that the policy was applied for other than as illustrated is retained until 3 years after the policy is no longer in force. (A copy does not have to be retained if the policy is not issued.)

A summary of illustration requirements is available with special requirements for:

- Basic illustrations;
- Supplemental illustrations;
- Interest-indexed universal life;
- Universal life; and
- Variable life.

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**STANDARDS
MARKETING AND SALES**

Standard 5
The insurer has suitability standards for its products, when required by applicable statutes, rules and regulations.

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Producer records

_____ Training materials

_____ Procedure manuals

Others Reviewed

NAIC Model References

Variable Life Insurance Model Regulation (#270), Section 3C
Suitability in Annuity Transactions Model Regulation (#275)
Suitability of Sales of Life Insurance and Annuities White Paper
Stranger-Originated Annuity Transactions (STOA) NAIC Sample Bulletin

Review Procedures and Criteria

Determine if multiple sales of the same product have been made to individuals. Identify and review a random sample of policyholders for which multiple policies exist.

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

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

Determine if negative enrollment practices are permitted and used.

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

For annuity products, ensure the regulated entity maintains a written statement specifying the standards of suitability used by the insurer. The standards should specify that an insurer’s issuance of an annuity shall be reasonable under all the circumstances actually known to the insurer at the time the annuity is issued.

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

Inquire if the company has detected any STOA transactions and if so, the examiner may want to determine if there were any suitability issues surrounding the sale of the STOA. If there were suitability issues, the examiner may want to inquire as to what actions were taken by the company to prevent further suitability issues and if the company took any action against the producer.

Note: Sales made in compliance with Financial Industry Regulatory Authority (FINRA) requirements pertaining to suitability and supervision of annuity transactions shall satisfy the requirements under this regulation. Examiners should be mindful of the fact that both variable annuity sales and variable life sales are typically sold using FINRA requirements.

Examiners may wish to remind insurers that sell annuities of the existence of the *Stranger-Originated Annuity Transactions NAIC Sample Bulletin* because sales of stranger-originated annuities may result in adverse suitability situations.

**STANDARDS
MARKETING AND SALES**

Standard 6
Preneed funeral contracts or prearrangement disclosures and advertisements are in compliance with statutes, rules and regulations.

Apply to: All preneed products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

Life Insurance Disclosure Model Regulation (#580), Section 7
Advertisements of Life Insurance and Annuities Model Regulation (#570), Section 5Y

Review Procedures and Criteria

Ensure there is evidence that the disclosures have been made in accordance with statutes, rules and regulations.

A summary of special requirements for preneed disclosures is available.

Advertisements for a preneed funeral contract or prearrangement that is funded or is to be funded by a life insurance policy or annuity contract should disclose the following:

- The fact that a life insurance or annuity contract is involved or being used to fund a prearrangement; and
- The nature of the relationship among the soliciting producer or producers, the provider of the funeral or cemetery merchandise or services, the administrator and any other person.

**STANDARDS
MARKETING AND SALES**

Standard 7
The regulated entity's policy forms provide required disclosure material regarding accelerated benefit provisions.

Apply to: All individual and group life insurance

Priority: Essential

Documents to be Reviewed

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

_____ Claim procedure/underwriting manuals

_____ Claim files

Others Reviewed

NAIC Model References

Accelerated Benefits Model Regulation (#620)

Review Procedures and Criteria

The terminology "accelerated benefit" shall be included in the descriptive title.

Disclosure is required that receipt of accelerated benefits may be a taxable event, and assistance should be sought from a personal tax advisor.

Disclosure providing description of accelerated benefit and definitions of the conditions or occurrences triggering payment of the benefits shall be given to the applicant.

Products marketed under this regulation shall not be described as long-term care insurance or as providing long-term care benefits.

**STANDARDS
MARKETING AND SALES**

**Standard 8
Policy and contract application forms used by depository institutions provide required disclosure material regarding insurance sales.**

Apply to: All individual and group life insurers and depository institutions

All covered persons³¹ as defined by the Gramm-Leach-Bliley Act. This includes any person who sells, solicits, advertises or offers an insurance product or annuity to a consumer at an office of the depository institution or on behalf of a depository institution.

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)
- _____ Underwriting manuals
- _____ Policy and contract application forms
- _____ Policy files

Others Reviewed

- _____
- _____

NAIC Model References

Bulletin pertaining to Voluntary Expedited Filing Procedures for Insurance Applications Developed to allow Depository Institutions to meet their Disclosure Obligations under Section 305 of the Gramm-Leach-Bliley Act

Review Procedures and Criteria

One notice provides the written disclosures that must be given to a consumer in connection with an initial purchase of an insurance or annuity product that is unrelated to an extension of credit.

The other notice provides the written disclosures that must be given to a consumer in connection with the solicitation, offer or sale of an insurance or annuity product that is related to an extension of credit.

For notices unrelated to an extension of credit: (1) the disclosure notice must inform the consumer that neither insurance nor annuities are a deposit, other obligation of, or guaranteed by the bank or any affiliate of the bank; (2) that neither insurance nor annuities are insured by the Federal Deposit Insurance Corporation (FDIC) or any agency of the United States, the bank or any affiliate; and (3) that there is the potential for investment risk, including the possible loss of value. (Note: The last requirement may not be required for all products.)

³¹ Please refer to the bulletin for a detailed explanation of what constitutes a covered person.

For notices related to an extension of credit (which includes solicited, offered or sold): (1) the bank or savings association must inform the consumer that it cannot condition the extension of credit upon the consumer also purchasing an insurance product or annuity from the bank or the bank's affiliate; (2) the bank or savings association must inform the consumer that it cannot condition the extension of credit upon the consumer not obtaining an insurance product or annuity from an entity not affiliated with the bank. In addition, (3) the disclosure notice must inform the consumer that neither insurance nor annuities are a deposit, other obligation of, or guaranteed by the bank or any affiliate of the bank; (4) that neither insurance nor annuities are insured by the Federal Deposit Insurance Corporation (FDIC) or any agency of the United States, the bank, or any affiliate; and (5) that there is the potential for investment risk, including the possible loss of value. Note: The last requirement may not be required for all products.

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**STANDARDS
MARKETING AND SALES**

Standard 9
Insurer rules pertaining to producer requirements with regard to suitability in annuity transactions are in compliance with applicable statutes, rules and regulations.

Apply to: All annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy/Other relevant files

_____ New business reports

_____ Policy/Underwriting files

Others Reviewed

NAIC Model References

Suitability in Annuity Transactions Model Regulation (#275)
Suitability of Sales of Life Insurance and Annuities White Paper

Review Procedures and Criteria

If the insurer has a business rule that calls for completion of a fact-finder or similar disclosure document, review policy files to determine if forms have been completed regarding suitability.

Review policy files. Copies of sales material other than insurer-approved materials, if permitted, must also be in the file or made available to the regulator upon request.

Examine for effectiveness the insurer's system of verifying that, prior to the execution of a purchase, exchange or replacement of an annuity resulting from a recommendation, an insurance producer, or an insurer where no producer is involved, has made reasonable efforts to obtain the consumer's suitability information.

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

- Age;
- Annual income;
- Financial situation and needs, including the financial resources used for the funding of the annuity;
- Financial experience;
- Financial objectives;
- Intended use of the annuity;
- Financial time horizon;

- Existing assets, including investment and life insurance holdings;
- Liquidity needs;
- Liquid net worth;
- Risk tolerance; and
- Tax status.

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

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

Review the insurer's system of monitoring sales made in compliance with FINRA annuity suitability and supervision requirements and applicable state annuity suitability statutes, rules and regulations. An insurer may demonstrate compliance in this area by:

- Monitoring the FINRA member broker-dealer using information collected in the normal course of an insurer's business; and
- Providing to the FINRA member broker-dealer information and reports that are reasonably appropriate to assist the FINRA member broker-dealer to maintain its supervision system.

Examine for effectiveness the insurer's system for review or oversight of annuity transactions that either may have violated the insurer's suitability procedures or where no suitability analysis was performed because:

- No recommendation was made;
- A recommendation was made and was later found to have been prepared based on inaccurate material information provided by the consumer;
- A customer refused to provide relevant suitability information and the annuity transaction was not recommended; or;
- A consumer decided to enter into an annuity transaction that was not based on a recommendation of the insurer or the insurance producer.

Review completed annuity transactions and compare the information obtained by the insurance producer to the type of product purchased to verify that when recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another transaction or series of transactions, the insurance producer, or the insurer, where no producer is involved, had reasonable grounds for believing that the product was suitable on the basis of the facts disclosed by the consumer as to his/her investments and other insurance products and as to his/her financial situation and needs, including the consumer's suitability information, and that there is a reasonable basis to believe all of the following:

- The consumer has been reasonably informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, potential charges for and features of riders, limitations on interest returns, insurance and investment components and market risk. (Note: If the applicable state has adopted the *Annuity Disclosure Model Regulation* (#245), examiners should be aware that the criteria of this examination standard are intended to supplement and not replace the disclosure requirements of the *Annuity Disclosure Model Regulation* (#245));
- The consumer would benefit from certain features of the annuity, such as tax-deferred growth, annuitization or death or living benefit;

- The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, and riders and similar product enhancements, if any, are suitable (and in the case of an exchange or replacement, the transaction as a whole is suitable) for the particular consumer based on his or her suitability information; and
- In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable including taking into consideration whether:
 - The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits (such as death, living or other contractual benefits), or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;
 - The consumer would benefit from product enhancements and improvements; and
 - The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 36 months.

Review policy/underwriting/other files to verify that an insurance producer has at the time of sale:

- Made a record of any recommendation subject to applicable state annuity suitability statutes, rules and regulations;
- Obtained a customer signed statement documenting a customer's refusal to provide suitability information, if any; and
- Obtained a customer signed statement acknowledging that an annuity transaction is not recommended if a customer decides to enter into an annuity transaction that is not based on the insurance producer's or insurer's recommendation.

**STANDARDS
MARKETING AND SALES**

Standard 10
Insurer rules pertaining to suitability in annuity transactions are in compliance with applicable statutes, rules and regulations.

Apply to: All annuity products

Priority: Essential

Documents to be Reviewed

- ___ Applicable statutes, rules and regulations
- ___ Policy/Underwriting files
- ___ Agency correspondence file/Agency bulletins
- ___ Agency procedural manual
- ___ Claim files
- ___ Complaint log
- ___ Agency sales/lapse records
- ___ Regulated entity's systems manual
- ___ Regulated entity's producer training materials

Others Reviewed

NAIC Model References

Suitability in Annuity Transactions Model Regulation (#275)
Suitability of Sales of Life Insurance and Annuities White Paper

Review Procedures and Criteria

Determine if the insurer has advised its producers of applicable state statutes, rules and regulations regarding suitability of annuity products and of the insurer's product-specific standards, policy and procedures regarding verification of suitability of annuity products.

Note: Determine if the insurer has the capacity to produce data required by the applicable state suitability statute, rule or regulation. If optional recordkeeping provisions of the *Suitability in Annuity Transactions Model Regulation (#275)* have been adopted, review policy files to determine that the insurer is retaining required records for required time frames.

Examine insurer's procedures for verifying producer supervision and compliance with requirements on suitability.

Examine for effectiveness the insurer's system of monitoring and reviewing that when recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another insurance transaction or series of insurance transactions, the insurance producer, or the insurer where no producer is involved, shall have reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to his/her investments and other insurance products and as to his/her financial situation and needs, including the consumer's suitability information, and that there is a reasonable basis to believe all of the following:

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

Monitor and determine that an insurance producer or, where no insurance producer is involved, the responsible insurer representative, has at the time of sale:

- Made a record of any recommendation subject to applicable state annuity suitability statutes, rules and regulations;
- Obtained a customer signed statement documenting a customer's refusal to provide suitability information, if any; and
- Obtained a customer signed statement acknowledging that an annuity transaction is not recommended if a customer decides to enter into an annuity transaction that is not based on the insurance producer's or insurer's recommendation.

Monitor and determine that, prior to the execution of a purchase, exchange or replacement of an annuity resulting from a recommendation, an insurance producer or an insurer where no producer is involved, has made reasonable efforts to obtain the consumer's suitability information.

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

- Age;
- Annual income;
- Financial situation and needs, including the financial resources used for the funding of the annuity;
- Financial experience;
- Financial objectives;
- Intended use of the annuity;
- Financial time horizon;

- Existing assets, including investment and life insurance holdings;
- Liquidity needs;
- Liquid net worth;
- Risk tolerance; and
- Tax status.

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

Examine for effectiveness the insurer's system of recording or monitoring whether an insurance producer or an insurer, proceeded with an annuity transaction that either may have violated the insurer's suitability procedures or where no suitability analysis was performed because:

- No recommendation was made;
- A recommendation was made and was later found to have been prepared based on inaccurate material information provided by the consumer;
- A consumer refused to provide relevant suitability information and the annuity transaction was not recommended;
- A consumer decided to enter into an annuity transaction that was not based on a recommendation of the insurer or the insurance producer.

Verify that the insurer has established a supervision system that is reasonably designed to achieve the insurer's and its insurance producers' compliance with applicable state suitability statutes, rules and regulations, including, but not limited to the following criteria:

- Examine the regulated entity's suitability policies and procedures to verify that the insurer maintains reasonable procedures to inform its insurance producers of the requirements of applicable state suitability statutes, rules and regulations. Verify that the requirements of applicable state suitability statutes, rules and regulations are incorporated into relevant insurance producer training manuals;
- Review the regulated entity's producer training materials to verify that the insurer establishes standards for insurance producer product training and maintains reasonable procedures to require its insurance producers to comply with the requirements of Section 7 of the *Suitability in Annuity Transactions Model Regulation* (#275). For more information on the requirements of Section 7 of Model #275, see Marketing and Sales Standard 11 in this chapter;
- Examine the regulated entity's producer training materials to ensure that the insurer provides adequate product-specific training and training materials which fully explain all material features of its annuity products to its insurance producers;
- Review the regulated entity's suitability policies and procedures to ensure that the insurer maintains adequate procedures for review of each recommendation, prior to issuance of an annuity, that are designed to ensure that there is a reasonable basis to determine that a recommendation is suitable. An insurer's review procedures may apply a screening system for the purpose of identifying selected transactions for additional review and the insurer's review process may be accomplished electronically or through other means including, but not limited to, physical review. Such an electronic or other system may be designed to require additional review only of those transactions identified for additional review by the selection criteria;

- Verify that the insurer maintains reasonable procedures to detect recommendations that are not suitable. Insurer procedures may include, but are not limited to, confirmation of consumer suitability information, systematic customer surveys, interviews, confirmation letters and programs of internal monitoring. If there is no provision in applicable state suitability statutes, rules or regulations to the contrary, an insurer may demonstrate compliance in this area by applying sampling procedures, or by confirming suitability information after issuance or delivery of the annuity; and
- Verify that the insurer annually provides a report to senior management, including to the senior manager responsible for audit functions, which details a review, with appropriate testing, reasonably designed to determine the effectiveness of the supervision system, the exceptions found, and corrective action taken or recommended, if any.

An insurer may contract for performance of one or more functions (including maintenance of procedures) under the criteria set forth in Section 6F(1) of the *Suitability in Annuity Transactions Model Regulation* (#275). An insurer is responsible for taking appropriate corrective action and may be subject to sanctions and penalties pursuant to Section 8 of Model #275 regardless of whether the insurer contracts for performance of a function and regardless of the insurer's compliance with subparagraph (b) of Section 6F(2) of Model #275.

An insurer's supervision system as described above should include supervision of contractual performance by third parties. This includes, but is not limited to, the following criteria:

- Verify that the insurer is monitoring and, as appropriate, conducting audits to assure that contracted function(s) are properly performed; and
- Review insurer procedures to verify that the insurer is annually obtaining a certification from a senior manager who has responsibility for the contracted function(s) that the manager has a reasonable basis to represent, and does represent, that the function is properly performed.

Review agency files and related documentation to verify that insurance producers do not dissuade, or attempt to dissuade, a consumer from:

- Truthfully responding to an insurer's request for confirmation of suitability information;
- Filing a complaint; or
- Cooperating with the investigation of a complaint.

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

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

Review the insurer's system of monitoring sales made in compliance with FINRA annuity suitability and supervision requirements and applicable state annuity suitability statutes, rules and regulations. An insurer may demonstrate compliance in this area by:

- Monitoring the FINRA member broker-dealer using information collected in the normal course of an insurer's business; and
- Providing to the FINRA member broker-dealer information and reports that are reasonably appropriate to assist the FINRA member broker-dealer to maintain its supervision system.

Review insurer records of corrective action taken in mitigation of apparent violations of suitability standards for sales directly by the insurer and by any insurance producers who are acting as agents for the entity.

Determine whether the insurer has elected to maintain records of the information collected from the consumer and other information used in making the recommendations that were the basis for insurance transactions, or if the insurer has elected to require its producers to maintain these records. Verify that such a system is in place and is monitored by the insurer.

Note: Review the insurer's denials for suitability reasons. Review underwriting data to determine if an annuity was subsequently issued to the client. If an annuity was subsequently issued, the examiner may want select a sampling to ensure the sale was appropriate.

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**STANDARDS
MARKETING AND SALES**

Standard 11
The insurer has procedures in place to educate and monitor compliance with insurer-specific education and training requirements and with applicable statutes, rules and regulations regarding the solicitation, recommendation and sale of annuity products.

Apply to: All annuity products

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity producer education/training files
- _____ Producer continuing education files
- _____ Producer new business/replacement log
- _____ Regulated entity producer training materials
- _____ Regulated entity standards for product training
- _____ Regulated entity policies and procedures
- _____ Complaint logs, complaint files and producer complaint logs/producer investigation files, if applicable

Others Reviewed

- _____
- _____

NAIC Model References

- Suitability in Annuity Transactions Model Regulation (#275)*
- Unfair Trade Practices Act (#880)*
- Producer Licensing Model Act (#218)*

Review Procedures and Criteria

Review regulated entity policies and procedures to ensure that the regulated entity has adequate procedures in place to provide training, including product-specific training that is appropriate to the specific product being sold. Review the regulated entity's procedures to inform producers of the regulated entity's standards for annuity product training and of applicable state statutes, rules or regulations regarding the solicitation, recommendation and sale of the annuity product.

Monitor and determine if the insurer has taken any actions against producers who lack adequate product knowledge and if so, was the action appropriate for the circumstances.

Compare data in producer continuing education files to applicable data in state insurance department producer continuing education records to monitor and determine that any insurance producer who engages in the sale of annuity products has met the one-time 4 hour credit training course in accordance with applicable state statutes, rules and regulations.

Determine that the regulated entity has adequate procedures in place to verify that a producer has completed necessary training, as required by applicable state statutes, rules and regulations, before allowing the producer to sell an annuity product for that insurer.

Review content of producer training materials for compliance with applicable state statutes, rules and regulations regarding solicitation, recommendation and sales of annuity products. Determine if the insurer product-specific training materials are appropriate and accurately reflect the features of the specific annuity.

Review complaint logs, any applicable complaint files and any producer investigation files for allegations of unsuitable, improper or misleading sales.

Automation Tip:

Examiners should request underwriting, policy and claim data using the NAIC standardized data requests for a period of three to five years. The expanded time frame allows the examiner to trend sales practices for a number of years.

Examiners should then use a program such as ACL to review underwriting data, product data and claims data for possible unsuitable sales.

Examiners can review and trend this data for:

- Sales from producers who were the subject of complaints and/or investigations that alleged unsuitable sales, misrepresentations, or improper sales activities;
- Sales of producers who had a materially large number of replacements or exchanges;
- Sales of producers who sell a materially large number of annuities that pay the highest commissions and have the longest surrender period or have the highest surrender amounts;
- Sales of producers who have had previous sales denied based on suitability reasons;
- sales of producers who had disciplinary actions – Financial Industry Regulatory Authority (FINRA) and state disciplinary actions;
- Sales from producers who have sold a materially large number of deferred annuities to consumers over age 75;
- Withdrawals from products where the consumer incurred a penalty (a contractual penalty or IRS tax penalty) for taking the withdrawal within two years of purchase of the annuity; and
- Sales from producers who have sold multiple annuities to the same consumer.

Examiners should realize that trending data is not a definitive means to identify unsuitable sales. Further review of the individual transaction will be necessary to determine suitability.

Examiners should cross-reference new business data and data in the replacement logs with the regulated entity's producer education/training files to ensure that prior to a sale of an annuity product the insurance producer has been trained in the regulated entity's standards for the specific annuity product and trained in the applicable state statutes, rules and regulations regarding the solicitation, recommendation and sale of annuity products.

**STANDARDS
MARKETING AND SALES**

Standard 12

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

Apply to: All annuity products

Priority: Essential

Documents to be Reviewed

- ___ Applicable statutes, rules and regulations
- ___ Agency correspondence file/Agency bulletins
- ___ Agency procedural manual
- ___ Agency sales/lapse records
- ___ Systems manuals
- ___ Producer training materials
- ___ Contracts with third-party vendors with compliance responsibilities

Others Reviewed

- ___ _____
- ___ _____

NAIC Model References

- Suitability in Annuity Transactions Model Regulation (#275)*
- Unfair Trade Practices Act (#880)*
- Producer Licensing Model Act (#218)*
- Suitability of Sales of Life Insurance and Annuities White Paper*

Review Procedures and Criteria

Contact other regulators that may have conducted a recent review of the insurer's training standards.

Review regulated entity's records to confirm that it verifies producers complete a one-time 4 credit hour general annuity training course prior to soliciting the sale of an annuity product.

Determine if the insurer product-specific training materials are appropriate and accurately reflect the specific annuity being recommended. Review regulated entity's records to determine if, when and how product-specific training occurred prior to a producer recommending an annuity.

Note: Testing is not a requirement of the *Suitability in Annuity Transactions Model Regulation (#275)*. Assessing compliance with this standard may require the examiner to access compliance with many facets of Model #275. The insurance producer training requirement of the model regulation requires that producers not solicit the sale of an annuity product unless the producer has adequate product knowledge to recommend the annuity. It is the insurer's responsibility to establish standards for product specific training for its producers. Insurers must also establish reasonable procedures to require its producers to have adequate product knowledge prior to the producer recommending an annuity.

If the examiners believe an unsuitable sale may have occurred, the examiner may need to determine the cause of the unsuitable sale.

Examiners will need to assess the product-specific training materials and determine if the materials were appropriate for the specific product. According to *Suitability in Annuity Transactions Model Regulation (#275)*, insurance producers may rely on insurer-provided product-specific training materials and standards to comply with Section 7 of Model #275.

Examiners will also need to assess the procedures the insurer established to require its producers have an adequate product knowledge before the producer recommends the annuity. Specifically the examiners will need to determine if the training for the specific product took place before the recommendation of an annuity, how the producer was trained and if the training was reasonably designed to require the producer to have adequate product knowledge prior to the sale.

Based upon the complexity of the product being offered, there is an expectation that the content of training materials and the way the training occurs may differ.

**STANDARDS
MARKETING AND SALES**

Standard 13

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

Apply to: All fixed-index annuity products

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Policy/Underwriting file
- _____ Agency correspondence file/Agency bulletins
- _____ Agency procedural manual
- _____ Claim files
- _____ Complaint log
- _____ Agency sales/lapse records
- _____ Systems manuals
- _____ Producer training materials
- _____ Contracts with third-party vendors with compliance responsibilities

Others Reviewed

NAIC Model References

- Unfair Trade Practices Act (#880)*
- Advertisements of Life Insurance and Annuities Model Regulation (#570), Section 3B*
- Annuity Disclosure Model Regulation (#245), Section 6 plus appendix*
- Suitability in Annuity Transactions Model Regulation (#275)*
- Suitability of Sales of Life Insurance and Annuities White Paper*

Review Procedures and Criteria

Review policy files to determine that required records are retained for required time frames.

Examine procedures for verifying producer compliance with established policies and procedures.

Review complaint log for complaints alleging improper or misleading sales practices.

Review claim files for proper crediting and computation of surrender charges at death.

Review commission structure and note any differences between indexed and non-indexed annuity products. If it appears that the difference may be significant enough to provide incentive to a producer to recommend one product over another regardless of suitability, perform further analysis to test that hypothesis.

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**STANDARDS
MARKETING AND SALES**

Standard 14
The insurer has procedures in place to provide full disclosure to consumers regarding all sales of products involving index life, and all sales are in compliance with applicable statutes, rules and regulations.

Apply to: All index life products

Priority: Essential

Documents to be Reviewed

- ___ Applicable statutes, rules and regulations
- ___ Policy/Underwriting file
- ___ Agency correspondence file/Agency bulletins
- ___ Agency procedural manual
- ___ Claim files
- ___ Complaint log
- ___ Agency sales/lapse records
- ___ Regulated entity's systems manual
- ___ Regulated entity's producer training materials
- ___ Contracts with third-party vendors with compliance responsibilities

Others Reviewed

- ___
- ___

NAIC Model References

Advertisements of Life Insurance and Annuities Model Regulation (#570), Section 3B

Life Insurance Disclosure Model Regulation (#580), Section 8C

Unfair Trade Practices Act (#880)

Life Insurance Illustrations Model Regulation (#582)

Actuarial Guideline 49 – The Application of the Life Illustrations Model Regulation to Policies with Index Based Interest

Review Procedures and Criteria

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

Examine the regulated entity's procedures for verifying producer compliance with the regulated entity's policy and procedures

Comment [RA6]: There are not necessarily new disclosure requirements in AG49 beyond what exists within Model #582. This reference could be removed because the additional requirements of AG49 are all covered in Standard #4 and the applicable checklist in Section I.

Review complaint log for complaints alleging improper or misleading sales practices.
Review claim files for proper interest crediting and computation of death claims.

Review commission structure and note any differences between indexed and non-indexed life insurance products.
If it appears that differences noted may be significant enough to provide incentive to a producer to recommend one product over another regardless of suitability, perform further analysis to test that hypothesis.

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STANDARDS

MARKETING AND SALES

Standard 15
The insurer's underwriting requirements and guidelines pertaining to travel are in compliance with applicable statutes, rules and regulations.

Apply to: All life products

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Life insurance applications and related disclosure and consent forms
- _____ Related questionnaires for applicants
- _____ Underwriting guidelines and field underwriting guidelines for producers
- _____ Review contracts with reinsurers of life insurance and all applicable guidelines from the reinsurer
- _____ Regulated entity's guidelines regarding lawful travel

Others Reviewed

- _____
- _____

NAIC Model References

Unfair Trade Practices Act (#880)

Review Procedures and Criteria

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

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

- The risk of loss for individuals who travel to a specified destination at a specific time is reasonably anticipated to be greater than if the individuals did not travel to that destination at the time; and
- The risk classification is based on sound actuarial principles and actual or reasonably anticipated experience.

Examples of the exceptions outlined above are future lawful travel plans to areas where the Centers for Disease Control and Prevention (CDC) have issued a highest level alert, including a recommendation for non-essential travel or to areas where there is an ongoing armed conflict involving the military of a sovereign nation foreign to the country of conflict.

Review the life insurers' and reinsurers' underwriting guidelines for guidelines pertaining to past and future travel.

Review applications and any related questionnaires for questions related to past and future travel plans.

Review contracts with applicable reinsurers for content regarding past and future lawful travel plans.

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D. Producer Licensing

Use the standards for this business area that are listed in Chapter 16—General Examination Standards.

E. Policyholder Service

Use the standards for this business area that are listed in Chapter 16—General Examination Standards and the standards set forth below.

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**STANDARDS
POLICYHOLDER SERVICE**

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

Apply to: All life products

Priority: Essential

Documents to be Reviewed

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

_____ Notice of reinstatement

Others Reviewed

NAIC Model References

Review Procedures and Criteria

Determine that notices were sent out in a timely manner.

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

Reinstatements should be applied per policy provisions.

**STANDARDS
POLICYHOLDER SERVICE**

Standard 2
Nonforfeiture options are communicated to the policyholder and contractholder and correctly applied in accordance with the policy contract.

Apply to: All life products

Priority: Essential

Documents to be Reviewed

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

_____ Underwriting file

_____ Policy and contract history file

_____ Regulated entity's procedures manual

Others Reviewed

NAIC Model References

Standard Nonforfeiture Law for Life Insurance (#808)

NAIC Procedure for Permitting Same Minimum Nonforfeiture Standards for Men and Women Insured Under 1980 CSO and 1980 CET Mortality Tables (#811)

Life Insurance Disclosure Model Regulation (#580)

Variable Life Insurance Model Regulation (#270)

Model Policy Loan Interest Rate Bill (#590)

Standard Nonforfeiture Law for Individual Deferred Annuities (#805)

Annuity Nonforfeiture Model Regulation (#806)

Review Procedures and Criteria

Determine if the correct policy option is provided in case of policy lapse.

Review correspondence with policyholders to determine if options were explained adequately.

If there are questions related to the nonforfeiture values, refer to statutes, rules and regulations regarding the calculation of nonforfeiture values for details on calculating the values.

Review the regulated entity's procedures and policies regarding the handling of each type of nonforfeiture transaction (including whether the request may be made verbally).

Cash Surrender Values

- Review the issue date of the policy to determine whether the policy is mature enough to provide surrender values (usually by the end of the second or third year);
- Calculate the service time to process the surrender by subtracting the date the request was received from the date the surrender check was mailed (should be within 60 days);
- Review the calculation of the net cash value to determine the appropriate surrender value (include any outstanding policy loans, policy loan interest and policy dividends);
- Compare calculated surrender value with illustration surrender value. Confirm that any variance can be explained and is in accordance with policy provisions (i.e., interest rates, surrender charges, policy fees);
- Confirm with the regulated entity that there is an audit procedure in place to verify the calculation of surrender values (they are usually calculated systematically);
- Review cash surrender check for accuracy, including mail date; and
- Review returned mail procedures.

Extended Term Insurance (ETI)

- Determine if the ETI was automatic at lapse or policyowner-requested;
- Review the policy's contract language for content;
- Confirm the regulated entity's calculated policy value by taking the face value of the policy adjusted for any indebtedness, such as policy loans or paid-up additions;
- Check to make sure the regulated entity issued the correct amount of term insurance; and
- Confirm with the regulated entity that there is an audit procedure in place to verify the values and calculations made.

Reduced Paid-Up (RPU)

- Determine how the RPU option came about, whether automatic at lapse or policyowner-requested;
- Review the policy's contract language for content;
- Review the calculation of net cash value (including years the policy was in force) to verify the amount used as the net single premium to purchase the paid-up life insurance. Verify that the paid-up insurance is of the same type of policy as the original policy; and
- Confirm with the regulated entity that there is an audit procedure in place to verify the values and calculations made.

Additional Paid-Up

- Review the policy for content and time schedule for allowed increases in coverage;
- Review the policyowner's request to elect the additional paid-up option benefit; and
- Check that evidence of insurability was required before the rider was added to the in force policy.

Automatic Premium Loan (APL)

- Review the policy's contract language for content;
- Review the application to see if the insured elected another option. If not, verify that the grace period expired prior to the initiation of the APL;
- Check the net cash value calculation to make sure that the proper amount was used to deduct the overdue premium; and
- Confirm with the regulated entity that there is an audit procedure in place to verify the values and calculations made.

Note: The examiner should be alert to occurrences of producers automatically selecting the APL option on the insurance application.

Ensure the regulated entity notifies policyowners of material changes to any non-guaranteed factors in accordance with statutes, rules and regulations.

For variable life products with flexible premiums, ensure that a report is sent to the policyholder if the amounts available under the policy on any policy processing day to pay the charges authorized by the policy are less than the amount necessary to keep the policy in force until the next following processing day. The report should include the minimum payment required under the terms of the policy to keep it in force and the length of the grace period for payment of the amount.

Ensure that at the time of processing policy loans, the insurer notifies policyholders of the initial rate of interest, maximum interest rates and the frequency at which rates may be adjusted. Such notice is to be provided within a reasonable time after processing premium loans.

Ensure the insurer sends advance notice to policyholders with loans, advising of any increases in loan rates.

For annuity contracts that provide cash surrender benefits, review the benefit provided to ensure it meets the requirements of statutes, rules and regulations. In no event shall any cash value benefit be less than the minimum nonforfeiture amount. The death benefit shall be at least equal to the cash surrender benefit.

For annuity contracts that do not provide cash surrender benefits, review the benefit provided to ensure it meets the requirements of statutes, rules and regulations. In no event shall the present value of a paid-up annuity be less than the minimum nonforfeiture amount.

**STANDARDS
POLICYHOLDER SERVICE**

Standard 3

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

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

Life Insurance Illustrations Model Regulation (#582), Section 10
Life Insurance Disclosure Model Regulation (#580), Section 5C(1)
Variable Annuity Model Regulation (#250), Section 8
Variable Life Insurance Model Regulation (#270), Section 9
Modified Guaranteed Annuity Model Regulation (#255) Section 11
Universal Life Insurance Model Regulation (#585), Section 9

Review Procedures and Criteria

Note: Traditional life (not universal or variable life) products that are not illustrated or that were issued prior to a jurisdiction's adoption of the equivalent of the *Life Insurance Illustrations Model Regulation* (#582) may not be required to provide annual reports.

If required, ensure annual reports are being provided annually.

For universal life, ensure the report includes:

- The beginning and end date of the current report period;
- The policy value at the end of the previous report period and at the end of the current report period;
- The total amounts that have been credited or debited to the policy value during the current report period, identifying each by type (e.g., interest, mortality, expense and riders);
- The current death benefit at the end of the current report period on each life covered by the policy;
- The net cash surrender value of the policy as of the end of the current report period; and
- The amount of outstanding loans, if any, as of the end of the current report period.

For fixed premium universal life policies, ensure the report includes:

- If, assuming guaranteed interest, mortality and expense loads and continued scheduled premium payments, the policy's net cash surrender value is such that it would not maintain insurance in force until the end of the next reporting period, a notice to this effect should be included in the report.

For flexible premium universal life policies, ensure the report includes:

- If, assuming guaranteed interest, mortality and expense loads, the policy's net cash surrender value will not maintain insurance in force until the end of the next reporting period, unless further premium payments are made, a notice to this effect should be included in the report.

For traditional life policies, where applicable, ensure the report includes:

- Current death benefit;
- Annual contract premium;
- Current cash surrender value;
- Current dividend;
- Application of current dividend; and
- Amount of outstanding loan.

Ensure that if there are policies that do not build nonforfeiture values, an annual report is provided for those years when a change has been made to non-guaranteed policy elements by the insurer.

Determine if the annual report includes an in force illustration. If it does not, it should contain the following notice displayed prominently: "**IMPORTANT POLICYOWNER NOTICE:** You should consider requesting more detailed information about your policy to understand how it may perform in the future. You should not consider replacement of your policy or make changes in your coverage without requesting a current illustration. You may annually request, without charge, such an illustration by calling (insurer's telephone number), writing to (insurer's name) at (insurer's address) or contacting your producer. If you do not receive a current illustration of your policy within 30 days from your request, you should contact your state insurance department." The insurer may vary the sequential order of the methods for obtaining an in force illustration.

If an adverse change in non-guaranteed elements that could affect the policy has been made by the insurer since the last annual report, the annual report should contain a notice of that fact and the nature of the change prominently displayed.

For variable annuity products, ensure there is a statement or statements reporting the investments held in a separate account. The statement report period should be not more than 4 months prior to the date of mailing. The statement should also include the number of accumulation units and the dollar value of an individual unit or the value of the contractholder's account.

For variable life products, ensure the annual report includes the following:

- The cash surrender value;
- Death benefit;
- Any partial withdrawal or policy loan;
- Any interest charge; and
- Any optional payments.
- The following disclosures:
 - In accordance with the investment experience of the separate account, the cash values and the variable death benefit may increase or decrease;
 - Prominent identification of any value which may be recomputed prior to the next annual report;
 - A statement if the policy guarantees the variable death benefit on the next policy anniversary date will not be less than the variable death benefit specified in the report;
 - For flexible premium policies, a reconciliation of the change since the previous report in cash value and cash surrender value, if different, because of payments made (less deductions for expense charges), withdrawals, investment experience, insurance charges and any other charges made to the cash value;

- The projected cash value and cash surrender value, if different, as of one year from the end of the period covered by the report, assuming that planned periodic premiums, if any, are paid as scheduled;
- Guaranteed costs of insurance are deducted;
- The net return is equal to the guaranteed rate or, in the absence of a guaranteed rate, is not greater than zero;
- If the projected value is less than zero, a warning message should be included that the policy may be in danger of terminating without value in the next 12 months, unless additional premium is paid;
- A summary of the financial statement of the separate account based on the last annual statement filed with the insurance department;
- The net investment return of the separate account for the last year, and, for each year after the first, a comparison of the investment rate of the separate account during the last year with the investment rate during prior years, up to a total of not less than 5 years, when available;
- A list of investments held by the separate account as of a date not earlier than the end of the last year for which an annual statement was filed with the insurance department;
- Any charges levied against the separate account during the previous year; and
- A statement of any change since the last report in the investment objective and orientation of the separate account, in any investment restriction or material quantitative or qualitative investment requirement applicable to the separate account or to the investment advisor of the separate account.

Annual reports for modified guaranteed life insurance policies shall state that the cash value may increase or decrease and shall prominently identify any value that may be recomputed prior to the next statement.

Determine if, upon the request of the policyowner, the insurer furnishes an in force illustration of current and future benefits and values based on the insurer's present illustrated scale. No signature or other acknowledgment of receipt of this illustration is required.

Also, determine, if a policyowner requests one, the insurer provides policy data for the policy. Unless otherwise requested, the data should be provided for 20 consecutive years beginning with the previous policy anniversary and include cash dividends according to the current dividend scale, the amount of outstanding policy loans and the current policy loan interest rate. Values shown should be based on the dividend option in effect at the time of the request. A reasonable fee may be charged for the preparation of the statement.

**STANDARDS
POLICYHOLDER SERVICE**

Standard 4

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

Apply to: All individual and group life products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files

_____ Policy files

Others Reviewed

NAIC Model References

Accelerated Benefits Model Regulation (#620), Sections 4, 6D and 8

Review Procedures and Criteria

Review the above documents to determine that proper disclosure has been made.

Verify that prior to payment of accelerated benefits the insurer has obtained from any assignee or irrevocable beneficiary a signed acknowledgment of concurrence for accelerated benefit payout.

The regulated entity may offer waiver of premium in absence of such provision in an existing policy. At the time accelerated benefits are claimed, the insurer must explain any continuing premium requirements to maintain the policy in force.

Unfair discrimination is prohibited.

F. Underwriting and Rating

Use the standards for this business area that are listed in Chapter 16—General Examination Standards and the standards set forth below.

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**STANDARDS
UNDERWRITING AND RATING**

Standard 1
Pertinent information on applications that form a part of the policy and contract is complete and accurate.

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

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

_____ All applications

Others Reviewed

NAIC Model References

Review Procedures and Criteria

Determine if the requested coverage is issued.

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

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

Determine how automatic premium loan options are disclosed on the application.

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

Verify that supplemental applications are used, where appropriate.

**STANDARDS
UNDERWRITING AND RATING**

Standard 2
The regulated entity complies with the specific requirements for Acquired Immune Deficiency Syndrome (AIDS)-related concerns in accordance with statutes, rules and regulations.

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Life insurance applications and related disclosure and consent forms
- _____ Health questionnaires for applicants
- _____ Medical underwriting guidelines
- _____ Regulated entity's guidelines regarding the handling of AIDS-related test results, if such tests are allowed

Others Reviewed

NAIC Model References

Review Procedures and Criteria

Ensure the regulated entity does not use medical records indicating AIDS-related concerns to discriminate against applicants without medical evidence of disease. Companies shall establish reasonable procedures related to the administration of an AIDS-related test.

- Medical underwriting guidelines may consider factual matters that reveal the existence of a medical condition. For example, no adverse underwriting decision shall be based on medical records that only indicate the applicant demonstrated AIDS-related concerns by seeking counseling from a health care professional;
- Disclosure forms signed by the applicant must clearly disclose the requirement, if any, for applicants to take an AIDS-related test and should be a part of the underwriting file; and
- Applications must contain a consent form for such testing.

Review any application forms and health questionnaires used by the regulated entity or its producers for questions that would require the applicant to provide information regarding sexual orientation.

- Questions may ask if the applicant has been diagnosed with AIDS or AIDS-Related Complex (ARC), if they are designed to establish the existence of the condition, but are not used as a proxy to establish sexual orientation of the applicant.

Ensure the regulated entity or insurance support organization does not use the sexual orientation of an applicant in the underwriting process or in the determination of insurability.

Underwriting guidelines must not consider an applicant's sexual orientation to be a factor in the determination of insurability.

A sample of underwriting files for denied applications should be reviewed to verify that denials were non-discriminatory.

Review inspection reports to determine if they are being used in a discriminatory manner, or ordered on the basis of the regulated entity's guidelines (e.g., based on the amount of insurance).

Neither the marital status, living arrangements, occupation, gender, medical history, beneficiary designation, nor the ZIP code or other territorial classification may be used to establish the applicant's sexual orientation.

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G. Claims

Use the standards for this business area that are listed in Chapter 16—General Examination Standards and the standards set forth below.

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**STANDARDS
CLAIMS**

Standard 1
The regulated entity provides the required disclosure material to policyholders at the time an accelerated benefit payment is requested.

Apply to: All life insurance products that contain a benefit provision or benefit rider for the payment of accelerated benefits

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Claim procedure manuals

_____ Claim files

_____ Claim complaint records

Others Reviewed

NAIC Model References

Accelerated Benefits Model Regulation (#620)

Review Procedures and Criteria

Review the regulated entity's procedures, training manuals and claim bulletins to determine if claim procedures meet the requirements for disclosure at the time benefits are requested. Required disclosures include:

- Disclosure of possible tax consequences and advice that the claimant seek assistance from a tax advisor;
- A written statement to the policyowner and to the irrevocable beneficiary explaining any effect the payment will have on the policy's cash value, accumulation account, death benefit, premium, policy loans and policy liens;
- A statement warning that receipt of accelerated benefits may adversely affect claimant eligibility for government benefits or entitlements;
- Administrative expense charges, if any, applicable to the payment of accelerated benefits;
- Any continuing premium requirement to keep the policy in force;
- Lump sum settlement options are required; and
- Any accidental death benefits remain intact.

Review claim files for documentation that required disclosure notices were issued in a timely manner.

Review claim-related complaint files for complaints from policyowners not receiving required disclosure material.

Accelerated benefits are available on the effective date of the policy or rider for accidents and no more than 30 days following the effective date for illness.

No restrictions are permitted on use of accelerated benefit proceeds.

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**STANDARDS
CLAIMS**

Standard 2
The regulated entity does not discriminate among insureds with differing qualifying events covered under the policy or among insureds with similar qualifying events covered under the policy.

Apply to: All life insurance products that contain a benefit provision or benefit rider for the payment of accelerated benefits

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity's claim procedures manual and claim bulletins
- _____ Claims training manual
- _____ Claim files

Others Reviewed

NAIC Model References

Accelerated Benefits Model Regulation (#620)

Review Procedures and Criteria

Review procedure manuals, training manuals and the regulated entity's internal claim bulletins to determine if regulated entity standards exist for consistent evaluation of criteria for approval of accelerated benefits payments.

Review claim files to verify that the regulated entity does not apply further conditions on the payment of accelerated benefits beyond those conditions specified in the policy or benefit rider.

**STANDARDS
CLAIMS**

Standard 3
The regulated entity provides the beneficiary, at the time a claim is made, written information describing the settlement options available under the policy and how to obtain specific details relevant to the settlement options.

Apply to: All life insurance companies

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Claim procedure manuals/claim training manuals/claim bulletins
- _____ Claim files
- _____ Claim complaint records
- _____ Disclosures provided to beneficiaries

Others Reviewed

- _____
- _____

NAIC Model References

Retained Asset Accounts Sample Bulletin (#573)

Review Procedures and Criteria

Review the regulated entity's procedures, training manuals and claim bulletins to determine if claim procedures meet the requirements for disclosure at the time benefits are requested. Required disclosures include:

- Written information provided to the beneficiary describing available settlement options under the policy; and
- Written information provided to the beneficiary informing the beneficiary how to obtain specific details regarding available settlement options;

A "retained asset account" as defined in the *Retained Asset Accounts Sample Bulletin (#573)* means any mechanism whereby the settlement of proceeds payable under a life insurance policy is accomplished by the insurer or an entity acting on behalf of the insurer depositing the proceeds into an account with check or draft writing privileges, where those proceeds are retained by the insurer, pursuant to a supplementary contract not involving annuity benefits.

If the regulated entity settles benefits through a retained asset account, examiners should review and verify in accordance with the applicable state's record retention requirements that the regulated entity has established and implemented procedures to ensure that the regulated entity has:

- a) Provided the following written disclosures to the beneficiary before the account is selected, if optional, or established, if not:
 - Payment of the full benefit amount is accomplished by delivery of the "draft book"/"check book";
 - One draft or check may be written to access the entire amount, including interest, of the retained asset account at any time;
 - Whether other available settlement options are preserved until the entire balance is withdrawn or the balance drops below the regulated entity's minimum balance requirements;
 - A statement identifying the account as either a checking or draft account and an explanation of how the account works;
 - Information about the account services provided and contact information where the beneficiary may request and obtain more details about such services;
 - A description of fees charged, if applicable;
 - The frequency of statements showing the current account balance, the interest credited, drafts/checks written and any other account activity;
 - The minimum interest rate to be credited to the account and how the actual interest rate will be determined;
 - The interest earned on the account may be taxable;
 - Retained asset account funds held by regulated entities are not guaranteed by the Federal Deposit Insurance Corporation (FDIC) but are guaranteed by the state guaranty associations (where permitted by state law). The beneficiary should be advised to contact the National Organization of Life and Health Insurance Guaranty Associations (www.nollga.com) to learn more about the coverage limitations to his or her account;
 - A description of the regulated entity's policy regarding retained asset accounts that may become inactive; and
- b) Provided the beneficiary with a supplemental contract that clearly discloses the rights of the beneficiary and obligations of the regulated entity under the contract.

Review claim files for documentation that required disclosure notices were issued in a timely manner.

Review claim-related complaint files for complaints from beneficiaries not receiving required disclosure material.

H. Supplemental Checklist for Marketing and Sales Standard #1

Yes	No	Requirement
For companies that use enrollment periods:		
		Advertisements should specify the date by which the applicant must mail the application, which should be not less than 10 days and not more than 40 days from the date the enrollment period is advertised for the first time.
For direct response policies:		
		The advertisement should not state or imply there is a cost savings because there is no insurance producer or commission, unless true.
		The advertisement should not use the terms “inexpensive,” “low cost” or other similar language when the policies are being marketed to persons who are 50 years of age or older when the policy is guaranteed-issue.
For graded or modified benefit policies:		
		The advertisement must prominently display any limitation of benefits.
		If the premium is level and coverage decreases or increases with age or duration, that fact must be prominently disclosed.
		If the death benefit varies with the length of time the policy has been in force, the advertisement should accurately describe and clearly call attention to the amount of minimum death benefit under the policy.
		The advertisement should not use the terms “inexpensive,” “low cost” or other similar language when the policies are being marketed to persons who are 50 years of age or older, when the policy is guaranteed-issue.
For policies with premium changes:		
		The advertisement for a policy with non-level premiums should prominently describe the premium changes.
		An advertisement in which the insurer describes a policy where it reserves the right to change the amount of the premium during the policy term, but which does not prominently describe this feature, is deemed to be deceptive and misleading and is prohibited.
For policies with non-guaranteed policy elements:		
		An advertisement should not utilize or describe non-guaranteed policy elements in a manner that is misleading or has the capacity or tendency to mislead.
		An advertisement should not state or imply that the payment or amount of non-guaranteed policy elements is guaranteed. If non-guaranteed policy elements are illustrated, they must be based on the insurer’s current scale, and the illustration must contain a statement to the effect that they are not to be construed as guarantees or estimates of amounts to be paid in the future.

H. Supplemental Checklist for Marketing and Sales Standard #1 (cont'd)

		An advertisement that includes any illustrations or statements containing or based upon non-guaranteed elements should set forth with equal prominence comparable illustrations or statements containing or based upon the guaranteed elements.
		If an advertisement refers to any non-guaranteed policy element, it should indicate that the insurer reserves the right to change any such element at any time and for any reason. However, if an insurer has agreed to limit this right in any way—such as, for example, if it has agreed to change these elements only at certain intervals or only if there is a change in the insurer’s current or anticipated experience—the advertisement may indicate any such limitation on the insurer’s right.
		An advertisement should not refer to dividends as “tax free” or use words of similar import, unless the tax treatment of dividends is fully explained, and the nature of the dividend as a return of premium is indicated clearly.
For policies sold to students:		
		The envelope in which insurance solicitation material is contained may be addressed to the parent(s) of students. The address may not include any combination of words which imply that the correspondence is from a school, college, university or other education or training institution, nor may it imply that the institution has endorsed the material or supplied the insurer with information about the student, unless such is a correct and truthful statement.
		All advertisements including, but not limited to, informational flyers used in the solicitation of insurance must be identified clearly as coming from an insurer or insurance producer, if such is the case, and these entities must be clearly identified as such.
		The return address on the envelope may not imply that the soliciting insurer or insurance producer is affiliated with a university, college, school or other educational or training institution, unless true.
For individual deferred annuity products or deposit funds:		
		Any illustrations or statements containing or based upon interest rates higher than the guaranteed accumulation interest rates should set forth with equal prominence comparable illustrations or statements containing or based upon the guaranteed accumulation interest rates. The higher interest rates should not be greater than those currently being credited by the company, unless the higher rates have been publicly declared by the company with an effective date for new issues not more than 3 months subsequent to the date of declaration.

H. Supplemental Checklist for Marketing and Sales Standard #1 (cont'd)

		If an advertisement states the net premium accumulation interest rate, whether guaranteed or not, it should also disclose in close proximity thereto and with equal prominence, the actual relationship between the gross and the net premiums.
		If a contract does not provide a cash surrender benefit prior to commencement of payment of annuity benefits, an illustration or statement concerning such contract should prominently state that cash surrender benefits are not provided.
<u>For combination life insurance and annuity products:</u>		
		An advertisement of a life insurance product and an annuity as a single policy or life insurance policy with an annuity rider should include a disclosure before the application is taken (if the policy contains an unconditional refund provision of at least 10 days, the disclosure statement can be delivered with the policy, or upon the applicant's request, whichever occurs sooner). The disclosure defines the gross annual life and premium annuity percentages and guaranteed cash value of the annuity and should include the first 5 policy years, the tenth and twentieth policy years, at least one age from 60 to 70 and the scheduled commencement of annuity payments.

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Deleted: Marketing and Sales Standard #3

I. Supplemental Checklist for Marketing and Sales Standard #4

For all illustrations: Determine if the illustration contains the following:

Yes	No	Requirement
		The illustration should be clearly labeled “life insurance illustration.”
		Name of insurer.
		Name and business address of producer or insurer’s authorized representative, if any.
		Name, age and gender of proposed insured except where a composite illustration is permitted.
		Underwriting or rating classification upon which the illustration is based.
		Generic name of the policy, the company product name, if different, and the policy form number.
		Initial death benefit.
		Dividend option election or application of non-guaranteed elements, if applicable.

(Life Insurance Illustrations Model Regulation (#582), Section 6A)

Note: “Generic name” means a short title descriptive of the policy being illustrated, such as “whole life,” “term life” or “flexible premium adjustable life.”

I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

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Determine if the *basic* illustration contains or complies with the following:

Yes	No	Requirement
		Date illustration prepared.
		Page numbers for entire illustration and explanatory notes.
		Assumed dates of payment receipt and benefit payout within a policy year.
		The issue age plus the number of years the policy is assumed to have been in force, if the age is shown as a component of tabular detail.
		Assumed payments on which the illustrated benefits and values are based are identified as premium outlay or contract premium. For policies that do not require a specific contract premium, the illustrated payments should be identified as premium outlay.
		Guaranteed death benefits and values available upon surrender, if any, for the illustrated premium outlay or contract premium should be shown and clearly labeled guaranteed.
		Non-guaranteed elements should not be based on a scale more favorable to the policyowner than the insurer's illustrated scale at any duration. These elements should be clearly labeled non-guaranteed.
		Guaranteed elements, if any, should be shown before corresponding non-guaranteed elements, and should be specifically referred to on any page of an illustration that shows or describes only the non-guaranteed elements.
		Account or accumulation value of a policy, if shown, should be identified by the name this value is given in the policy being illustrated and shown in close proximity to the corresponding value available upon surrender.
		Value available upon surrender should be identified by the name this value is given in the policy being illustrated and should be the amount available to the policyowner in a lump sum after deduction of surrender charges, policy loans and policy interest, as applicable.
		Illustration may show policy benefits and values in graphic or chart form in addition to tabular form.
		Non-guaranteed elements should be accompanied by a statement indicating that, "The benefits and values are not guaranteed; the assumptions on which they are based are subject to change by the insurer, and actual results may be more or less favorable."

I. Supplemental Checklist for **Marketing and Sales Standard #4 (cont'd)**

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		If the illustration shows that the premium payor may have the option to allow policy charges to be paid using non-guaranteed values, the illustration must clearly disclose that a charge continues to be required and that, depending on the actual results, the premium payor may need to continue or resume premium outlays. Similar disclosure should be made for premium outlay of lesser amounts or shorter duration than the contract premium. If a contract premium is due, the premium outlay should not be left blank or show zero unless accompanied by an asterisk or similar mark to draw attention to the fact that the policy is not paid.
		If the applicant plans to use dividends or policy values, guaranteed or non-guaranteed, to pay all or a portion of the contract premium policy charges, or for any other purpose, the illustration may reflect those plans and the effect on future policy benefits and values.
		A brief description of the policy being illustrated, including a statement that it is a life insurance policy.
		A brief description of the premium outlay or contract premium, as applicable, for the policy. For a policy that does not require payment of a specific contract premium, the illustration should show the premium outlay that must be paid to guarantee coverage for the term of the policy, subject to maximum premiums allowable to qualify as a life insurance policy under the applicable provisions of the Internal Revenue Code.
		A brief description of any policy features, riders or options, guaranteed or non-guaranteed, shown in the basic illustration, and the effect they may have on the benefits and values of the policy.
		Identification and a brief definition of column headings and key terms used in the illustration.
		The following statement, "This illustration assumes that the currently illustrated non-guaranteed elements will continue unchanged for all years shown. This is not likely to occur. Actual results may be more or less favorable than those shown."
		Following the narrative summary, a basic illustration should include a numeric summary of the death benefits and values and the premium outlay and contract premium as applicable. For a policy that provides for a contract premium, the guaranteed death benefits and values should be based on the contract premium. This summary should be shown for at least policy years 5, 10, 20 and at age 70, if applicable, on the three bases shown below. For multiple life policies the summary should show policy years 5, 10, 20 and 30.

I. Supplemental Checklist for **Marketing and Sales Standard #4 (cont'd)**

Deleted: Marketing and Sales Standard #3

		<p>The columns of the numeric summary should include:</p> <p>Bases 1: Policy guarantees</p> <p>Bases 2: Insurer's illustrated scale</p> <p>Bases 3: Insurer's illustrated scale used, but with the non-guaranteed elements reduced as follows:</p> <ul style="list-style-type: none"> • Dividends at 50 percent of the dividends contained in the illustrated scale used; • Non-guaranteed credited interest at rates that are the average of the guaranteed rates and the rates contained in the illustrated scale used; and • All non-guaranteed charges, including, but not limited to, term insurance charges and mortality and expense charges, at rates that are the average of the guaranteed rates and the rates contained in the illustrated scale used.
		<p>If coverage would cease before policy maturity or age 100, the year in which coverage ceases should be identified for each of the three bases.</p>
		<p>The following statement signed and dated by the applicant or policyowner: "I have received a copy of this illustration and understand that any non-guaranteed elements illustrated are subject to change and could be either higher or lower. The agent has told me they are not guaranteed."</p>
		<p>The following statement signed and dated by the insurance producer or other authorized representative of the insurer: "I certify that this illustration has been presented to the applicant, and that I have explained that any non-guaranteed elements illustrated are subject to change. I have made no statements that are inconsistent with the illustration."</p>

I. Supplemental Checklist for **Marketing and Sales Standard #4 (cont'd)**

Deleted: Marketing and Sales Standard #3

		<p>A basic illustration must include the following for at least each policy year from one to 10 and for every fifth policy year thereafter, ending at age 100, policy maturity or final expiration, and except for term insurance beyond the 20th year, for any year in which the premium outlay and contract premium, if applicable, is to change:</p> <ul style="list-style-type: none">• Premium outlay and mode the applicant plans to pay and the contract premium as applicable;• The corresponding guaranteed death benefit, as provided in the policy;• Corresponding guaranteed value available upon surrender, as provided in the policy;• Non-guaranteed elements may be shown if described in the contract. In the case of an illustration for a policy on which the insurer intends to credit terminal dividends, they may be shown if the insurer's current practice is to pay terminal dividends. If any non-guaranteed elements are shown, they must be shown at the same durations as the corresponding guaranteed elements, if any; and• If no guaranteed benefit value is available at any duration for which a non-guaranteed benefit or value is shown, a zero should be displayed in the guaranteed column.
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“Basic illustration” means a ledger or proposal used in the sale of a life insurance policy that shows both guaranteed and non-guaranteed elements.

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I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

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A supplemental illustration may be provided as long as:

Yes	No	Requirement
		It is appended to, accompanied by, or preceded by a basic illustration.
		The non-guaranteed elements shown are not more favorable to the policyowner than the corresponding elements in the basic illustration.
		It contains the same statement required of a basic illustration that non-guaranteed elements are not guaranteed.
		The premium outlay/contract premium must be equal to the premium outlay/contract premium shown in the basic illustration.
		A notice is included referring to the basic illustration for guaranteed elements and other important information.

“Supplemental illustration” means an illustration furnished in addition to a basic illustration that meets the applicable requirements of [*Life Insurance Illustrations Model Regulation* (#582)], and that may be presented in a format differing from the basic illustration, but may only depict a scale of non-guaranteed elements that is permitted in a basic illustration.

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I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

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Determine if the *universal life* illustration has the following:

Yes	No	Requirement
		Any statement of policy cost factors or benefits shall contain: <ul style="list-style-type: none"> • The corresponding guaranteed policy cost factors or benefits, clearly identified; • A statement explaining the non-guaranteed nature of any current interest rates, charges or other fees applied to the policy, including the insurer's rights to alter any of these factors; • Any limitations on the crediting of interest, including identification of those portions of the policy to which a specified interest rate shall be credited; • Any illustration of the policy value shall be accompanied by the corresponding net cash surrender value; • Any statement regarding the crediting of a specific current interest rate shall also contain the frequency and timing by which such rate is determined; • If any statement refers to the policy being interest-indexed, the index shall be described. In addition, a description shall be given of the frequency and timing of determining the interest rate and of any adjustments made to the index in arriving at the interest rate credited under the policy; • Any illustrated benefits based upon non-guaranteed interest, mortality or expense factors shall be accompanied by a statement indicating that these benefits are not guaranteed; and • If the guaranteed cost factors or initial policy cost factor assumptions would result in policy values becoming exhausted prior to the policy's maturity date, such fact shall be disclosed, including notice that coverage will terminate under such circumstances.

(*Universal Life Insurance Model Regulation* (#585), Section 8A)

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I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

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Determine whether *indexed universal life* illustrations contain or comply with the following in addition to all other illustration requirements:

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Yes	No	Requirement
		If the insurer offers a Benchmark Index Account with the illustrated policy, the illustration actuary uses the current annual cap for the Benchmark Index Account. (AG49, Section 4.A.i.)
		If the insurer does not offer a Benchmark Index Account with the illustrated policy, the illustration actuary uses a hypothetical, supportable current annual cap for a hypothetical, supportable Index Account that meets the definition of a Benchmark Index Account. (AG49, Section 4.A.ii) Note: Actuarial judgment may be used by the illustration actuary. Support for the determination of the hypothetical cap may be requested of the illustration actuary by the examiner. Examiner may refer this support to actuarial or investment specialist for review as necessary.
		The maximum credited rate used for the Illustrated Scale is the arithmetic mean of the geometric average annual credited rates calculated in 4.A. per Actuarial Guideline 49. (AG49, Section 4.B.) Note: Review may be referred by the examiner to an actuarial or investment specialist as necessary.
		Where other Index Accounts are used in illustrations, the illustration actuary determined the Illustrated Scale according to Actuarial Guideline 49, Section 4.C. Note: Review may be referred by the examiner to an actuarial or investment specialist as necessary.
		The insurer updated the credited rate for each Index Account in accordance with Actuarial Guideline Sections 4(B) and 4(C) within 3 months of the beginning of the calendar year of the illustration. (AG 49, Section 4.D.)
		If the illustration includes a loan, the illustrated rate credited to the loan balance shall not exceed the illustrated loan charge by more than 100 basis points. (AG 49, Section 6)
		The basic illustration includes a ledger using the Alternate Scale shown alongside the ledger using the Illustrated Scale with equal prominence. (AG49, Section 7.A.)
		The basic illustration includes a table showing the minimum and maximum of the geometric average annual credited rates calculated in Actuarial Guideline Section 4.A. (AG49, Section 7.B.)
		The basic illustration includes a table showing actual historical index changes and corresponding hypothetical interest rates using current index parameters for the most recent 20-year period for each Index Account illustrated. (AG49, Section 7.C.)

(Actuarial Guideline 49 – The Application of the Life Illustrations Model Regulation to Policies with Index Based Interest)

I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

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Ensure variable life illustrations contain or comply with the following:

Yes	No	Requirement
		The hypothetical interest rates used to illustrate accumulated policy values must be an annual effective gross rate after brokerage expenses and prior to any deduction for taxes, expenses and contract charges.
		If illustrations of accumulated policy values are shown, then for the highest interest rate used, one illustration must be based solely upon guarantees contained in the policy contract being illustrated.
		Except for illustrations contained in the prospectus, the pattern of premium

		payments used in an illustration should be the initial pattern requested by the proposed policyholder at inception or upon changes in face amount requested by the policyholder.
		If the illustrated policy contract provides for a variety of investment options, the illustration may either use an asset charge, which is reasonably representative, or use the asset charge of a particular option. The illustration should clearly identify the asset charge and either label it "hypothetical" or identify the fund.
		The illustration must disclose the transaction charges that will be levied against the contract because of transactions requested in accordance with rights and privileges specified in the policy contract. Any charge for the exercise of a right or privilege upon which the illustration is based must be reflected in the illustrated values. The nature of any other such charges must be disclosed in a clear statement accompanying such illustrations.
		A clear statement must be made following the table of illustrated accumulated policy values that use of hypothetical investment results does not in any way represent actual results or suggest that such results will be achieved and must indicate that the policy values which actually arise will differ from those shown, whenever the actual investment results differ from the hypothetical rates illustrated. Assumptions upon which illustrations are based must be clearly disclosed.
		Any sales illustration to a prospective policyholder must reflect the policy being presented accurately. Misleading statements or captions or other misrepresentations are prohibited.
		The requested sales illustration must be printed clearly and legibly on hard paper copy. An illustration displayed on a computer screen may be used in addition to, but not as a substitute for, hard paper copy.

I. Supplemental Checklist for **Marketing and Sales Standard #4 (cont'd)**

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	<p>In connection with variable life insurance contracts offering both fixed and variable funding options:</p> <ul style="list-style-type: none">• An illustration of the variable funding option must comply with these guidelines;• If an illustration of the fixed funding option is shown, accumulated policy values must be shown on the basis of guaranteed rates. One or more additional rates may also be shown, but such rates may not exceed current rates; and• A summary illustration may be given in which results from comparable illustrated and hypothetical interest rates are combined. Such summary must cross-reference to the accompanying separate illustrations of the fixed and variable funding options.
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(Life Insurance Illustrations Model Regulation (#582))

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J. Supplemental Checklist for Marketing and Sales Standard #8

Yes	No	Requirement
Ensure the disclosures include:		
		The fact that a life insurance policy is involved or being used to fund a prearrangement.
		The nature of the relationship among the soliciting agent or agents, the provider of the funeral or cemetery merchandise or services, the administrator and any other person.
		The relationship of the life insurance policy to the funding of the prearrangement and the nature and existence of any guarantees relating to the prearrangement.
		<p>The impact on the prearrangement of the following:</p> <ul style="list-style-type: none"> • Any changes in the life insurance policy including, but not limited to, changes in the assignment, beneficiary designation or use of the proceeds; • Any penalties to be incurred by the policyholder as a result of failure to make premium payments; • Any penalties to be incurred or monies to be received as a result of cancellation or surrender of the life insurance policy; • A list of the merchandise and services which are applied or contracted for in the prearrangement and all relevant information concerning the price of the funeral services, including an indication that the purchase price is either guaranteed at the time of purchase or to be determined at the time of need; • All relevant information concerning what occurs and whether any entitlements or obligations arise, if there is a difference between the proceeds of the life insurance policy and the amount actually needed to fund the prearrangement; • Any penalties or restrictions, including, but not limited to, geographic restrictions or the inability of the provider to perform, on the delivery of merchandise, services or the prearrangement guarantee; and • The fact that a sales commission or other form of compensation is being paid and, if so, the identity of such individuals or entities to whom it is paid.

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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 poses 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.

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| 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.

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

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

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| 11. Does the regulated entity utilize a third party to test the VIN numbers of the vehicles it insures for validity? |
| 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.

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| 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.

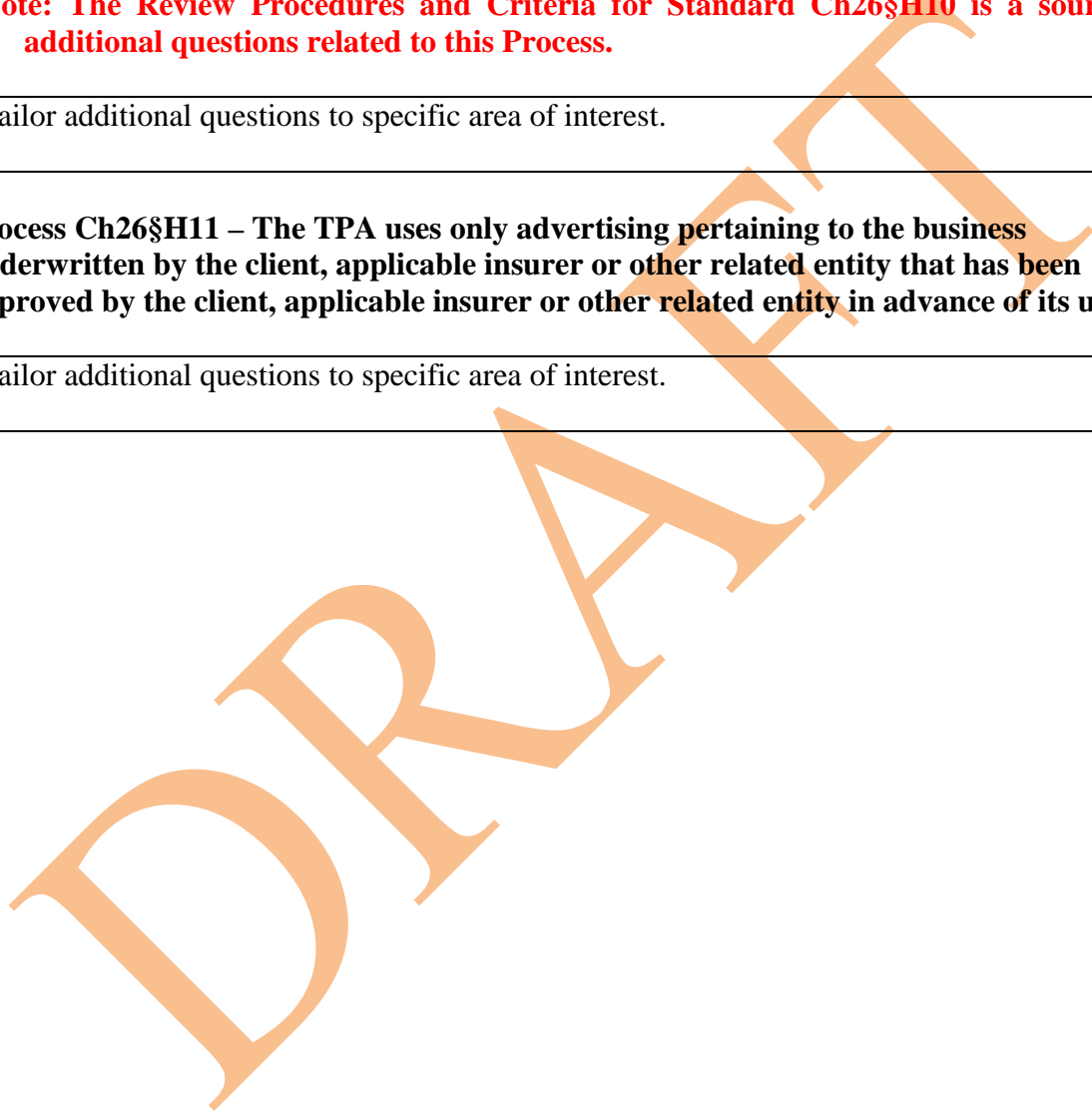
Process Ch26§H10 – The TPA maintains and makes available to the client, applicable insurer or other related entity complete books and records of all transactions performed on behalf of the client, applicable insurer or other related entity.

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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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.

Comment [BC(1): I believe this should read “process is applicable.”

- | |
|--|
| 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 |

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.

Comment [BC(2): I would suggest replacing "this" with "producer" or "the term producer."



NorthStarExams

Insurance Regulatory Consultants and Examiners

Attachment 8

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June 14, 2017

Petra Wallace, AAI, ACP, AMCM, ASLI
Market Regulation Specialist
NAIC Market Regulation
1100 Walnut Street, Suite 1500
Kansas City, MO 64106

Dear Petra

The question posed by Carla Bailey of Washington at the MCESWG meeting was a good one. The note on page 21 of my proposal following Ch16§A01 #12 does not need the second sentence. Removal of that sentence allows the rest of the note to apply to on and off site examinations. It would be appropriate to remove the sentence.

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.

Thank you.

Sincerely,

Don Koch

NSE 100 Rev. 04/10/12

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