Draft: 12/11/18

Market Conduct Examination Standards (D) Working Group
Conference Call
November 29, 2018

The Market Conduct Examination Standards (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Nov. 29, 2018. The following Working Group members participated: Bruce R. Ramge, Chair, and Laura Arp, (NE); Jim Mealer, Vice Chair, and Cynthia Amann (MO); Melissa Grisham and Mel Heaps (AR); Damion Hughes (CO); Kurt Swan (CT); Howard Liebers, David Moore and Cheryl Wade (DC); Lindsay Bates (IA); Russell Hamblen (KY); Mary Lou Moran (MA); Paul Hanson (MN); Maureen Belanger, Denise Lamy, Jennifer Patterson (NH); Ralph Boeckman (NJ); Peggy Willard-Ross (NV); Sylvia Lawson (NY); Angela Dingus (OH); Richard Hendrickson (PA); Julie Fairbanks and Yolanda Tennyson (VA); Christina Rouleau (VT); John Haworth and Jeanette Plitt (WA); Barbara Belling, Diane Dambach, Sue Ezalarab, Jo LeDuc, Darcy Paskey, Rebecca Rebholz and Mary Kay Rodriguez (WI); and Barbara Hudson (WV). Also participating were Theresa Morfe and Darci Smith (MD).

1. Discussed New Mental Health Parity-Related Revisions to the Handbook

Director Ramge said that the two mental health parity-related exposure drafts before the Working Group consist of: 1) a general guidance document addressing mental health parity review, which includes a series of questions to be posed to health carriers by examiners, to be inserted in a chapter or area to be determined of the *Market Regulation Handbook* (Handbook); and 2) a regulator data collection tool for mental health parity analysis. He said the drafts, which were developed with the assistance of regulator subject matter experts (SMEs) in mental health parity review, were circulated on July 9; they were initially discussed during the Working Group's July 25 conference call and subsequently during its Aug. 29 call. Ms. Arp revised the two draft documents on Oct. 18 to incorporate informal suggestions received from Mary Nugent (Center for Consumer Information and Insurance Oversight—CCIIO).

Ms. Morfe and Ms. Smith presented comments dated Oct. 31, 2018, indicating that Question 9 in the general guidance document be revised, and that numerous areas of the data collection tool in Section 1 – Financial Requirements and Quantitative Treatment Limitations and Section 2 – Non-Quantitative Treatment Limitations should also be revised. Ms. Morfe and Ms. Smith suggest incorporating the federal Centers for Medicare & Medicaid Services (CMS) non-quantitative treatment limitations (NQTL) Table 5 to the data collection tool.

Pamela Mobberley (Cigna) presented comments dated Oct. 31, 2018, on behalf of Pamela Greenberg (Association for Behavioral Health and Wellness—ABHW). Ms. Mobberley said that the language in the table of the data collection tool should be revised to clarify that the testing of financial requirements and quantitative treatment limitations (QTLs) applied to medical/surgical benefits dictates the type and/or level of the financial requirements and quantitative treatment limits, if any, that may be applied to the corresponding mental health/substance use disorder classifications of benefits. Such testing is based upon the percentage of expected plan payments for the medical/surgical benefits within each classification of benefits for the plan year.

Ms. Mobberley suggested that in the section addressing NQTLs, the content of the tool should align with the federal Mental Health Parity and Addiction Equity Act (MHPAEA) and its regulations by permitting flexibility in NQTL methodologies and processes, as long as such NQTL methodologies and processes are comparable to, and applied no more stringently, to mental health/substance use disorder benefits as compared to medical/surgical benefits within each classification.

Ms. Mobberley said that in regard to comments advocating for the data collection tool to incorporate the four-step NQTL analysis referenced within the recently amended Self-Compliance Tool published by the federal tri-agencies─the U.S. Department of Labor (DOL), the U.S. Department of Health and Human Services (HHS) and the U.S. Department of the Treasury (Treasury Department—in April 2018, the ABHW has concerns the four-step NQTL analysis may be misinterpreted as requiring a prescriptive approach—such as requiring every NQTL to be based upon a list of factors and requiring every factor to be based upon an evidentiary standard and/or source information. Ms. Mobberley suggested that the data collection tool should clarify that the parity regulations governing NQTLs are not prescriptive and should not be misinterpreted as requiring that NQTLs or NQTL factors be based upon an evidentiary standard—the evidentiary standard being disclosed and defined only if an NQTL factor is based upon an evidentiary standard. Ms. Mobberley said that the four-step analysis referenced within the Self-Compliance Tool is merely proposed guidance that has not yet been finalized; the DOL will be scheduling a meeting in January 2019 for interested parties to review and discuss the public comments submitted in response to the proposed guidance.

Ms. Mobberley suggested that the NQTL Table 5, which is used by CMS, be incorporated into the draft guidance before the Working Group. Regulator use of Table 5 will ensure a more consistent and uniform approach in parity enforcement efforts of NQTLs. Ms. Mobberley said that Table 5 is clear and easy to read, which will aid examiners in conducting efficient and productive NQTL examinations.

Andrew Sperling (National Alliance on Mental Illness—NAMI) presented Nov. 26 comments submitted jointly by the following NAIC consumer representatives: Ashley Blackburn (Community Catalyst); David Chandrasekaran (Training Consultant and Certified Application Counselor); Laura Colbert (Georgians for a Healthy Future); Deborah Darcy (American Kidney Fund—AKF); Anna Howard (American Cancer Society Cancer Action Network—ACS CAN); Debra Judy (Colorado Consumer Health Initiative—CCHI); Katie Keith (Out2Enroll); Sarah Lueck (Center on Budget and Policy Priorities—CBPP); James Roberts (Alaska Native Tribal Health Consortium—ANTHC); Carl Schmid (The AIDS Institute); Matthew Smith (Coalition Against Insurance Fraud—CAIF); Mr. Sperling; Lorri Shealy Unumb (Autism Speaks); and Silvia Yee (Disability Rights Education and Defense Fund—DREDF).

Mr. Sperling provided a broad overview of the NAIC consumer representatives comments, which fall into four general categories: 1) definition of mental health conditions and substance use disorders; 2) question 4 and question 5 relating to prescription drug formulary tiering and in-network provider tiering, respectively; 3) financial requirements and quantitative treatment limitations; and 4) non-quantitative treatment limitations.

Director Ramge said that the mental health parity drafts have been on the Working Group's agenda since July. He recognized the work that has been done thus far on the drafts, by the regulator SMEs, Ms. Morfe, Ms. Smith and Ms. Arp. Director Ramge said the mental health parity guidelines in the drafts could be adopted soon by the Working Group and subsequently revised as needed, as future final guidance is finalized by the tri-agencies. Mr. Mealer agreed and said that mental health parity guidelines for examiners is needed. He said guidelines can be put in place and subsequently revised as needed on subsequent Working Group conference calls.

Ms. Arp said that she would make additional changes to both draft documents, taking the comments from Ms. Morfe and Ms. Smith into consideration, as well as the comments from ABHW and the joint comments from the NAIC consumer representatives.

Director Ramge asked that comments be submitted to Petra Wallace (NAIC) on the mental health parity drafts by Dec. 13.

2. Reviewed Insurance Data Security Pre- and Post-Breach Checklists, Nov. 19 Draft

Director Ramge said the Insurance Data Security Pre- and Post-Breach Checklists, which were first distributed on July 16, were developed to correlate with the *Insurance Data Security Model Law* (#668), which was adopted by the Executive (EX) and Plenary Committee on Oct. 24, 2017. The checklists, developed by regulator SMEs in the fields of market examinations and financial examinations, provide examiners with guidance on evaluating the insurance data security of regulated entities. Director Ramge said that the draft checklists were initially discussed during the Working Group's July 25 call, and a revised draft was distributed on Nov. 19.

Director Ramge said the Nov. 19 draft incorporates language that had been adopted by the IT Examination (E) Working Group in October, for inclusion in Section III–General Examination Considerations of that Working Group's published financial examination guidance. The IT Examination (E) Working Group had received comments in October from the joint trade associations and the American Insurance Association (AIA), which were, for the most part, identical to comments the Market Conduct Examination Standards (D) Working Group received from these two entities in August. The IT Examination (E) Working Group subsequently adopted language to address the trade associations' and the AIA's concerns regarding collaboration of market and financial examiners and the states' adoption of Model #668. Director Ramge said that the same language is incorporated into the pre- and post-breach checklists draft for the Working Group's consideration.

Director Ramge said that a minor change had been suggested by NAIC staff to add "or legislation which is substantially similar to the model" so that the language then reads: "Note: The guidance that follows should only be used in states that have enacted the NAIC *Insurance Data Security Model Law* (#668) or legislation which is substantially similar to the model. Moreover, in performing work during an exam in relation to the Model Law, it is important the examiners first obtain an understanding and leverage the work performed by other units in the department including but not limited to financial examination-related work."

Director Ramge said the issue of what type of examiner (market, financial) should perform what type of review (pre-breach, post-breach) in an insurance data security-related examination would be difficult for NAIC leadership/state insurance

departments to uniformly agree upon because staffing levels, departmental structuring, budget constraints, etc. vary greatly across all jurisdictions. Director Ramge said the purpose of the Handbook is not to specify how each jurisdiction should allocate market regulation staff and financial regulation staff with regard to pre-breach review and post-breach review when conducting an insurance data security-related exam.

Director Ramge suggested that the Handbook: 1) incorporate the post-breach checklist; and 2) make available, in the Handbook reference documents, examiner guidance that a jurisdiction may wish to use, in instances when conducting a market conduct-related pre-breach examination is warranted.

Director Ramge recommended that the post-breach checklist be incorporated within the relevant exam standard in Chapter 20 of the Handbook (the General Examination Standards chapter), and that language be included in the chapter itself stating that: 1) financial exam standards exist with regard to insurance data security and each state will want to coordinate with financial examiners to avoid duplication of efforts; and 2) each state will need to decide how to handle whether market examiners, financial examiners or a combination of the two perform pre-breach and post-breach review in an insurance data security review of regulated entities.

Director Ramge suggested that language be incorporated within the relevant exam standard in Chapter 20 stating that a pre-breach checklist is available and can be found in the Handbook reference documents on StateNet. Director Ramge provided the following sample language:

"Pre-breach examination of insurance data security is typically covered during financial examination, but for those jurisdictions or instances wishing to have such a review conducted by market conduct examiners, suggested review criteria are available in the reference documents of the *Market Regulation Handbook*."

Angela Gleason (American Insurance Association—AIA) asked if the Working Group will be considering the AIA's other comments, submitted in August. Director Ramge said that the Working Group will wait to review Ms. Gleason's comments during a subsequent Working Group conference call. Emily Micale (American Council of Life Insurers—ACLI) said that she would be submitting comments on the checklists. Mr. Mealer asked that the Working Group have more time to review the language of the pre- and post-breach checklists.

Director Ramge asked that comments be submitted to Ms. Wallace on the pre- and post-breach checklists by Dec. 13.

3. Reviewed New Standardized Data Requests for Inclusion in the Reference Documents of the Handbook

Director Ramge said that two new private passenger auto standardized data requests and a personal lines declination standardized data request had been developed by regulator SMEs for the Working Group's review, discussion and adoption. When the standardized data requests are adopted, they will replace the private passenger auto portion of the NAIC personal lines standardized data request.

Mr. Hamblen said for clarity of examiner use, two separate private passenger auto data requests were developed to address: 1) in force policies; and 2) claims. A third standardized data request was developed to capture fields typically used by regulators when evaluating regulated entity personal lines declinations (personal auto and homeowners). Mr. Hamblen said revisions were also made to the Contents section and the Uses section of each standardized data request, and the standardized data requests were edited to have the same format, style and consistency in field names/definitions as the standardized data requests that have been previously adopted by the Working Group.

Mr. Hamblen provided a brief explanation of the NAIC standardized data requests and their use. Mr. Hamblen said the NAIC standardized data requests offer uniform instruction to regulators with regard to obtaining data elements from regulated entities for the purposes of a targeted data call or an examination. Mr. Hamblen said the NAIC standardized data requests are designed to be used as a template or guide for regulators, noting that the states may tailor the standardized data requests for a specific or targeted purpose. Mr. Hamblen said the NAIC standardized data requests are not one-size-fits-all documents, and the states may remove fields or add fields as necessary, depending on the circumstances, scope and purpose of an examination.

Birny Birnbaum (Center for Economic Justice—CEJ) asked how regulators would respond if a regulated entity said it does not capture the data requested in the standardized data request. Mr. Hamblen said that before asking for data, the Kentucky Department of Insurance (DOI) makes a practice of contacting the regulated entity to review the requested data fields and field descriptions in the standardized data request that will be used with the regulated entity, which provides the regulated entity with an opportunity to ask questions and obtain feedback about how the data is to be provided to the insurance

department. Mr. Hamblen said that the Kentucky DOI would then work with the regulated entity to determine a workaround for such a situation. Mr. Mealer said that a DOI may also provide a reasonable amount of time for regulated entities to produce the data that is requested.

Director Ramge asked that comments be submitted to Ms. Wallace on the standardized data requests by Dec. 31.

4. Discussed Other Matters

Director Ramge said NAIC staff will provide advance email notice of the next Working Group conference call.

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

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_____ (*Chapter/Section/Title TBD*)—Conducting the Mental Health Parity and Addiction Equity Act (MHPAEA) Related Examination

Introduction

The intent of _____ (*Chapter/Section/Title TBD*)—Conducting the Mental Health Parity and Addiction Equity Act (MHPAEA) Related Examination in the *Market Regulation Handbook* is primarily to provide guidance when reviewing insurers whose business includes major medical policies offering mental health and/or substance use disorder coverage.

The examination standards in *Market Regulation Handbook* Chapter 20—Conducting the Health Examination provide guidance specific to all health insurers, but large group coverage may or may not include mental health and/or substance use disorder coverage. _____ (*Chapter/Section/Title TBD*) strictly applies to examinations to determine compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) found at 42 U.S.C. 300gg-26 and its implementing regulations found at 45 CFR 146.136 and 45 CFR 147.160, and is to be used for plans that offer mental health and/or substance use disorder benefits.

Generally, MHPAEA regulations require that any financial requirement (FR) (e.g.. copayments, deductibles, coinsurance, or out-of-pocket maximums) or quantitative treatment limitation (QTL) (e.g., day or visit limits) imposed on mental health and substance use disorder (MH/SUD) benefits not be more restrictive than the predominant financial requirement or treatment limitation of that type that applies to substantially all medical and surgical benefits, on a classification-by-classification basis, as discussed below. With regard to any nonquantitative treatment limitation (NQTL) (e.g., preauthorization requirements, fail-first requirements), MHPAEA regulations prohibit imposing an NQTL with respect to MH/SUD benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical (M/S) benefits in the same classification.

MHPAEA applies to major medical group and individual health insurance. Mental health and substance use disorder treatment as an essential health benefit under the Patient Protection and Affordable Care Act, so examination of individual and small group ACA-compliant plans will include parity analysis. In the large group market, an insurer's plan is not required to cover mental health and/or substance use disorder services. If the insurer's large group plan does cover mental health and/or substance use disorder services, parity requirements apply. MHPAEA does not apply to excepted benefit plans, nor to short-term limited duration insurance. Some states may have mental health parity requirements that are stricter than federal requirements.

Federal law relies on state insurance regulators as the first-line enforcers of health reform provisions in the individual, small group, and large group insurance markets.

Examination Standards

Each examination standard includes a citation to MHPAEA or its implementing regulations, but additional information can be found in federal guidance documents and state law or state interpretation of federal law. Please note that the federal government periodically updates its guidance documents related to MHPAEA. Examiners should refer to the U.S. Departments of Labor, Health and Human Services, and the Treasury for any updates or new MHPAEA guidance. MHPAEA allows states to enact statutes or regulations that are stricter than federal requirements. Examiners should contact their state's legal division for assistance and interpretation of federal guidance, as well as any additional state requirements. Where there is a reasonable interpretation of MHPAEA, that reasonable interpretation should be given due consideration.

Collaboration Methodology

The development of state market conduct compliance tools for MHPAEA will result in enhanced state collaboration, to provide more consistent interpretation and review of parity standards.

LIST OF QUESTIONS[LLA1] **Laura Arp (NE) Commented:** NAIC Consumer Representatives suggested an additional question: : "Are all conditions that are defined as being or as not being a mental health condition, a substance use disorder, or a medical condition defined in a manner that is consistent with generally recognized independent standards of current medical practice?"

Question 1.
Is this insurance coverage exempt from MHPAEA (45 CFR 146.136(f))? If so, please indicate the reason (e.g., retiree-only plan, excepted benefits (45 CFR § 146.145(b)), short term, limited duration insurance[1], small employer exemption (45 CFR § 146.136(f)), increased cost exemption (45 CFR § 146.136(g)).

Question 2.
If not exempt, does the insurance coverage provide MH and/or SUD benefits in addition to providing M/S benefits?

Unless the insurance coverage is exempt or does not provide MH/SUD benefits (note that MH/SUD is one of the EHBs for non-grandfathered coverage in the individual and small group markets), continue to the following sections to examine compliance with requirements under MHPAEA.

Question 3.
Does the insurance coverage provide MH/SUD benefits in every classification in which M/S benefits are provided?

Under the MHPAEA regulations, the six classifications of benefits are:

1) *inpatient, in-network;*
2) *inpatient, out-of-network;*
3) *outpatient, in-network;*
4) *outpatient, out-of-network;*
5) *emergency care; and*
6) *prescription drugs.*

See 45 CFR 146.136(c)(2)(ii).

Because parity analysis for this standard is at the classification level, data must be collected for each classification. An example data collection tool is provided, which collects information needed to answer this question.

Question 4.
If the plan includes multiple tiers in its prescription drug formulary, are the tier classifications based on reasonable factors (such as cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up) determined in accordance with the rules for NQTLs at 45 CFR 146.136(c)(4)(i), and without regard to whether the drug is generally prescribed for MH/SUD or M/S benefits? Explain how the plan's tiering factors for MH/SUD prescription drugs are comparable to and are applied no more stringently than the tiering factors for M/S prescription drugs.

See 45 CFR 146.136(c)(3)(iii)(A).

Question 5.
If the plan includes multiple network tiers of in-network providers, is the tiering based on reasonable factors (such as quality, performance, and market standards) determined in accordance with the rules for NQTLs at 45 CFR 146.136(c)(4)(i), and without regard to whether a provider provides services with respect to MH/SUD benefits or M/S benefits? Explain how the plan's tiering factors for MH/SUD network tiers are comparable to and are applied no more stringently than the tiering factors for M/S network tiers.

See 45 CFR 146.136(c)(3)(iii)(B).

Question 6.

[1] Under the Public Health Services Act (as added by HIPAA), short term limited duration insurance is excluded from the definition of individual health insurance coverage (45 C.F.R. § 144.103).

Does the plan comply with the parity requirements for aggregate lifetime and annual dollar limits, including the prohibition on lifetime dollar limits or annual dollar limits for MH/SUD benefits that are lower than the lifetime or annual dollar limits imposed on M/S benefits? List the services subject to lifetime or annual limits, separated into MH/SUD and M/S benefits.

See 45 CFR 146.136(b). This prohibition applies only to dollar limits on what the plan would pay, and not to dollar limits on what an individual may be charged. If a plan or issuer does not include an aggregate lifetime or annual dollar limit on any M/S benefits, or it includes one that applies to less than one-third of all M/S benefits, it may not impose an aggregate lifetime or annual dollar limit on MH/SUD benefits. 45 CFR 146.136(b)(2). Also note that the parity requirements regarding lifetime and annual dollar limits only apply to the provision of MH/SUD benefits that are not EHBs because lifetime limits and annual dollar limits are prohibited for EHBs, including MH/SUD services.

Question 7.
Does the plan impose any financial requirements (e.g., deductibles, copayments, coinsurance, and out-of-pocket maximums) or quantitative treatment limitations (e.g., annual, episode, and lifetime day and visit limits) on MH/SUD benefits in any classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation of that type that applies to substantially all M/S benefits in the same classification? Demonstrate compliance with this standard by completing the attached data collection tool.

See 45 CFR 146.136(c)(2). Because parity analysis is at the classification level and analysis is based on the dollar amount for expected benefits paid, data must be collected per classification. An example data collection tool is provided, which collects information needed to answer this question.

Financial Requirements (FRs) include deductibles, copayments, coinsurance, and out-of-pocket maximums. 45 CFR 146.136(c)(1)(ii). Quantitative Treatment Limitations (QTLs) include annual, episode, and lifetime day and visit limits, such as number of treatments, visits, or days of coverage. 45 CFR 146.136(c)(1)(ii).

If a plan includes a FR (copayment or coinsurance) or QTL (session or day limit) for MH/SUD benefits, the first step is to identify the comparison point by looking at M/S benefits for that classification. Determine whether the FR or QTL applies to at least two-thirds ("substantially all") of the M/S benefits in that classification. For purposes of determining whether a type of FR or QTL applies to at least two-third of all M/S benefits in a classification, the FR or QTL is considered to apply regardless of the magnitude or level of that type of FR or QTL. For example, a copayment, coinsurance, session or day limit is considered to apply to the benefits regardless of the dollar amount, coinsurance percentage, or number of sessions or days for that type of FR or QTL. The portion of M/S benefits subject to the FR or QTL is based on the dollar amount of expected payments for M/S benefits in a year. If the type of FR or QTL applies to less than two-thirds of the M/S benefits in a classification, then that type of FR or QTL cannot be applied to MH/SUD benefits in that classification. If the type of FR or QTL applies to two-thirds or more of the M/S benefits in the classification, as determined under 45 CFR 146.136(c)(3)(i)(A), the examiner will go to the next step to look at the level of the FR or QTL, for example the specific copayment dollar amount, coinsurance percentage, or limitation on number of sessions or days.

If the type of FR or QTL is imposed on at least two-thirds of the M/S benefits in a classification, then the "level" (e.g., copayment dollar amount, coinsurance percentage, or limitation on number of days or sessions) is analyzed to determine the "predominant" level. In this second step, the examiner will look at the M/S benefits to which the FR or QTL applies and find the "predominant" level of the limitation—this means the specific dollar amount, coinsurance percentage, or limitation on number of sessions or days that applies to more than 50% of the M/S benefits in that classification subject to the FR or QTL. The FR or QTL imposed on MH/SUD benefits cannot be more restrictive than the predominant level.

If less than 50% of the M/S benefits that are subject to the FR or QTL in a classification are subject to a certain "level" of FR or QTL levels of the FR or OTL can be combined to reach50% of the M/S benefits in the classification, with the least restrictive level within the combination being the level that can be applied to MH/SUD benefits in the classification.

Question 8.
Does the plan apply any cumulative financial requirement or cumulative QTL for MH/SUD benefits in a classification that accumulates separately from any cumulative financial requirement or QTL established for M/S benefits in the same classification? Demonstrate compliance with this standard by completing the attached data collection tool.

See 45 CFR 146.136(c)(3)(v). For example, a plan may not impose an annual $250 deductible on M/S benefits in a classification and a separate $250 deductible on MH/SUD benefits in the same classification. Cumulative financial requirements are financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maximums (but do not include aggregate lifetime or annual dollar limits because those two terms are excluded from the meaning of financial requirements). 45 CFR 146.136(a).

Cumulative financial requirements and treatment limitations are also subject to the predominant and substantially all tests in Question 7.

Question 9.
Does the plan impose Non-Quantitative Treatment Limitations (NQTLs) on MH/SUD benefits in any classification? If so, ~~do the NQTLs comply with parity requirements? Please provide or make available copies of documents that contain the required disclosures, with the disclosures flagged in those documents, then~~ demonstrate compliance with ~~this standard~~parity requirements by completing the attached data collection tool.

Examples of NQTLs (not exclusive):

- **a) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;**
- **b) Prior authorization and ongoing authorization requirements;**
- **c) Concurrent review standards;**
- **d) Formulary design for prescription drugs;**
- **e) For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;**
- **f) Standards for provider admission to participate in a network, including reimbursement rates;**
- **g) Plan or insurer's methods for determining usual, customary and reasonable charges;**
- **h) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as "fail-first" policies or "step therapy" protocols);**
- **i) Restrictions on applicable provider billing codes;**
- **j) Standards for providing access to out-of-network providers;**
- **k) Exclusions based on failure to complete a course of treatment;**
- **l) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan; and**
- **m) Any other non-numerical limitation on MH/SUD benefits.**

Note that not every NQTL needs an evidentiary standard. There is flexibility under MHPAEA for plans to use NQTLs. The focus is on finding out what processes and standards the plan actually uses.

See 45 CFR 146.136(c)(4) and pages 14-20 of the Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA) for analysis advice available at https://www.dol.gov/sites/default/files/ebsa/about-ebsa/out-activities/resource-center/publications/compliance-guide-appendix-a-mhpaea.pdf.

Question 10.

Does the insurer comply with MHPAEA disclosure requirements including (1) criteria for medical necessity determinations for MH/SUD benefits, and (2) the reasons for any denial?

See 45 CFR 146.136(d)(1) and (2).

Note that the state's grievance procedure and external review statutes may contain additional disclosure requirements.

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DATA COLLECTION TOOL FOR MENTAL HEALTH PARITY ANALYSIS

Most parity analysis examines benefits by comparing MH/SUD to M/S within a classification. 45 CFR 146.136(c)(2)(i). The exception is aggregate lifetime or annual dollar limits (to the extent the plan is not prohibited from imposing such limits under Federal or State law), which are examined for the plan as a whole. 45 CFR 146.136(b). The following is intended to simplify data collection for parity analysis at the classification level. Examiners may find it helpful to identify a person with MHPAEA experience, from the state's legal or health policy division, to interpret results after data is received from the insurer.

GUIDANCE FOR PLACING BENEFITS INTO CLASSIFICATIONS:

MH/SUD and M/S benefits must be mapped to one of six classifications of benefits: (1) inpatient in-network, (2) inpatient out-of-network, (3) outpatient in-network, (4) outpatient out-of-network, (5) prescription drugs, and (6) emergency care. 45 CFR 146.136(c)(2)(ii).

- The "inpatient" classification typically refers to services or items provided to a beneficiary when a physician has written an order for admission to a facility, while the "outpatient" classification refers to services or items provided in a setting that does not require a physician's order for admission and does not meet the definition of emergency care.

- "Office visits" are a permissible sub-classification separate from other outpatient services.

- The term "emergency care" typically refers to services or items delivered in an emergency department setting or to stabilize an emergency or crisis, other than in an inpatient setting.

- Some benefits, for example lab and radiology, may fit into multiple classifications depending on whether they are provided during an inpatient stay, on an outpatient basis, or in the emergency department.

- Insurers should use the same decision-making standards to classify all benefits, so that the same standard applies to M/S and MH/SUD benefits. For example, if a plan classifies care in skilled nursing facilities and rehabilitation hospitals for M/S benefits as inpatient benefits, it must classify covered care in residential treatment facilities for MH/SUD benefits as inpatient benefits.

FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT LIMITATIONS:

Types of Financial Requirements (FRs) include deductibles, copayments, coinsurance, and out-of-pocket maximums. 45 CFR 146.136(c)(1)(ii). Types of Quantitative Treatment Limitations (QTLs) include annual, episode, and lifetime day and visit limits, for example number of treatments, visits, or days of coverage. 45 CFR 146.136(c)(1)(ii). A two-part analysis applies to financial requirements (FRs) and quantitative treatment limitations (QTLs). In general, MHPAEA regulations require that any FR or QTL imposed on MH/SUD benefits not be more restrictive than the predominant level of financial requirement or treatment limitation of that type that applies to substantially all medical/surgical benefits in a classification.

If the plan applies a cumulative FR or QTL (a FR or QTL that determine whether or to what extent benefits are provided based on accumulated amounts), the FR or QTL must not accumulate separately from any established for M/S benefits in a classification.

FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT LIMITATIONS						
	Inpatient In-Network (if network tiers, may separate into tiers in accordance with 45 CFR 146.136(c)(3)(iii)(B)).	Inpatient Out-of-Network	Outpatient In-Network (Issuer can choose to have subclassifications for Outpatient Office Visits, and Other Outpatient Services) (if network tiers, may separate into tiers in accordance with 45 CFR 146.136(c)(3)(iii)(B))	Outpatient Out-of-Network (Issuer can choose to have subclassifications for Outpatient Office Visits, and Other Outpatient Services)	Emergency Care	Prescription Drugs
Does the plan provide MH/SUD benefits?						
Does the plan provide M/S benefits?						
~~Total dollar amount of all plan payments for MH/SUD benefits expected to be paid for the relevant plan year~~						
Total dollar amount of all plan payments for M/S benefits expected to be paid for the relevant plan year						
List each financial requirement that applies to the classification for MH/SUD benefits,~~, and attribute expected plan payments to each applicable financial requirement~~						
For each type of financial requirement that applies to MH/SUD benefits, list the expected percentage of plan payments for M/S benefits in each classification that are subject to that same type of financial requirement.						
For each level of each type of financial requirement that applies to at least 2/3rds of all M/S/ benefits in the classification, ~~,~~ list the expected percentage of plan						

payments for M/S benefits subject to that financial requirement, that are subject to that level.						
Does the plan impose a separate cumulative financial requirement or QTL for MH/SUD benefits that accumulates separately from any cumulative financial requirement or QTL for M/S benefits?						

	Inpatient In-Network (if network tiers, may separate into tiers in accordance with 45 CFR 146.136(c)(3)(iii)(B)).	Inpatient Out-of-Network	Outpatient In-Network (Issuer can choose to have subclassifications for Outpatient Office Visits, and Other Outpatient Services) (if network tiers, may separate into tiers in accordance with 45 CFR 146.136(c)(3)(iii)(B))	Outpatient Out-of-Network (Issuer can choose to have subclassifications for Outpatient Office Visits, and Other Outpatient Services)	Emergency Care	Prescription Drugs
List each QTL that applies to the classification for MH/SUD benefits.						
-For each type of QTL that applies to MH/SUD benefits, list the expected percentage of plan payments for M/S benefits in each classification that are subject to that same type of QTL.						
For each level of each type of QTL that applies to at least 2/3rds of all M/S benefits in the classification, ~~,~~ list the expected percentage of plan payments for M/S benefits subject to that QTL, that are subject to that level.						

NON-QUANTITATIVE TREATMENT LIMITATIONS:

Non-Quantitative Treatment Limitations include but are not limited to medical management techniques such as step therapy and pre-authorization requirements. Coverage cannot impose a NQTL with respect to MH/SUD benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to M/S benefits in the classification. Note that not every NQTL needs an evidentiary standard. There is flexibility under MHPAEA for plans to use NQTLs. The focus is on finding out what processes and standards the plan actually uses.

All plan standards that are not FRs or QTLs and that limit the scope or duration of benefits for services are subject to the NQTL parity requirements. This includes restrictions such as geographic limits, facility-type limits, and network adequacy.

The following data collection chart is modeled after a tool used in federal MHPAEA examinations. Insurers who have completed "Table 5" for NQTLs may substitute those documents for completion of this chart.

~~[insert Table 5]~~

NON-QUANTITATIVE TREATMENT LIMITATIONS			
Submit a separate form for each benefit plan design. Plan Name: Date: Contact Name: Telephone Number: Email: Line of Business (HMO, EPO, POS, PPO): Contract Type (large group, small group, individual): Benefit Plan Effective Date: Benefit Plan Design(s) Identifier(s):			
Area	**Medical/Surgical Benefits**	**Mental Health/Substance Use Disorder Benefits**	**Explanation**
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described and list this documentation in the space provided below.
A. Definition of Medical Necessity What is the definition of medical necessity?			

B. Prior-authorization Review Process Include all services for which prior authorization is required. Describe any step therapy or "fail first" requirements and requirements for submission of treatment request forms or treatment plans. Inpatient, In-Network:			
Outpatient, In-Network: Office Visits:			
Outpatient, In-Network: Other Outpatient Items and Services:			
Inpatient, Out-of-Network:			
Outpatient, Out-of-Network: Office Visits:			
Outpatient, Out-of-Network: Other Items and Services:			
C. Concurrent Review Process, including frequency and penalties for all services. Describe any step therapy or "fail first" requirements and requirements for submission of treatment required forms or treatment plans. Inpatient, In-Network:			
Outpatient, In-Network: Office Visits:			
Outpatient, In-Network: Other Outpatient Items and Services:			
Inpatient, Out-of-Network:			
Outpatient, Out-of-Network: Office Visits:			
Outpatient, Out-of-Network: Other Items and Services:			
D. Retrospective Review Process, including timeline and penalties. Inpatient, In-Network:			
Outpatient, In-Network: Office Visits:			
Outpatient, In-Network: Other Outpatient Items and Services:			
Inpatient, Out-of-Network:			
Outpatient, Out-of-Network: Office Visits:			

Outpatient, Out-of-Network: Other Items and Services:			
E. Emergency Services			
F. Pharmacy Services Include all services for which prior authorization is required, any step therapy or "fail first" requirements, any other NQTLs. Tier 1:			
Tier 2:			
Tier 3:			
Tier 4:			
G. Prescription Drug Formulary Design How are formulary decisions made for the diagnosis and medically necessary treatment of medical, mental health and substance use disorder conditions?			
Describe the pertinent pharmacy management processes, including, but not limited to, cost-control measures, therapeutic substitution, and step therapy.			
What disciplines, such as primary care physicians (internists and pediatricians) and specialty physicians (including psychiatrists) and pharmacologists, are involved in development of the formulary for medications to treat medical, mental health and substance use disorder conditions?			
H. Case Management What case management services are available?			
What case management services are required?			
What are the eligibility criteria for case management services?			
I. Process for Assessment of New Technologies Definition of experimental/investigational:			

Qualifications of individuals evaluating new technologies:			
Evidence consulted in evaluating new technologies:			
J. Standards for Provider Credentialing and Contracting Is the provider network open or closed?			
What are the credentialing standards for physicians?			
What are the credentialing standards for licensed non-physician providers? Specify type of provider and standards; e.g., nurse practitioners, physician assistants, psychologists, clinical social workers?			
What are the credentialing/contracting standards for unlicensed personnel; e.g., home health aides, qualified autism service professionals and paraprofessionals?			
K. Exclusions for Failure to Complete a Course of Treatment Does the plan exclude benefits for failure to complete treatment?			
L. Restrictions that Limit Duration or Scope of Benefits for Services Does the plan restrict the geographic location in which services can be received; e.g., service area, within the state, within the United States?			
Does the plan restrict the type(s) of facilities in which enrollees can receive services?			
M. Restrictions for Provider Specialty Does the plan restrict the types of provider specialties that can provide certain M/S and/or MH/SUD benefits?			
List of Documents Referenced Above *List each document referenced above, including reference to exhibit number, file name, or other identifying information for examiners.*			

Memo of changes to Mental Health Parity Handbook documents:

These changes were made by Laura Arp following the November 29, 2018 call.

Parity Introduction and List of 10 Questions:

Questions 4 and 5– made changes requested by NAIC Consumer Representatives.

Question 9 – deleted request for copies of documents with "disclosures" flagged (this was confusing), in response to comments by Theresa Morfe (MD) and the NAIC Consumer Representatives.

Data Collection Tool:

Deleted third row and part of the fifth row of the chart – they asked for dollar amounts for MH/SUD benefits and that information is not needed, as pointed out by Theresa Morfe (MD), ABHW, and the NAIC Consumer Representatives.

Added "plan payments for" to the sixth, seventh, tenth, and eleventh rows of the chart to make it clear the request is for dollar amounts of expected benefits paid for M/S benefits in each classification, as requested by Theresa Morfe (MD).

Added "Table 5" to the Data Collection Tool, as requested by Theresa Morfe (MD) and ABHW. Rather than adding "Table 6" (referenced in the instruction, "Provide the relevant pages of the documents in which the NQTLs are described and list this documentation on Table 6"), this version of Table 5 states, "Provide the relevant pages of the documents in which the NQTLs are described and list this documentation in the space provided below." Then at the bottom of the chart, language is added, "List of Documents Referenced Above. List each document referenced above, including reference to exhibit number, file name, or other identifying information for examiners."

Changes not made but up for consideration, so included as comments:

Additional question the NAIC Consumer Representatives suggested we add to the list of questions: "Are all conditions that are defined as being or as not being a mental health condition, a substance use disorder, or a medical condition defined in a manner that is consistent with generally recognized independent standards of current medical practice?"

The NAIC Consumer Representatives also suggested we add a column asking insurers to state how the MH/SUD benefits compare to the M/S benefits. My initial impression is that the "Explanation" column requires that insurers explain how application of the NQTL is in compliance with 45 CFR § 146.136(c)(4), which provides the parity standard for NQTLS. But if the group disagrees, a column can easily be added to the chart asking the insurers to explain any difference in the handling of M/S benefits compared to MH/SUD benefits.

ABHW
Advancing Health Care Policy
for Mental Health and Addiction

December 5, 2018

Via Electronic Mail (Petra Wallace - pwallace@naic.org)
Director Bruce R. Ramge
Nebraska Department of Insurance
941 O Street, Suite 400
Lincoln, NE 6850

Dear Director Ramge,

Thank you for the opportunity to provide oral comments related to mental health and addiction parity on the November 29th Market Conduct Exam Standards (D) Working Group call.

As a reminder, ABHW is the leading association working to advance federal policy on mental health and addiction services. Our members include top national and regional health plans that care for more than 175 million people in both the public and private sectors.

We are writing today to reiterate our comments that were made on the call in regard to the mental health parity provisions in the Market Regulation Handbook and in particular, the Data Collection Tool for Mental Health Parity Analysis.

In the testing analysis of financial requirements and quantitative treatment limits (QTLs) in the Data Collection Tool we believe the language within the table ought to be revised to make clear it is the testing of the financial requirements and QTLs applied to medical/surgical (M/S) benefits that dictates the type and/or level, of the financial requirements and QTLs, if any, that may be applied to the

Association for Behavioral Health and Wellness
1325 G Street NW · Suite 500 · Washington DC, 20005 · 202.449.7660 · ABHW.ORG

corresponding mental health/substance use disorder (MH/SUD) classifications of benefits. Such testing is based upon the percentage of expected plan payments for the M/S benefits within each classification of benefits for the plan year.

In the section addressing non-quantitative treatment limitations (NQTLs) we believe it is important for the tool to maintain a fidelity to the Mental Health Parity and Addiction Equity Act (MHPAEA) and its regulations. The tool could do this by permitting flexibility in NQTL methodologies and processes as long as such NQTL methodologies and processes are comparable to, and applied no more stringently, to MH/SUD benefits as compared to M/S benefits within each classification.

In response to comments advocating for the tool to adopt the 4-step NQTL analysis referenced within the recently amended Self-Compliance Tool published by the federal tri-agencies this past April, we are concerned that the 4-step NQTL analysis may be misinterpreted as requiring a prescriptive approach; such as, requiring every NQTL to be based upon a list of factors and requiring every factor to be based upon an evidentiary standard and/or source information.

We believe the data collection tool should make clear that the parity regulations governing NQTLs are not prescriptive and should not be misinterpreted as requiring NQTLs or NQTL factors to be based upon an evidentiary standard. However, if an NQTL factor is based upon an evidentiary standard that evidentiary standard should be disclosed and defined.

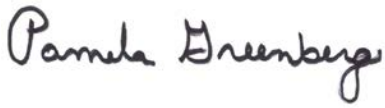
Moreover, we wish to point out that the 4-step analysis referenced within the Self-Compliance Tool is merely proposed guidance that is not yet final. It is our understanding the Department of Labor (DOL) is scheduling a meeting in January for interested parties to review and discuss the public comments submitted in response to the proposed guidance. We expect that after the discussion changes may be made to the

proposed guidance.

Regarding the proposed NQTL table, we suggest the use of Table 5 -- which is used by the Centers for Medicare and Medicaid Services (CMS) -- to ensure a consistent and uniform approach in parity enforcement efforts of NQTLs. We believe Table 5 shows a fidelity to MHPAEA and its regulations by providing flexibility to issuers in regard to disclosing information on "any processes, strategies, evidentiary standards or other factors" *actually utilized* by the issuer. Moreover, we feel Table 5 is clear and easy to read which will ultimately aid examiners in conducting efficient and productive NQTL examinations.

We continue to be appreciative of your consideration of our comments on the Workgroup's draft guidance. If you would like to discuss our recommendations I can be reached at greeenberg@abhw.org or (202) 449-7660.

Sincerely,



Pamela Greenberg, MPP
President and CEO

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MARKET REGULATION HANDBOOK
INSURANCE DATA SECURITY PRE-BREACH AND POST-BREACH CHECKLISTS

Company Name	
Period of Examination	
Examination Field Date	
Prepared By	
Date	

GUIDANCE

NAIC Insurance Data Security Model Law (#668)

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

OVERVIEW

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

REVIEW GUIDELINES AND INSTRUCTIONS

When reviewing a Licensee's Information Security Program for compliance with the Insurance Data Security Model Law (NAIC Model #668) for the prevention of a Cybersecurity Event as defined in the model law, please refer to the examination checklist attached as Exhibit A hereto.

When reviewing a Licensee's Information Security Program and response to a Cybersecurity Event for compliance with the Insurance Data Security Model Law subsequent to a suspected and/or known Cybersecurity Event as defined in the model law, please refer to both examination checklists attached as Exhibits A and Exhibit B hereto.

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

Exhibit A: Supplemental Incident Response Plan Readiness (Pre-Breach) Checklist for Operations/Management Standard #17 Insurance Data Security Model Law #668, Section 4

INFORMATION SECURITY PROGRAM (Sections 4A and 4B)

REVIEW CRITERIA	**NOTES *(YES, NO, NOT APPLICABLE, OTHER)***
1. Does the Licensee have a written Information Security Program (ISP)?	
2. Does the ISP clearly state the person(s) at the Licensee responsible for the program?	
3. Has the ISP been reviewed and approved by the Licensee's executive management?	
4. Has the ISP been reviewed and approved by the Licensee's Board of Directors? (Section 4E)	
5. Has the ISP been reviewed and approved by the Licensee's IT steering committee?	
6. How often is the ISP reviewed and updated? (Section 4G)	
7. Are any functions of the ISP outsourced to third parties? (*If YES, identify any such providers, review their roles and responsibilities, and the Licensee's oversight of the third parties*.)	
8. Does the ISP contain appropriate administrative, technical and physical safeguards for the protection of Nonpublic Information and the Licensee's Information Systems?	
9. Does the Licensee stay informed regarding emerging threats and vulnerabilities? (Section 4D(4))	
10. Does the Licensee regularly communicate with its employees regarding security issues?	
11. Does the Licensee ensure that employees' hardware is updated on a timely basis to ensure necessary security software updates and patches have been downloaded and installed?	
12. Does the Licensee provide cybersecurity awareness training to its personnel? (Section 4D(5))	
13. How soon after onboarding a new employee does the Licensee provide cybersecurity awareness training? At what intervals is the training renewed?	
14. Does the Licensee utilize reasonable security measures when sharing information? (Section 4D(4))	

Exhibit A: Supplemental Incident Response Plan Readiness (Pre-Breach) Checklist for Operations/Management Standard #17 Insurance Data Security Model Law #668, Section 4

RISK ASSESSMENT (Section 4C)

REVIEW CRITERIA	**NOTES *(YES, NO, NOT APPLICABLE, OTHER)***
15. Has the Licensee conducted a Risk Assessment to identify foreseeable internal and external threats to its information security?	
16. When was the last Risk Assessment conducted or updated?	
17. Has the Licensee designed its ISP to address issues identified in its Risk Assessment?	
18. Are Cybersecurity Risks included in the Licensee's Enterprise Risk Management process? (Section 4D(3))	

COMPONENTS OF INFORMATION SECURITY PROGRAM (Section 4D)

REVIEW CRITERIA	**NOTES *(YES, NO, NOT APPLICABLE, OTHER)***
19. Has the Licensee determined that the following security measures are appropriate, and has the Licensee implemented them as part of its ISP? *(If NO for any item, interview the appropriate responsible personnel to discuss the reason(s) such measures were not implemented.)*	
19a. Access controls to limit access to Information Systems to Authorized Individuals?	
19b. Physical controls on access to Nonpublic Information to limit access to Authorized Individuals?	
19c. Protection of Nonpublic Information by encryption or other appropriate means while being transmitted externally or stored on portable computing devices or media?	
19d. Secure development practices for in-house applications and procedures for testing the security of externally developed applications?	
19e. Controls for individuals accessing Nonpublic Information such as Multi-Factor Authentication?	
19f. Regular testing and monitoring of systems to detect actual and attempted attacks or intrusions into Information Systems?	
19g. Audit trails in the ISP to detect and respond to Cybersecurity Events and permit reconstruction of material financial transactions?	
19h. Measures to prevent Nonpublic Information from physical damage, loss or destruction?	
19i. Secure disposal procedures for Nonpublic Information?	

Exhibit A: Supplemental Incident Response Plan Readiness (Pre-Breach) Checklist for Operations/Management Standard #17 Insurance Data Security Model Law #668, Section 4

THIRD-PARTY SERVICE PROVIDERS (Section 4F)

REVIEW CRITERIA	**NOTES *(YES, NO, NOT APPLICABLE, OTHER)***
20. Does the Licensee have Third-Party Service Providers with which it shares Nonpublic Information?	
21. Does the Licensee include information security standards as part of its contracts with such providers?	
22. Does the Licensee conduct inspections or reviews of its providers' information security practices?	

INCIDENT RESPONSE PLAN (Section 4H)

REVIEW CRITERIA	**NOTES *(YES, NO, NOT APPLICABLE, OTHER)***
23. Does the ISP contain a written incident response plan and/or detailed process for responding to a Cybersecurity Event?	
24. Does the incident response plan provide clear guidance on when to initiate a Cybersecurity Event investigation?	
25. Does the incident response plan contain a list of clear and well-defined objectives?	
26. Does the incident response plan provide clear roles, responsibilities and levels of decision-making authority?	
27. Does the incident response plan require written assessment of the nature and scope of a Cybersecurity Event?	
28. Does the incident response plan require determination of whether any Nonpublic Information was exposed during a Cybersecurity Event and to what extent?	
29. Does the incident response plan provide clear steps to be taken to restore the security of any information systems compromised in a Cybersecurity Event?	
30. Does the incident response plan sufficiently address steps to take when a Cybersecurity Event occurs at a Third-Party Service Provider where data provided by the Licensee is potentially at risk?	
31. Does the incident response plan provide detailed instructions for external and internal communications, as well as information sharing with regulatory authorities?	
32. Does the incident response plan define various levels of remediation based on the severity of identified weaknesses?	

Exhibit A: Supplemental Incident Response Plan Readiness (Pre-Breach) Checklist for Operations/Management Standard #17 Insurance Data Security Model Law #668, Section 4

DOCUMENTATION AND REPORTING

REVIEW CRITERIA	**NOTES *(YES, NO, NOT APPLICABLE, OTHER)***
33. Does the ISP describe documentation and reporting procedures for Cybersecurity Events and related incident response activities? (Section 4H)	
34. Does the ISP require a post-event evaluation following a Cybersecurity Event? (Section 4H)	
35. Does the ISP require retention of all records related to Cybersecurity Events for a minimum of five years? (Section 5D)	
36. Has the Licensee prepared and submitted annual certifications to its domiciliary state Commissioner/Director of Insurance? (Section 4I)	

PRIOR EXAMINATION FINDINGS

REVIEW CRITERIA	**NOTES *(YES, NO, NOT APPLICABLE, OTHER)***
37. Has the Licensee addressed and implemented corrective actions to any material findings from any prior examinations?	

Exhibit B: Supplemental Incident Response Plan Investigation (Post-Breach) and Notification Cybersecurity Event Checklist for Operations/Management Standard #17 Insurance Data Security Model Law #668, Section 5 and 6

POST-EVENT INVESTIGATION BY LICENSEE (Section 5)

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

NOTICE TO COMMISSIONER/DIRECTOR OF INSURANCE (Section 6)

REVIEW CRITERIA	**NOTES *(YES, NO, NOT APPLICABLE, OTHER)***
3. Did the Licensee provide timely notice (no later than 72 hours) to the Commissioner or Director of Insurance following the Cybersecurity Event? (Section 6A)	
4. Did the Notification to the Commissioner or Director of Insurance include the following information, to the extent reasonably available? (Section 6B)	
4a. The date of the Cybersecurity Event, or the date upon which it was discovered?	
4b. A description of how the Nonpublic Information was exposed, lost, stolen or breached, including the specific roles and responsibilities of Third-Party Service Providers, if any?	
4c. How the Cybersecurity Event was discovered?	
4d. Whether any lost, stolen or breached Nonpublic Information has been recovered, and if so, how this was done?	
4e. The identity of the source of the Cybersecurity Event?	
4f. Whether the Licensee has filed a police report or has notified any regulatory, government, or law enforcement agencies? *(If YES, did the Licensee provide the date(s) of such notification(s)?)*	
4g. A description of the specific types of Nonpublic Information acquired without authorization?	
4h. The period during which the Information System was compromised by the Cybersecurity Event?	
4i. A best estimate of the number of total Consumers in this state and globally affected by the Cybersecurity Event?	
4j. The results of any internal review of automated controls and internal procedures and whether or not such controls and procedures were followed?	
4k. A description of efforts being undertaken to remediate the circumstances which permitted the Cybersecurity Event to occur?	
4l. A copy of the Licensee's privacy policy and a statement outlining the steps the Licensee will take to investigate the Cybersecurity Event and to notify affected Consumers?	
4m. The name of a contact person familiar with the Cybersecurity Event and authorized to act for the Licensee?	
5. Did the Licensee provide timely updates to the initial notification and Questions 4a-4m above? (Section 6B)	

OTHER NOTIFICATIONS (Section 6)

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

THIRD PARTY SERVICE PROVIDERS

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

POST-EVENT ANALYSIS

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

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OLD REPUBLIC NATIONAL TITLE INSURANCE COMPANY

Robyn E. Anderson
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400 Second Avenue South, Minneapolis, MN 55401-2499 | T: 612.336-7062
randerson3@oldrepublictitle.com

December 13, 2018

Director Bruce R. Ramge, Chair
Market Conduct Examination Standards (D) Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106

Attn: Petra Wallace
Via e-mail pwallace@naic.org

Re: Insurance Data Security Pre-and Post-Breach Checklists

Dear Director Ramge,

We appreciate the opportunity to offer the following observations regarding the draft Pre-and Post-Breach Checklists (Checklists). It appears that the draft Checklists are intended to follow the requirements of the NAIC Data Security Model Law (Model Law).[1] Assuming that is the case, we offer the following observations to demonstrate where the Checklists appear to depart from the language of the Model Law which could create confusion and/or additional requirements beyond that of the Model Law:

1) Under Information Security Program (Sections 4A and 4B)
   a) Item number 2 asks, "Does the ISP clearly state the persons(s) at the licensee responsible for the program." There is nothing in Sections 4A or 4B that mentions this requirement. Section 4C(1) provides that pursuant to the risk assessment, "[t]he licensee shall designate one or more employees….who is responsible for the Information Security Program." There is a difference between these two requirements. A licensee may have designated responsible persons but not named those persons in the Company ISP documentation.
   b) Item number 3 asks, "Has the ISP been reviewed and approved by the Licensee's executive management?" There is nothing in Sections 4A or 4B that mentions this requirement. Section 4E(3) provides that "[I]f executive management delegates any of its responsibilities under section 4,…it shall oversee the development, implementation and maintenance of the Licensee's Information Security Program

[1] The review guidelines and instructions provide "[w]hen reviewing a Licensee's Information Security Program for compliance with the Insurance Data Security Model Law (NAIC Model #668)…please refer to …[e]xamination checklists attached as Exhibit A [a]nd B hereto."

prepared by the delegate(s) and shall receive a report from the delegates…" The difference here is the language "review and approve" versus "oversee".

c) Item number 4 asks, "Has the ISP been reviewed and approved by the Licensee's Board of Directors?" There is nothing in Sections 4A or 4B that mentions Board approval. In addition, Section 4E, which does address Board oversight, does not require review and approval of the ISP by the Licensee's Board of Directors. Rather, it provides that a committee of the Board shall "[r]equire the Licensee's executive management or its delegates to develop, implement, and maintain the Licensee's Information Security Program…"
d) Item number 5 asks, "Has the ISP been reviewed and approved by the Licensee's IT steering committee." We cannot find where there is such a requirement in the Model Law.
e) Items 10 and 12 appear to call for the same information regarding employee training. It is unclear if these requirements are intended to solicit different responses.
f) Item 13 appears to anticipate certain timing with regard to employee training but the Model Law provides only the following requirements, "[P]rovide its personnel with cybersecurity awareness training that is updated as necessary to reflect risks identified by the Licensee in the Risk Assessment (4)(d)(5) and, [A]ssess the sufficiency of policies, procedures, Information Systems and other safeguards in place to manage these threats, including consideration of threats in each relevant area of the Licensee's operations, including: (a) Employee training and management." (C)(4)(a). Neither of these requirements set a timetable for employee training.

2) Under Components of Information Security Program (section 4D)
   a) Item 19d states, "[S]ecure development practices for in-house applications and procedures for testing the security of externally developed applications." Section 4(D)(2)(e) of the Model Law provides the following language, "[p]rocedures for evaluating, assessing or testing." The deletion of the terms "evaluating" and "assessing" removes two of the three options available in the Model Law.

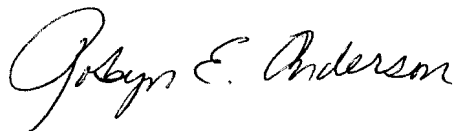
3) Under Incident Response Plan (section 4H)
   a) Item 30 introduces additional language and requirements into the Incident Response Plan regarding Third-Party Servicers that is not found in the Model Law section 4(H)(2)(a)-(g).
   b) Item 32 also appears to introduce additional language regarding "[v]arious levels of remediation based on the severity of identified weaknesses." This language is not found in 4(H)(2)(e).

4) Under Documentation and Reporting Review Criteria
   a) Items 33 through 35 require certain documentation within the Licensee's ISP when it appears to be addressing requirements of 4(H) and therefore, requirements of documentation within the Licensee's Incident Response Plan.

To be clear, we are not taking the position that the items in the Pre- and Post-Breach Checklists are unreasonable. We simply want to raise the issue that because the language used is different than the Model Law language there could be confusion and/or additional requirements imposed that go beyond the Model Law adopted by the NAIC.

We thank you for your consideration of these observations.

Sincerely,



Robyn E. Anderson
First Vice President, Chief Cybersecurity and Privacy Counsel

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December 17, 2018

Director Bruce R. Ramge, Chair
Mr. Jim Mealer, Vice Chair
Market Conduct Examination Standards (D) Working Group
NAIC Central Office
1100 Walnut, Suite 1500
Kansas City, MO 64106-2197

Attn: Petra Wallace, Market Regulation Specialist

VIA Electronic Mail: pwallace@naic.org

RE: Additional Comments on the New Insurance Data Security Pre-Breach Checklists for Inclusion in the Market Regulation Handbook

Dear Director Ramge and Mr. Mealer:

The American Insurance Association (AIA) appreciates the continued dialogue related to the National Association of Insurance Commissioners' (NAIC) draft Insurance Data Security Pre- & Post-Breach Checklists (Checklists) for inclusion in the Market Regulation Handbook (Handbook). The background and explanations on committee calls has been very helpful and we provide the following additional feedback for your consideration.

AIA recognizes and supports the regulators' responsibility and need to review an insurer's information security program taking into consideration the risk-based characteristics of these programs. On the November 30th call of Market Conduct Examination Standards (D) Working Group (Working Group), it was noted that pre-examination of insurance data security is typically covered in the financial exam, but due to budget and staffing constraints uniformity is not an objective that the handbook or leadership can provide definitive guidance on. As such the pre-breach checklist can serve as a reference document for those states that perform cyber examinations as part of the market conduct exam.

After further consideration, while we understand and appreciate the challenges to create uniformity, we believe that it is a worthwhile and important effort to encourage pre-breach assessments to be performed as part of the Financial Examination. We believe this approach would foster rather than harm corporate resiliency for the following reasons:

(1) **Efficiency:** The IT Examination component of the financial examination is a robust review that has incorporated the security elements of the Insurance Data Security Model Law and was recently amended to ensure there were no gaps related to the Model Law. Further, the financial exam is a review of the whole organization, so it provides a better understanding of the company's security

practices. Additionally, reviewing pre-breach security measures as part of the market conduct examination and the IT portion of the financial examination makes a lot of the pre-exam examination work redundant. The market conduct pre-breach checklist is also redundant to the annual certification that licensees must file as part of the Model Law requirements. The IT examination portion of the Financial Examination should be the sole vehicle for examining pre-breach security measures.

(2) **Expertise:** Arguably the individuals conducting the market conduct exam will not have the same expertise that those performing the IT examination do. This raises timing concerns, because key personnel could be taken away from core resiliency efforts to explain processes and procedures to unfamiliar examiners. This concern becomes elevated in the instance that there are several states performing cyber reviews as part of their market conduct examination process on the same group of companies in a given year. Now integral IT security personnel could be pulled away multiple times to explain the same processes and procedures. Finally, some Departments may hire special contractors to perform cyber reviews thereby resulting in unnecessary expenses that increase the cost of an examination that ultimately is redundant.

(3) **Coordination:** **C**onsistency in the examination framework is essential to avoid duplication and inconsistent examination standards for the same system with the same legal expectations in a risk-based environment. As such, the Financial examination process creates greater efficiency for companies and regulators.

(4) **Scope**: Market conduct examinations are directed at how the insurer interacts with consumers and agents reviewing primarily underwriting and claim handling practices. Security can have a consumer angle, but that is in a post-breach situation and in that context we can understand why a market conduct exam may be conducted to ensure all notification requirements were met in a timely manner.

We appreciate the recommendation to incorporate the guidance into Section 20 of the handbook, but, respectfully, feel that this is misplaced. Chapter 20 on its face appears to be the right fit given its review of the operations and management of the insurer, but it is our understanding that this review is for purposes of understanding the structure of the insurer and its operations to get a better understanding of the examinee not necessarily to duplicate the financial examination review.

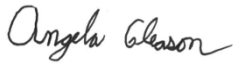
(5) **Adaptability:** We can't stress enough that cybersecurity cannot be a checkbox exercise. Companies need to create risk-based programs that are adaptable to the rapidly evolving nature of the threat and technology solutions. Unfortunately, the yes/no checkbox tool used by the market conduct examination does not support a flexible risk-based program. In our August 15th comment letter we identified some of the problems and concerns that yes/no questions raise.

(6) **Confidentiality:** The confidentiality and protection of information in this context is critical. Consideration should be given as to what examination method provides the strongest confidentiality protections.

For these reasons, we respect the effort and diverse regulatory needs, but urge the Working Group to eliminate a pre-breach checklist for inclusion in the market conduct exam. Instead, it may be useful to understand the current cyber examination landscape and survey the states to determine which states rely on the Market Conduct, Financial Exam, other examination tool, or combination of all of the above. This information can help create an examination framework that promotes resiliency and meets regulator needs.

AIA appreciates the opportunity to provide additional feedback and remains committed to a constructive and collaborative dialogue. Our feedback on the post-breach checklist can be found in our August 15th letter. Please let us know if you have any questions or if we can be of any further assistance.

Respectfully submitted,



Angela Gleason
Senior Counsel

POLICY IN FORCE STANDARDIZED DATA REQUEST
Property & Casualty Line of Business
Private Passenger Auto

Contents: This file should be downloaded from company system(s) and contain one record for each vehicle insured under a private passenger auto policy issued in [applicable state] which was in force at any time during the examination period.

For any fields where there are multiple entries, please repeat field as necessary.

Uses: Data will be used to determine if the company follows appropriate procedures with respect to the issuance and/or termination of private passenger automobile policies in [applicable state] within the scope of the examination:

- 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**)
PolStTyp	32	3	A		Policy status type for the record (i.e., new or renewal) **Please provide a list to explain any codes used**
PolTyp	35	25	A		Type of policy, if any (i.e., standard, preferred, nonstandard) **Please provide a list to explain any codes used**
PolForm	60	10	A		Policy form number as filed with the insurance department
PrCode	70	9	A		Company internal producer, CSR, or business entity producer identification code **Please provide a list to explain any codes used**
NPN	79	6	A		National producer number
InsFirst	85	15	A		First name of the first named insured
InsMid	100	15	A		Middle name of the first named insured
InsLast	115	20	A		Last name of the first named insured
InsAddr	135	25	A		Insured street address (mailing)
InsCity	160	20	A		Insured city (mailing)
InsSt	180	2	A		Insured state (mailing)
InsZip	182	9	A		Insured ZIP code (mailing)
GarAddr	191	25	A		Vehicle garaging address
GarCity	216	20	A		Vehicle garaging city
GarSt	236	2	A		Vehicle garaging state

GarZip	238	9	A		Vehicle garaging ZIP code
PUndDrSx	247	1	A		Primary underwritten driver's sex
PUndDrMs	248	1	A		Primary underwritten driver's marital status
PUndDrEd	249	25	A		Primary underwritten driver's education level **Please provide a list to explain any codes used**
PUndDrOc	274	50	A		Primary underwritten driver's occupation **Please provide a list to explain any codes used**
VehUBI	324	1	A		Does usage based insurance apply to vehicle (Y/N)
PolPrem	325	11	N	2	Total policy premium amount (Sum of all premium for all vehicles, which includes premium, fees, etc.)
UWTier	336	25	A		Underwriting tier (policy or vehicle), if tier rating is utilized **Please provide a list to explain any codes used**
VehYr	361	4	A		Vehicle year
VehMake	365	15	A		Vehicle make **Please provide a list to explain any codes used**
VehModel	380	20	A		Vehicle model **Please provide a list to explain any codes used**
VIN	400	17	A		Vehicle identification number
VehSym	417	5	A		Vehicle symbol **Please provide a list to explain any codes used**
VehPrem	422	11	N	2	Total vehicle premium amount (Sum of all premium for the vehicle, involving all premium, fees, etc.)
BIBas	433	11	N	2	Bodily injury liability term base premium for this limit
BICls	444	6	A		Bodily injury liability driver class factor **Please provide a list to explain any codes used**
BIDev	450	6	A		Bodily injury liability deviation factors (i.e., discounts, credits, etc.) **Please provide a list to explain any codes used**
BILmtPP	456	3	N		Bodily injury limit per person (in thousands)
BILmtPA	459	3	N		Bodily injury limit per accident (in thousands)
BITrm	462	6	A		Bodily injury liability term factor
PDBas	468	11	N	2	Property damage liability term base premium
PDCls	479	6	A		Property damage liability driver class factor **Please provide a list to explain any codes used**
PDDev	485	6	A		Property damage liability deviation factors (i.e., discounts, credits, etc.) **Please provide a list to explain any codes used**
PDLmt	491	3	N		Property damage liability limit per accident (in thousands)
PDTrm	494	6	A		Property damage liability term factor
LiaCsl	500	3	N		Single liability limit (in thousands)
CLBas	503	11	N	2	Collision term base premium
CLCls	514	6	N		Collision driver class factor
CLDed	520	11	N	2	Collision deductible
CLDev	531	6	A		Collision deviation factors (i.e., discounts, credits, etc.) **Please provide a list to explain any codes used**
CLDedFct	537	6	A		Collision deductible factor
CLTrm	543	6	A		Collision term factor
CMBas	549	11	N	2	Comprehensive term base premium for this model year and symbol vehicle

CMCls	560	6	A		Comprehensive class factor
CMDed	566	11	A	2	Comprehensive deductible
CMDev	577	6	A		Comprehensive deviation factor (i.e., discounts, credits, etc.) **Please provide a list to explain any codes used**
CMFact	583	6	A		Comprehensive deductible factor
CMTrm	589	6	A		Comprehensive term factor
MPBas	595	11	N	2	Medical payments term base premium for this limit
MPCls	606	6	A		Medical payments class factor
MPDev	612	6	A		Medical payments deviation factors (i.e., discounts, credits, etc.) **Please provide a list to explain any codes used**
MPLmt	618	11	N	2	Medical payments limit
MPTrm	629	6	A		Medical payments term factor
ERSTrm	635	11	N	2	Emergency road service term base premium
ERSOpt	646	11	N	2	Emergency road service optional benefit **If codes are used, provide a list of codes along with their meanings**
RentTrm	657	11	N	2	Rental reimbursement term base premium
RentDay	668	11	N	2	Rental reimbursement daily limit
RentAgg	679	11	N	2	Rental reimbursement aggregate
UMPDBas	690	11	N	2	Uninsured motorist property damage term base premium
UMPDDev	701	6	A		Uninsured motorist property damage deviation factors **If codes are used, provide a list of codes along with their meanings**
UMPDLmt	707	3	N		Uninsured motorist property damage limit (in thousands)
UMPDDed	710	11	N	2	Uninsured motorist property damage deductible
UMPDFact	721	6	A		Uninsured motorist property damage deductible factor
UMBIBas	727	11	N	2	Uninsured motorist bodily injury term base premium
UMBIDev	738	6	A		Uninsured motorist bodily injury deviation factors **If codes are used, provide a list of codes along with their meanings**
UMBIPP	744	11	N	2	Uninsured motorist bodily injury limit per person (in thousands)
UMBIPA	755	3	N		Uninsured motorist bodily injury limit per accident (in thousands)
UMCsl	758	3	N		Uninsured motorist combined single limit (in thousands)
UIMBas	761	11	N	2	Underinsured motorist term base premium
UIMDev	772	6	A		Underinsured motorist deviation factors **If codes are used, provide a list of codes along with their meanings**
UIMPP	778	3	N		Underinsured motorist limit per person (in thousands)
UIMPA	781	3	N		Underinsured motorist limit per accident (in thousands)
UIMTrm	784	6	A		Underinsured motorist term factor
RateTerr	790	5	A		Code specifying rating territory **Provide a list of codes along with their meanings**

MVRDt	795	10	D		Date of most recent motor vehicle record (MVR) [MM/DD/YYYY]
DrDOB	805	10	D		Driver date of birth [MM/DD/YYYY]
VehSur	815	11	N	2	Vehicle surcharge amount (2 decimal places. Do not use commas or dollar signs.) **If codes are used, provide a list of codes along with their meanings**
VehDis	826	5	A		Vehicle discounts **If codes are used, provide a list of codes along with their meanings**
DrSur	831	11	N	2	Driver surcharge amount (2 decimal places. Do not use commas or dollar signs.) **If codes are used, provide a list of codes along with their meanings**
DriDis	842	5	A		Driver discounts **If codes are used, provide a list of codes along with their meanings**
AppRecDt	847	10	D		Date application received [MM/DD/YYYY]
AppProDt	857	10	D		Date application processed [MM/DD/YYYY]
InceptDt	867	10	D		Inception date of the policy [MM/DD/YYYY]
EffDt	877	10	D		Policy effective date [MM/DD/YYYY]
ExpDt	887	10	D		Policy expiration date (MM/DD/YYYY)
PdDt	897	10	D		Date policy was paid to before cancellation [MM/DD/YYYY]
CanReqDt	907	10	D		Date cancellation requested, if applicable [MM/DD/YYYY]
CanTerRs	917	64	A		Reason for cancellation/termination of coverage (i.e., lapse, insured request, company cancellation) **If codes are used, provide a list of codes along with their meanings**
CanTer	981	1	A		Who cancelled the coverage **C=Consumer and I=Insurer**
CanTerDt	982	10	D		Date policy cancelled/terminated [MM/DD/YYYY]
CanTerNt	992	10	D		Date the cancellation/termination notice was mailed [MM/DD/YYYY]
PremRef	1002	11	N	2	Amount of premium refunded to the insured
RfndDt	1013	10	D		Date premium refund mailed [MM/DD/YYYY]
RefMthd	1023	25	A		Refund method (i.e., 90%, pro rata, etc.) **If codes are used, provide a list of codes along with their meanings**
SurAmt	1048	11	N	2	Surcharge amount (2 decimal places. Do not use commas or dollar signs.)
TrafVio	1059	3	A		Number of rated traffic violations
MVAccd	1062	3	A		Number of rated vehicle accidents
EndRec	1065	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.

CLAIMS STANDARDIZED DATA REQUEST
Property & Casualty Line of Business
Private Passenger Auto

Contents: This file should be downloaded from company system(s) and contain one record for each claim transaction (i.e. paid/denied/pending/closed w/o payment) that the company processed within the scope of the examination. Include all claims open during the examination period. Do not include expense payments to vendors.

Uses: Data will be used to determine if the company follows appropriate procedures with respect to the handling of Property & Casualty claims 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; and
- Cross-reference to state (s) licensing information to ensure proper adjuster 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**)
ClmNo	32	15	A		Claim number
ClmPre	47	3	A		Claim number prefix (**Blank if NONE**)
ClmSuf	50	3	A		Claim number suffix (**Blank if NONE**)
Cov	53	5	A		Coverage under which claim was submitted
CovStat	58	10	A		Coverage status (e.g. paid, denied, pending, etc.) **Please provide a list to explain any codes used**
CATCode	68	6	A		Catastrophe (CAT) loss code, if applicable (**Blank if NONE**)
InsFirst	74	15	A		First name of insured
InsMid	89	15	A		Middle name of insured
InsLast	104	20	A		Last name of insured
InsAddr	124	100	A		Insured street address (mailing)
InsCity	224	20	A		Insured city (mailing)
InsSt	244	2	A		Insured resident state (mailing)
InsZip	246	5	A		Insured ZIP code (mailing)
CmtFirst	251	15	A		First name of claimant
CmtMid	266	15	A		Middle name of claimant
CmtLast	281	20	A		Last name of claimant (Entity filing proof of loss, e.g. business, etc.)

Field Name	Start	Length	Type	Decimals	Description
CmtAddr	301	100	A		Claimant street address
CmtCity	401	20	A		Claimant city
CmtSt	421	2	A		Claimant state
CmtZip	423	5	A		Claimant ZIP code
ClmStat	428	10	A		Claim status P = Paid, D = Denied, N = Pending, H = Partial Payment, C = Closed Without Payment, R = Rescinded
AdjCode	438	9	A		Internal adjuster identification code **Please provide a list to explain any codes used**
NPN	447	6	A		National (adjuster) number
LossDt	453	10	D		Date loss occurred [MM/DD/YYYY]
RcvdDt	463	10	D		First notice of loss [MM/DD/YYYY]
ClmAckDt	473	10	D		Date company or its producer acknowledged the claim [MM/DD/YYYY]
DtClmFrm	483	10	D		Date claim forms sent to claimant [MM/DD/YYYY]
NtcInvDt	493	10	D		Date of written notice to insured/claimant regarding incomplete investigation [MM/DD/YYYY]
PdClmAmt	503	11	N	2	Total amount of claim paid
ClmPay	514	50	A		Claim payee
ClmPdDt	564	10	D		Claim paid date [MM/DD/YYYY]
IntPdAmt	574	11	N	2	Amount of interest paid, if applicable
IntPdDt	585	10	D		Date interest paid [MM/DD/YYYY]
ClmDnyDt	595	10	D		Date claim was denied [MM/DD/YYYY]
ClmDenRsn	605	100	A		Reason for claim denial **Please provide a list to explain any codes used**
Subro	705	1	A		Indicate whether claim was subrogated (Y/N)
SubRecdDt	706	10	D		Date company received subrogation refund [MM/DD/YYYY]
SubAmt	716	11	N	2	Subrogation received amount
AmtSubRm	727	11	N	2	Amount of subrogation reimbursed to insured
SubRefDt	738	10	D		Date subrogation refunded to insured [MM/DD/YYYY]
TotalLoss	748	1	A		Indicate whether claim was a "Total Loss" (Y/N)
FrstLiab	749	5	N	2	Percentage of first party comparative negligence (e.g. 30%= 0.30), if applicable
ThrdLiab	754	5	N	2	Percentage of third party comparative negligence (e.g. 30%= 0.30), if applicable (repeat if necessary)
VehYr	759	4	A		Vehicle year
VehMake	763	20	A		Vehicle make **Please provide a list to explain any codes used**
VehModel	783	20	A		Vehicle model **Please provide a list to explain any codes used**
VIN	803	17	A		Vehicle identification number
NumOcc	820	2	A		Number of occupants in vehicle at time of accident

Field Name	Start	Length	Type	Decimals	Description
NetRpr	822	1	A		Repair handled through network repair shop (Y/N)
EndRec	823	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.

DECLINATION STANDARDIZED DATA REQUEST
Property & Casualty Personal Line of Business

Contents: This file should be downloaded from company or agency system(s) and contain one record for each policy application declined in [applicable state] at any time during the examination period.

Uses: Data will be used to determine if the company/agency follows appropriate procedures with respect to the declination of policy applications in [applicable state] at any time during the examination period:

- 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.

Field Name	Start	Length	Type	Decimals	Description
CoCode	1	5	A		NAIC company code
AppNo	6	10	A		Application number or quote number
PRCode	16	9	A		Company internal producer, CSR, or business entity producer identification code **Please provide a list to explain any codes used**
NPN	25	6	A		National producer number
LOB	31	3	A		Line of business according to annual financial statement **Please provide a list to explain LOB codes**
AppFirst	34	15	A		First name of applicant
AppMid	49	15	A		Middle name of applicant
AppLast	64	20	A		Last name of applicant
AppAddr	84	25	A		Applicant address
AppCity	109	20	A		Applicant city
AppState	129	2	A		Applicant state
AppZip	131	9	A		Applicant ZIP code
AppRecDt	140	10	D		Date application received [MM/DD/YYYY]
DeclDt	150	10	D		Date of declination [MM/DD/YYYY]
DeclRsn	160	20	A		Reason for declining application **If codes are used, provide a list of codes along with their meanings**
EndRec	180	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.