NAIC
National Association of Insurance Commissioners

Market Regulation Handbook

VOLUME IV

2019

NAIC
National Association of Insurance Commissioners

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NAIC Executive Office
444 North Capitol Street, NW
Suite 700
Washington, DC 20001
202.471.3990

NAIC Central Office
1100 Walnut Street
Suite 1500
Kansas City, MO 64106
816.842.3600

NAIC Capital Markets
& Investment Analysis Office
One New York Plaza, Suite 4210
New York, NY 10004
212.398.9000

Market Regulation Handbook

2019 Edition

Volume IV

Review/Examination Criteria for Specific Types of Insurance and Regulated Entities

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This guidance is as adopted by the NAIC as of December 2018. Please note that there are modifications to the chapters that are included in this handbook during each calendar year, as such guidance is subject to the maintenance process. To address this, the NAIC has a web page dedicated to providing the holder of this manual with the latest information/interim adoptions which impact the content of this handbook.

State regulators may access updates adopted after December 2018 and *Market Regulation Handbook* Reference Documents via myNAIC on StateNet at the link Market Regulation Handbook, Handbook Updates and Reference Documents.

Non-regulator purchasers of the 2019 *Market Regulation Handbook* may access updates adopted after December 2018 and *Market Regulation Handbook* Reference Documents via the Account Manager login at *www.naic.org/account_manager.htm*.

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VOLUME IV—FORWARD
Review/Examination Criteria for Specific Types of Insurance and Regulated Entities

There are three types of market conduct examination standards in the *Market Regulation Handbook*: 1) general examination standards, which apply to all lines of business; 2) line of business-specific or product-specific examination standards; and 3) examination standards which pertain to specific types of regulated entities.

Within each chapter, examination standards are further broken down into categories corresponding to the business area being reviewed by examiners. The examination of the insurance operations of a regulated entity may involve reviewing one or more of the following business areas:

- Operations/Management;
- Complaint Handling;
- Marketing and Sales;
- Producer Licensing;
- Policyholder Service;
- Underwriting and Rating; and
- Claims.

The business areas in each of the following chapters vary, depending upon the line of business, type of insurance product, or type of regulated entity. The examination standards in each business area may suggest other areas of review that may be appropriate on an individual state basis.

Intended Use of the *Market Regulation Handbook*

This handbook is only a guide and should be used by each jurisdiction as a tool for developing jurisdiction-specific procedures and guidelines. To effectively use this handbook, it is recommended that each jurisdiction closely review the handbook to determine those standards that reflect the statutes and regulations of the given jurisdiction and those that do not. This handbook is designed solely to provide assistance to each jurisdiction in developing effective and consistent methodology. It does not reflect policies or procedures that are required to be implemented by any jurisdiction. It is not intended that market regulators apply any requirements to the market regulation process beyond the laws of their respective jurisdictions. To the extent possible, jurisdictions are encouraged to follow the standards established in this handbook. The text of this handbook becomes the procedure or policy of a given jurisdiction only after it has been adopted by that agency. Deviations from this handbook by an agency to accommodate the specific requirements of its own jurisdiction should not be construed as a failure of that agency to implement adequate examination or other market regulation procedures.

It is also important that each jurisdiction communicate to its market regulators the intent and scope of its market regulatory efforts. This includes direction regarding in which areas a jurisdiction's market analysis, market conduct initiatives and regulatory responses are to be concentrated, and what standards and criteria are to be considered within any particular subject area. For example, a jurisdiction may wish to concentrate on market analysis of complaint data and trends in a specific line of business or a jurisdiction may wish to focus upon a regulated entity's compliance with a limited number of key components of a particular state regulation. Specific direction provided by a jurisdiction to its market regulators will serve to sharpen the jurisdiction's focus on its market regulatory activities and will also conserve jurisdiction and company staff resources.

Structure of the *Market Regulation Handbook*

Beginning with the 2018 edition of the *Market Regulation Handbook*, the subject matter of the handbook is restructured and divided into four volumes:

- Overview of market regulation oversight;
- What is market analysis;
- How to conduct market conduct examinations; and
- Review/Examination criteria for specific types of insurance and regulated entities.

The *Market Regulation Handbook* table of contents outlines the subject areas contained within each volume. The purpose of the restructuring of the handbook is to combine interrelated chapters into the broad categories outlined above and to provide regulators with functional guidance to support state insurance department market surveillance activities.

Updating the *Market Regulation Handbook*

This handbook is updated and released on an annual basis. Updates to the *Market Regulation Handbook* that are adopted periodically during the year by the Market Regulation and Consumer Affairs (D) Committee will be posted on the NAIC website. Instructions for accessing the updates on the NAIC website are located at the front of the most recently published *Market Regulation Handbook*.

Chapter 20—General Examination Standards

The examination of the insurance operations of a regulated entity may involve reviewing one or more of the following business areas:

A. Operations/Management
B. Complaint Handling
C. Marketing and Sales
D. Producer Licensing
E. Policyholder Service
F. Underwriting and Rating
G. Claims

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

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

This chapter contains examination standards that are relevant to nearly all types of examinations. Chapters 21 through 32 contain standards that are specific to various product lines and specialized entities.

A. Operations/Management

1. Purpose

The Operations/Management portion of the examination is designed to provide a view of what the regulated entity is and how it operates. It is not based on sampling techniques; it is more concerned with structure. This review is not intended to duplicate a financial examination review, but is important in providing the market conduct examiner with an understanding of the examinee. Many troubled companies have become so because management has not been structured to recognize and address the problems that can arise in the insurance industry. The areas to be considered in this kind of review include:

a. History;
b. Profile;
c. Subcontractor oversight;
d. Internal audits;
e. Antifraud initiatives;
f. Certificates of authority;
g. Disaster recovery plan;
h. Computer systems;
i. Minutes from all meetings attended by the board of directors; and
j. Privacy.

2. Techniques

Typically, the items to be reviewed here can be prepared by the regulated entity and provided at the pre-examination conference. Supplemental information, including history and profile may be available in the insurance department files. Other items suggest an active review of regulated entity files relating to managing general agent (MGA) or subcontractor oversight, internal audits, procedure manuals, record management, computer systems controls and antifraud plans. The latter category of items should have substantial supporting documentation.

The absence of subcontractor oversight, internal audit functions, written procedures or an antifraud plan should be specifically noted when preparing the examination report.

a. History

The examiner should prepare for the examination report a very brief history of the regulated entity, including its formation; its type; its structure, including the parent corporation and other members of the group; and any major changes that are relevant to the current examination.

b. Profile

The profile includes an overview of the regulated entity's operations, including management structure, type of carrier, states where the regulated entity is licensed and the entity's major line(s) of business. A total change in the management team may generate the need to review the regulated entity on an abbreviated time cycle.

The examiner should review Market Action Tracking System (MATS) findings from prior examinations, Regulatory Information Retrieval System (RIRS) results, complaint index reports and reports from other NAIC applications and databases to determine if other regulators have expressed concerns that may require additional attention during the examination. RIRS and MATS information should not be included in the examination report.

The total written premiums for the major lines of business should be compared to the total writing in a given state to determine the market share. The loss, expense and combined ratios can be obtained from the expense exhibit attached to the annual statement or the NAIC Financial Analyst Workbench (FAW) system and may be calculated for the specific jurisdiction. Review IRIS ratios, which can be an indicator of market conduct problems. The surplus ratio should also be examined and noted for the period under review. Substantial shifts in the geographical area of operation and kinds of business written and volume should be noted, questioned and described.

c. Subcontractor Oversight

The jurisdiction's statutes on MGAs and other subcontractors are sources of tests for this oversight. The aim is to ensure that the regulated entity using subcontractors engages in a realistic level of oversight. Contracts should be reviewed to ensure compliance with the MGA statutes governing contract content and oversight features. The focus is on the oversight impacting records and actions considered in a market conduct examination such as, but not limited to, trade practices, claims practices, policy selection and issuance, rating, complaint handling, etc. Examiners should pay particular attention to a subcontractor's dealings with policyholders and claimants.

d. Internal Audits

A regulated entity that has no internal audit function lacks the ready means to detect structural problems until after problems have occurred. Any questionable findings about the internal audit function should be referred to the Examiner-in-Charge.

e. Antifraud Plans

The regulated entity should have antifraud plans which are reasonably calculated to detect, prosecute and prevent fraudulent insurance acts. Written procedural manuals or guides and antifraud plans should provide sufficient detail to enable employees to perform their functions in accordance with the goals and direction of management. In addition, insurers may be required by law to establish antifraud plans, and examiners should be aware of any state-specific legal requirements pertaining to antifraud measures.

The guidelines set forth in the *Antifraud Plan Guideline* (#1690), adopted by the NAIC in March 2011, are intended to provide a road map for state fraud bureaus, insurers' Special Investigative Units (SIU)s or contracted SIU vendors for preparation of an antifraud plan.

Flexibility should be allowed for each insurer to develop a plan that meets its individual needs and still meet state compliance standards. The *Antifraud Plan Guideline* does not preempt other state laws or preempt or amend any guidance previously published by the NAIC Antifraud (D) Task Force or in the *Fraud Prevention Model Act* (#680).

f. Certificates of Authority

The examiner should determine if the regulated entity's operations conform with the regulated entity's certificates of authority.

g. Disaster Recovery Plan

It is essential that the regulated entity has a formalized disaster recovery plan that will detail procedures for continuing operations in the event of any type of disaster. The examiners should determine if the regulated entity maintains separate backups of all records and facilities to continue operations.

h. Computer Systems

The examiners should determine the types of controls, safeguards and procedures for protecting the integrity of the computer information. The focus in this case is on those records subject to a market conduct examination that are maintained in electronic format, such as, but not limited to, underwriting files, claim files, rate and form filings, complaint files, statistical data used to support rates, etc.

The regulated entity should identify the location(s) of all websites maintained by or for and authorized by the regulated entity and all approved producer sites.

In addition, an Internet search using the regulated entity's name should be conducted using a search engine such as Yahoo, Google or a metasearch (aggregator) search engine such as WebCrawler. If any additional sites are located that the regulated entity did not identify, it should be specifically noted when preparing the examination report. The examiner should be mindful that some searches may produce a large volume of "hits." In such a situation, the examiner should employ sampling techniques to determine the regulated entity's general practices on the Internet.

i. Minutes from All Meetings Attended by the Board of Directors

A review of the minutes of meetings with the board of directors should be conducted to ensure the board has proper oversight of the company's operations and activities. Note: When a credit company is the subject of an examination, examiners should be aware that there may be statutes, rules, and regulations with specific requirements regarding the organization and structure of credit organizations.

j. Privacy

The NAIC has adopted several sets of privacy requirements, and examiners will need to determine which requirement(s) the state imposes to conduct an examination. The first is the *NAIC Insurance Information and Privacy Protection Model Act* (#670) (hereinafter, the 1982 Model Act). The second NAIC approach was the *Health Information Privacy Model Act* (#55), which, according to NAIC records, as of April 2015 had not been adopted by any state, although a few states have related laws.

The NAIC then adopted a model titled *Privacy of Consumer Financial and Health Information Regulation* (#672) (hereinafter, the 2000 Model Privacy Regulation) to assist states with promulgation of regulations to comply with certain requirements of Title V of the federal Gramm-Leach-Bliley Act (GLBA) (PL 102-106), enacted by Congress in 1999. And in 2002, the *Standards for Safeguarding Customer Information Model Regulation* (#673) (hereinafter, the 2002 Model Information Security Regulation) was adopted to assist states in establishing standards for development and implementation of safeguards by insurers to protect customer information, also required by Title V of GLBA.

In some cases, a state may have one or more of these measures, or a combination thereof, in force. NAIC records indicate that as of April 2015, 39 states plus the District of Columbia and Puerto Rico have enacted regulations/laws based on the 2000 Model Privacy Regulation.

1982 Model Act (#670)
The 1982 Model Act is focused primarily on the insurance application process, underwriting, policy issuance and related transactions. It requires various disclosures to applicants regarding the insurer's practices (e.g., that an investigative consumer report may be obtained and that information may be disclosed to insurance support organizations which, in turn, may retain and later re-disclose the information to others) and the applicant's rights (e.g., that the applicant has a right to obtain a copy of any investigative consumer report and that the applicant has the rights of access to and correction of information about him/her).

Notices providing these disclosures may be required at application and whenever there is a "change of status"—e.g., at renewal or reinstatement—if new or additional information is to be collected from a source other than the applicant. There is no requirement for annual notices. If an insurer intends to disclose information for the marketing of a product or service, the customer must be given an opportunity to opt out. Operations/Management Examination Standards #10 and #11 in this chapter are applicable only for those states that have enacted the 1982 Model Act or substantially similar privacy requirements.

2000 Model Privacy Regulation (#672)
The 2000 Model Privacy Regulation was adopted to implement certain privacy provisions of the Gramm-Leach-Bliley Act. Title V of GLBA addressed the confidentiality of information about customers of "financial institutions," a term that includes insurance companies, banks and depository institutions, broker-dealers, investment companies, registered investment advisors and a variety of other kinds of businesses. Title V, as further implemented by the 2000 Model Privacy Regulation, requires that financial institutions establish and implement a privacy policy and

provide notices to customers describing such policies and the customer's rights to opt out of disclosures other than those allowed by the exceptions in Sections 14 through 16 (Section 17B of the 2000 Model Privacy Regulation sets forth exceptions for the customer authorization requirement for certain health information disclosures). The adoption of regulations and guidelines was delegated to the functional regulators of the various financial institutions.

The federal functional regulators (including, among others, the Securities and Exchange Commission, the Office of the Comptroller of Currency and the Federal Trade Commission) and the NAIC have taken substantially similar positions in their regulations regarding the disclosure of customer personal information and notices. The federal regulations are nearly identical to each other, with very minor differences to reflect the different financial products and services involved and related business practices. The 2000 Model Privacy Regulation is very similar to the federal regulations with respect to the treatment of financial information, with appropriate changes for insurance products and services, as well as established business practices and relationships.

The notices required by the 2000 Model Privacy Regulation include initial, revised and annual privacy notices, which must reflect the privacy policy, including financial information disclosure practices, of the insurance regulated entity or other licensee. It should be noted that privacy policies differ from insurer to insurer, from insurer to other licensee, etc. There is no set format required for privacy notices, although they must be "clear and conspicuous" as that term is defined in the regulation. The regulation does, however, list the topics that the privacy notice must address. Since a privacy notice reflects a specific insurer's or other licensee's own particular financial information privacy practices, notices will legitimately differ.

The 2000 Model Privacy Regulation differs from the federal agency regulations in that the model includes protections for certain health information. In general, a licensee must get an individual's approval (opt-in) prior to disclosing nonpublic personal health information, unless the disclosure falls under an exception listed in Subsection 17B or the licensee is in compliance with the health privacy regulation promulgated by the U.S. Department of Health and Human Services (HHS) pursuant to the federal Health Information Portability and Accountability Act (HIPAA). Even if the licensee is not subject to HIPAA, the 2000 Model Privacy Regulation allows the option of complying with the HHS standards as an alternative to the NAIC standards.

Operations/Management Examination Standards #12, #13, #14, #15 and #16 in this chapter are applicable for examination of compliance with the 2000 Model Privacy Regulation regarding the disclosure of customer information.

2002 Model Information Security Regulation (#673)

The 2002 Model Information Security Regulation was adopted to establish standards regarding safeguarding of customer information also required by Title V of GLBA. It should be noted that the 2002 Model Information Security Regulation requires that a licensee establish an information security program "appropriate to the size and complexity of the licensee," as well as appropriate to the "nature and scope of (the licensee's) activities." The regulation provides illustrative examples of various factors that a licensee may consider when developing its information security program.

Operations/Management Examination Standard #17 in this chapter is applicable for examination of compliance with the 2002 Model Information Security Regulation for security standards.

3. Tests and Standards

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

STANDARDS
OPERATIONS/MANAGEMENT

Standard 1
The regulated entity has an up-to-date, valid internal or external audit program.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Audit plan and regulated entities' procedural manuals

_____ Audit reports and results

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Consumer Credit Insurance Model Regulation (#370), Section 12
Model Regulation to Require Reporting of Statistical Data by Property and Casualty Insurance Companies (#751), Section 11
Best Practices Organizations White Paper

Review Procedures and Criteria

Review audit reports to determine if the function is providing meaningful information to management. If external, obtain an explanation.

Determine how management is using the reports.

Determine if the regulated entity responds to internal audit recommendations to correct, modify and implement procedures.

Determine if accuracy of internal statistical data and information systems is periodically tested by the regulated entity's audit program.

Determine if the regulated entity conducts periodic reviews of creditors with respect to their credit insurance business with such creditors.

Determine if the regulated entity has adopted edit and audit procedures to screen and check data submitted by the regulated entity's statistical agent.

Note: The examiner should be mindful of the proprietary nature of internal audit reports. Administrative action should not be recommended by the examiner based on results of internal audit findings for which the regulated entity has taken appropriate corrective action.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 2
The regulated entity has appropriate controls, safeguards and procedures for protecting the integrity of computer information.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Electronic records control, recovery/backup plan and regulated entity's procedural manuals; whether the records are electronic

_____ Negotiated contracts

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Insurance Information and Privacy Protection Model Act (#670)
Health Information Privacy Model Act (#55)
Standards for Safeguarding Consumer Information Model Regulation (#673)

Review Procedures and Criteria

Review regulated entity records, central recovery and backup procedures. The plan and procedures should be valid and up-to-date.

Review computer security procedures.

If the regulated entity permits changes to be made to policies either electronically or verbally, check what security procedures the regulated entity has established to permit these changes. These may include who has authority to make those changes, and what verification is done by the regulated entity with the insured after changes are made.

Ensure there is adequate security of applicant/insured data during the electronic transference of information. Identify any areas where the applicant's/insured's privacy is not properly protected.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 3
The regulated entity has antifraud initiatives in place that are reasonably calculated to detect, prosecute and prevent fraudulent insurance acts.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity antifraud plan and procedural manuals

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Insurance Fraud Prevention Model Act (#680)
Antifraud Plan Guideline (#1690)
Stranger-Originated Annuity Transactions (STOA) NAIC Sample Bulletin

Review Procedures and Criteria

Review the regulated entity's antifraud initiatives in conjunction with applicable statutory requirements. Antifraud initiatives may include fraud investigators, who may be insurer employees or independent contractors, and an antifraud plan.

Verify that the insurer, if required by applicable state statutes, rules and regulations, submits its antifraud plan to the insurance commissioner:

- Within ninety days of receiving a certificate of authority;
- Every five years thereafter; and
- Within thirty days of a material change made to the antifraud plan.

Determine if the plan is adequate, up-to-date and in compliance with statutes, rules and regulations.

Review the regulated entity's implementation (staffing, support, etc.) of its plan and, if necessary, discuss with management.

Note: An SIU antifraud plan may cover several insurer entities within a regulated entity, if one SIU has the fraud investigation mission for all entities.

Verify that the insurer's antifraud plan includes the following five sections:

1. General Requirements
    - An acknowledgment that the SIU has established criteria that will be used for the investigation of acts of suspected insurance fraud relating to the different types of insurance offered by that insurer;
    - An acknowledgement that the insurer or SIU shall record the date that suspected fraudulent activity is detected, and shall record the date that reports of such suspected insurance fraud were sent directly to the insurance department or other applicable state regulatory agency within a specific time frame;
    - A provision stating whether the SIU is an internal unit or an external or third-party unit;
    - If the SIU is an internal unit, provide a description of whether the unit is part of the insurer's claims or underwriting departments, or whether it is separate from such departments;
    - A written description or chart outlining the organizational arrangement of the insurer's antifraud positions responsible for the investigation and reporting of possible fraudulent insurance acts:
        - If the SIU is an internal unit, the insurer shall provide general contact information for the company's SIU;
        - If the SIU is an external unit, the insurer shall provide (1) the name of the company or companies used; (2) contact information for the company; and (3) a company organizational chart. The insurer shall specify the person or position at the insurer responsible for maintaining contact with the external SIU company; and
        - If an external SIU is employed for purposes of surveillance, the insurer shall include a description of the policies and procedures implemented;
    - A provision where the insurer provides the appropriate NAIC individual and group code numbers;
    - A statement as to whether the insurer has implemented a fraud awareness or outreach program. If the insurer has an awareness or outreach program, a brief description of the program shall be included; and
    - If the SIU is a third-party unit, a description of the insurer's policies and procedures for ensuring that the third-party unit fulfills its contractual obligations to the insurer and a copy of the contract with the third-party vendor.

    Note: States that do not mandate fraud reporting should revise or remove inapplicable requirements from this section.

2. Prevention, Detection and Investigation of Fraud
    - A description of the insurer's corporate policies for preventing fraudulent insurance acts by its policyholders;
    - A description of the insurer's established fraud detection procedures (i.e. technology and other detection procedures);
    - A description of the internal referral criteria used in reporting suspicious claims of insurance fraud for investigation by the SIU;
    - A description of the SIU investigation program (i.e. by business line, external form claims adjustment, vendor management Statement of Positions (SOPs); and
    - A description of the insurer's policies and procedures for referring suspicious or fraudulent activity from its claims or underwriting departments to the SIU.

3. Reporting of Fraud
    - A description of the insurer's reporting procedures for the mandatory reporting of possible fraudulent insurance acts to the insurance commissioner or applicable state regulatory agency pursuant to applicable state statutes, rules and regulations;

- A description of the insurer's criteria or threshold for reporting fraud to the insurance commissioner; and
- A description of the insurer's means of submission of suspected fraud reports to the insurance commissioner (e.g., the NAIC Online Fraud Reporting System (OFRS), National Insurance Crime Bureau (NICB), National Health Care Anti-Fraud Association (NHCAA), electronic state system or other).

Note: States that do not mandate fraud reporting should revise or remove inapplicable requirements from this section.

Note: The examiner should be aware of any applicable state statutes, rules and regulations regarding state antifraud mandatory reporting methods.

4. Education and Training
    - If applicable, a description of the insurer's plan for antifraud education and training initiatives of any personnel involved in antifraud related efforts. This description shall include:
        - The internal positions the insurer offers regular education and training, such as underwriters, adjusters, claims representatives, appointed agents, attorneys, etc.;
        - If the training will be internal and/or external;
        - Number of hours expected per year; and
        - If training includes ethics, false claims or other legal-related issues.

5. Internal Fraud Detection and Prevention
    - A description of insurer's internal fraud detection policy for employees, consultants or others, such as underwriters, claims representatives, appointed agents, etc.; and
    - A description of the insurer's internal fraud reporting system.

Determine if the regulated entity has procedures in place to prevent persons convicted of a felony involving dishonesty or breach of trust from participating in the business of insurance.

Determine if the regulated entity has procedures in place to provide information regarding fraudulent insurance acts to the insurance commissioner and in a manner prescribed by the insurance commissioner.

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

STANDARDS
OPERATIONS/MANAGEMENT

Standard 4
The regulated entity has a valid disaster recovery plan.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Description of the regulated entity's disaster recovery plan, procedural manuals and controls

_____ Description of protective devices for various hazards and procedures/controls for protection from those hazards

_____ Negotiated contracts

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Market Conduct Record Retention and Production Model Regulation (#910)

Review Procedures and Criteria

Determine that the regulated entity's database(s) are protected from various hazards, including environmental hazards.

Review the regulated entity's documents. Any additional areas or lack of information should be discussed with the regulated entity's management. The disaster recovery plan should be valid, specific and operational, with procedures for implementation and should also be current. Failure of the regulated entity to adequately plan for the future means the standard was not met.

Failure of the regulated entity to adequately (on an ongoing basis) provide for off-site backup, failure of the regulated entity to provide adequate controls and in the case of a catastrophe, failure to provide for recovery, means the standard was not met.

Operations/Management Examination Standard #[illegible] this chapter also addresses disaster recovery issues.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 5
Contracts between the regulated entity and entities assuming a business function or acting on behalf of the regulated entity, such as, but not limited to, managing general agents (MGAs), general agents (GAs), third-party administrators (TPAs) and management agreements, must comply with applicable licensing requirements, statutes, rules and regulations.

Apply to All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Contracts

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Service Contracts Model Act (#685)
Managing General Agents Act (#225)
Registration and Regulation of Third-Party Administrators, An NAIC Guideline (#1090)
Third Party Administrator Statute (#90)

Review Procedures and Criteria

Review the contract to determine compliance with state statutes and rules.

The contract should specify the responsibilities of the subcontractor regarding recordkeeping and responsibilities of the regulated entity for conducting audits.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 6
The regulated entity is adequately monitoring the activities of any entity that contractually assumes a business function or is acting on behalf of the regulated entity.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Contracts

_____ Audit reports

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Managing General Agents Act (#225), Section 5
Registration and Regulation of Third-Party Administrators, An NAIC Guideline (#1090)
Third Party Administrator Statute (#90), Section 6
Consumer Credit Insurance Model Regulation (#370), Section 12
Variable Life Insurance Model Regulation (#270)

Review Procedures and Criteria

Entities can include an MGA, GA or TPA. Suppliers of consulting, investment, administrative, sales, marketing, custodial or other services with respect to variable life insurance operations are also considered entities (*Variable Life Insurance Model Regulation* (#270), Section 3E).

Review entity contracts to determine compliance with statutes, rules and regulations. The contract should specify the responsibilities of the MGA, GA and TPA concerning recordkeeping and responsibilities of the regulated entity for conducting audits.

Review audit reports to determine whether the regulated entity is adequately monitoring the activities of the contracted entity.

Review activities of entities to ensure compliance with applicable statutes and rules.

For credit insurance, each insurer is responsible for conducting a thorough periodic review of creditors with respect to their credit insurance business. The review should ensure compliance with statutes, rules and regulations. Written records of the reviews must be maintained by the insurer.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 7
Records are adequate, accessible, consistent and orderly and comply with state record retention requirements.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ All records, files and documents

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation for Complaint Records to be Maintained Pursuant to the NAIC Unfair Trade Practices Act (#884)
Market Conduct Record Retention and Production Model Regulation (#910)
Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Model Law on Examinations (#390), Section 4
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
The Use of Social Media in Insurance White Paper

Review Procedures and Criteria

Evaluate the orderly organization, legibility and structure of files.

Review state record retention requirements to determine regulated entity compliance.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 8
The regulated entity is licensed for the lines of business that are being written.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Certificate of authority or other similar documents

_____ Access NAIC financial system

_____ Regulated entity system

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Service Contracts Model Act (#685)
Nonadmitted Insurance Model Act (#870)
Unauthorized Transaction of Insurance Criminal Model Act (#890)

Review Procedures and Criteria

Review certificates of authority; compare writings with authorized lines.

Review financial annual statement submitted to the NAIC; compare writings with authorized states.

Obtain explanation of any discrepancies.

Access regulated entity system to verify that writings are in line with written premium reported in the financial annual statement.

Automation Tip:
The Financial Applications section of NAIC iSite+ contains the annual statement financial information for insurance companies that report to the NAIC. The most useful for market conduct examiners would be the annual statement Pick-a-Page. The State Page Exhibit displays the direct written premiums in any particular state for any particular year.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 9
The regulated entity cooperates on a timely basis with examiners performing the examinations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations, especially insurance examination law

_____ All records, files and documents

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Law on Examinations (#390)

Review Procedures and Criteria

Monitor regulated entity's cooperation during the course of the examination; this may be noted in the examination report.

Automation Tip:
Requests for information or "crits" can be monitored using either a database or spreadsheet. The information that should be captured includes: area of review, type of request, contact person, date given, date due and date received. Databases and spreadsheets contain functions that will calculate the number of days between two dates. The information can be easily sorted and reviewed to see what is still outstanding and if the regulated entity is responding in a timely fashion.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 10
The regulated entity has procedures for the collection, use and disclosure of information gathered in connection with insurance transactions so as to minimize any improper intrusion into the privacy of applicants and policyholders.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Written procedures of regulated entity for maintaining personal information and privileged information of applicants and policyholders

_____ The "Notice of Information Practices" required to be provided to applicants and policyholders

_____ Disclosure authorization forms

_____ Written procedures for the correction, amendment or deletion of recorded personal information

Others Reviewed

____ _____

____ _____

NAIC Model References

NAIC Insurance Information and Privacy Protection Model Act (#670)
Health Information Privacy Model Act (#55)
Unfair Discrimination Against Subjects of Abuse in Property and Casualty Insurance Model Act (#898)
Unfair Discrimination Against Subjects of Abuse in Life Insurance Model Act (#896)
Unfair Discrimination Against Subjects of Abuse in Health Benefit Plans Model Act (#895)
The Use of Social Media in Insurance White Paper

Review Procedures and Criteria

Determine if the regulated entity appropriately provides a "notice of information practices" that contains the required information.

Determine if the content of disclosure authorization forms meet content standards.

Determine if the regulated entity properly handles the use of investigative consumer reports.

Determine if the regulated entity's procedures appropriately limit access to personal information.

Determine if the regulated entity provides specific and accurate reasons for adverse underwriting decisions.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 11
The regulated entity has developed and implemented written policies, standards and procedures for the management of insurance information.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity procedure manual

_____ Regulated entity training manual

_____ Internal regulated entity claim audit procedures

_____ Regulated entity bulletins regarding insurance information

_____ Contractual arrangements between the carrier and a person other than the covered person

Others Reviewed

____ _____

____ _____

NAIC Model References

Health Information Privacy Model Act (#55), Section 5
NAIC Insurance Information and Privacy Protection Model Act (#670), Sections 4-9

Review Procedures and Criteria

Review regulated entity procedures, training manuals and claim bulletins to determine if regulated entity standards exist and whether standards comply with state law.

Review contractual arrangements between the regulated entity and other persons to determine if the contracts address privacy procedures and standards for the person with whom the regulated entity is contracting.

Review the regulated entity's methods for handling, disclosing, storing and disposing of insurance information. The examiners should determine whether there are procedures in place to ensure proper authorization is obtained prior to disclosure of insurance information.

Review the regulated entity's training manual to determine whether the regulated entity's employees are properly trained on the handling of insurance information.

Verify that the regulated entity provides a "Notice of Information Practices" to all applicants or policyholders or has procedures in place for the producer to deliver the notice. The examiner should determine whether the notice contains all provisions required by applicable state law.

Verify that the regulated entity specifies those questions designed to obtain information solely for marketing or research purposes.

Verify that the regulated entity has implemented reasonable procedures to address investigative consumer reports and personal interviews.

Verify that the regulated entity has established procedures to address access to, correction, amendment or deletion of recorded personal information.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 12
The regulated entity has policies and procedures to protect the privacy of nonpublic personal information relating to its customers, former customers and consumers that are not customers.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity privacy policies and procedures

_____ Other regulated entity manuals/instruction books

_____ Communication provided by the regulated entity to employees and producers subject to the regulated entity's privacy policies

_____ Prior to conducting an examination, the examiner should review the state's definition of "customer" and "consumer" to determine appropriate usage of the terms. The examiner should also review the various exceptions and exclusions contained in the state's privacy act/regulation.

Others Reviewed

____ _____

____ _____

NAIC Model References

Privacy of Consumer Financial and Health Information Model Regulation (#672)

Review Procedures and Criteria

Review the regulated entity's policies, practices and procedures regarding protection and disclosure of nonpublic personal information of customers, former customers and consumers who are not customers, to verify that they comply with applicable state laws regarding privacy.

Review employee procedures regarding the treatment of nonpublic personal information to verify that they comply with the regulated entity's privacy policies, practices and procedures and with applicable state laws regarding privacy.

As applicable, verify that the regulated entity/licensee has provided a copy of its privacy notice to its producers.

Determine that the regulated entity does not unfairly discriminate against customers and consumers who are not customers who (1) have opted out from the disclosure of nonpublic personal financial information to nonaffiliated third parties; and (2) have not authorized disclosure of nonpublic personal health information, if applicable.

Review all privacy-related consumer complaints and inquiries.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 13
The regulated entity provides privacy notices to its customers and, if applicable, to its consumers who are not customers regarding treatment of nonpublic personal financial information.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity privacy policies and procedures

_____ Sample notices to customers: initial, annual, revised and simplified, if applicable

_____ Sample notices to consumers that are not customers, if applicable: initial (standard and short-form) notices and revised notice

_____ Prior to conducting an examination, the examiner should review the state's definition of "customer" and "consumer" to determine appropriate usage of the terms. The examiner should also review the various exceptions and exclusions contained in the state's privacy act/regulation.

Others Reviewed

____ _____

____ _____

NAIC Model References

Privacy of Consumer Financial and Health Information Model Regulation (#672)

Review Procedures and Criteria

Review the content of the regulated entity's initial, annual and revised notices.

Verify that these notices are clear and conspicuous and accurately reflect privacy policies and practices.

Notices should include the following:

- Identification of the regulated entity, if applicable;
- The categories of nonpublic personal financial information that the regulated entity collects;
- The categories of nonpublic personal financial information that the regulated entity discloses, if applicable;
- The categories of affiliates and nonaffiliated third parties to whom the regulated entity discloses nonpublic personal financial information, other than disclosures permitted under Sections 15 and 16 of Model #672, if applicable;
- The categories of nonpublic personal financial information about the regulated entity's former customers that the regulated entity discloses and the categories of affiliates and nonaffiliated third parties to whom the regulated entity discloses nonpublic personal financial information about the regulated entity's former customers, other than disclosures permitted under Sections 15 and 16 of Model #672, if applicable;

- If a regulated entity discloses nonpublic personal financial information to a nonaffiliated third party under Section 14 of Model #672, a separate description of the categories of information the regulated entity discloses and the categories of third parties with whom the regulated entity has contracted;
- An explanation of the consumer's right to opt out of the disclosure of nonpublic personal financial information to nonaffiliated third parties, including the methods by which the consumer may exercise that right, if applicable;
- Any disclosures that the regulated entity may make under Section 603(d)(2)(A)(iii) of the federal Fair Credit Reporting Act (15 USC Section 1681a(d)(2)(A)(iii) (i.e., notices regarding the ability to opt out of disclosures of information among affiliates, other than transaction and experience information);
- The regulated entity's policies and practices with respect to protecting the confidentiality and security of nonpublic personal information; and
- If a regulated entity only discloses nonpublic personal financial information as authorized under Sections 15 and 16 of Model #672, a statement that indicates the regulated entity makes disclosures to other affiliated or nonaffiliated third parties, as applicable, as permitted by law.

Review the content of the regulated entity's simplified notice, if applicable, which shall include:

- Identification of the regulated entity and affiliates or subsidiaries, if applicable;
- The categories of nonpublic personal financial information that the regulated entity collects;
- The regulated entity's policies and practices with respect to protecting the confidentiality and security of nonpublic personal information; and
- That the regulated entity only discloses nonpublic personal financial information to affiliates and nonaffiliated third parties, as applicable, as authorized under Sections 15 and 16 of Model #672.

Review the content of the regulated entity's short-form notice for consumers who are not customers, if applicable, which shall state that the regulated entity's privacy notice is available upon request and provide a reasonable means by which the consumer may obtain a full notice.

Verify that the regulated entity's process for delivery of notices includes:

- Initial notice, if applicable, to consumers who are not customers;
- Initial notice to all customers, as required;
- Annual notice to all customers, as required;
- Revised notice to customers and consumers who are not customers entitled to notice, if applicable;
- Where applicable, simplified notices to customers, if the regulated entity only discloses nonpublic personal financial information about customers and former customers to affiliates and nonaffiliated third parties as authorized under Sections 15 and 16 of Model #672 (or the applicable sections under state law regarding privacy); and
- Short-form notices to consumers who are not customers, in lieu of initial notices, if applicable.

Verify that a notice is delivered to the regulated entity's customers at or prior to the time the regulated entity establishes a customer relationship (initial notice), and at least once in any period of 12 consecutive months or once in each calendar year thereafter (annual notice) during the continuation of the customer relationship, if appropriate. If initial notice was provided to customers after the customer relationship was established, verify that the notice was delivered within a reasonable time after the customer relationship was established and (1) establishing the customer relationship was not at the customer's election; or (2) providing notice at or prior to the establishment of the relationship would have substantially delayed the customer's transaction and the customer agreed to receive the notice at a later time.

Verify that if the regulated entity discloses any consumer's nonpublic personal financial information to any nonaffiliated third party, other than as authorized under Section 15 or 16 of Model #672 (or the applicable sections under state laws regarding privacy), the regulated entity delivers a notice before disclosing the information.

Verify that individuals deemed consumers under applicable law are provided with an initial notice where applicable (such as where a licensee discloses a claimant's nonpublic personal financial information outside Sections 14 through 16 of Model #672 or its equivalent under state laws regarding privacy).

Verify that a notice was delivered to the regulated entity's customers and, if applicable, to consumers who are not customers in a manner that can reasonably be expected to provide actual notice. Verify that a notice was provided to the regulated entity's customers and, if applicable, to consumers who are not customers, in writing, or, if the licensee provides and if the consumer has agreed, electronically.

Verify that the regulated entity has provided customers with clear and conspicuous initial, annual and revised notices in a manner that allows the customer to retain the notices or obtain them later in writing or, if the customer has agreed, electronically.

If the regulated entity is an excess lines insurer and does not disclose nonpublic personal financial information to nonaffiliated third parties, except as authorized under Sections 15 and 16 of Model #672, verify that the notice set forth in Section 4Q(3)(ii) of Model #672 has been delivered to all customers at the time the regulated entity established ongoing relationships with the customers. If the regulated entity makes disclosures other than as authorized under Sections 15 and 16 of Model #672, the regulated entity is required to comply with applicable initial, annual and revised notice requirements and the opt-out requirements.

Review the regulated entity's notice content and notice delivery procedures to verify that the regulated entity complies with applicable statutes, rules and regulations regarding privacy.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 14
If the regulated entity discloses information subject to an opt-out right, the regulated entity has policies and procedures in place so that nonpublic personal financial information will not be disclosed when a consumer who is not a customer has opted out, and the regulated entity provides opt-out notices to its customers and other affected consumers.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity privacy policies and procedures

_____ Sample notices to customers: initial, annual and, if applicable, revised

_____ Sample notices to consumers who are not customers, if applicable

_____ Sample opt-out notice, if applicable

_____ Regulated entity records of consumers and other customers who have opted out, if applicable

_____ Communication of customers' and consumers who are not customers' opt-out elections to producers of record

_____ Prior to conducting an examination, the examiner should review the state's definition of "customer" and "consumer" to determine appropriate usage of the terms. The examiner should also review the various exceptions and exclusions contained in the state's privacy act/regulation.

Others Reviewed

____ _____

____ _____

NAIC Model References

Privacy of Consumer Financial and Health Information Model Regulation (#672)

Review Procedures and Criteria

Determine whether the regulated entity discloses nonpublic personal information relating to customers or consumers who are not customers beyond the scope permitted under Sections 14, 15 and 16 of Model #672.

- Verify that consumers who may be affected by such disclosures have been offered the opportunity to opt out before the disclosures are made. Continue with Steps 1 through 5 below.
- If not, verify that any communications the regulated entity makes regarding opt-out rights are accurate and are in compliance with applicable law.
    1. If applicable, verify that the regulated entity has policies and procedures in place so that customers and other affected consumers may opt out of the disclosure of their nonpublic personal

financial information to nonaffiliated third parties, except to the extent such disclosure is permitted under Sections 14, 15 and 16 of Model #672.

2. If applicable, review the regulated entity's policies and procedures to verify that the regulated entity has the capability to keep nonpublic personal financial information from being unlawfully disclosed to nonaffiliated third parties when a consumer has opted out.

3. If applicable, verify that the regulated entity does not disclose, directly or through any affiliate, unless authorized or permitted by applicable federal and/or state law or regulations, nonpublic personal financial information about a consumer or to a nonaffiliated third party except when:
   - The regulated entity has provided a notice to the consumer;
   - The regulated entity has provided an opt-out notice to the consumer;
   - The regulated entity has given the consumer a reasonable opportunity to opt out of the disclosure before the regulated entity discloses the consumer's nonpublic personal financial information to a nonaffiliated third party; and
   - The consumer does not opt out.

4. As applicable, determine that the regulated entity's initial, annual, revised and short-form notices accurately explain the consumer's right to opt-out, including the methods by which the consumer may exercise that right at any time, in accordance with applicable law and the regulated entity's policies and procedures.

5. If applicable, review the content of the regulated entity's opt-out notice to determine if it is clear and conspicuous and includes, either on the form or on the initial privacy notice:
   - A statement that the regulated entity discloses or reserves the right to disclose nonpublic personal financial information about its consumer to a nonaffiliated third party;
   - A statement that the consumer has the right to opt out of that disclosure; and
   - A reasonable means by which the consumer may exercise the opt-out right.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 15
The regulated entity's collection, use and disclosure of nonpublic personal financial information are in compliance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity privacy policies and procedures

_____ Joint marketing agreements, if any

_____ Sample service agreements, if any, with nonaffiliated third parties involved in the regulated entity's marketing activities

_____ Prior to conducting an examination, the examiner should review the state's definition of "customer" and "consumer" to determine appropriate usage of the terms. The examiner should also review the various exceptions and exclusions contained in the state's privacy act/regulation.

Others Reviewed

____ _____

____ _____

NAIC Model References

Privacy of Consumer Financial and Health Information Model Regulation (#672)

Review Procedures and Criteria

If the regulated entity discloses nonpublic personal financial information of its customers or consumers who are not customers to nonaffiliated third parties for joint marketing purposes, verify that all such disclosures are in compliance with Model #672:

- Verify that the regulated entity has provided initial notices to its customers and other affected consumers that include the required information regarding the regulated entity's joint marketing and servicing activities; and
- Review joint marketing agreements, where applicable, to verify that they prohibit the nonaffiliated third party from disclosing or using the nonpublic personal financial information received from the regulated entity other than to carry out the purposes for which the regulated entity disclosed the information, including use under an exception in Sections 15 or 16 of Model #672.

Verify that the regulated entity does not disclose nonpublic personal financial information that it receives from a nonaffiliated financial institution, except in compliance with Model #672.

Review sample service agreements under which a third party markets a licensee's own products and services, if any, to verify inclusion of non-disclosure requirements.

Verify that the regulated entity prohibits disclosure of policy numbers or similar forms of access numbers or access codes for a consumer's policy or transaction account to any nonaffiliated third party, except as permitted by applicable law or regulation regarding privacy.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 16
In states promulgating the health information provisions of the *Privacy of Consumer Financial and Health Information Model Regulation* (#672), or providing equivalent protection through other substantially similar laws under the jurisdiction of the insurance department, the regulated entity has policies and procedures in place so that nonpublic personal health information will not be disclosed, except as permitted by law, unless a customer or a consumer who is not a customer has authorized the disclosure.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity privacy policies and procedures

_____ Sample authorizations used by the regulated entity to permit disclosure of nonpublic personal health information, if applicable

_____ Regulated entity records of customer and other consumer authorizations

_____ Prior to conducting an examination, the examiner should review the state's definition of "customer" and "consumer" to determine appropriate usage of the terms. The examiner should also review the various exceptions and exclusions contained in the state's privacy act/regulation.

Others Reviewed

____ _____

____ _____

NAIC Model References

Privacy of Consumer Financial and Health Information Model Regulation (#672)

Review Procedures and Criteria

If applicable, verify that the regulated entity has policies and procedures in place to secure authorizations from its customers and consumers who are not customers before disclosing their nonpublic personal health information to nonaffiliated third parties, except to the extent such disclosure is permitted under Subsection 17B of (Model #672).

If applicable, verify that the regulated entity has obtained valid authorizations from customers and consumers who are not customers before disclosing their nonpublic personal health information, except to the extent such disclosures are permitted under Subsection 17B of (Model #672). A valid authorization shall include:

- The identity of the consumer who is the subject of the nonpublic personal health information;
- A general description of the types of nonpublic personal health information to be disclosed;
- A general description of the parties to whom the licensee discloses nonpublic personal health information;
- A general description of the purpose of the disclosure of the nonpublic personal health information;
- A general explanation of how the nonpublic personal health information will be used;

- The signature of the consumer who is the subject of the nonpublic personal health information or the individual who is legally empowered to grant disclosure authority and the date signed;
- A notice of the length of time for which the authorization is valid; and
- A notice that the consumer may revoke the authorization at any time, and an explanation of the procedure for making a revocation.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 17
Each licensee shall implement a comprehensive written information security program for the protection of nonpublic customer information.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity written materials describing its information security program

_____ Regulated entity policies, procedures and other materials it uses to implement its information security program

_____ Prior to conducting an examination, the examiner should review the state's definition of "customer" and "consumer" to determine appropriate usage of the terms. The examiner should also review the various exceptions and exclusions contained in the state's privacy act/regulation.

Others Reviewed

____ _____

____ _____

NAIC Model References

Standards for Safeguarding Customer Information Model Regulation (#673)

Review Procedures and Criteria

Review the regulated entity's written information security program to determine whether the security program includes administrative, technical and physical safeguards.

Determine whether, when developing safeguards, the regulated entity took into consideration the:
- Size and complexity of the regulated entity; and
- Nature and scope of regulated entity's activities.

In making the assessment above, consider factors such as: (1) the products and services offered by the regulated entity; (2) the methods of distribution for the products and services; (3) the types of information maintained by the regulated entity; (4) the size of the regulated entity (which may include the number of employees and the volume of business, etc.); (5) the marketing arrangements; and (6) the extent to which, or methods by which, the regulated entity communicates electronically with customers, producers and other third parties.

Evaluate whether the regulated entity's information security program is designed to:
- Ensure the security and confidentiality of customer information;
- Protect against any anticipated threats or hazards to the security or integrity of the information; and
- Protect against unauthorized access to or use of the information that could result in substantial harm or inconvenience to any customer.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 18
All data required to be reported to departments of insurance is complete and accurate.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Claim files

_____ Underwriting files

_____ Regulated entity's medical professional liability closed claim reports (if applicable)

_____ Regulated entity's Market Conduct Annual Statement (MCAS) submissions

_____ Regulated entity's responses to state-specific data requests

Others Reviewed

Statutory or regulatory authority for state-specific data requests

____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Medical Professional Liability Closed Claim Reporting Model Law (#[illegible])
Market Conduct Surveillance Model Law (#693)

Review Procedures and Criteria

Interview the regulated entity's personnel who prepare loss statistical reports, medical professional liability loss reports, MCAS data and state-specific data requests; analyze regulated entity's internal communications between various departments which report same.

Determine that the regulated entity reviews data errors and subsequent changes are made.

Determine if the regulated entity's medical professional liability closed claims reports are accurate and reported within the required time frame.

Request that the regulated entity reconcile closed claims reports, state-specific data requests and MCAS data with the State Page of the annual statement to include payments, case reserves, and defense cost containment expenses, and explain differences.

Request that the regulated entity reconcile closed claims reports to data provided on the standardized data request.

B. Complaint Handling

1. Purpose

The NAIC definition of a complaint is "any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the state's insurance laws. An oral communication, which is subsequently converted to a written form, would meet the definition of a complaint for this purpose." The examiner should review the regulated entity's procedures for processing consumer or other related complaints. Specific problem areas may necessitate an overall review of a particular segment of the regulated entity's operation.

If a regulated entity is using social media, the examiner should review the regulated entity's policies and procedures with regard to regulated entity handling of complaints received via social media, in which the regulated entity is active.

2. Techniques

A review of complaint handling should incorporate both consumer direct complaints to the regulated entity and those complaints filed with the insurance department. The examiner should reconcile the regulated entity's complaint register with a list of complaints from the insurance department. A random sample of complaints should be selected for review from the regulated entity's complaint register. If such a register is not maintained, alternative methods of isolating complaints may be implemented.

The examiner should review the frequency of similar complaints and be aware of any patterns of specific type of complaints. The examiner should take into consideration the increase of complaints that typically follows a catastrophe. Should the type of complaints generated be cause for unusual concern, specific measures should be instituted to investigate other areas of the regulated entity's operations. This may include modifying the scope of examination to examine specific regulated entity behavior.

The examiner should review the NAIC Complaints Database System (CDS) to determine the regulated entity's complaint index, along with any adverse trends in complaint volume. The examiner may wish to review complaint trends and the complaint index for the preceding three years.

The examiner should review the final disposition of the complaints and determine if the regulated entity has taken adequate steps to finalize the complaint. The examiner should determine if the actions taken are in compliance with statutes, rules and regulations.

In states that have established a statutory or regulatory standard of promptness, a study should be conducted to determine how promptly the regulated entity responds to complaints, the adequacy of the responses and what, if any, actions were taken to resolve the problems.

If the examination involves a depository institution or their affiliates, it may also be regulated by a federal agency, such as the Office of the Comptroller of the Currency, the Federal Reserve Board, the Office of Thrift Supervision or the Federal Deposit Insurance Corporation. In addition, banks may also be regulated at the state level. If the state has entered an agreement to share complaint information with these agencies, any adverse trends or pattern of concern to the examiners may be identified and relayed to the agency.

3. Tests and Standards

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

STANDARDS
COMPLAINT HANDLING

Standard 1
All complaints are recorded in the required format on the regulated entity's complaint register.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity complaint register

_____ Insurance department's complaint records

_____ Direct consumer complaints

_____ Complaints received electronically (i.e., via Internet or email)

Others Reviewed

____ _____

____ _____

NAIC Model References

Model Regulation for Complaint Records to be Maintained Pursuant to the NAIC Unfair Trade Practices Act (#884)
Consumer Complaints White Paper
Unfair Trade Practices Act (#880), Section 4K

Review Procedures and Criteria

All of the above should be reviewed to make sure the regulated entity is:

- Recording all complaints (both consumer direct and insurance department); and
- Recording required information in the regulated entity complaint register.

Determine if the regulated entity complaint register meets minimum standards as required by law. At a minimum, the complaint register should include:

- Line of business;
- Function (underwriting, marketing and sales, claims, policyholder services or miscellaneous); and
- Reason for complaint (underwriting, application, cancellation, recission, nonrenewal).

Automation Tip:
Most companies maintain this information in some sort of PC-based spreadsheet format, such as Lotus or Excel. Request that this spreadsheet be copied in its usual format for comparison with insurance department records. Do not specify which data to be supplied, but instead go with exactly what the regulated entity tracks. A review can be made to see if they contain the information that should be collected from each complaint. Then, a sample can be pulled to review individual complaints to see if the regulated entity's procedures are being followed.

Obtain complaint data file from the insurance department (in whatever format available; e.g., ASCII text file, Microsoft Access, etc.). Convert the data file to a format compatible to the spreadsheet/database from the regulated entity. Compare the complainant name, claim number, policy number, etc., in both files to determine if all of the insurance department complaints were correctly logged by the regulated entity.

STANDARDS
COMPLAINT HANDLING

Standard 2
The regulated entity has adequate complaint handling procedures in place and communicates such procedures to policyholders.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Complaint handling procedure manuals

_____ Policy files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Consumer Complaints White Paper

Review Procedures and Criteria

Review the regulated entity's manuals to verify that complaint procedures exist.

Determine whether there are sufficient procedures in place to require satisfactory handling of complaints received, as well as internal procedures for analysis in areas developing complaints.

Determine whether there is a method for distribution of and obtaining and recording responses to complaints. This method should be sufficient to allow response within the time frame required by state law.

The regulated entity should provide a telephone number and address for consumer inquiries.

STANDARDS
COMPLAINT HANDLING

Standard 3
The regulated entity takes adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules and regulations and contract language.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

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

_____ Regulated entity complaint register

_____ Complaint letter or email and regulated entity complaint response

_____ Supporting documentation (claim files, underwriting files, etc.)

_____ Regulated entity correspondence

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Consumer Complaints White Paper

Review Procedures and Criteria

Review complaints documentation to determine if the regulated entity response fully addresses the issues raised. If the regulated entity did not properly address/resolve the complaint, the examiner should ask the regulated entity what corrective action it intends to take.

Criteria for reviewing complaint responses:

- The response is timely;
- The response is complete and responds to all issues raised;
- The response includes adequate documentation to support the respondent's position;
- The respondent's actions are appropriate from a business practice standpoint;
- The respondent's actions comply with all applicable statutes, rules and policy or contract provisions; and
- The appropriate remedies for the consumer are identified.

STANDARDS
COMPLAINT HANDLING

Standard 4
The time frame within which the regulated entity responds to complaints is in accordance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Complaint letter or email

_____ Regulated entity response and supporting documentation

_____ Regulated entity complaint register

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#90[illegible])
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#[illegible])
Consumer Complaints White Paper

Review Procedures and Criteria

Review complaints to ensure regulated entity is maintaining adequate documentation.

Determine if the regulated entity's response is timely. The examiner should refer to state laws for the required time frame.

Automation Tip:
Most companies maintain this information in some sort of PC-based spreadsheet format, such as Lotus or Excel. Request that this spreadsheet be copied in its usual format for comparison with insurance department records. Using either an Excel spreadsheet or a Microsoft Access database, calculate the number of days between the date the complaint was received and the date a final resolution was sent to the complainant. Use the features of either application to identify those complaints where the number of days to resolve the complaint exceeds the statutory standard.

C. Marketing and Sales

1. Purpose

The Marketing and Sales portion of the examination is designed to evaluate the representations made by the regulated entity about its product(s) or services. It is not typically based on sampling techniques. The areas to be considered in this kind of review include all media (radio, television, videotape, electronic medium, social media, etc.), written and verbal advertising and sales materials.

2. Techniques

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

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

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

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

3. Tests and Standards

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

STANDARDS
MARKETING AND SALES

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

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

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

_____ All regulated entity advertising and sales materials, including radio and audiovisual items such as television commercials, telemarketing scripts, pictorial materials, social media or other electronic medium

_____ Policy forms as they coincide with advertising and sales materials

_____ Producer's own advertising and sales materials

_____ Regulated entity policies and procedures

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Trade Practices Act (#880)
Advertisements of Life Insurance and Annuities Model Regulation (#570), Section 3B
Risk-Based Capital (RBC) for Insurers Model Act (#312), Section 8B
Life Insurance Disclosure Model Regulation (#580), Section 7C
Life and Health Insurance Guaranty Association Model Act (#520), Section 19A
Long-Term Care Insurance Model Act (#640)
Life Insurance Illustrations Model Regulation (#582)
Small Employer and Individual Health Insurance Availability Model Act (#35)
Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Model Act (#171), Section 7(H)(1)(a)(I)
Advertisements of Accident and Sickness Insurance Model Regulation (#40)
Individual Health Insurance Portability Model Act (#37), Section 5
Title Insurers Model Act (#628)
Title Insurance Agent Model Act (#230)
Home Service Disclosure Model Act (#920)
Marketing Insurance Over the Internet White Paper
Group Health Insurance Standards Model Act (#100)
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)
The Use of Social Media in Insurance White Paper

IIPRC Uniform Standard References

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

Review Procedures and Criteria

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

Materials should not:

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

Materials should:

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

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

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

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

For the review of Internet advertisements:

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

For the review of social media:

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

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

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

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

STANDARDS
MARKETING AND SALES

Standard 2
Regulated entity internal producer training materials are in compliance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity's producer training manuals, videos and sales scripts

Others Reviewed

____ _____

____ _____

NAIC Model References

Producer Licensing Model Act (#218)
Life Insurance Disclosure Model Regulation (#580), Section 5A(2)
Advertisements of Life Insurance and Annuities Model Regulation (#570)
Small Employer and Individual Health Insurance Availability Model Act (#35)
Individual Health Insurance Portability Model Act (#37), Sections 11D and 11E
Title Insurers Model Act (#628)
Title Insurance Agent Model Act (#230)
Advertisements of Accident and Sickness Insurance Model Regulation (#[illegible]0)
Group Health Insurance Standards Model Act (#100)
Long-Term Care Insurance Model Act (#640)
Medicare Supplement Insurance Minimum Standards Model Act (#[illegible]0)
Model Regulation to Implement the Medicare Supplement Insurance Minimum Standards Model Act (#651)

Review Procedures and Criteria

Review all producers' training materials for compliance with state statutes, rules and regulations.

Review materials for references to employing unfair discrimination tactics or avoiding statutory compliance.

Determine whether producers' prepared materials are permitted and, if so, under what conditions and controls.

The examiners should be aware of the results of the review of common consumer complaints against the regulated entity, as that could point toward problems in this area.

Automation Tip:
Enter a summary of all training materials of whatever description in an Excel spreadsheet. Capture the regulated entity's name of the material; the form number, if any; the edition date, if any; source, if applicable; and media, such as video, sales script, etc. Include fields to note exceptions, such as incomplete disclosure or possible misleading statements. Insert each possible violation/exception in a separate field.

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

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

STANDARDS
MARKETING AND SALES

Standard 3
Regulated entity communications to producers are in compliance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Bulletins, newsletters and memos

_____ Organizational chart of marketing division

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Trade Practices Act (#880)
Small Employer and Individual Health Insurance Availability Model Act (#35)
Title Insurers Model Act (#628)
Title Insurance Agent Model Act (#230)
Group Health Insurance Standards Model Act (#100)
Long-Term Care Insurance Model Act (#640)
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the Medicare Supplement Insurance Minimum Standards Model Act (#651)

Review Procedures and Criteria

Review written and electronic communication between the regulated entity and producers in accordance with applicable statutes, rules and regulations.

Determine if communication includes references to new rates, rules and regulations.

Determine if communication conforms to Marketing and Sales Examination Standard #1 in this chapter when referencing advertising and sales.

Determine if the regulated entity uses email to communicate with producers. The examiner should ask to review saved, stored or archived email that was broadcast to the sales force.

Automation Tip:
Enter a summary of all producer communications of whatever description in an Excel spreadsheet. Capture the regulated entity's title or subject line for the communication, the date of the communication, source of the communication, etc. Include fields to note exceptions, such as misleading statements or instructions to producers that are in conflict with statutes or regulations. Insert each possible violation/exception in a separate field.

Statistics and statements are likely to be repeated in more than one regulated entity communication. It is also possible that a single regulated entity communication will contain more than one violation/exception.

The Excel spreadsheet will make it easier to track any repeated statements and to identify any regulated entity communications containing apparent multiple violations/exceptions.

D. Producer Licensing

1. Purpose

The producer licensing portion of the examination is designed to test a regulated entity's compliance with state producer licensing laws and rules. The focus of the standard relating to producer accounts current is to aid in the detection of fraud or misuse of funds held by the producer in a fiduciary capacity.

2. Techniques

The examiner should review and compare information obtained from insurance departments and regulated entity records pertaining to licenses held by individuals or entities soliciting business on behalf of the regulated entity. Information related to producer licensing may be obtained from the NAIC State Producer Licensing Database (SPLD). In addition to aggregate listings of licensed/appointed/terminated producers, compliance with producer licensing statutes should be verified during the review of individual policy files, which take place during other portions of the examination (see Section F Underwriting and Rating in this chapter).

The examiner should compare information obtained from insurance departments and regulated entity records pertaining to the licenses held by individuals or entities soliciting business on behalf of the regulated entity. Insurance department records may be obtained through the NAIC SPLD, if the state is actively submitting information to the database. The SPLD contains information about a producer's license and any appointments they have with a regulated entity.

3. Tests and Standards

The producer licensing review includes, but is not limited to, the following standards related to producer licensing. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
PRODUCER LICENSING

Standard 1
Regulated entity records of licensed and appointed (if applicable) producers and in jurisdictions where applicable, licensed company or contracted independent adjusters agree with insurance department records.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Insurance department listing of producers and, if applicable, adjusters or the SPLD (State Producer Licensing Database)

_____ Regulated entity listing of currently licensed and/or appointed producers and, if applicable, adjusters

_____ Regulated entity listing of commissions

Others Reviewed

____ _____

____ _____

NAIC Model References

Mass Marketing of Property and Liability Insurance Model Regulation (#710)
Producer Licensing Model Act (#218)
Title Insurance Agent Model Act (#230)
Independent Adjuster Licensing Guideline (#1224)

Review Procedures and Criteria

Reconcile above regulated entity lists with corresponding insurance department lists to determine any discrepancies. If the state is actively participating in the State Producer Licensing Database (SPLD), the examiner should validate the producer's or adjuster's licensure status through the SPLD in lieu of obtaining a hardcopy of the producer's or adjuster's license.

Determine that any producer writing business in connection with a mass marketing plan is appropriately licensed.

Refer discrepancies to appropriate division within the insurance department.

Automation Tip:
Obtain from the regulated entity a list of all producers licensed and appointed at any time during the examination period, and, where applicable, all company or contracted independent adjusters licensed at any time during the examination period. Include the producer's or adjuster's National Producer Number (NPN) or, if unavailable, Social Security number, Federal Employer Identification number, name, address, licensed date, appointed date, type of license, and internal regulated entity or employee number for the producer. Obtain from the insurance department's licensing division a similar list. Obtain from the regulated entity a list of all producers who received commission during the examination period. Include the producer's National Producer Number (NPN) or, if unavailable, Social Security number, Federal Employer Identification number, name, address, licensed date, appointed date, type of license, date first commission received and internal regulated entity or employee number for the producer. Obtain from the regulated entity a list of all new business written during the examination period. Include the date the policy was issued and the producer's internal regulated entity or employee number.

- Compare the regulated entity's producer and adjuster licensing list to the insurance department's licensed producers list by comparing National Producer Numbers (NPN) or, if unavailable, Social Security numbers, Federal Employer Identification numbers, extracting any producers on the regulated entity's list who are not on the insurance department's list;
- Compare the regulated entity's commissions list to the insurance department's licensed producers list by comparing National Producer Numbers (NPN) or, if unavailable, Social Security numbers, Federal Employer Identification numbers, extracting any producers on the regulated entity's list who are not on the insurance department's list. Also compare commission first earned dates to the insurance department license/appointment dates to see if commissions were earned prior to license/appointment dates; and
- Compare the regulated entity's new business written list to the insurance department's licensed producers list by comparing National Producer Numbers (NPN) or, if unavailable, Social Security numbers, Federal Employer Identification numbers or internal regulated entity/employee numbers, extracting any producers on the regulated entity's list who are not on the insurance department's list. Also compare policy issued date to the insurance department's license/appointment dates to see if policies were written prior to license/appointment date. This may need to be cross-referenced with the regulated entity's licensed producer list to correlate the producer's National Producer Number (NPN) and the internal regulated entity/employee number.

STANDARDS
PRODUCER LICENSING

Standard 2
The producers are properly licensed and appointed and have appropriate continuing education (if required by state law) in the jurisdiction where the application was taken.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ New business application

_____ Insurance department listing of licensed and/or appointed producers or the State Producer Licensing Database (SPLD)

_____ Copy of producer's license or electronic verification of producer's license via the State Producer Licensing Database (SPLD)

_____ Regulated entity listing of all currently licensed and/or appointed producers

_____ Notice of appointment

_____ Regulated entity procedures for appointing a producer

_____ Regulated entity list of commissions paid by line of business

Others Reviewed

____ _____

____ _____

NAIC Model References

Producer Licensing Model Act (#218)
Title Insurance Agent Model Act (#230)
Unfair Trade Practices Act (#880)
Long-Term Care Insurance Model Act (#640)

Review Procedures and Criteria

Review the regulated entity's procedures for the appointment of producers.

Review the producer's license and the appointment records. Determine if the appointment was effective within 15 days of the producer writing business on behalf of the regulated entity.

Review the producer's authority for the types of business he/she is eligible to solicit. Determine if the producer is acting within the scope of that authority.

Determine that the producer has met continuing education requirements and, if appropriate, has met the producer training requirements for selling long-term care insurance.

Identify the producer of each selected policy and determine proper licensure and appointment (if required).

Automation Tip:
Obtain from the regulated entity a list of all producers licensed and appointed at anytime during the examination period. Include the producer's National Producer Number (NPN) or, if unavailable, Social Security number or Federal Employer Identification number, name, address, licensed date, appointed date, type of license and internal regulated entity or employee number for the producer. Obtain from the insurance department's licensing division a list of all producers licensed and appointed at any time during the examination period. Include the producer's National Producer Number (NPN) or, if unavailable, Social Security number or Federal Employer Identification number, name, address, licensed date, appointed date, applicable jurisdictions and type of license. Obtain from the regulated entity a list of all applications taken during the examination period. Include the date the application was taken, the producer's internal regulated entity or employee number and the jurisdiction where the application was taken. Compare these files using National Producer Numbers (NPN) or, if unavailable, Social Security numbers or Federal Employer Identification numbers and internal regulated entity/employee number for the producer and jurisdictions. Extract any producers who took applications from jurisdictions where they were not licensed/appointed.

STANDARDS
PRODUCER LICENSING

Standard 3
Termination of producers complies with applicable standards, rules and regulations regarding notification to the producer and notification to the state, if applicable.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity/agency contracts

_____ Regulated entity listing of producer terminations for examination review period

_____ Regulated entity listing of commissions

_____ Insurance department listing of terminations

_____ Copies of individual termination notifications sent to terminated producers

_____ Copies of individual termination notifications sent to insurance department

Others Reviewed

____ _____

____ _____

NAIC Model References

Producer Licensing Model Act (#218)
Title Insurance Agent Model Act (#230)

Review Procedures and Criteria

Reconcile the regulated entity's listing of producer terminations with the listing of commissions paid to determine if payouts are being made properly to terminated producers.

Review individual termination notices from the regulated entity to producers to determine compliance with termination notification periods and allowance for renewal commissions.

Refer any discovery of terminated producers still submitting new business to appropriate divisions within the insurance department.

Review the regulated entity's contracts with producers to determine how commissions are paid to producers who have been terminated (e.g., vesting provisions).

Compare the regulated entity's listing of producer terminations with the National Insurance Producer Registry (NIPR) to ensure accuracy of reporting.

STANDARDS
PRODUCER LICENSING

Standard 4
The regulated entity's policy of producer appointments and terminations does not result in unfair discrimination against policyholders.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Listing of appointments and terminations for examination review period

_____ Listing of producer appointments by line of business (if applicable) by producer's business ZIP code

_____ Listing of terminations by line of business (if applicable) by producer's business ZIP code

_____ Regulated entity market plan or synopsis

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Compare the number of appointments/terminations for the current review period with previous review period and, if difference is significant, determine the reason(s).

Review the regulated entity's marketing plan.

Review ZIP code listings to determine the placement of producers and if there is evidence of under-served or over-served geographical areas.

Automation Tip:
Obtain from the regulated entity a list of all producers licensed and appointed at any time during the examination period. Include the producer's National Producer Number (NPN) or, if unavailable, Social Security number, Federal Employer Identification number, name, address, county, ZIP code, licensed date, appointed date, termination date, type of license and internal regulated entity or employee number for the producer. Extract a list of all producers that were licensed, appointed and/or terminated during the examination period. Run a count on the number of producers that are licensed, appointed by ZIP code or county and a count on the number of producers terminated by ZIP code or county. Also run a count on the original file by ZIP code or county. A comparison of the counts may show ZIP codes or counties that are under-served or over-served.

STANDARDS
PRODUCER LICENSING

Standard 5
Records of terminated producers adequately document reasons for terminations.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity listings of terminated producers for examination review period

_____ Regulated entity individual files of terminated producers

_____ Insurance department's list of acceptable reasons for terminations

Others Reviewed

____ _____

____ _____

NAIC Model References

Producer Licensing Model Act (#218)
Title Insurance Agent Model Act (#230)

Review Procedures and Criteria

Determine reasons for producer terminations.

Review all or sample of individual terminated producer files.

Review above documents for inadequately or inaccurately documented termination reasons. If necessary, refer to the appropriate division within the insurance department.

Compare the regulated entity's listing of producer terminations with NIPR to ensure accuracy in reporting.

Determine if the insurance department is notified of termination for cause (if applicable).

Automation Tip:
Obtain from the regulated entity a list of all producers terminated at any time during the examination period. Include the producer's National Producer Number (NPN) or, if unavailable, Social Security number, Federal Employer Identification number, name, address, termination date and reason for termination. Review the regulated entity's files for these producers to determine if the terminations were adequately documented.

STANDARDS
PRODUCER LICENSING

Standard 6
Producer account balances are in accordance with the producer's contract with the insurer.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Listing of producer accounts current exceeding contract limits

_____ Producer and/or agency contracts

Others Reviewed

____ _____

____ _____

NAIC Model References

Producer Licensing Model Act (#218)
Title Insurance Agent Model Act (#230)
Unfair Trade Practices Act (#880)
Insurance Fraud Prevention Model Act (#680)

Review Procedures and Criteria

Review listing of producer accounts current.

Discuss excessive balances with the regulated entity.

Accounts current exceeding contract limits may indicate producer mishandling of funds.

Refer to appropriate division within the insurance department.

E. Policyholder Service

1. Purpose

The policyholder service portion of the examination is designed to test a regulated entity's compliance with statutes regarding notice/billing, delays/no response, and premium refund and coverage questions.

2. Techniques

While larger companies may have a full staff to handle policyholder service, smaller companies may well do policyholder service as a function of the claims or underwriting department.

Policyholder service departments vary from regulated entity to regulated entity. Some companies do only what is required of them by state statute (i.e., notification of the toll-free number or policyholder complaint telephone number). In contrast, some actually contact policyholders that have had occasion to deal directly with the regulated entity, such as presenting a claim or requesting a policy change.

It is important that the examiner check with the examination coordinator to determine where the policyholder service function lies and then apply the following tests to determine the effectiveness of the unit.

3. Tests and Standards

The policyholder service review includes, but is not limited to, the following standards related to the adequacy and level of policyholder service provided by the regulated entity. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
POLICYHOLDER SERVICE

Standard 1
Premium notices and billing notices are sent out with an adequate amount of advance notice.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

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

_____ Underwriting files

_____ Underwriting procedure manuals

Others Reviewed

____ _____

____ _____

NAIC Model References

Improper Termination Practices Model Act (#915)
Property Insurance Declination, Termination and Disclosure Model Act (#720)
Automobile Insurance Declination, Termination and Disclosure Model Act (#725)
Universal Life Insurance Model Regulation (#585), Section 7F

Review Procedures and Criteria

Check renewal business to determine if the regulated entity's procedures for handling renewals are in accordance with state guidelines.

Check underwriting files to determine if premium notices or endorsements were sent timely, and not at audit or policy expiration.

Check mailroom for billings sent out by the regulated entity to ensure timeliness.

Automation Tip:
Obtain from the regulated entity a data file of all cancellations due to nonpayment. Include in the file the policy number, the date the notice was generated/mailed and the effective date of the cancellation. Using either a spreadsheet or database (if the file is quite large) or ACL), calculate the number of days between the date the regulated entity represents the notice was generated/mailed and the effective date of the cancellation. Using ACL or some other sampling software, select a sample of cancellation and premium notices that appear to conform to state requirements. Request documentation that the notice was mailed on the date reported by the regulated entity. Also extract a report of all notices, which apparently fail to comply with state requirements and submit to the regulated entity for explanations.

STANDARDS
POLICYHOLDER SERVICE

Standard 2
Policy issuance and insured-requested cancellations are timely.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting manuals

_____ Insured's request for cancellation

_____ Cancellation notices

_____ Procedure manuals

_____ Underwriting files

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Determine if insured-requested cancellations are handled in a timely manner without excessive paperwork requirements for the insured.

Perform a time study on policy issuance to determine that policies and endorsements are issued in a timely manner.

STANDARDS
POLICYHOLDER SERVICE

Standard 3
All correspondence directed to the regulated entity is answered in a timely and responsive manner by the appropriate department.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity correspondence files

_____ Electronic correspondence

_____ Policy/Underwriting files

Others Reviewed

____ _____

____ _____

NAIC Model References

NAIC Insurance Information and Privacy Protection Model Act (#670)
Unfair Claims Settlement Practices Act (#990)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Title Insurers Model Act (#628)
Title Insurance Agent Model Act (#230)

Review Procedures and Criteria

Review correspondence to ensure that the response was made by the appropriate department.

Ensure the original question or problem was properly addressed in a timely manner.

Determine if the regulated entity responds to inquiries from the applicant regarding the specific reason(s) for adverse underwriting decisions.

Review correspondence contained in the policy file from the regulated entity to determine appropriateness and timeliness of handling.

STANDARDS
POLICYHOLDER SERVICE

Standard 4
Whenever the regulated entity transfers the obligation of its contracts to another regulated entity pursuant to an assumption reinsurance agreement, the regulated entity has gained prior approval of the insurance department, and the regulated entity has sent the required notices to affected policyholders.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Assumption reinsurance agreements

_____ Order of insurance commissioner approving assumption reinsurance agreement

_____ Notice of transfer sent to policyholders, producers and brokers

_____ Response card sent to policyholders

_____ Written regulated entity procedures for handling inquiries regarding the assumption transaction and for processing the policyholders' response cards

Others Reviewed

____ _____

____ _____

NAIC Model References

Assumption Reinsurance Model Act (#803)

Review Procedures and Criteria

According to the model act, "assumption reinsurance agreement" means any contract which both:

- Transfers insurance obligations and/or risks of existing or in force contracts of insurance from a transferring insurer to an assuming insurer; and
- Is intended to affect a novation of the transferred contract of insurance with the result that the assuming insurer becomes directly liable to the policyholders of the transferring insurer.

Determine if any assumption reinsurance agreements exist.

Obtain a list of policyholders covered by any assumption reinsurance agreements in order to determine sample.

Determine if the class of policyholder or type of product was covered by the assumption reinsurance agreement.

Determine if affected policyholders received the notice of transfer and the response card and that each includes appropriate language.

Determine whether the regulated entity appropriately handled a policyholder's right to reject the transfer.

STANDARDS
POLICYHOLDER SERVICE

Standard 5
Policy transactions are processed accurately and completely.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

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

_____ Regulated entity correspondence files

_____ Policy underwriting files involving nonforfeiture, surrenders, benefit changes, existing policy changes and other post-issue transactions

Others Reviewed

____ _____

____ _____

NAIC Model References

Modified Guaranteed Annuity Model Regulation (#255), Section 6B(1)(b)
Consumer Credit Insurance Model Act (#360)

Review Procedures and Criteria

Ensure proper documentation is maintained for the following:

- Cash surrenders;
- Policy loans;
- Bank draft acceptance and clearance; and
- Beneficiary changes.

Ensure that policyholder requests are processed as soon as reasonably possible.

Ensure that matured endowments are processed when due. Determine if the regulated entity takes appropriate steps to notify policyholders of guaranteed options to purchase additional insurance.

Premium refunds for modified guaranteed life products. Special requirements may exist, under policy provisions or state law, for calculation of refunds including "10-day right to return" periods for life products, which include a separate account.

For credit insurance, if a debt is refinanced prior to the scheduled maturity date, the in force insurance must be terminated before any new insurance is issued.

STANDARDS
POLICYHOLDER SERVICE

Standard 6
Reasonable attempts to locate missing policyholders or beneficiaries are made.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Schedule F of the annual statement

_____ Policies scheduled for matured endowments

_____ Underwriting files

_____ Unpaid payees of returned benefit checks

Others Reviewed

____ _____

____ _____

NAIC Model References

Review Procedures and Criteria

Determine if the regulated entity has made reasonable attempts to locate beneficiaries, policyholders and recipients of unclaimed properties.

STANDARDS
POLICYHOLDER SERVICE

Standard 7
Unearned premiums are correctly calculated and returned to the appropriate party in a timely manner and in accordance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

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

_____ Policy contract

_____ Notice of cancellation/nonrenewal

_____ Refund check or complete documentation of refund, if canceled check information is maintained on the computer system

Others Reviewed

____ _____

____ _____

NAIC Model References

Consumer Credit Insurance Model Regulation (#370)
Universal Life Insurance Model Regulation (#585)

Review Procedures and Criteria

Calculate the unearned premium (short rate, pro rata, sum of digits method) in accordance with policy provisions or state law.

Verify that refunds provided to producers are properly distributed.

Verify that unearned premiums were returned to the insured in a timely manner.

Verify that the regulated entity adheres to applicable "free look" periods.

For credit insurance:

- If the creditor has opened a line of credit for a debtor and is charging for the line of credit rather than the amount of debt (i.e., credit cards), at the debtor's death the insured amount due is the amount of established credit against which premium was last charged;
- If a debtor prepays the debt in full, any credit insurance shall be terminated and an appropriate refund of premium shall be paid or credited to the debtor; and
- In the event of termination, no charge may be made for the first 15 days of a month and a full month may be charged for over 15 days.

F. Underwriting and Rating

1. Purpose

These standards, in general, apply to insurance companies, although some or all of these standards may be applicable to other regulated entities to the extent that they address functions that have been delegated to them by insurance companies.

The underwriting portion of the examination is designed to provide a view of how the regulated entity treats the public and whether that treatment is in compliance with applicable statutes, rules and regulations. It is typically determined by testing a random sampling of files and applying various tests to the sampled files. It is concerned with compliance issues. The areas to be considered in this kind of review include:

a. Rating practices;
b. Underwriting practices;
c. Use of correct and properly filed and approved forms and endorsements;
d. Termination practices;
e. Unfair discrimination;
f. Use of proper disclosures, buyers' guides and delivery receipts;
g. Reinsurance; and
h. Statistical coding.

2. Techniques

During an examination, it is necessary for examiners to review a number of information sources, including:

- Rating manuals and rate cards;
- Rate classifications;
- Symbol manuals or tables;
- Rating systems filed with regulators;
- Payment plans;
- Minimum premiums;
- Policy fees;
- Discounts;
- Dividend rating plans;
- Regulated entity automated rating systems;
- Rating materials provided to producers;
- Reinsurer policies/treaties;
- Reinsurer guidelines and manuals;
- Documentation of required disclosures and delivery receipts;
- Premium statements and billing statements;
- Premium refund documentation;
- Replacement and conservation materials;
- Underwriting manuals, guidelines and classification manuals;
- Medical underwriting manuals;
- Issued and renewed policy and certificate files;
- Canceled and nonrenewed policy and certificate files;
- Declined applications and notices;
- Individual and group lapsed policy files and notices;
- Individual and group nonforfeiture files and notices;

- Rescission files;
- Underwriting guidelines;
- Sample of premium audit files;
- Applicable policy forms and endorsements and summaries;
- Producer licensing information;
- Group trust and association arrangements where applicable;
- Producer compensation agreements where applicable;
- Statistical reporting requirements; and
- Underwriting files content and structure.

For purposes of this chapter, "underwriting file" means the file or files containing the new business application; renewal application; rate calculation sheets; billings; audits, including binders; engineering reports; inspection reports; risk or hazard investigative or evaluation reports; motor vehicle reports (MVRs); credit reports; all underwriting information obtained or developed; policy declaration page; endorsements; premium finance agreements with regulated entities activities; cancellation or reinstatement notices; correspondence; and any other documentation supporting selection, classification, rating or termination of the risk.

In selecting samples for testing, personal lines should generally not be combined with commercial lines. These two areas are generally not homogeneous, and conclusions or inferences to be made from the results of sampling may not be valid if combined. The examiner should be familiar with any statutory or regulatory distinctions made between personal lines and commercial lines as respects the various tests to be developed. Then examiners also should be familiar with the process for gathering and processing underwriting information, and the quality controls for the issuance of policies, endorsements and premium statement/billings. The list of files from which a sample is to be drawn may be generated through a computer run or in some cases through a policy register covering the period of time selected in the notice or call of examination.

Determine the regulated entity's policy population (policy count) by line of business. Review a random selection of business for application of a particular test or apply specific tests to a census population using automated tools. (In the event specific files are chosen for a target review, the examiner must be certain the examination results are clearly identified as being from the target selection.) The examiner should maintain a list of the various tests to be applied to each file in the sample. This will aid in consistency by ensuring that each test is considered for each file in the sample.

If exceptions are noted, the examiner must determine if the exception is caused by such practices as use of faulty automated rating systems, or development of improper or vaguely worded manuals or guidelines. When exceptions are noted, it is advisable to determine the scope and extent of the problem. The examiner responses should maximize objectivity; the examiner should avoid replacing examiner judgment for regulated entity judgment.

a. Rating Practices

It is necessary to determine if the regulated entity is in compliance with rating systems that have been filed with, and, in some cases, approved by the various state insurance departments. Where rates are not required to be filed with an applicable regulatory agency, it is prudent to determine if rates are being applied consistently and in accordance with the regulated entity's own rating methods. In general, rates should not be unfairly discriminatory. Wide-scale application of incorrect rates by a regulated entity may raise financial solvency questions or be indicative of inadequate management oversight. Deviation from established rating plans may also indicate a regulated entity is engaged in unfair competitive practices. Inconsistent application of rates, individual risk premium modifications, modification factors and deviations can result in unfair discrimination.

The procedure for determining adherence to rates filed or used by a regulated entity varies between personal lines and commercial lines. There can also be considerable variation by kind of insurance. The examiner should become familiar with the regulated entity's policy form numbers or other identification procedures, inasmuch as references may be made to such numbers or procedures in lieu of having the particular form attached. If policies are issued by an automated system, the examiner should manually rate policies based on a selection of various classes and various territories to verify that the computer has been programmed correctly. Once this has been established, the examiner should check only the input data for other policies against the information included in the inspection report or from information obtained from other sources in order to determine that they have been rated correctly. If rating exceptions are noted, the examiner must determine if the exception is caused by such practices as use of faulty automated rating systems, or development of improperly or vaguely worded rating manuals. When exceptions are noted, it is advisable to determine the scope and extent of the problem.

When possible, the examination team should make use of audit software to verify correct application of specific rating components. This allows for a more thorough review and can save time during the examination process. All new automated audit applications that are developed should be submitted to the NAIC File Repository, in order to assist in building a comprehensive set of audit programs.

Rating practices of renewal policies, as well as newly issued policies, should be reviewed. By reviewing renewal policies, the examiner can verify whether the regulated entity is updating rating components, such as vehicle-identification number (VIN) symbol changes or property protection class changes. The examiner can look for cases where initial year premium rates were set at artificially low levels for competitive reasons.

The complexity of rating systems varies greatly from line to line. Some lines require little in the way of documentation focused on the appropriate use of the rating system. Some systems are so complex that appropriate determination is difficult if a worksheet is not maintained. This is generally more true of commercial lines than it is for personal lines. The examiner should ensure that the underwriting files contain sufficient information to support the rates that have been applied to a policy. Therein in the more complex systems is the concern for unfair discrimination.

Examiners may wish to review situations involving multiple related companies under common underwriting management for issues involving unfair discrimination between similarly situated policyholders.

Restraint of trade issues also may be involved if there are indications of two or more unrelated companies attempting to conspire to monopolize an insurance market.

b. Underwriting Practices

The examiner should review relevant underwriting information; e.g., the regulated entity's underwriting guidelines, underwriting bulletins, declination procedures, agency agreements and correspondence with producers. Interoffice memoranda and regulated entity minutes, which may furnish evidence of anti-competitive behavior, may also be requested. In addition to reviewing the content of the above information for indications of unfairly discriminatory practices, the examination team also will use the above information to determine regulated entity compliance with its own manuals and guidelines. The examiner should confirm that the regulated entity's underwriters and producers consistently apply the regulated entity's guidelines for all business selected or rejected. The examination team should verify that the regulated entity has correctly classified insured individuals.

File documentation should also be sufficient to support underwriting decisions made. Underwriting decisions that are adequately documented generally afford management of the regulated entity the opportunity to know what business it has selected through its underwriters and producers. The examiner should verify that properly licensed and appointed (where applicable) producers have been used in the production of business.

Underwriting guidelines may vary by geographic areas in the jurisdiction and, therefore, such guidelines should be reviewed for each regional office being examined.

Any practice suggesting anti-competitive behavior may involve legal considerations that should be referred to insurance department counsel. Ultimately, the information obtained may be useful in drafting legislation or regulations.

In some lines of business, a survey of nonstandard (e.g., surplus lines markets), consent-to-rate filings) and residual markets (e.g., FAIR—Fair Access to Insurance Requirements Plan, JUA—Joint Underwriting Association and high-risk health pools) may provide some insight into general industry underwriting practices.

c. Use of Correct and Properly Filed Forms and Endorsements

The examination team should verify that all policy forms and endorsements used have been filed with the appropriate regulatory authority, if applicable. Additionally, the examination team should verify the consistent and correct use of policy forms and endorsements. The examiner should also be mindful of possible outdated forms or endorsements. If coverages and riders requested by the applicant are not issued, proper notification should be provided to the applicant. In some cases, supplemental applications are appropriate.

If the forms have been approved by the Interstate Insurance Product Regulation Commission (IIPRC), the examiner should verify that the compacting state was included in the IIPRC-approved product filing and the form being marketed has a prefix of "ICCxx" (where "xx" represents the appropriate year the form was submitted for filing). If IIPRC-approved forms are being used or mixed and matched with forms approved by the compacting state, the examiner may wish to verify the forms approved by the compacting state were identified on the statement of intent schedule, which is required to be submitted, updated and maintained by the insurer in the product filing submitted to the IIPRC. Compacting states have access through the NAIC System for Electronic Rate and Form Filing (SERFF) to product filings submitted to the IIPRC for approval and filed in their respective state or jurisdiction and can use the export tool in SERFF to extract relevant information.

d. Termination Practices

The examiner should review the regulated entity's declination, cancellation and nonrenewal of policy practices to determine compliance with applicable statutes, rules and regulations and to determine conformance with regulated entity rules, guidelines and policy provisions.

The review of cancellation and nonrenewal practices in a particular line of insurance should involve a request for the underwriting file for each policy selected from the random sample of canceled policies. For nonrenewals, the examiner should select the sample from the expiration list. Cancellations of specific lines of business have unique requirements. The sampling should be completed separately for each product line in order to get a fair sampling for each line of business to be reviewed. The examiner should review material submitted to determine that the cancellations comply with statutory provisions and policy provisions.

Cancellation processing for nonpayment of premium should include a formal notice to the insured. Some companies use the last billing notice as the cancellation notice. If this is the case, that billing notice must clearly state the effective date of termination of coverage, the insured's rights to an explanation, as provided by statutes where required, and a concise statement of the reason for termination of coverage. Make sure that the loss payee is receiving a copy of the same notice, or separate notice from the regulated entity, to advise that coverage is being terminated. Refer to the specific statute and rule that applies.

The accuracy of return premiums on canceled policies and, in particular, pro rata vs. short rate return of premiums should be verified. When coverage other than homeowners is canceled at the request of the insured, short rate methodology should be used. Cancellations initiated by the regulated entity and all homeowner cancellations should be pro rata.

The examination team should review reinstatement offers and determine what the regulated entity practice is for offering reinstatement. Additionally, the examination team should be mindful of billing practices that may encourage policy lapses.

e. Declination Practices

The examiner should review the regulated entity's declination of policy practices to determine compliance with applicable statutes, rules and regulations and to determine conformance with regulated entity rules and guidelines. "Declination" includes only refusal of an insurer to issue a policy upon receipt of a written nonbinding application or written request for coverage from a producer or an applicant, or the refusal of a producer or broker to transmit to an insurer a written nonbinding application or written request for coverage.

Insurers should maintain declination files and producers should maintain files on declinations made on behalf of the regulated entity. The applicant must be provided with a written, specific reason for the declination.

The review of declination practices in a particular line of insurance should involve a request for the underwriting file for each policy selected from the random sample of declinations. The sampling should be completed separately for each product line in order to get a fair sampling for each line of business to be reviewed. The examiner should review material submitted to determine that the declinations are in compliance with the applicable rules and regulations and in conformance with the rules and guidelines for the specific line of business.

f. Reinsurance

Most state statutes include a feature that for many lines of business the regulated entity is not permitted to place more than 10 percent of its surplus to policyholders at risk on any one placement of insurance. While this is primarily a solvency issue, it is one that market conduct examiners are in an ideal position to test in view of the sampling of underwriting files utilized for other tests.

Adherence to the requirement is easy to test but requires familiarity with the structure and content of the reinsurance treaties covering the business written by the regulated entity. This item is particularly important for companies that hold minimal policyholder surplus accounts (i.e., surplus of less than $10 million). It may also reflect on the care the regulated entity's management places on its selection of business, and represent a danger to the financial health of the regulated entity. Errors in this area should result in alerts to the insurance department's financial examiners. Any tests of this type must be coordinated with the state's financial examiners.

3. Tests and Standards

The underwriting and rating review includes, but is not limited to, the following standards addressing various aspects of the regulated entity's underwriting activities. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
UNDERWRITING AND RATING

Standard 1
The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the regulated entity's rating plan.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ New business application

_____ All underwriting information obtained

_____ Rating manuals

_____ Policy declaration page

_____ Underwriter's file or notes on a system log

Others Reviewed

____ _____

____ _____

NAIC Model References

Property and Casualty Model Rating Law Guideline (File and Use Version) (#1775)
Property and Casualty Model Rating Law Guideline (Prior Approval Version) (#1780)
Property and Casualty Commercial Rate and Policy Form Model Law (Condensed) (#777)
Small Employer and Individual Health Insurance Availability Model Act (#35)
Stop Loss Insurance Model Act (#92)
Individual Health Insurance Portability Model Act (#37), Sections 5A-H, 5J, 5K, 7 and 9
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Verify all rating factors, including class, territory, symbol assignment, surcharges, deductible factors and increased limit factors.

If no source document application exists, review what procedures the regulated entity has in place to determine the accuracy of the information that was given to issue the policy.

Calculate the policy premium to verify it is in accordance with filed rates.

Verify that the proper rules are being used.

Verify that the filed implementation date is used uniformly, including at different branches.

Confirm that rates in use were filed and approved prior to use, where required.

Confirm that rates in use have been submitted as required, if system is other than prior approval.

Verify the basis of premium is correct.

Verify that the protection classes and other rating factors are correct.

Verify that the rating rules are properly utilized. The examiner should be alert for incorrect interpretation of rating rules.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable), and PEO accounts.

Automation Tip:
Obtain from the regulated entity a data file that contains new business written during the examination period. The file should contain policy number, policy form, address, territory code or any other rating factor that is standardized by the regulated entity. Obtain from the regulated entity a data file that contains those standardized rating factors. For example, if the regulated entity underwrites by county, then obtain a data file that contains the county codes and a new business file that contains the policyholder's county. Compare the two files to see if the appropriate rating code is being applied. Since variations can happen, ask for explanations only in areas where the error rate is unacceptable.

STANDARDS
UNDERWRITING AND RATING

Standard 2
All mandated disclosures are documented and in accordance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

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

_____ Underwriting or policy files

_____ Lapsed policies

_____ Rating/Quote information provided electronically

Others Reviewed

____ _____

____ _____

NAIC Model References

Cancer Insurance Shopper's Guide
Model Regulation to Implement the Small Employer Insurance Portability Model Act (#119)
Small Employer and Individual Health Insurance Availability Model Act (#35)
Accident and Sickness Insurance Minimum Standards Model Act (#170), Section
Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171), Sections 8A(10) and 8A(11)
Consumer Credit Insurance Model Act (#360)
Individual Health Insurance Portability Model Act (#37), Section 11
Unfair Trade Practices Act (#880)
Long-Term Care Insurance Model Act (#640)
Long-Term Care Insurance Model Regulation (#641)
Life Insurance Disclosure Model Regulation (#580), Section 5A(1)
Life Insurance Illustrations Model Regulation (#582)
Consumer Credit Insurance Model Regulation (#370)
Charitable Gift Annuities Model Act (#
Charitable Gift Annuities Exemption Model Act (#
Bulletin pertaining to Voluntary Expedited Filing Procedures for Insurance Applications Developed to allow Depository Institutions to meet their Disclosure Obligations under Section 305 of the Gramm-Leach-Bliley Act
Group Life Insurance Definition and Group Life Insurance Standard Provisions Model Act (#565)
Military Sales Practices Model Regulation (#568)
Group Health Insurance Standards Model Act (#100)
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)

Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Verify that written notice of Medicare supplement replacements are provided to applicants and existing insurers and that appropriate buyer's guides are used.

Verify that appropriate notices regarding credit-related coverages are documented.

Verify that notices regarding the existence of health insurance pools are provided, where applicable.

Review other notices and disclosures required by various jurisdictions.

Determine if state law requires that telephone help numbers be provided, including state insurance department telephone numbers and addresses.

Determine if changes in coverage are disclosed in a timely manner.

Determine if the regulated entity underwriting guidelines comply with applicable statutes, rules and regulations.

Determine if mandated optional coverages are disclosed and documented.

Verify that quotations are made accurately and in a timely manner.

Verify that delivery receipts are obtained where necessary.

Verify that changes in rates are disclosed in a timely manner and in accordance with applicable statutes, rules, regulations and policy provisions.

Determine if the regulated entity is in compliance with rules related to fair marketing.

Verify that the *Shopper's Guide to Cancer Insurance* complies with required disclosures and policy limitations.

Ensure disclosures to consumers represent the applicable consumer protections required by state law, including:

- Limits on preexisting condition exclusions;
- Prohibitions on discrimination based on health status and related factors;
- Guaranteed renewals for all policies, with certain exceptions;
- Limits on the factors that can be used to establish and change premium rates; and
- Descriptive information about all available health benefit plans.

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

Where required, individual accident and sickness insurance policies shall include with delivery or application an outline of coverage, in a prescribed format. Outlines of coverage delivered in connection with individual hospital confinement indemnity, specified disease or limited benefit health insurance coverages to persons eligible for Medicare by reason of age shall contain language that indicates "This policy IS NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the regulated entity."

Insurers shall give any person applying for specified disease insurance a buyer's guide approved by the insurance commissioner. Direct response insurers shall provide the buyer's guide upon request, but not later than the time the policy is delivered.

Credit disability income products

Ensure the debtor is provided a disclosure with the following information prior to the election to purchase insurance:

- That the purchase of consumer credit insurance is optional and not a condition of obtaining credit approval;
- If more than one kind of consumer credit insurance is being made available to the debtor, whether the debtor can purchase each kind separately or the multiple coverages only as a package;
- The conditions of eligibility;
- That, if the consumer has other insurance that covers the risk, he or she may not want or need credit insurance;
- That within the first 30 days after receiving the individual policy or group certificate, the debtor may cancel the coverage and have all premiums paid by the debtor refunded or credited. Thereafter, the debtor may cancel the policy at any time during the term of the loan and receive a refund of any of the unearned premium. However, only in those instances where insurance is a requirement for the extension of credit the debtor may be required to offer evidence of alternative insurance acceptable to the creditor at the time of cancellation;
- A brief description of the coverage, including a description of the amount, the term, any exceptions, limitations and exclusions, the insured event, any waiting or elimination period, any deductible, any applicable waiver of premium provision, to whom the benefits would be paid and the premium rate for each coverage or for all coverages in a package; and
- That, if the premium or insurance charge is financed, it will be subject to finance charges at the rate applicable to the credit transaction.

Long-term care products

Verify that written notice of long-term care replacements are provided to applicants and existing insurers, suitability worksheets are completed and submitted and that appropriate buyer's guides and contract or policy summaries are used.

Ensure the entity maintains, at its home office or principal office, a complete file containing one specimen copy of each disclosure document authorized and used by the entity (i.e., buyer's guide, contract, outline of coverage, statement of policy information for applicant, etc.). The file should contain one copy of each authorized form for a period of 3 years following the date of its last authorized use. Many jurisdictions have repealed the requirement for policy summaries if the product is declared to be marketed with an illustration that meets the requirements of statutes, rules and regulations.

Workers' compensation products

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

IIPRC-approved products

If the forms and advertisements have been approved by the Interstate Insurance Product Regulation Commission (IIPRC), please note that the notices and disclosures required to be included within the approved forms and advertisements are governed by the IIPRC uniform standards and not state law. State law that requires notices and disclosures during the sale, underwriting and claims processes are still applicable to products and advertisements approved by the IIPRC, provided such state law requirements do not pertain to or affect the content or approval of the IIPRC-approved products and advertisements.

STANDARDS
UNDERWRITING AND RATING

Standard 3
The regulated entity does not permit illegal rebating, commission-cutting or inducements.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Complaint files/logs

_____ Underwriting files

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Trade Practices Act (#880)
Producer Licensing Model Act (#218)
Interest-Indexed Annuity Contracts Model Regulation (#235)
Consumer Credit Insurance Model Regulation (#370)
Individual Health Insurance Portability Model Act (#37), Section 11
Title Insurers Model Act (#628)
Title Insurance Agent Model Act (#230)
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)

Review Procedures and Criteria

Check commission schedule for inappropriate variances.

Determine that producer commissions adhere to the commission schedule and, if not, verify that the file documentation reflects reasons for the variance.

Check billings and invoices for varying commission percentages.

Check regulated entity advertising for indications of illegal commission-cutting or inducements.

STANDARDS
UNDERWRITING AND RATING

Standard 4
The regulated entity's underwriting practices are not unfairly discriminatory. The regulated entity adheres to applicable statutes, rules and regulations and regulated entity guidelines in the selection of risks.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ New business and renewal applications

_____ All underwriting information obtained

_____ Regulated entity underwriting guidelines

_____ Underwriting bulletins

_____ Declination procedures

_____ Agency agreements and correspondence with producers

_____ Interoffice memoranda and regulated entity minutes

_____ Policy declaration page

_____ Underwriter's file or notes on a system log

Others Reviewed

____ _____

____ _____

NAIC Model References

Insurance Fraud Prevention Model Act (#680)
Model Regulation on Unfair Discrimination in Life and Health Insurance on the Basis of Physical or Mental Impairment (#887)
Model Regulation on Unfair Discrimination on Basis of Blindness or Partial Blindness (#888)
Unfair Trade Practices Act (#880)
Title Insurers Model Act (#628)
Title Insurance Agent Model Act (#230)
Military Sales Practices Model Regulation (#568)
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)
Small Employer and Individual Health Insurance Availability Model Act (#35)
Group Health Insurance Standards Model Act (#100)
Stranger-Originated Annuity Transactions (STOA) NAIC Sample Bulletin

Review Procedures and Criteria

Review relevant underwriting information to ensure that no unfair discrimination is occurring according to the state's definition of unfair discrimination.

Determine if the regulated entity is following its underwriting guidelines, and that the guidelines conform to state laws and are not unfairly discriminatory.

Determine, if required, that the regulated entity's underwriting guidelines have been filed with the insurance department.

Review interoffice memoranda for evidence of anti-competitive behavior.

Underwriting guidelines may vary by geographic areas in the jurisdiction and, therefore, such guidelines should be reviewed for each regional office being examined.

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

Ensure that the regulated entity's procedures are in compliance with the Genetic Information Nondiscrimination Act (GINA).

Some indication of industry underwriting practices may be obtained by a survey of residual markets (FAIR Plan and JUA), surplus lines markets and consent-to-rate filings.

Inconsistent handling of rating or underwriting practices, even if not intentional, can result in unfair discrimination, including requests for supplemental information.

Examine new business and renewal applications for the required fraud warning statement.

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

STANDARDS
UNDERWRITING AND RATING

Standard 5
All forms, including policies, contracts, riders, amendments, endorsement forms and certificates are filed with the insurance department, if applicable.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

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

_____ New business application

_____ Policy or contract determination page

_____ Regulated entity's approval register

_____ Insurance department's approval for all forms, including policies, contracts, riders, amendments, endorsements and certificates (Note: All forms submitted to the IIPRC for approval in the applicable compacting state can be verified through the NAIC System for Electronic Rate and Form Filing (SERFF) or by contacting the designated IIPRC representative(s) within the compacting state)

Others Reviewed

____ _____

____ _____

NAIC Model References

Health Policy Rate and Form Model [Act] [Regulation] (#1[illegible])
Individual Health Insurance Portability Model Act (#37), Sections 7 and 9
Insurance Fraud Prevention Model Act (#680)
Unfair Trade Practices Act (#880)
Group Health Insurance Standards Model Act (#100)
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Determine if the forms and endorsements have been filed. Where required, determine that either prior approval has been obtained or that applicable waiting periods following the filing have been met.

Determine if the regulated entity lists on the summary page, all forms that constitute a part of the contract.

Examine new business applications for the required fraud warning statement.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

STANDARDS
UNDERWRITING AND RATING

Standard 6
Policies, contracts, riders, amendments and endorsements are issued or renewed accurately, timely and completely.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

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

_____ Underwriting files

_____ Application

_____ Underwriting procedure manuals

_____ Underwriting and binding guidelines

Others Reviewed

____ _____

____ _____

NAIC Model References

Anti-Arson Application Model Bill (#715)
Improper Termination Practices Model Act (#915)
Property Insurance Declination, Termination and Disclosure Model Act (#724)
Automobile Insurance Declination, Termination and Disclosure Model Act (#725)
Consumer Credit Insurance Model Regulation (#370)
Consumer Credit Insurance Model Act (#360)
Health Policy Rate and Form Model [Act] [Regulation] (#165)
Uniform Individual Accident and Sickness Policy Provision Law (#230), Sections 2A(7), 2B(5) and 5C
Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act (#171), Sections 6G and 8A(2)
Administrative Procedure Relative to Renewability and Cancellation Provisions in the Approval of Accident and Health Policies Drafted In Accordance with the Uniform Individual Accident and Sickness Provision Law, Section 8
Individual Health Insurance Portability Model Act (#997), Sections 6, 7, 8 and 11
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)
Small Employer and Individual Health Insurance Availability Model Act (#35)
Group Health Insurance Standards Model Act (#100)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1960)

Review Procedures and Criteria

Determine if policies and endorsements are issued in appropriate time frames.

Verify how much time elapses between completion of the application and issuance of coverage.

Note that this standard may need flexibility or special application when dealing with assigned risk plans, joint insurance arrangements, anti-arson applications, FAIR (Fair Access to Insurance Requirements) plans or other involuntary business.

Review new issues prior to mailing to ensure correct procedures, forms, disclosures, etc., are used.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

STANDARDS
UNDERWRITING AND RATING

Standard 7
Rejections and declinations are not unfairly discriminatory.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy contract

_____ Notice of declination

_____ Regulated entity guidelines for cancellation/nonrenewal/declination

_____ Producer records/issued policies and declinations

Others Reviewed

_____ The Genetic Information Nondiscrimination Act (GINA)

____ _____

NAIC Model References

NAIC Insurance Information and Privacy Protection Model Act (#670), Sections 10-12
Small Employer and Individual Health Insurance Availability Model Act (#35)
Group Health Insurance Standards Model Act (#100)
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)
Unfair Trade Practices Act (#880)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Determine if the regulated entity provides valid reasons for rejection/declination when required.

Determine if the regulated entity responds to inquiries from the applicant regarding the specific reason(s) for adverse underwriting decisions. Was the adverse underwriting decision based on previous adverse underwriting decisions?

Determine if the regulated entity cites valid reasons for rejection/declination and documents these reasons.

Review the regulated entity's procedures for rejection/declination to determine if the regulated entity is following its own guidelines.

Determine if the regulated entity monitors agency rejection/declination for appropriate practices.

Review for any unfairly discriminatory practices.

Verify appropriate refund has been made to the applicant.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

STANDARDS
UNDERWRITING AND RATING

Standard 8
Cancellation/nonrenewal, discontinuance and declination notices comply with policy and contract provisions, state laws and the regulated entity's guidelines.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

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

_____ Policy contract

_____ Notice of cancellation/nonrenewal

_____ Agent's/MGA's/Underwriter's file or notes on a system log

_____ Producer records/notices issued

_____ Insured's request (if applicable)

_____ Regulated entity cancellation/nonrenewal guidelines

Others Reviewed

____ _____

____ _____

NAIC Model References

Property Insurance Declination, Termination and Disclosure Model Act (#720)
Automobile Insurance Declination, Termination and Disclosure Model Act (#725)
Improper Termination Practices Model Act (#915), Section 8
Unfair Trade Practices Act (#880)
Group Coverage Discontinuance and Replacement Model Regulation (#110)
Individual Health Insurance Portability Model Act (#), Section 11
Long-Term Care Insurance Model Act (#640)
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)
Small Employer and Individual Health Insurance Portability Model Act (#35)
Group Health Insurance Standards Model Act (#100)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#19

Review Procedures and Criteria

Determine if the reason for cancellation/nonrenewal or declination was valid according to policy provisions and state law.

Review the regulated entity's procedures for cancellation/nonrenewal and declinations to determine if the regulated entity is following its own guidelines.

Review regulated entity-initiated cancellations and consider a separate sample for insured-initiated cancellation.

Determine if the regulated entity monitors agency cancellation, declination and nonrenewals for appropriate practices.

Review for any unfairly discriminatory practices.

Review declinations, including declinations made by producers on behalf of the regulated entity. Declinations shall, as required, include the specific reasons for the declination.

Review notice of cancellation/nonrenewal to determine that it was mailed or delivered by the insurer to the first named insured's last known address.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

Automation Tip:
Obtain from the regulated entity a data file of all cancellations/nonrenewals and declinations during the examination period. Include in the file the policy number, the date the notice was generated/mailed and the effective date of the cancellation/nonrenewal or declination. Using either a spreadsheet or database (if the file is quite large, use ACL), calculate the number of days between the date the regulated entity represents the notice was generated/mailed and the effective date of the cancellation/nonrenewal or declination. Using ACL or some other sampling software, select a sample of cancellation and premium notices that appear to conform to state requirements. Request documentation that the notice was mailed on the date reported by the regulated entity. Also extract a report of all notices which apparently fail to comply with state requirements and submit to the regulated entity for explanations.

STANDARDS
UNDERWRITING AND RATING

Standard 9
Rescissions are not made for non-material misrepresentation.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ List of rescinded policies

_____ Underwriting files and supporting documentation, including claim files

Others Reviewed

_____ Case law for state impacted

____ _____

____ _____

NAIC Model References

Improper Termination Practices Model Act (#915)
Unfair Trade Practices Act (#880)
Long-Term Care Insurance Model Act (#640)
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)
Group Health Insurance Standards Model Act (#100)

Review Procedures and Criteria

Determine if rescinded policies indicate a trend toward post-claim underwriting practices.

Determine if decisions to rescind policies are made in accordance with applicable statutes, rules and regulations.

G. Claims

1. Purpose

These standards, in general, apply to insurance companies, although some or all of these standards may be applicable to other regulated entities to the extent that they address functions that have been delegated to them by insurance companies. The claims portion of the examination is designed to provide a view of how the regulated entity treats claimants and whether that treatment is in compliance with applicable statutes, rules and regulations. It is determined by testing a random sampling of files and applying various tests to open and closed claims.

For purposes of this chapter, "claim file" means the file or files containing the notice of claim, claim forms, proof of loss, medical records, health facility pre-admission certification or utilization review documentation, settlement demands, accident reports, police reports, adjusters' logs, claim investigation documentation, inspection reports, supporting bills (including electronic payment records, estimates and valuation worksheets), correspondence to and from insureds and claimants or their representatives, complaint correspondence, copies of claim checks and/or check numbers and amounts, releases, all applicable notices and correspondence used for determining and concluding claim payments or denials, subrogation and salvage documentation, and any other documentation necessary to support claim-handling activity.

The review is concerned with the regulated entity's claims practices by line of business for compliance with statutes, rules and regulations and policy provisions. The areas to be considered in this kind of review include:

a. Time studies to measure acknowledgment, investigation and settlement times;
b. General handling study;
c. Total loss valuation survey;
d. Closed without payment survey;
e. Subrogation survey;
f. Litigation survey;
g. Unfair claims practices survey;
h. Claims form review;
i. Loss statistical reporting survey;
j. Time study on canceled checks; and
k. Review of other procedures, as deemed necessary.

2. Techniques

Each area of claims review involves selecting a sample of claims (open, closed without payment, closed, denied). However, it is not necessary to use different samples to review timeliness of payment, conformity to policy language or adequacy of proof.

A general approach to examination would be to:

- Define the scope of the examination in terms of the lines of business and type of claims covered. Lines of business should be defined as specifically as possible; e.g., physical damage coverage rather than automobile coverage.
- Become familiar with the regulated entity's claim handling procedures for the line of business identified. Review corresponding policy forms for coverage, exclusions and nonstandard provisions. Review the methods for processing claims from notification to conclusion. Review with the claim manager or other appropriate personnel the maintenance of claim records and draft and settlement authority.

- Select a representative sample of files to be reviewed. Chapter 17—Sampling of this handbook should be reviewed. If field sizes are relatively small and the regulated entity's records appear complete, representative samples or a census should be selected. In the case of large field sizes and incomplete or complicated records, the use of audit software should be considered. Care should be taken that no adverse selection occurs.
    a. Time studies to measure acknowledgment, investigation and settlement times

        Record the date of loss/claim, the date reported to the producer or regulated entity, the date sufficient information was available to determine the regulated entity's liability and the date the regulated entity accepted or rejected the claim. Record identifying data, such as the claim/policy number and the claimant's name.

        Determine for each claim the number of days the regulated entity took to accomplish each category. Compare days required by regulated entity to appropriate state standards and document those claims that exceed standards for inclusion in the report. Delays beyond the control of the regulated entity should be excluded; e.g., a delay caused by an uncooperative insured. Establish a mean and median time to acknowledge, investigate and accept/deny claims, if necessary, to determine a business practice.

        Caution: If a file has a violation of a standard with multiple tests, and the standard is the item measured, the file can only fail one time. If the individual test is the item measured, the file can fail each test. If failure of a standard or of a test ensures failure of another standard or test under another standard, then no substitution of the file need occur. The relationship, however, should be explained.

    b. General handling study

        Record identifying data such as claim/policy number, date of loss and claimant name. Files should be reviewed for adequate and accurate documentation. Correct application of deductibles, coinsurance and limits of coverage should be established. Mathematical accuracy should be determined. Reductions based on depreciation, obsolescence, etc., should be reviewed for fairness and accuracy.

        Checks or drafts should be reviewed for correct payees. Files should be reviewed for specific state requirements. Compliance with the regulated entity's own standards should be established.

    c. Closed without payment review

        This includes denied, rejected, incomplete and claims not paid for any other reason, including deductibles/waiting periods not met. Conduct tests similar to "General handling study" above. Record identifying data such as claim/policy number, date of loss and claimant name. Review specific state requirements for content and method of denial notification to the claimant. Note general handling by the regulated entity to determine validity of its action in the final disposition of these types of claims.

    d. Litigation survey

        Determine the extent of suits against the regulated entity. Separate first- and third-party actions. If review is deemed appropriate, select a representative sample or census.

Record identifying data such as claim/policy number, date of loss and claimant name. Files should be reviewed to determine the basis for suit and the regulated entity's position for denial or settlement offer. Closed litigated files should be reviewed to determine accuracy, regulated entity position and if punitive or bad faith judgments were rendered. Recognition of attorney-client privileged documents or work products should occur during the file review. A principal focus is compliance with unfair claims practices statutes and regulations.

e. Unfair claims practices review

Record identifying data such as claim/policy number, date of loss and claimant name. Review selected files for violations of specific state unfair claims practices, such as misrepresentation of policy provisions or concealment of coverage.

Calculate error ratios for the sample and field sizes. This is especially important in this study, since most unfair claims practices statutes make reference to "business practices."

f. Claim forms

Request copies of all claim forms in use for the lines of business being examined. Forms should be reviewed for content and appropriate usage. Inappropriate forms should be documented and included in the report. Claim forms also may be reviewed as they are encountered in the file reviews.

g. Review of canceled drafts/checks

This review should be considered if solvency is an issue, if the examiner determines delays in issuing a payment, or if consumer complaints indicated delays that are not supported by other time studies.

From the regulated entity's records, select a representative sample of the type of claims being reviewed. The selection should include drafts/checks reflecting a substantial payment amount on any one claim. Compare the date the regulated entity indicated the draft/check was forwarded to the claimant with the date the draft/check was presented for payment. If the review indicates significant and numerous delays in presenting drafts/checks for payment, additional investigation to determine the causes should be done.

Canceled checks should be reviewed to verify that the amount paid and the claim amount approved are the same, that payees are the same and that the information recorded in the computer system matches what is on the check (payee, amount, date of check, etc.).

h. Review of other procedures

Other review, as deemed necessary, should follow the same format for objectivity and sampling techniques as those already described. These reviews may be instituted by consumer complaints regarding specific claims practices and should be tailored to resolve specific issues.

3. Tests and Standards

The claims review includes, but is not limited to, the following standards addressing various aspects of the regulated entity's claim handling practices. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
CLAIMS

Standard 1
The initial contact by the regulated entity with the claimant is within the required time frame.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity claims procedure manuals

_____ Claims training manuals

_____ Internal regulated entity claims audit reports

_____ Claim files

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Title Insurers Model Act (#628)
Title Insurance Agent Model Act (#230)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Review the regulated entity's procedures, training manuals and bulletins to determine if regulated entity standards exist. Determine whether the regulated entity's standards comply with applicable statutes, rules and regulations.

Determine if initial contact procedures are in place and in compliance with the mandated time frame. Perform a time study of acknowledgment times.

Determine if initial contact with claimants meets required contract standards.

Determine if subsequent responses and claim handling delay notices comply with applicable statutes, rules and regulations.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

STANDARDS
CLAIMS

Standard 2
Timely investigations are conducted.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity claims procedure manuals

_____ Claims training manual

_____ Internal regulated entity claims audit reports

_____ Claim bulletins

_____ Antifraud procedures

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Consumer Credit Insurance Model Act (#360)
Title Insurers Model Act (#628)
Title Insurance Agent Model Act (#230)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Review the regulated entity's procedures, training manuals and claim bulletins to determine if regulated entity standards exist and whether standards comply with state statutes.

Determine if investigations are initiated and concluded in compliance with state statutes.

When conducting an examination of workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

STANDARDS
CLAIMS

Standard 3
Claims are resolved in a timely manner.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity claims procedure manuals

_____ Claims training manuals

_____ Internal regulated entity claims audit reports

_____ Review of canceled claim checks

_____ Claim files

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Consumer Credit Insurance Model Act (#360)
Title Insurers Model Act (#628)
Title Insurance Agent Model Act (#230)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Review the regulated entity's procedures, training manuals and claim bulletins to determine if regulated entity standards exist and whether standards comply with state statutes.

Determine if claim resolutions—i.e., liability, determinations, coverage questions and claims payment—are made in accordance with state requirements. Perform time studies to measure the settlement time of claims.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

Automation Tip:
Obtain from the regulated entity a listing of claims closed with payment or claims closed without payment by claim feature. Include in the file the claim number(s), date the claim was reported to the regulated entity, the first payment date (if applicable), and the date the claim feature was closed. Using ACL, a database or spreadsheet, calculate the number of days from the date the claim feature was closed to the date the claim was reported. Group the number of days in any appropriate time periods, for example, 1 to 15 days, 16 to 30 days, etc., and perform a count on each time period. Investigate any patterns of untimeliness.

STANDARDS
CLAIMS

Standard 4
The regulated entity responds to claims correspondence in a timely manner.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity claims procedure manuals

_____ Claims training manuals

_____ Claim files

_____ Electronic claims correspondence

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Consumer Credit Insurance Model Act (#360)
Title Insurers Model Act (#628)
Title Insurance Agent Model Act (#230)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Review the regulated entity's procedures, training manuals and claim bulletins to determine if regulated entity standards exist and whether standards comply with state statutes.

Determine if correspondence related to claims is responded to in accordance with state requirements.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

STANDARDS
CLAIMS

Standard 5
Claim files are adequately documented.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity claims procedure manuals

_____ Electronic records of claims activities

_____ Claims training manuals

_____ Internal regulated entity claims audit reports

_____ Claim bulletins

_____ Claim files

_____ Claim forms

Others Reviewed

____ _____

____ _____

NAIC Model References

Insurance Fraud Prevention Model Act (#680)
Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Title Insurers Model Act (#628)
Title Insurance Agent Model Act (#230)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Review the regulated entity's procedures, training manuals and claim bulletins to determine if regulated entity standards exist and whether standards comply with state statutes.

Determine if quality of the claim documentation meets state requirements.

Determine if claim files retention/destruction program meets state requirements.

Determine if claim files documentation is sufficient to support or justify the ultimate claim determination.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

STANDARDS
CLAIMS

Standard 6
Claims are properly handled in accordance with policy provisions and applicable statutes (including HIPAA), rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity claims procedure manuals

_____ Claims training manuals

_____ Internal regulated entity claims audit reports

_____ Claim bulletins

_____ Regulated entity claim forms manual

_____ Regulated entity subrogation and salvage logs

_____ Claim files

_____ Regulated entity depreciation schedules

_____ Auto—total loss evaluation procedures

Others Reviewed

____ _____

____ _____

NAIC Model References

Insurance Fraud Prevention Model Act (#680)
Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Retained Asset Accounts Sample Bulletin (#573)
Consumer Credit Insurance Model Regulation (#360)
Long-Term Care Insurance Model Act (#640)
Coordination of Benefits Model Regulation (#120)
Off-Label Drug Use Model Act (#148), Section 4
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1960)

Review Procedures and Criteria

Review regulated entity procedures, training manuals and claim bulletins to determine if regulated entity standards exist and whether standards comply with state statutes.

Determine if the regulated entity's procedures provide for the detection and reporting of fraudulent or potentially fraudulent insurance acts to the commissioner.

Determine if claim handling meets state-specific statutes and regulations as applied to total loss evaluations, sales tax payment, disposition of salvage, correct payees, improper release of claims, proper payment of non-disputed claims and proper referral of suspicious claims.

Determine if coverage was checked for proper application of deductible or appropriate exclusionary language.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

STANDARDS
CLAIMS

Standard 7
Regulated entity claim forms are appropriate for the type of product.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Claim forms for product being examined

_____ Electronic claims notification screens

_____ Claim files

Others Reviewed

____ _____

____ _____

NAIC Model References

Insurance Fraud Prevention Model Act (#680)
Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Standardized Health Claim Form Model Regulation (#30)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Determine if claim form(s) include appropriate content and are used appropriately. Use of inappropriate forms should be documented and included in the examination report.

Review claim forms as they are encountered in the file reviews.

Examine all claim forms for the required fraud warning statement.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

STANDARDS
CLAIMS

Standard 8
Claim files are reserved in accordance with the regulated entity's established procedures.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity claims procedure manuals

_____ Claims training manuals

_____ Internal claims audit reports

_____ Individual claim file

_____ Average reserve data

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Review the regulated entity's claims procedure manuals for established reserving practices.

Determine if individual reserves are evaluated and posted.

Determine if reserve adjustments are made.

Determine if reserves are excessive/inadequate.

Determine if reserves are reduced, if a redundancy is apparent.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard, voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

STANDARDS
CLAIMS

Standard 9
Denied and closed without payment claims are handled in accordance with policy provisions and state law.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity claims procedure manuals

_____ Claims training manuals

_____ Internal regulated entity claims audit reports

_____ Claim bulletins

_____ Claim files

Others Reviewed

____ _____

____ _____

NAIC Model References

Insurance Fraud Prevention Model Act (#680)
Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Determine if denied and closed without payment claims are based on policy provisions and applicable state statutes and regulations.

Determine if notices of claim denials reference specific policy provisions or exclusions.

Determine if the regulated entity provides claimants with a reasonable basis for the denial, when required by statutes, rules or regulations.

Where required, determine if claimants are provided with instructions for having rebuttals to denials reviewed by the insurance department or by the regulated entity.

Determine if the regulated entity refers suspicious claims to a regulatory authority/law enforcement agency, when appropriate.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

STANDARDS
CLAIMS

Standard 10
Canceled benefit checks and drafts reflect appropriate claim handling practices.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Cashed benefit checks and drafts

_____ Regulated entity claims procedure manuals

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)

Review Procedures and Criteria

Perform a time study on canceled claim checks or drafts to ascertain whether claim proceeds are being promptly mailed or delivered.

Determine if canceled checks include the correct payee and are for the correct amount.

Ascertain whether payment checks indicate the payment is "final" when such is not the case.

Ascertain whether checks or drafts purport to release the insurer from total liability when such is not the case.

Review endorsements to see if they are consistent with the payee name listed on the check.

If drafts are used, ascertain whether there is prompt clearance by the insurer.

STANDARDS
CLAIMS

Standard 11
Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than is due under the policy.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Closed litigated claim files

_____ Regulated entity claims procedure manuals

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)

Review Procedures and Criteria

Review a sample or entire population of closed litigated claim files, if feasible. Determine if litigated files indicate problematic claim handling practices. If warranted, notify the insurance department's financial examination division.

Note: The examiner should review applicable state statutes to determine which particular claims should adhere to this standard. For example, bodily injury claims may not readily fit this standard.

Chapter 21—Conducting the Property and Casualty Examination

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

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

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

A. Operations/Management
B. Complaint Handling
C. Marketing and Sales
D. Producer Licensing
E. Policyholder Service
F. Underwriting and Rating
G. Claims

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

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

A. Operations/Management

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

B. Complaint Handling

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

C. Marketing and Sales

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

STANDARDS
MARKETING AND SALES

Standard 1
The regulated entity's mass marketing of property/casualty insurance is in compliance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ New business policy forms

_____ Advertising materials

_____ Disclosure materials

_____ Marketing complaints

_____ Underwriting guidelines

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Mass Marketing of Property and Liability Insurance Model Regulation (#[illegible])
Group Personal Lines Property and Casualty Insurance Model Act (#[illegible])

Review Procedures and Criteria

Review documentation in new business policy files to determine a legitimate basis for the group. If not evident from the file, request additional documentation from the regulated entity to verify that the group is not fictitious.

Review underwriting guidelines, new business policy files, advertising materials, disclosure materials and complaints to verify:

- Compulsory participation not required for employment or group membership;
- Tie-in sales are not a condition of purchase; and
- Disclosures are provided, as required.

D. Producer Licensing

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

E. Policyholder Service

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

STANDARDS
POLICYHOLDER SERVICE

Standard 1
Claims history and loss information is provided to the insured in a timely manner.

Apply To: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Claim files

_____ Regulated entity's procedures manuals

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Unfair Trade Practices Act (#880), Section 4(O)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Review sample claim files to determine if the regulated entity is providing loss information for the three previous years to the first named insured within 30 days of receipt of the written request including:

- On all claims, the date and description of occurrence and the total amount of payment; and
- For any occurrence not included above, the date and description of occurrence.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

F. Underwriting and Rating

1. Statistical Coding

In addition to the general standards, the examiner should review the regulated entity's statistical coding procedures. Coding on individual policies should be current and accurate. The examiner should determine to what statistical agencies the regulated entity reports its rating/underwriting data.

The examiner should confirm that the regulated entity is using the most current codes, classes, territories, town protection classes, ZIP codes, etc.

Errors should be noted with regard to overcharges or undercharges.

Additional introductory material is located in Chapter 20—General Examination Standards of this handbook.

STANDARDS
UNDERWRITING AND RATING

Standard 1
Credits, debits and deviations are consistently applied on a non-discriminatory basis.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files and supporting documentation

_____ Insurance department approval of deviations (if applicable)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Property and Casualty Model Rating Guideline (File and Use Version) (#1775)
Property and Casualty Model Rating Guideline (Prior Approval Version) (#1780)
Property and Casualty Commercial Rate and Policy Form Model Law (Condensed) (#777)
Unfair Trade Practices Act (#880)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Credits and deviations should be filed, where required.

Determine if credits and deviations are applied consistently.

Determine if the reasons for use of credits and deviations are documented.

Verify proper handling of consent-to-rate or excess rate forms.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

STANDARDS
UNDERWRITING AND RATING

Standard 2
Schedule rating or individual risk premium modification plans, where permitted, are based on objective criteria with usage supported by appropriate documentation.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files, including the Individual Risk Premium Modification (IRPM) worksheet

_____ Schedule rating worksheet where IRPM worksheet is used

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Property and Casualty Model Rating Guideline (File and Use Version) (#1775)
Property and Casualty Model Rating Guideline (Prior Approval Version) (#1780)
Property and Casualty Commercial Rate and Policy Form Model Law (Constructed) (#777)
Unfair Trade Practices Act (#880)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Verify that the application of the plan complies with limitations imposed by the state.

Verify that changes in the amounts of credit or debit are supported by documentation or an explanation that is consistent with the change. Also verify that the basis for use is appropriate (i.e., based on objective criteria, not on perceived competitive pressures).

Determine if the regulated entity is adjusting individual premiums to target premium levels for competitive reasons. Typically, the test for this is to review the documentation in the underwriting files.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

STANDARDS
UNDERWRITING AND RATING

Standard 3
Verification of use of the filed expense multipliers; the regulated entity should be using a combination of loss costs and expense multipliers filed with the insurance department.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ National Council on Compensation Insurance (NCCI) pure premium tables

_____ Regulated entity's filed multipliers that modify the NCCI's (or similar advisory organization) filed loss costs

_____ Rate charts by classification codes (charts maintained at the regulated entity level)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Property and Casualty Model Rating Guideline (File and Use Version) (#1775)
Property and Casualty Model Rating Guideline (Prior Approval Version) (#1780)
Property and Casualty Commercial Rate and Policy Form Model Law (Condensed) (#777)

Review Procedures and Criteria

Obtain from the regulated entity the filed expense multipliers which were applicable at the inception of the policy. (This filing should be stamped either "Approved" or "Filed" by the insurance department.)

Obtain the regulated entity's table of rates for each classification code. Check the sample's premium audit data (showing the actual rate charged to an employer for individual classification codes) against the table of rates, which includes the NCCI's (or similar advisory organization) loss costs and the filed expense multiplier, to verify accuracy.

The regulated entity's documents should be reviewed. Any additional areas or lack of information should be discussed with the regulated entity's management.

STANDARDS
UNDERWRITING AND RATING

Standard 4
Verification of premium audit accuracy and the proper application of rating factors.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Insurance department approved and/or filed rating plans, including risk modification plans

_____ Copies of cost containment certificates and loss improvement criteria to determine cost containment discount

_____ Final rate manual tables by classification codes applicable to the period under examination (tables maintained at the regulated entity level)

_____ Workers' Compensation Experience Modification Rating Sheets pertaining to the policy sample (experience modifiers as published by the NCCI and similar advisory organizations)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Property and Casualty Model Rating Guideline (File and Use Version) (#1775)
Property and Casualty Model Rating Guideline (Prior Approval Version) (#1786)
Property and Casualty Commercial Rate and Policy Form Model Law (Condensed) (#777)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

The purpose of this review is to determine that the final premium charged to the employer is being applied correctly, fairly and consistently.

The sample's premium audits should contain specific information on each policy. The sample's information should be compared to the NCCI unit statistical report and to the company's rating plan, to verify accuracy in the application and reporting of the following factors when applicable:

- Premiums by classification code;
- Payroll exposure;
- Schedule rating;
- Cost containment discount;
- Premium discounting;
- Designated medical provider discount;

- Expense loading;
- Application of the correct experience modifier;
- Small employer discount;
- Discount for rehiring previously disabled employees; and
- Any other rating elements.

The company documents should be reviewed. Any additional areas or lack of information should be discussed with company management.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

STANDARDS
UNDERWRITING AND RATING

Standard 5
Verification of experience modification factors.

Apply to: All workers' compensation examinations

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Premium audit reports from the policy sample

_____ Experience rating rules published by the NCCI (and similar advisory organizations)

_____ Workers' compensation experience modification rating sheets pertaining to the policy sample (experience modifiers pertaining to the policy sample as published by the NCCI and similar advisory organizations)

_____ Unit statistical reports pertaining to the policy sample and used to report the regulated entity's information (data) to the NCCI and similar advisory organizations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Property and Casualty Model Rating Guideline (File and Use Version) (#1775)
Property and Casualty Model Rating Guideline (Prior Approval Version) (#1780)
Property and Casualty Commercial Rate and Policy Form Model Law (Condensed) (#777)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

The experience modifier issued by the NCCI (and similar advisory organizations) should reflect the information reported to the NCCI (or similar advisory organizations) using the unit statistical reports. Experience modifiers should be reconciled to what is reported on the unit statistical reports and what is shown on the workers' compensation experience modification rating sheets.

Net loss reporting should be properly applied to both large and small deductible policies.

The regulated entity's documents should be reviewed. Any additional areas or lack of information should be discussed with the regulated entity's management.

STANDARDS
UNDERWRITING AND RATING

Standard 6
Verification of loss reporting.

Apply to: All workers' compensation examinations

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ NCCI (and similar advisory organizations') rules governing the reporting of losses on unit statistical reports

_____ Loss data pertaining to the policy sample and maintained by the regulated entity

_____ Unit statistical reports pertaining to the policy sample and used to report regulated entity information to the NCCI (and similar advisory organizations)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Property and Casualty Model Rating Guideline (File and Use Version) (#1773)
Property and Casualty Model Rating Guideline (Prior Approval Version) (#1780)
Property and Casualty Commercial Rate and Policy Form Model Law (Condensed) (#177)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Losses under each policy should be clearly and accurately maintained at the regulated entity, so that paid amounts, reserves and deductibles can be easily reviewed. The sample data should be compared to the unit statistical reports to verify accuracy of reporting of the following items:

- Paid losses;
- Paid loss adjustment expenses;
- Net of deductible reporting on the unit statistical reports;
- Adjustments to reserves and revised unit statistical reports; and
- Any other adjustments, such as subrogation.

The regulated entity's documents should be reviewed. Any additional areas or lack of information should be discussed with the regulated entity's management.

STANDARDS
UNDERWRITING AND RATING

Standard 7
Verification of the regulated entity's data provided in response to the NCCI call on deductibles.

Apply to: All workers' compensation examinations

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ The NCCI (or similar advisory organization) data call and resulting report made by the insurance regulated entity to the NCCI (or similar advisory organization)

_____ Loss data pertaining to sample policies written on a deductible basis and maintained by the regulated entity

_____ Unit statistical reports pertaining to sample policies written on a deductible basis and used to report regulated entity information to the NCCI (and similar advisory organizations)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Property and Casualty Model Rating Guideline (File and Use Version) (#1775)
Property and Casualty Model Rating Guideline (Prior Approval Version) (#1780)
Property and Casualty Commercial Rate and Policy Form Model Law (Casualty) (#777)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Note that a new sample (the "deductible sample") should be taken for this standard, sampling only policies with deductibles (both large and small deductibles).

During an examination, it should be verified that losses are reported on the unit statistical reports to the NCCI (or similar advisory organizations) net of deductibles. The Independent Deductible Data Call that the NCCI requests should be reported gross, including the deductibles. This must be verified with the policy sample, unit statistical reports and loss data maintained by the regulated entity.

The regulated entity's documents should be reviewed. Any additional areas or lack of information should be discussed with the regulated entity's management.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

STANDARDS
UNDERWRITING AND RATING

Standard 8
Underwriting, rating and classification are based on adequate information developed at or near inception of the coverage rather than near expiration, or following a claim.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Application

_____ Underwriting files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Decisions should be based on information that reasonably should have been developed at the inception of the policy or during initial underwriting and not, through audit or other means, after the policy has expired.

Determine if the initial underwriting of a policy is based on the information obtained after a claim is submitted.

STANDARDS
UNDERWRITING AND RATING

Standard 9
Audits, when required, are conducted accurately and timely.

Apply to: All auditable personal policies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files

_____ Premium audits pertaining to the policy sample

_____ Payroll records associated with the premium audits and with the policy sample

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Verify that all auditable commercial policies have a structured system for conducting payroll or other audits used to verify final premium.

Verify what is all auditable commercial policies' procedure for waiving audits. Verify that the basis is reasonable.

Determine what is all auditable commercial policies' time frame for completion of audits. Companies typically have a time frame for the completion of an audit following expiration.

Verify if all auditable commercial policies' auditors or independent auditors conduct audits.

Perform an independent verification to ensure that return premiums are received by insureds in a timely manner.

STANDARDS
UNDERWRITING AND RATING

Standard 10
The regulated entity's underwriting practices are not unfairly discriminatory. The regulated entity adheres to applicable statutes, rules and regulations and the regulated entity's guidelines in the selection of risks.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ New business application

_____ All underwriting information obtained

_____ Regulated entity's underwriting guidelines

_____ Underwriting bulletins

_____ Declination procedures

_____ Agency agreements and correspondence with producers

_____ Interoffice memoranda and regulated entity minutes

_____ Policy declaration page

_____ Underwriter's file or notes on a system log

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Insurance Fraud Prevention Model Act (#680)
Model Regulation on Unfair Discrimination in Life and Health Insurance on the Basis of Physical or Mental Impairment (#887)
Model Regulation on Unfair Discrimination on Basis of Blindness or Partial Blindness (#888)
Unfair Trade Practices Act (#880)
Credit Reports and Insurance Underwriting White Paper

Review Procedures and Criteria

Review relevant underwriting information to ensure that no unfair discrimination is occurring, according to the state's definition of unfair discrimination.

Determine if the regulated entity is following its underwriting guidelines, and that the guidelines conform to state laws and are not unfairly discriminatory.

Determine, if required, that the regulated entity's underwriting guidelines have been filed with the insurance department.

Review interoffice memoranda for evidence of anti-competitive behavior.

Underwriting guidelines may vary by geographic areas in the jurisdiction and, therefore, such guidelines should be reviewed for each regional office being examined.

Some indication of industry underwriting practices may be obtained by survey of residual markets (e.g., FAIR Plan and JUA), surplus lines markets and consent-to-rate filings.

Inconsistent handling of rating or underwriting practices, even if not intentional, can result in unfair discrimination, including requests for supplemental information.

Examine new business applications for the required fraud warning statement.

STANDARDS
UNDERWRITING AND RATING

Standard 11
All forms and endorsements forming a part of the contract are listed on the declaration page and should be filed with the insurance department (if applicable).

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ New business application

_____ Policy declaration page

_____ Insurance department approval for forms and endorsements

_____ Regulated entity's files or register of approved forms

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Unfair Trade Practices Act (#880)
Insurance Fraud Prevention Model Act (#680)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Determine if the forms and endorsements have been filed.

Determine if the regulated entity lists all forms and endorsements that form part of the contract on the declaration page.

Examine new business applications for the required fraud warning statement.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

STANDARDS
UNDERWRITING AND RATING

Standard 12
Regulated entity verifies that the VIN number submitted with the application is valid and that the correct symbol is utilized.

Apply to: All automobile lines

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files

_____ Regulated entity's rating system

_____ Regulated entity's symbol or Insurance Services Office (ISO) symbol manual

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Unfair Trade Practices Act (#880)
Insurance Fraud Prevention Model Act (#680)

Review Procedures and Criteria

Determine how the regulated entity checks the validity of the vehicle identification number (VIN) on the application. The regulated entity may use an automated program to verify the accuracy of the VIN.

Verify if the regulated entity is a member of or reports to any fraud detection bureau or organization. Some state statutes require reporting of suspected fraud.

Determine how a regulated entity handles updated symbols.

Determine if the correct symbol has been used.

STANDARDS
UNDERWRITING AND RATING

Standard 13
The regulated entity does not engage in collusive or anti-competitive underwriting practices.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Any practice suggesting anti-competitive behavior may involve legal considerations that should be referred to insurance department legal counsel. This would include engaging in collusive underwriting practices that may inhibit competition; e.g., entering into an agreement with other companies to divide the auto market within the jurisdiction by territory.

The examiner should be aware of unlawful pricing and other prohibited anti-competitive acts or practices.

STANDARDS
UNDERWRITING AND RATING

Standard 14
The regulated entity's underwriting practices are not unfairly discriminatory. The regulated entity adheres to applicable statutes, rules and regulations in its application of mass marketing plans.

Apply to: All property and casualty companies with mass marketing plans

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ New business policy files

_____ Underwriting guidelines

_____ Canceled and nonrenewed policies

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Mass Marketing of Property and Liability Insurance Model Regulation (#71
Credit Reports and Insurance Underwriting White Paper

Review Procedures and Criteria

Review documentation in new business policy files and underwriting guidelines to determine that the regulated entity does not apply underwriting standards to a mass marketing program that are more restrictive than those applied to an individually underwritten program.

Review underwriting guidelines, canceled and nonrenewed policy files to verify that failure of the employer or group to remit premium is not regarded as "nonpayment of premium" for the insured, unless the insured is sent appropriate notice and has failed to make timely payment.

Review underwriting guidelines and policy forms to verify that the employee or group member is given the right to continue coverage for 60 days after leaving employment or the group.

Review canceled and nonrenewed policies to verify that the notice of right to employee or member is given at cancellation or nonrenewal; allowing the employer or group to provide additional explanation why the individual should not be canceled.

STANDARDS
UNDERWRITING AND RATING

Standard 15
All group personal lines property and casualty policies and programs meet minimum requirements.

Apply to: Group personal lines property and casualty insurance

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Master policy

_____ Program rules

_____ Certificates

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Group Personal Lines Property and Casualty Insurance Model Act (#760)

Review Procedures and Criteria

Check for state jurisdictional requirements regarding group policies.

Verify that conversion options are included in notices of individual termination.

Determine that conversion policies issued on an individual basis effective upon termination or ineligibility date have coverage and limits at least equal to the minimum coverage and limits required by statute.

Determine that program rules do not contain any provision making participation in the group program a condition of employment or membership in a group, nor subject employees or members to any penalty for non-participation.

Determine that group coverage is not contingent upon the purchase of any other insurance, product or service.

Confirm that any experience refund or dividend is applied for the sole benefit of the insured employee or member to the extent that any experience refund or dividend exceeds the policy or certificateholder's contribution to the premium for the period covered.

STANDARDS
UNDERWRITING AND RATING

Standard 16
Cancellation/nonrenewal notices comply with policy provisions and state laws, including the amount of advance notice provided to the insured and other parties to the contract.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy contract

_____ Notice of cancellation/nonrenewal

_____ Insurance department's approval of forms

_____ Underwriter's file or notes on a system log

_____ Insured's request (if applicable)

_____ Regulated entity's cancellation/nonrenewal guidelines

_____ Certificate of mailing

_____ Producer records/notices issued

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Determine if the notice of cancellation/nonrenewal is valid according to policy provisions and state law.

Does the notice of cancellation include the specific reason for cancellation where required?

Are adverse underwriting decision notices provided where required?

Review cancellation notice and billing notices, grace period descriptions, reinstatement offers, lapse notices, etc., to ensure the form, if necessary, has been approved by the insurance department.

Review the notice and the certificate of mailing to ensure that adequate notice of cancellation/nonrenewal was provided to the insured and any mortgagees or lien holders.

Does the regulated entity lull insureds into a false sense of security through use of misleading billing notices, grace period descriptions, reinstatement offers, lapse notices, etc.?

If cancellation was at the insured's request, ensure that there is proper documentation.

STANDARDS
UNDERWRITING AND RATING

Standard 17
All policies are correctly coded.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files

_____ Regulated entity's rating system

_____ Regulated entity's coding manual

_____ Rating organization's coding manual

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Require Reporting of Statistical Data by Property and Casualty Insurance Companies (#751)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Determine that the regulated entity confirms that the coding as reported by the producer is correct and current.

Determine that the regulated entity promptly updates all coding manuals and programs.

Determine that the regulated entity correctly codes all policies according to current codes.

Determine that the regulated entity reviews data errors and subsequent changes are made.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

STANDARDS
UNDERWRITING AND RATING

Standard 18
Application or enrollment forms are properly, accurately and fully completed, including any required signatures, and file documentation adequately supports decisions made.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Application

_____ Underwriting files

_____ Electronic documentation

_____ Policy

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Application should be complete and signed, where required (includes electronic signatures).

Determine that the underwriting file contains necessary information to tell the regulated entity what exposure it has.

Determine when and under what conditions the regulated entity requires a physical inspection, a motor vehicle report (MVR), an inspection report, a credit report or other underwriting information to confirm exposure or premium basis.

Verify that when a policy is issued on a basis other than applied for, that notice of an adverse underwriting decision is provided in accordance with applicable state statutes and regulations.

G. Claims

In addition to the general examination techniques, the examiner should define the scope of the property/casualty claims examination in terms of the lines of business and type of claims covered. Lines of business should be defined as specifically as possible; e.g., physical damage coverage rather than automobile coverage. Types of claims covered should differentiate between first-party and third-party claims or total losses and partial losses.

Claim procedure manuals, adjuster training manuals and claim bulletins should be reviewed. Regulated entity procedures for total loss settlement, salvage disposition and subrogation efforts should be determined. If the jurisdiction licenses company or independent adjusters, licensing records should be cross checked with claim adjustment records to ensure that assigned adjusters are properly licensed.

a. Total loss survey

   Record identifying data, such as claim/policy number, date of loss and claimant's name. Review files for accuracy and adequacy of documentation. Review files for method of vehicle evaluation and compare with specific state requirements. Review reductions in value for appropriateness and accuracy. Review file for state-specific additions to value, such as sales tax or title fees.

   Review file for correct disposition of salvage and compliance with specific state requirements for disposition of title and registration.

b. Subrogation survey

   From the regulated entity's records, select a representative sample of the subrogated files with complete or partial recoveries. Record identifying data such as claim/policy number, date of loss and claimant name. Review files to determine if the subrogated amount included the insured's deductible. It should also be determined if the deductible was recovered and whether it was returned to the insured.

   If a partial recovery was made, was a pro rata amount returned? Specific state requirements should be reviewed to determine the regulated entity's compliance. Determine if the insured's recovery was reduced by collection charges. Determine if the specific state law permits the reductions. Determine if recovery was reduced by written or oral agreements with other companies. Determine if such agreement is in compliance with specific state laws.

c. Loss statistical reporting

   Determine to which statistical agencies the regulated entity reports its loss data. Review claim drafts to determine if loss data is correctly coded as to the proper line of business. Review drafts to determine if claim expenses are separated from claim payments. If the review indicates significant errors in coding, the data should be included in the report.

STANDARDS
CLAIMS

Standard 1
Regulated entity uses the reservation of rights and excess of loss letters, when appropriate.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity's claim procedure manuals

_____ Claim training manuals

_____ Claim files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Review the regulated entity's procedures manual to determine if guidelines exist for the use of the reservation of rights letter and notice of excess of loss.

Claims where the regulated entity has reason to question coverage should have a reservation of rights letter sent to the insured.

Claims where it is apparent that the amount of loss will exceed policy limits should have an excess of loss letter send to the insured.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

STANDARDS
CLAIMS

Standard 2
Deductible reimbursement to insureds upon subrogation recovery is made in a timely and accurate manner.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Subrogation register

_____ Subrogation files

_____ Review the regulated entity's subrogation and recovery procedures

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Determine if the regulated entity refunds deductibles from subrogation proceeds.

Determine if, upon complete recovery, the insured's deductible is promptly refunded.

Determine if refunds are made periodically on no less than a pro rata basis for long-term subrogation cases. Requirements may vary among states.

Determine if recovery payments are made to employees under workers' compensation, when applicable.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

STANDARDS
CLAIMS

Standard 3
Loss statistical coding is complete and accurate.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Claim files

_____ Regulated entity's claims coding manual

_____ Regulated entity's coding system

_____ Rating organization's coding manual

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Require Reporting of Statistical Data by Property and Casualty Insurance Companies (#751)
Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Determine that the regulated entity codes the correct loss data onto the draft copies or system.

Determine that the regulated entity promptly updates all coding manual and programs.

Determine that the regulated entity accurately codes the loss amounts. Determine that the regulated entity separates loss amounts from loss expense amounts.

Determine that the regulated entity reviews data errors and subsequent changes are made.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

Chapter 22—Conducting the Title Insurance Company and Title Insurance Agent Examination

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

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

For the purpose of licensing standards, the term "producer" is used, instead of "title agent." It will be necessary to refer to Chapter 20—General Examination Standards of this handbook relating to producer licensing.

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

A. Operations/Management
B. Complaint Handling
C. Marketing and Sales
D. Producer Licensing
E. Policyholder Service
F. Underwriting and Rating
G. Claims
H. Escrow, Settlement, Closing or Security Deposit Funds
I. Title Insurance Producer (Agent) Licensing and Relations
J. Special Considerations for Title Insurance Companies and Title Insurance Agents
K. Example Title Letter
L. Example Title Interrogatory
M. Sample Checklist

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

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

A. Operations/Management

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

STANDARDS
OPERATIONS/MANAGEMENT

Standard 1
The title insurance company acts within the scope of its license.

Apply to: All title companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Certificate of authority

_____ Title insurance company system

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurers Model Act (#628)

Review Procedures and Criteria

No title insurance company may transact any class, type or kind of business other than title insurance.

Title insurance may not be transacted, underwritten or issued by any title insurance company transacting or licensed to transact any other class, type or kind of business.

The title insurance company shall do only title insurance business, reinsure title insurance policies and perform ancillary activities, including examining titles to real property and any interest in real property and procuring and furnishing related information and information about relevant personal property when not in contemplation of, or in conjunction with, the issuance of a title insurance policy.

A title insurance company shall not engage in the business of guaranteeing payment of the principal or the interest of bonds or mortgages.

The title insurance company is expressly authorized to issue closing or settlement protection to a proposed insured upon request, if the title insurance company issues a preliminary report, binder/commitment or title insurance policy.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 2
No member of the board of directors of the title insurance company may be a title insurance agent who wrote 1 percent or more of the direct premiums for the previous calendar year.

Apply to: All title insurance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurers Model Act (#628)

Review Procedures and Criteria

This requirement does not apply if the relationship is covered by the state's insurance holding company act.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 3
The agency and all applicable employees have in place an errors and omissions policy, fidelity coverage, and/or a surety bond (or alternative financial arrangement, where permitted), if required by statutes, rules and regulations.

Apply to: All title insurance agents

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations, especially insurance examination law

_____ Records of errors and omissions policy, fidelity coverage, surety or financial arrangement

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurance Agent Model Act (#230)

Review Procedures and Criteria

Some jurisdictions require fidelity coverage to cover all individuals who handle escrow, security deposits and/or closing funds.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 4
Business is diversified as required by statutes, rules and regulations.

Apply to: All title insurance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Annual statement

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurers Model Act (#628)

Review Procedures and Criteria

Business is diversified as required by statutes, rules and regulations. Prior written approval from the insurance department may override the following restrictions.

An independent title insurance agent's aggregate premiums may not exceed a percentage of the title insurance company's gross premiums written during the prior calendar year (as required by applicable statutes, rules and regulations).

Direct operations business may not be accepted from a single source in excess of the allowed percentage of the title insurance company's gross premiums written during the prior calendar year.

A single source means a person that refers business to the title insurance company and any other person that controls, is controlled by or is under common control with that person.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 5
There is a periodic review and testing of the title plant built, owned, controlled or maintained by a title agent.

Apply to: All title plants where a title insurance agent builds, owns, controls or maintains the title plant

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations, especially insurance examination law

_____ Title insurance company or title insurance agent standards for title plant construction, use and maintenance

_____ Title plant

_____ Agency contract, if applicable

_____ Claim files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurance Agent Model Act (#230)

Review Procedures and Criteria

Determine if there are established title plant standards and periodic tests to see that standards are met.

Review claim files to determine if losses paid arise from faulty search of title.

Determine if adequate provisions concerning the title plant are in the agency contract, if applicable.

Note: In some instances, the title insurance company is responsible for overseeing the activities of its agents with respect to maintenance of the title plant. The examiner should be aware that in other instances, the title insurance company and the title insurance agent may be in direct competition with each other. In those situations, the title insurance agent is accountable for ensuring standards for appropriate maintenance of the title plant.

B. Complaint Handling

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

C. Marketing and Sales

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

STANDARDS
MARKETING AND SALES

Standard 1
Controlled business is handled in accordance with statutes, rules and regulations.

Apply to: All title insurance agents

Priority: Essential

Documents to be Reviewed

_____ Applicable state and federal statutes, rules, and regulations, including the federal Real Estate Settlement Procedures Act (RESPA) (12 U.S. Code §2601)

_____ RESPA 12 USC 2602 – Definitions – AfBA

_____ RESPA 12 USC 2607 – Prohibition against kickbacks and unearned fees (Section 8)

_____ RESPA 12 USC 2608 – Title companies; liability of seller (Section 9)

_____ RESPA 12 USC 5565 – Relief available (penalties)

_____ RESPA 12 CFR 1024 – Use of HUD-1 or HUD-1A settlement statement

_____ RESPA 12 CFR 1024.14 – Prohibition against kickbacks and unearned fees (Section 8)

_____ RESPA 12 CFR 1024.15 – AfBA

_____ RESPA 12 CFR 1024.16 (Section 9)

_____ Affiliated business arrangement disclosures

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurance Agent Model Act (#230)

Review Procedures and Criteria

The title insurance agent must advise customers prior to commencing a transaction of the controlled business arrangement, if required by statutes, rules, bulletins and regulations. Compare any disclosure form to RESPA Appendix D, which refers to affiliated business arrangements and any additional state-based disclosure requirements that pertain to affiliated entities or controlled businesses.

If a referral is received from an individual who constitutes a controlled business arrangement, the person being referred must be notified that he or she is not required to use a specified title insurance agent or title insurance company, if required by statutes, rules and regulations.

- Referrals must be in compliance with the provisions of applicable state and federal statutes, rules and regulations as they relate to controlled business. Federal guidelines applicable to affiliated businesses can be found in RESPA, Section 8. With regard to national banks and their affiliates conducting title insurance, see 15 USC §6713. Recent enforcement actions and rulings ordered by the Consumer Financial Protection Bureau (CFPB) can be found on the CFPB web page at *www.consumerfinance.gov/*.

STANDARDS
MARKETING AND SALES

Standard 2
Inducements are not provided, directly or indirectly, in consideration of referral of title insurance business, escrow or other services provided by a title insurance agent.

Apply to: All title insurance companies and title insurance agents

Priority: Essential

Documents to be Reviewed

_____ Applicable state and federal statutes, rules, and regulations, including the federal Real Estate Settlement Procedures Act (RESPA) (12 U.S. Code §2601)

_____ RESPA 12 USC 2602 – Definitions – AfBA

_____ RESPA 12 USC 2607 – Prohibition against kickbacks and unearned fees (Section 8)

_____ RESPA 12 USC 2608 – Title companies; liability of seller (Section 9)

_____ RESPA 12 USC 5565 – Relief available (penalties)

_____ RESPA 12 CFR 1024 – Use of HUD-1 or HUD-1A settlement statement

_____ RESPA 12 CFR 1024.14 – Prohibition against kickbacks and unearned fees (Section 8)

_____ RESPA 12 CFR 1024.15 – AfBA

_____ RESPA 12 CFR 1024.16 (Section 9)

_____ Title insurance company's correspondence files

_____ Closing statements

_____ Policy files

_____ Customer/affiliated business arrangement (AfBA) listing chart

_____ AfBA documents, including contracts and bank accounts

_____ Financial and operational documents for title agency and AfBA operations

_____ Fee schedule

_____ Services schedule

_____ Service fee invoices, bills and accounting records

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurance Agent Model Act (#230)
Title Insurers Model Act (#628)
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

All transactions must be in compliance with the provisions of applicable statutes, rules and regulations as it relates to referrals.

Test for discounting of, or waiving of, service fees, including escrow, as a form or illegal inducements. Test to ensure affiliate business referrers are not receiving preferential services or pricing of common services. Review closing statement and policy files to identify improper discounting, waiving of service fees or any other thing of value or otherwise illegal behavior. Compare services offered and prices charged to affiliated and nonaffiliated entities to determine if preferential treatment is provided to affiliated entities. Ensure that comparison includes like products or services as there are many different title products available in most states, including new or existing home purchases and refinance arrangements. Review closing statements and policy files for application of appropriate charges and discounts. Refer to Chapter 20 for sampling procedures appropriate to the size of the company.

The customer/affiliated business arrangement (AfBA) list or chart should include all referring customers for the examination period.

The examiner collects a list of all AfBAs in effect during the examination period, as well as a copy of any and all documents, including agreements/contracts between members and affiliates, however structured.

AfBA agreements include corporate/LLC/partnership operating, membership, and specific work and/or product agreements.

Service schedule: Examiner should collect a list of all (title, escrow/closing/settlement and AfBA) services the entity provides during the examination period, including but not limited to:

- Closing services;
    - Closings/settlements;
    - Document preparation;
    - Receiving and sending wires;
    - Sending or couriering overnight packages;
    - Processing (if separately charged from other services); and
    - Recording handling.
- Title services; and
    - Abstracting/searching;
    - Examining title/underwriting;
    - Creating commitment or title search report (TSR);
    - Updating title commitments (before closing, before issuing policies);
    - Clearing title defects;
    - Ordering payoffs;
    - Scheduling closings; and

    - Writing/issuing policies.
- AfBA services.
    - Title services listed above;
    - Closing services listed above;
    - Management;
    - Advertising/marketing;
    - Accounting; and
    - Compliance regulatory.

Fee schedule: The examiner should collect a complete fee schedule for the examination period that includes all services listed in the services schedule, which also should include variations for all transaction types, including, but not limited to, purchase transactions (full and bifurcated/split closing), refinance, construction, vacant land, for sale by owner (FSBO) and foreclosures. Fee schedules also should include any changes (up or down) during the examination period, each with an explanation and/or justification.

Testing of fees and services should begin with a cross comparison to ensure that all services are represented by a fee. The examiner should determine the appropriateness when a service is provided without a fee, according to state and federal statutes and regulations, and regional common practice.

Fee testing can be done against a series of samples (random, judgmental or consensus, depending on the examinee's size and/or situation), including referrer customer files (for consistency across customers), transaction types (for consistency across transaction type) or a random sample of transactional files (applying Chapter 17 sampling methodology) to test for overall operational fee consistency. Any deviations from stated fees or variations between customers or transaction-type fees should be included as a preliminary finding and sorted out using a crit issued to the examinee before determining if there is a violation.

When testing AfBA documents directly, agreements, invoices, bills and accounting records should be scrutinized, in addition to fee testing of customer samples, to ensure that AfBAs are charged no more or less for services than any other customer. Examiners should review AfBA agreements as well to ensure that all contracted services are included in the service and fee schedules mentioned above. Ultimately, the examiner will determine if any customer, including affiliated customers, are receiving services for less than normally charged, including for free.

Referrals may not be originated from a producer or other person that requires, directly or indirectly, placement of the title insurance through a particular agency or title insurance company as a condition precedent to providing a loan, credit, sale, property, contract, lease or service, if prohibited by statute, rules and regulations.

Thing of Value: The definition of (illegal) rebating, including through inducements, in Section 4H of the *Unfair Trade Practices Act* (#880), as has been adopted by many states, includes the statement or as adopted, statements of such similar meaning, "… paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement …" and "or anything of value whatsoever …". The emphasis of this guidance focuses on the "directly or indirectly" and "anything of value" or more accurately, the any "thing-of-value" items that may constitute an illegal rebate by inducement. Ultimately, the examiner should know his or her respective state's regulations that address rebating and illegal inducements.

Certain financial and operations records of the title entity, including AfBA operations, should be collected or available to inspect in order to do a proper review for potential rebating and illegal inducements. These items include, but are not limited to, profit and loss (P&L) statements, balance sheets, business and officer tax returns, third-party and internal accounting audit reports, bank account records, reconciliations and statements for all escrow and operations accounts, operational accounts payable receipts, positive pay and reverse-positive pay records, cancelled/cleared checks (or access to on line check review programs), advertising and co-advertising agreements and receipts, employee and officer expense account reports, sales reports, and employee time sheets and salary/payroll records.

As title insurance is primarily generated through business referrals, it does not focus so much on inducements directed at the prospective insured, but instead focuses on inducements or kickbacks to the referring customers/clients, including, but not limited to, AfBA client referrers. Review and consider whether the affiliated person is paying or receiving no more than a reasonable market value for the things and services provided, and that those things and services are actually being provided and performed. Consideration also can be given to these same schemes from a RESPA Section 8 illegal kickback perspective and through which a "thing of value" can be found more formally defined. "Consideration" is something of value given by both parties to a contract that induces them to enter into the agreement to exchange mutual performances (*www.legal-dictionary.thefreedictionary.com/consideration*). The examiner should test to see if there is any additional consideration given beyond the written consideration of the contract, such as the referral of title orders.

A direct rebate (directly from premium or profit derived from premium) as inducement can be found in the form of a cash or other direct monetary payment (checks) for the referral of business. Cash payments can be difficult to trace, however, as it is uncommon for businesses to have legitimate reason for significant cash withdrawals. All cash withdrawals from business accounts should be tracked, justified and substantiated with legitimizing documentation provided by the title entity being examined. All cash payments to officers, owners or employees of the company, which may be disguised as legitimate business payment, including profit distributions, should be substantiated, including through the verification of year-end tax documents for inclusion in the case of personal distributions. Other monetary payments (checks) to referrer clients also should be scrutinized to ensure they are proper, legitimate and legal payments. For AfBAs, profit sharing (dividends) based upon ownership interests is an example of a legitimate and legal payment, while payments to a sham entity is an example of an illegitimate payment.

An indirect thing-of-value can be found to include just about anything and, therefore, all outgoing payments from business accounts should be scrutinized to ensure that whatever the payment is for, even if it appears to be legitimized under a sound agreement, is an actual payment for actual services that actually occur, and that the consideration for the agreement is not the thing-of-value that constitutes a quid pro quo (this for that) situation, which makes it an illegal inducement or kickback. State laws may provide that actual referral or placement of business (this for that) is not required.

Some items such as tickets to sporting events, Broadway-style shows and other entertainment festivities will be more obvious. Although the payment is not hidden, the underlying reality may still be obscured by erroneous explanations, such as that the events were sales meetings. An apparent legitimate event may actually be in excess of a reasonable amount for a "sales meeting," or it may turn out that the client attended the event alone, negating the possibility of any actual "meeting" taking place. Other more or less conspicuous items may include the title agency or company monetarily sponsoring the referrer's social, business and/or even "charity" events, including golf outings, customer appreciation galas, open houses at the referrer's offices or providing refreshments or giveaway prizes at real estate open houses) and end-of-the-year parties.

Other forms of indirect things of value may include, but are not limited to:

- Furnishing or offering to furnish, without reasonable charge, all or part of the time or productive effort of any employee of the title entity for the benefit of the referrer, including the referrer's title production. (Review agreements, time sheets and payroll records.);
- Providing or offering to provide, without reasonable charge, any business, office or computer equipment, or any title or non-title services (escrow, computerized bookkeeping or programing, forms management, etc.). (Review agreements and accounts payable receipts for title and AfBA entity. AfBAs should have receipts for all equipment they purchased.);
- Providing or offering to provide, without reasonable charge, any advertisements, in any form, for the benefit of the referrer entity. (Review advertisement agreements and accounts payable receipts.);
- Disbursing escrow funds prior to the actual deposit or prior to conditions of the escrow having been met. (Review escrow account and individual transactional escrow accounting records, including ledgers, settlement statements, disbursement summaries, and deposit and bank statements.);

- Paying or offering to pay cancellation fees for title orders or preliminary title reports. (Review agreements, time sheets, cash withdrawals and payroll records.);
- Paying or offering to pay the fees of charges of any outside professional including, but not limited to, an attorney, engineer, appraiser or surveyor whose services are required for a prospective transaction or for the referrer entities' business operations. (Review escrow account and individual transactional escrow accounting records, including ledgers, settlement statements, disbursement summaries, and deposit and bank statements. Verify the title entity is collecting and retaining 100% of his or her monies due at closing.);
- Paying or offering to pay any part of the salary of an employee of the referrer entity. (Review agreements, time sheets, cash withdrawals and payroll records.);
- Paying or offering to pay the salary or any part of the salary of a relative of any producer of title business in which payment is in excess of the reasonable value of work performed. (Review agreements, time sheets, cash withdrawals and payroll records. Interview staff, verify salaries are in line with all other employees performing the same or similar functions, and verify work is being done for subject employees.);
- Paying or offering to pay for services by any referrer in which services are required to be performed by the referrer in his or her capacity as a real estate or mortgage broker or salesperson or agent that are and should normally be paid by the referrer in that capacity. (Review escrow account and individual transactional escrow accounting records, including ledgers, settlement statements, disbursement summaries, and deposit and bank statements. Verify the title entity is collecting and retaining 100% of his or her monies due at closing.);
- Overpaying for office rental space within the referrer entity's offices or real estate or leasing office space that is not in use by the title entity. (Review rental and AfBA agreements, verify use and reasonable prices for the regional area, and verify monies properly changed hands.);
- Providing or offering to provide rental space to the referrer client for occupancy for any amount below actual cost. (Review rental and AfBA agreements, verify use and reasonable prices for the regional area, and verify monies properly changed hands.); and
- Providing or offering to provide, waiving or offering to waive reimbursement for escrow cash advances for the referrer clients' customer's benefit, including payoff administrative fees, subordination agreement fees or any other similar fees. (Review the escrow account and individual transactional escrow accounting records, including ledgers, settlement statements, disbursement summaries, and deposit and bank statements.);

STANDARDS
MARKETING AND SALES

Standard 3
Affiliated business arrangements are organized and operated in compliance with statutes, rules and regulations.

Apply to: All title insurance companies and title insurance agents

Priority: Essential

Documents to be Reviewed

_____ Applicable state and federal statutes, rules, and regulations, including the federal Real Estate Settlement Procedures Act (RESPA) (12 USC §2601)

_____ RESPA 12 USC 2602 – Definitions – AfBA

_____ RESPA 12 USC 2607 – Prohibition against kickbacks and unearned fees (Section 8)

_____ RESPA 12 USC 2608 – Title companies; liability of seller (Section 9)

_____ RESPA 12 USC 5565 – Relief available (penalties)

_____ RESPA 12 CFR 1024 – Use of HUD-1 or HUD-1A settlement statement

_____ RESPA 12 CFR 1024.14 – Prohibition against kickbacks and unearned fees (Section 8)

_____ RESPA 12 CFR 1024.15 – AfBA

_____ RESPA 12 CFR 1024.16 (Section 9)

_____ Policy files

_____ Response(s) to pre-examination AfBA interrogatories

_____ Accounting records, including but not limited to, copies of cancelled checks, front and back, and disbursements to owners from operating accounts

_____ Ownership documents

_____ Applications, reports and disclosures to the regulatory authority, if required

_____ Documentation of disclosures to consumers, if required

_____ Contracts and service agreements between affiliates

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurance Agent Model Act (#230)
Title Insurers Model Act (#628)

Review Procedures and Criteria

All arrangements must be organized and operated in compliance with the provisions of applicable statutes, rules and regulations as they relate to referrals, illegal kickbacks, and providing things of value to agency/company owners, referrers of business and potential referrers of business.

Core services are performed by in-house agency/company staff, including title examinations, determination of insurability, clearance of exceptions or objections, the issuance of preliminary commitment, issuance of title policies, and if normally performed by title agents in the state, conducting the title search and handling of the closing.

All contracted services provided by a party related to the affiliated business entity are obtained at fair market prices, including, for example, accounting, information technology, human resources, payroll, title search, title examination, providing preliminary commitment or issuing title policy. Review contracts, service agreements and disbursements to analyze such affiliate transactions.

Analyze performance of core services, including a review of employee activities and disbursements for contracted services.

Analyze the original source of business. Make note of common settlement producers and the amount of business being referred by each. If the majority of referrals are being submitted by a few persons or entities, examine the ownership/relationship of the referring settlement producer and the entity under examination. Review disbursements for marketing, sales and core service activities to analyze potential referral fees.

The agency/company must be capitalized in compliance with applicable statutes, rules and regulations.

If a referral is received from a person or entity who is part of the affiliated business arrangement, the agency/company and/or referrer must provide its customers in a timely manner with all disclosures required by statutes, rules and regulations, including, for example, disclosure of the affiliated business arrangement and notification that the person being referred is not required to use the specific agency/company. If documentation of disclosure is required, review such documentation. Compare the disclosure form to RESPA Appendix D, which refers to affiliated business arrangements and any additional state-based disclosure requirements that pertain to affiliated entities or controlled businesses. Consider contacting a sample of customers to verify that they received required disclosures.

Determine if reports, applications or disclosures of the affiliated business arrangement to the regulatory authority are required under state statutes, rules and regulations. If so, determine if such documents have been properly filed.

D. Producer Licensing

Not applicable.

E. Policyholder Service

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

F. Underwriting and Rating

1. Purpose

The underwriting portion of the examination is designed to provide a view of how the title insurance company treats the public and whether that treatment is in compliance with applicable statutes, rules and regulations. It is typically determined by testing a random sampling of files and applying various tests to the sampled files. It is concerned with compliance issues. The areas to be considered in this kind of review include:

a. Rating practices;
b. Underwriting practices;
c. Use of correct and properly filed and approved forms and endorsements;
d. Unfair discrimination;
e. Use of proper disclosures, buyers' guides and delivery receipts; and
f. Statistical coding.

2. Techniques

During an examination, it is necessary for examiners to review a number of information sources, including:

- Rating manuals and rate cards;
- Rate classifications;
- Rating systems filed with regulators;
- Policy fees;
- Discounts;
- Title insurance company automated rating system;
- Rating materials provided to title insurance agents;
- Underwriting guidelines;
- Applicable policy forms and endorsements;
- Title insurance agent compensation agreements, where applicable;
- Statistical reporting requirements; and
- Underwriting/closing/escrow files content and structure.

For purposes of this chapter, "underwriting/closing/escrow file" means the file or files containing rate calculation sheets, billings, and audits—including binders/commitments, all underwriting information obtained or developed, policy schedules A and B, endorsements, the lender's written closing instructions, settlement statements (HUD-1) and Good Faith Estimate (HUD-GFE) forms (if available), correspondence, and any other documentation. In many cases, all applicable documentation will not be contained in one file, but rather will be found in separate underwriting and closing files. Additionally, it should be noted that, since HUD-GFE forms are not required to be given to the title entity, such forms might not be available in all circumstances.

In selecting samples for testing, residential coverages should generally not be combined with commercial coverages. These two areas are not always homogeneous and conclusions or inferences to be made from the results of sampling may not be valid if combined. The examiner should be familiar with any statutory or regulatory distinctions made between residential coverages and commercial coverages with respect to the various tests to be developed. The examiner also should be familiar with the process for gathering and processing underwriting information and the quality controls for the issuance of policies and endorsements. The list of files from which a sample is to be drawn may be generated through a computer run or, in some cases, through a policy register covering the period of time selected in the notice or call of examination.

Determine the title insurance company's policy population (policy count). Review a random selection of business for application of a particular test or apply specific tests to a census population using automated tools. (In the event specific files are chosen for a target review, the examiner must be certain the examination results are clearly identified as representative of the target selection.) The examiner should maintain a list of the various tests to be applied to each file in the sample. This will aid in consistency by ensuring that each test is considered for each file in the sample.

If exceptions are noted, the examiner must determine if the exception is caused by such practices as the use of faulty automated rating systems or the development of improperly or vaguely worded manuals or guidelines. When exceptions are noted, it is advisable to determine the scope and extent of the problem. The examiner's responses should maximize objectivity; the examiner should avoid replacing examiner judgment for title insurance company judgment.

a. Rating Practices

It is necessary to determine if the title insurance company is in compliance with rating systems which have been filed with and, in some cases, approved by, the various state insurance departments. Where rates are not required to be filed with an applicable regulatory agency, it is prudent to determine if rates are being applied consistently and in accordance with the title insurance company's own rating methods. In general, rates should not be unfairly discriminatory. Wide-scale application of incorrect rates by a title insurance company may raise financial solvency questions or be indicative of inadequate management oversight. Deviation from established rating plans may also indicate that a title insurance company is engaged in unfair competitive practices. Inconsistent application of rates, individual risk premium modifications, modification factors and deviations can result in unfair discrimination.

The procedure for determining adherence to rates filed or used by a title insurance company may vary between residential coverages and commercial coverages. The examiner should become familiar with the title insurance company's policy form numbers or other identification procedures, inasmuch as references may be made to such numbers or procedures in lieu of having the particular form attached.

When possible, the examination team should make use of audit software to verify correct application of specific rating components. This allows for a more thorough review and can save time during the examination process.

Rating practices of policies and endorsements should be reviewed. The examiner should ensure that the underwriting/closing/escrow files contain sufficient information to support the rates that have been applied to a policy or endorsement. Inherent in the more complex systems is the concern for unfair discrimination.

b. Underwriting Practices

The examiner should review relevant underwriting information; e.g., the title insurance company's underwriting guidelines, underwriting bulletins, agency agreements and correspondence with title insurance agents. The examiner may review interoffice memoranda and title insurance company minutes for indications of anti-competitive behavior or unfairly discriminatory practices. The examination team also will use the above information to determine title insurance company compliance with its manuals and guidelines. The examiner should confirm that the title insurance company underwriters and title insurance agents consistently apply the title insurance company guidelines for all business selected. The examination team should verify that the title insurance company has correctly classified insured individuals.

File documentation should also be sufficient to support underwriting decisions made. Underwriting decisions that are adequately documented generally afford management of the title insurance company the opportunity to know what business it has selected through its underwriters and title insurance agents. Files should be reviewed for compliance with all written instructions provided by relevant parties. In most cases, this will apply to lenders' closing instructions. However, other written instructions, such as tax or escrow agreements, disbursement instructions, etc., should also be reviewed. The examiner should verify that properly licensed and appointed (where applicable) title insurance agents have been used in the production of business.

Any practice suggesting anti-competitive behavior may involve legal considerations which should be referred to insurance department legal counsel. Ultimately, the information so obtained may be useful in drafting legislation or regulations.

c. Use of Correct and Properly Filed Forms and Endorsements

The examination team should verify that all policy forms and endorsements used have been filed with the appropriate regulatory authority, if applicable. Additionally, the examination team should verify the consistent and correct use of policy forms and endorsements. The examiner should also be mindful of possible outdated forms or endorsements. If coverages and riders requested by the applicant are not issued, proper notification should be provided to the applicant. In some cases, supplemental applications are appropriate.

d. Unfair Discrimination

The examination team should be mindful of company underwriting practices that may be unfairly discriminatory. The classification of insureds into rating or underwriting groups must be based on sound business or actuarial principles. Failure to follow established rating and underwriting guidelines may result in unintentional yet unfair discrimination. Unfair trade practice acts and related regulatory rules adopted in the applicable jurisdiction also may prohibit specific underwriting practices.

e. Use of Proper Disclosures, Buyers' Guides and Delivery Receipts

The examiner should inquire into any reinsurance agreements or affiliated business arrangements or agreements with a third party whereby insurance is arranged, reinsured, purchased through or ceded on title business written on personal or commercial properties. Errors should be noted with regard to overcharges or undercharges.

f. Statistical Coding

The examiner should review the title insurance company's statistical coding procedures. Coding on individual policies should be current and accurate. The examiner should determine to what statistical agencies the title insurance company reports its rating/underwriting data.

3. Tests and Standards

The underwriting and rating review includes, but is not limited to, the following standards addressing various aspects of the title insurance company's underwriting activities. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
UNDERWRITING AND RATING

Standard 1
Re-issue and refinance credits are applied consistently in compliance with statutes, rules and regulations.

Apply to: All title insurance companies and title insurance agents

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ New business application

_____ Policy schedules A and B

_____ Settlement statement forms including, but not limited to, HUD-1, TILA-RESPA Integrated Disclosure (TRID) and any applicable state-specific settlement statement forms

_____ Good Faith Estimate (GFE), (HUD) and final settlement statement forms (if applicable)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurance Agent Model Act (#230)
Title Insurers Model Act (#628)

Review Procedures and Criteria

A copy of the previously issued title insurance policy should be maintained on file, if necessary, pursuant to rate requirements.

Documentation should be maintained to ensure there was adequate inquiry made regarding the existence of a prior title insurance policy, if necessary, pursuant to rate requirements.

In cases where a prior policy is not required in the application of a re-issue or refinance rate, documentation should be maintained to ensure there was adequate inquiry and/or examination made regarding the applicability of discounts used in calculating rates.

STANDARDS
UNDERWRITING AND RATING

Standard 2
The title insurance company does not engage in collusive or anti-competitive underwriting practices.

Apply to: All title insurance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting/closing/escrow files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurers Model Act (#628)

Review Procedures and Criteria

Any practice suggesting anti-competitive behavior may involve legal considerations which should be referred to insurance department legal counsel. This would include engaging in collusive underwriting practices that may inhibit competition.

The examiner should be aware of unlawful pricing and other prohibited anti-competitive acts or practices.

STANDARDS
UNDERWRITING AND RATING

Standard 3
Charges or fees other than premium for providing coverage are in compliance with statutes, rules and regulations.

Apply to: All title insurance companies and title insurance agents

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Applicable state fee filings

_____ Underwriting/closing/escrow files

_____ Settlement statement forms including, but not limited to, HUD-1, TILA-RESPA Integrated Disclosure (TRID) and any applicable state-specific settlement statement forms

_____ Good Faith Estimate (GFE) (if applicable)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurance Agent Model Act (#230)
Title Insurers Model Act (#628)

Review Procedures and Criteria

Review a random sample of real estate transaction underwriting and/or closing/escrow files to determine whether charges and fees, other than premium, being charged to consumers are in accordance with applicable filings, laws, rules or regulations (if any). Review applicable statutes, rules, and regulations relating to such charges and fees. The laws in this area will vary widely by state from prior-approved all-inclusive rates to non-regulated rates and fees.

Review charges and fees to determine if such charges and fees are RESPA (Real Estate Settlement Procedures Act, Section 4 and Section 8) compliant.

Review settlement statement forms associated with the above random sample of real estate transaction closing/escrow files to confirm that all charges and fees identified above are properly disclosed on applicable settlement statement forms. In the event that charges required to be disclosed on a settlement statement form vary from charges previously issued to the consumer, verify that proper revised settlement forms have been re-issued to the consumer, within the time period established by and in accordance with RESPA rules.

If a settlement provider chooses to use average pricing as a means of calculating and disclosing settlement charges, review fee filings to verify that there is proper documentation of (1) all charges qualifying for average pricing and (2) the average pricing structure in effect at the time of closing, pursuant to applicable state statutes, rules and regulations.

Review closing/escrow files to determine if (1) any agreements between the lender and the title agent, or (2) any guarantees made by the title agent to the lender, guaranteeing any prices other than the title agent's filed fees or charges, have been made.

Review written documentation of the written instructions in the closing/escrow files to verify that all instructions provided by the relevant parties were followed. Review closing/escrow files to determine if transactions in escrow are ever closed in the absence of written instructions.

STANDARDS
UNDERWRITING AND RATING

Standard 4
Other than closing or settlement protection, the title insurance company does not provide any other coverage which purports to indemnify against improper acts or omissions of a person with regard to escrow, settlement or closing services.

Apply to: All title insurance companies

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Settlement statement forms including, but not limited to, HUD-1, TILA-RESPA Integrated Disclosure (TRID) and any applicable state-specific settlement statement forms

_____ Good Faith Estimate (GFE) (if applicable)

Others Reviewed

_____ Case law for state impacted

_____ _____

_____ _____

NAIC Model References

Title Insurers Model Act (#628)

Review Procedures and Criteria

Review all coverage being offered and/or issued by the title insurance company to determine if it is within the definition of title insurance under the applicable statutes, rules and regulations.

Some jurisdictions require that all forms be filed and approved prior to use. In such jurisdictions, review forms to confirm that forms have been properly filed with the appropriate insurance department.

STANDARDS
UNDERWRITING AND RATING

Standard 5
The closing or settlement protection conforms to the terms of coverage and form of instrument as required by statutes, rules and regulations.

Apply to: All title insurance companies and title insurance agents

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ Case law for state impacted

_____ _____

_____ _____

NAIC Model References

Title Insurance Agent Model Act (#230)
Title Insurers Model Act (#628)

Review Procedures and Criteria

Where permitted or required, determine if closing or settlement protection is being offered by the company and/or agent.

Confirm that any closing or settlement protection being offered is in a form that complies with the applicable statutes, rules and regulations.

Some jurisdictions require that all closing or settlement protection forms be filed and approved prior to use. In such jurisdictions, review forms to confirm that forms have been properly filed with the appropriate insurance department.

STANDARDS
UNDERWRITING AND RATING

Standard 6
Reports and disclosures are made in accordance with statutes, rules and regulations.

Apply to: All title insurance companies and title insurance agents

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Commitment issuance procedure

_____ Underwriting procedures

_____ Underwriting documents

_____ Affiliated business arrangement (AfBA) and other state-required disclosures

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurance Agent Model Act (#230)
Title Insurers Model Act (#628)

Review Procedures and Criteria

The title insurance report and/or commitment shall be furnished to the purchase-mortgagor or its representative as soon as reasonably possible prior to closing if the report includes an offer to issue an owner's policy covering the resale of the owner-occupied residential property and all disclosures, including, but not limited to, AfBA disclosures if applicable, shall be furnished on a timely basis to the consumer.

Documentation of the reason for delay is maintained for title insurance reports, which are not delivered prior to the day of closing.

Required disclosures are made on reports not delivered prior to the day of closing:

> "Please read the exceptions and the terms shown or referred to herein carefully. The exceptions are meant to provide you with notice of matters, which are not covered under the terms of the title insurance policy and should be carefully considered.
>
> It is important to note that this form is not a written representation as to the condition of title and may not list all liens, defects and encumbrances affecting title to the land."

In accordance with applicable law, a written statement is provided or obtained when a lender's title insurance policy is issued in conjunction with a mortgage loan made simultaneously with the purchase of all or part of the real estate securing the loan where no owner's title insurance policy has been requested.

The notice must be provided to the purchaser-mortgagor at the time the commitment is prepared.

The notice shall explain that a lender's title insurance policy is to be issued protecting the mortgage-lender and that the policy does not provide title insurance protection to the purchaser-mortgagor as the owner of the property being purchased.

The notice shall explain what a title insurance policy insures against through the purchase of an owner's policy.

The notice shall explain that the purchaser-mortgagor may obtain an owner's title insurance policy protecting the property owner at a specified or approximate cost, if the proposed coverages or amount of insurance is not known.

Copies of written notices prepared when a lender's title insurance policy is issued in conjunction with a mortgage loan made simultaneously with the purchase of all or part of the real estate securing the loan where no owner's title insurance policy has been requested are maintained in the underwriting file for at least five years after the effective date of the policy.

Test to ensure AfBA personnel engaged in abstracting and examining of title and writing commitments are qualified, fit and proper. Test to ensure an affiliate business referrer does not receive preferential underwriting or relaxed underwriting standards.

Testing personnel qualifications of an AfBA employee engaged in abstracting, examining, and preparing and editing title insurance commitments includes determining and comparing what functions the employee actually performs against the employee's qualifications and obtaining evidence satisfactory to demonstrate that the employee is actually performing the purported work.

Underwriting documents include all underwriter-provided policies, procedures, bulletins, directive and/or guidelines for the production of title commitments and policies. Underwriter bulletins vary, so if the examinee is an agency, then underwriting documents must be collected and reviewed for each separate underwriter with whom the agency is appointed.

Testing to ensure that an affiliate business referrer is not receiving preferential underwriting is accomplished by reviewing underwriting documents and cross-comparing the underwriting requirements to actual underwriting practices. This can be accomplished by interviewing abstractors and title examiners performing underwriting for both affiliated and nonaffiliated customers' business, and reviewing sample transaction files for nonaffiliated business, to establish a baseline of underwriting practices, and then comparing those practices with practices applied to AfBA business. Ultimately, the examiner is substantiating that the AfBA business is receiving the same level of underwriting as all other business, according to the underwriter's requirements, and that no undue influence by anyone with a potential conflict of interest is resulting in a higher underwriter risk for the AfBA business—that is, no one is pushing deals through faster than they should or eliminating defects erroneously.

STANDARDS
UNDERWRITING AND RATING

Standard 7
The title insurance company complies with statutes, rules and regulations regarding the recording, reporting and validation of revenue, loss and expense experience.

Apply to: All title insurance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files

_____ Rating organization's coding manual

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurers Model Act (#628)

Review Procedures and Criteria

Validation may include certification by oath of the title insurance company or title insurance agent's president, vice president or secretary.

Audits may be required by the insurance department. The audit should be conducted by an independent certified public accountant.

An actuarial certification is required to be filed with the title insurance company annual statement. The actuarial certification must conform to the NAIC annual statement instructions.

STANDARDS
UNDERWRITING AND RATING

Standard 8
All policies are correctly coded.

Apply to: All title insurance companies and title insurance agents

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files

_____ Title insurance company's rating system

_____ Title insurance company's coding manual

_____ Rating organization's coding manual

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Require Reporting of Statistical Data by Property and Casualty Insurance Companies (#751)
Title Insurance Agent Model Act (#230)
Title Insurers Model Act (#628)

Review Procedures and Criteria

Determine that the title insurance company confirms the coding as reported by the title insurance agent is correct and current in accordance with applicable statutes, rules and regulations.

Determine that the title insurance company promptly updates all coding manuals and programs.

Determine that the title insurance company correctly codes all policies according to current codes.

G. Claims

1. Purpose

The claims portion of the examination is designed to provide a view of how the title insurance company treats claimants and whether that treatment is in compliance with applicable statutes, rules and regulations. It is determined by testing a random sampling of files and applying various tests to open and closed claims. For purposes of this chapter "claim file" means the file or files containing the notice of claim; claim forms; settlement demands; claim investigation documentation; correspondence to and from insureds and claimants or their representatives; complaint correspondence; copies of claim checks or check numbers and amounts; releases; all applicable notices and correspondence used for determining and concluding claim payments or denials and any other documentation necessary to support claim handling activity.

The review is concerned with the title insurance company's claims practices for compliance with statutes, rules and regulations and policy provisions. In addition to the general areas of review discussed in Chapter 20—General Examination Standards, a loss statistical reporting survey should also be performed.

Determine to which statistical agencies the title insurance company reports its loss data. Review claim drafts to determine if loss data is correctly coded as to the proper line of business. Review drafts to determine if claim expenses are separated from claim payments. If the review indicates significant errors in coding, the data should be included in the report.

STANDARDS
CLAIMS

Standard 1
Indemnification of a proposed insured solely against the loss of settlement funds may only be made for events as authorized by statutes, rules or regulations.

Apply to: All title insurance companies and title insurance agents

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Title insurance company's claim manuals

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurance Agent Model Act (#230)
Title Insurers Model Act (#628)

Review Procedures and Criteria

Where addressed by applicable statutes, rules and regulations, ensure that the [illegible]ing of settlement protection only indemnifies against the following acts of a title insurance agent:

- Theft of settlement funds; and
- Failure to comply with written closing instructions by the proposed insured when agreed to by the title insurance agent relating to title insurance coverage.

STANDARDS
CLAIMS

Standard 2
Loss statistical coding is complete and accurate.

Apply to: All title insurance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Claim files

_____ Title insurance company's claims coding manual

_____ Title insurance company's coding system

_____ Rating organization's coding manual

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Require Reporting of Statistical Data by Property and Casualty Insurance Companies (#751)
Title Insurers Model Act (#628)
Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)

Review Procedures and Criteria

Determine that the title insurance company codes the correct loss data onto the draft copies or system.

Determine that the title insurance company promptly updates all coding manuals and programs.

Determine that the title insurance company accurately codes the loss amounts.

Determine that the title insurance company separates loss amounts from loss expense amounts.

H. Escrow, Settlement, Closing or Security Deposit Funds

1. Purpose

Title insurance companies, title insurance agents, approved attorneys and escrow companies provide services that reflect the unique nature of real estate transactions in our society. Services provided vary from one area of the country to another and may include acting as escrow agent, obtaining releases and conducting the actual closing or settlement. However, the essential purpose is the same; i.e., to assist the parties in real estate transactions by ensuring the acquisition or transfer of property interest can be effected with a maximum degree of efficiency, security and safety.

An escrow is a transaction in which an impartial third party acts in a fiduciary capacity as an agent for the seller, buyer, borrower and lender. In some states or jurisdictions, this function is performed by the title insurance company or agency.

The escrow holders have fiduciary and contractual responsibility for prudent processing, safeguarding and accounting for funds entrusted to them by escrow customers. Accordingly, this responsibility results in significant exposure to losses from inadvertent or intentional failure to execute their duties properly.

2. Techniques

The authority for review of escrow, settlement, closing and security deposit funds activities may or may not belong to the state insurance department. The examiner should ensure this area falls under their department's jurisdiction prior to review of these standards.

3. Tests and Standards

The escrow, settlement, closing and security deposit funds review includes, but is not limited to, the following standards addressing various aspects of these fiduciary responsibilities. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
ESCROW, SETTLEMENT, CLOSING OR SECURITY DEPOSIT FUNDS

Standard 1
All escrow, settlement, closing or security deposit funds are submitted for collection to or deposited in a separate fiduciary trust account in a qualified financial institution promptly and in accordance with statutes, rules and regulations.

Apply to: All title insurance companies and title insurance agents

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurance Agent Model Act (#230)
Title Insurers Model Act (#628)

Review Procedures and Criteria

The funds are the property of the person(s) entitled to them and are segregated for each depository by escrow, settlement, security deposit or closing in the records which allows individual identification.

The funds are applied in accordance with the terms of the individual instructions or agreements by which the funds were accepted.

Ensure the funds are handled as follows:

- Funds held in escrow are disbursed pursuant to the written instruction or agreement specifying how and to whom the funds should be disbursed;
- Funds held in a security deposit account are disbursed in accordance with the written agreement; and
- The written agreement for funds held in a security deposit account complies with requirements of statutes, rules and regulations:
    - The agreement includes what actions the indemnitor needs to take to satisfy his or her obligation under the agreement; and
    - The agreement includes the duties of the title insurance company and title insurance agent with respect to the disposition of the funds held.
    - There is a requirement to maintain evidence of the disposition of the title exception or objection before any balance may be paid over to the depositing party or their designee.

STANDARDS
ESCROW, SETTLEMENT, CLOSING OR SECURITY DEPOSIT FUNDS

Standard 2
Interest received on funds deposited in connection with any escrow, settlement, security deposit or closing shall be paid in accordance with applicable statutes, rules and regulations.

Apply to: All title insurance companies and title insurance agents

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurance Agent Model Act (#230)
Title Insurers Model Act (#628)

Review Procedures and Criteria

Administrative costs (i.e.., the cost of maintaining the accounts) may be recovered from the interest.

Instructions for the funds or a governing statute may override this standard.

Refer to local statutes, rules and regulations relative to administrative interest cost recovery. In the event of remittance delays that are contrary either to local law or the agency contract itself, the examiner may wish to explore the agency's financial condition vis-à-vis cash flow problems. If a pattern of delay exists relative to tax statements, and if funds are found to be commingled (i.e., funds in the premium account are being used in addition to an operating account; operating costs are being paid out of a trust account; etc.), for solvency reasons, examiners should report such findings to their appropriate financial examination section.

STANDARDS
ESCROW, SETTLEMENT, CLOSING OR SECURITY DEPOSIT FUNDS

Standard 3
Disbursements made from an escrow, settlement or closing account are done in accordance with statutes, rules and regulations.

Apply to: All title insurance companies and title insurance agents

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

Expedited Funds Availability Act, 12 USC Section 4001 et seq. as amended, and related regulations of the Federal Reserve System

_____ _____

NAIC Model References

Title Insurance Agent Model Act (#230)
Title Insurers Model Act (#628)

Review Procedures and Criteria

Files should be balanced prior to closing to ensure sufficient deposits have been made to equal calculated disbursements. Disbursements should be made only from collected funds related to the same escrow.

"Collected funds" as used herein means:

- Cash;
- Wire transfers that are unconditionally received and available for disbursement;
- Certified, cashier and teller checks from an institution insured by the Federal Deposit Insurance Corporation (FDIC) or the National Credit Union Share Insurance Fund (NCUSIF);
- U.S. Treasury checks; or
- Checks that have cleared the banking system.

I. Title Insurance Producer (Agent) Licensing and Relations

Use the standards set forth below.

STANDARDS
TITLE INSURANCE PRODUCER (AGENT) LICENSING AND RELATIONS

Standard 1
Written underwriting contracts, which include required provisions, are in place between title insurance agencies and all applicable title companies, and business is not placed without a contract.

Apply to: All title insurance companies and title insurance agents

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Written agreements

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurance Agent Model Act (#230)
Title Insurers Model Act (#628)

Review Procedures and Criteria

The agreement shall set forth the responsibilities of each party and explain the division of responsibilities if a particular function is a shared responsibility between the two parties.

The agreement should incorporate underwriting guidelines and limitations on title claims settlement authority.

The written agreement should include the following:

- Responsibilities of each party and division of responsibilities clearly specified;
- Provisions applicable to contract termination and notice of cancellation;
- Provisions specifying requirements for reporting and remittal of funds.
- Provisions related to the fiduciary capacity and handling of title insurance company funds;
- Provisions related to ownership and access to policy records, escrow files and claim files;
- Provisions applicable to assignment of the contract;
- Guidelines related to the basis of rates charged, types of risks which may be written, maximum limits of liability, territorial limitations, title searches, examinations and underwriting;
- Provisions regarding the reporting of claims, claim settlement authority and risk retention;
- Where prohibited, the contract may not permit title insurance agents to bind reinsurance on behalf of the title insurance company or appoint a title insurance sub-agent; and
- The title insurance agent shall not bind reinsurance or retrocessions on behalf of the title insurance company.

STANDARDS
TITLE INSURANCE PRODUCER (AGENT) LICENSING AND RELATIONS

Standard 2
Policies and premiums are reported and remitted on a timely basis.

Apply to: All title insurance companies and title insurance agents

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Listing of title insurance agent accounts current exceeding contract limits

_____ Title insurance agent and/or agency contracts

_____ Agency listing of issued and unexpired commitments where the final title insurance policy has not yet been issued

_____ Agency listing of issued title insurance policies that have not yet been reported to the title insurer

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurance Agent Model Act (#230)
Title Insurers Model Act (#628)

Review Procedures and Criteria

The focus of this standard relating to title insurance agency accounts current is to aid in the detection of fraud or misuse of funds held by the title insurance agent in a fiduciary capacity.

In many cases, title insurance premium is paid to the agency at the time of a real estate closing. Following the closing, certain conditions—such as mortgage releases or filings—may need to be met prior to issuance of the policy. Payment of premium to the title insurer by the agency often occurs after policy issuance. Examiners should request a listing of all files where agents have issued commitments but the final title insurance policies have not been issued. Preferably, the listing should provide an aging of those files. If not, the examiner should sample the files to determine the aging and reasons why final policies have not been issued. Examiners should determine what procedures are in place at the agency to follow-up on those files to hasten completion, especially for those files in which premium payment has been received by the agency. In instances where a listing is not readily available, the examiner should physically inspect all locations where such files are stored to obtain an inventory or approximation.

Examiners should request a listing of all files where the agency has issued final title policies, but not yet reported the policies to the title insurer. Determine that reporting is being handled in accordance with the insurer/agency agreement and ascertain an estimated reporting date and reason for any policies outside the scope of that agreement.

For both issued commitments pending issuance of the title policy (where the agency has collected premium) and issued policies not yet reported to the insurer, the examiner should obtain an estimated premium owed. The examiner should determine that the agency has kept those funds available for remittance to the insurer.

Review a listing of title insurance agent accounts current.

Discuss excessive balances with the title insurance company.

Refer to the appropriate division within the insurance department, if necessary.

STANDARDS
TITLE INSURANCE PRODUCER (AGENT) LICENSING AND RELATIONS

Standard 3
The title insurance company maintains a record of financial stability for each title insurance agent under contract with the title insurance company.

Apply to: All title insurance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Errors and omissions, fidelity coverage and surety bonds

_____ Credit history report

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurers Model Act (#628)

Review Procedures and Criteria

Verify that errors and omissions, fidelity coverage and surety bonds are in place, if required by statutes, rules and regulations.

STANDARDS
TITLE INSURANCE PRODUCER (AGENT) LICENSING AND RELATIONS

Standard 4
The title insurance company conducts a review of underwriting, claims and escrow practices of the title insurance agent in accordance with statutes, rules and regulations.

Apply to: All title insurance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Insurer audit reports of agent reviews

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurers Model Act (#628)

Review Procedures and Criteria

This review should include a review of the title insurance agent's policy inventory and processing operations.

If the title insurance agent does not maintain separate bank or trust accounts for the premiums for each title insurance company the agent represents, the title insurance company shall verify that the funds held on its behalf are reasonably ascertainable from the books of account and records of the title insurance agent.

Note: In some jurisdictions, the title insurance company is required to conduct this review on-site.

STANDARDS
TITLE INSURANCE PRODUCER (AGENT) LICENSING AND RELATIONS

Standard 5
The title insurance company maintains an inventory of all policy forms or policy numbers allocated to each title insurance agent.

Apply to: All title insurance companies

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy register, stock list, log or similar record

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurers Model Act (#628)

Review Procedures and Criteria

Reconcile policies on hand with the policy register, stock list, log or similar record, if applicable.

J. Special Considerations for Title Insurance Companies and Title Insurance Agents

In title insurance, there is risk elimination where potential defects that would produce loss are identified and specifically excluded from coverage or where certain risks may be over-insured, excluded or corrected. The policy is written to indemnify against losses to the title to real property, as stated in the policy on the date of policy issuance and has no expiration. Coverage is provided at any time thereafter, if the title was not as stated in the policy at that precise point in time.

Title insurance companies and title insurance agents may also be regulated or governed by banking authorities, the U.S. Department of Housing and Urban Development (HUD) or other authorities. In some states, title insurance statutes reference the federal Real Estate Settlement Procedures Act (RESPA), in which case the examiner should be familiar with the provisions of RESPA, 12 USC Section 2607, as amended. The Expedited Funds Availability Act, 12 USC Section 4001 et seq. as amended and related regulations of the Federal Reserve System should also be referenced.

Many of the requirements in this chapter are in accordance with the *Title Insurers Model Act* (#628) and the *Title Insurance Agents Model Act* (#230). Examiners should be familiar with the applicable statutes in their jurisdiction and apply only those standards and tests suggested in this chapter that are based in statute, rule or regulation in their jurisdiction.

An examination of title insurance agencies should include verification of compliance with issues which are both common with other types of insurance and unique to title insurance. In addition to licensing, appointment, disclosure, policyholder treatment and record retention requirements, the examiner should review issues relating to referrals, controlled or affiliated business relationships, underwriting contracts with companies, bonds and errors and omissions coverage requirements, escrow accounts and audits.

An understanding of terms, definitions and typical business practices which are unique to title insurance is also helpful. An example is the term "producer" as used by the title insurance profession. Whereas the term "producer" in most lines of insurance may be used to refer to an insurance agent or broker, the term "producer," as it relates to title insurance, refers to persons involved in the buying and selling of real estate, mortgage loans, lenders or attorneys. It is significant that many in the title insurance profession do not view the property owner as their customer. They view persons involved in the buying and selling of real estate, mortgage loans, lenders or attorneys as their customer—as these are entities that frequently exercise the ability to select a title insurer or title insurance agent on behalf of the named insured. The examiner should be aware that in some jurisdictions, on a purchase transaction, policies are commonly issued to both the owner and mortgagee, while in other jurisdictions, on a purchase transaction, policies may only be issued to the mortgagee although the owner always has the option to purchase a policy. When the transaction involves a refinance, the mortgagee commonly purchases a policy but the owner does not, although the owner always has the option to purchase a policy. When the transaction involves a refinance, the mortgagee commonly purchases a policy but the owner does not.

In most jurisdictions, title insurance is a monoline policy, which can only be written by title insurance companies who are prohibited from writing any other line of business. In addition to issuing a title policy, in some jurisdictions, title insurance agencies may perform a variety of functions, including performing title searches, abstracting, performing underwriting functions, establishing and handling escrow funds and performing real estate closings. Approved attorneys, depending on the jurisdiction, will perform many of the same tasks as a title agent, but generally do not issue title policies. Approved attorneys are licensed by their local state bar association and are not licensed by the insurance department.

The agreement by the title insurer to provide the typical title insurance policy is usually referred to as a "commitment" or "preliminary commitment to title insurance." The commitment generally specifies what defects need to be corrected prior to title policy issuance, together with the conditions, exclusions or exceptions that will appear in the title policy when issued. When issued, a title policy may cover the interests of the real estate lender or the buyer whose interests differ. Title insurance rates vary from state to state and are regulated in a variety of

ways: promulgation, prior approval, file and use, use and file and no direct regulation. Under all of the above, there is usually a discount applied for simultaneously issued policies, refinancing or to a property for which a previous title policy was issued within some specified period of time.

In many instances, the examiner will need to access and review records at the title insurance agent's office during a title insurance company examination.

In some jurisdictions, there are "title plants" that duplicate the public record affecting real property and reorganize those records, typically by legal description. In those jurisdictions in which the title insurance agent builds, owns, controls or maintains a title plant used to search title preliminary to the issuance of a title policy, it is important that the examiners verify that there are appropriate standards for maintenance of the title plant. It is also critical that the insurer provide an adequate level of oversight of such an agent.

The examiners should request the following items upon initiating a title insurance agent examination:

- Issued commitment files with no policy issued;
- A listing of all files or orders in which commitments have been issued, but policies have not yet been issued (whether or not outstanding conditions have been met and reported);
- Issued policies not yet reported to the underwriter; and
- A listing of all issued title policies and endorsements for which reporting to the title insurer is pending or not yet accomplished, as of the date of the request.

K. Example Title Letter

DATE

Address

Re: **Affiliated Business Arrangements**

Dear

The _____ Division of Insurance is conducting an investigation of affiliated business arrangements ("AfBAs") in the title insurance industry. The Division is sending this letter to all title insurance agencies licensed in the State of _____ to facilitate the investigation. **Please respond to this inquiry within ten (10) business days from the date of this letter**.

According to _____ law, the term "affiliated business arrangements" means:

"Settlement producer" means: _____.

"Affiliate" means: _____.

State insurance commissioners are authorized to enjoin violations of the federal Real Estate Settlement Procedures Act (RESPA).

RESPA defines an affiliated business arrangement (AfBA) as:

(A)n arrangement in which (A) a person who is in a position to refer business incident to or a part of a real estate settlement service involving a federally-related mortgage loan, or an associate of such person, has either an affiliate relationship with or a direct or beneficial ownership interest of more than 1 percent in a provider of settlement services; and (B) either of such persons directly or indirectly refers such business to that provider or affirmatively influences the selection of that provider. 12 USC §2602(7).

Furthermore, RESPA defines "associate" as follows:

The term "associate" means one who has one or more of the following relationships with a person in a position to refer settlement business: (A) a spouse, parent or child of such person; (B) a corporation or business entity that controls, is controlled by, or is under common control with such person; (C) an employer, officer, director, partner, franchisor or franchisee of such person; or (D) anyone who has an agreement, arrangement or understanding, with such person, the purpose or substantial effect of which is to enable the person in a position to refer settlement business to benefit financially from the referrals of such business. 12 USC §2602(8).

Using the definitions contained in Division of Insurance regulation _____ and RESPA, please respond to the following questions. Submit your response to the Division of Insurance within seven (7) business days of the date of this letter. An officer of the company must attest to the accuracy of the responses and sign the responses. Failure to supply complete, signed responses within the seven (7) day time frame subjects your company to monetary or other penalties pursuant to Division of Insurance regulation _____.

Please note that in accordance with §_____ all working papers, claim files, recorded information and documents disclosed to the Division of Insurance will be given confidential treatment until the informal investigation is concluded. If documentation submitted to the Division of Insurance is additionally protected from disclosure under the exceptions to the _____ Open Records Act of §_____, you must mark each document

as confidential. In addition, you must submit an index of the documents that describes the content of each document, the basis for the claim of confidentiality and the supporting rationale for the claim. This index must accompany the documentation.

Finally, please be advised that you may or may not receive further correspondence from the Division of Insurance concerning AfBAs, regardless of how you respond to the following question:

Is the title entity to which this letter is addressed, or any of its affiliates or associates, an affiliated business arrangement as defined by Division of Insurance regulation _____ or RESPA?

Please mark the appropriate response:

☐ YES ☐ NO

As an officer of the company who is authorized to sign on behalf of the company, I do hereby attest to the accuracy of the above responses.

Company Name (as licensed)

Company Officer (print full name) Title

Signature of Company Officer Date

Please return this entire letter with complete, signed response to:

_____ *Division of Insurance* *Scan and email to:*

or

Thank you for your cooperation and prompt response.

Very truly yours,

L. Example Title Interrogatory

Affiliated Business Arrangements Interrogatories

The following terms, definitions and law shall apply when answering all questions:

State Law Definitions:
"Affiliate" means _____.

"Affiliated Business Arrangements" means _____.

(See _____ Division of Insurance Regulation _____)

"Settlement producer" means _____.

"Title entity" means _____.

"Title insurance business" means _____.

Federal Law Definitions:
In addition to enforcing state laws, state insurance commissioners are authorized to enjoin violations of the federal Real Estate Settlement Procedures Act (RESPA). The following RESPA definitions shall also apply when answering these questions:

"Affiliate Relationship" means the relationship among business entities where one entity has effective control over the other by virtue of a partnership or other agreement or is under common control with the other by a third entity or where an entity is a corporation related to another corporation as parent to subsidiary by an identity of stock ownership. 24 CFR §3500.15(c)(2).

"Affiliated Business Arrangement" means (a)n arrangement in which (A) a person who is in a position to refer business incident to or a part of a real estate settlement service involving a federally-related mortgage loan, or an associate of such person, has either an affiliate relationship with or a direct or beneficial ownership interest of more than 1 percent in a provider of settlement services; and (B) either of such persons directly or indirectly refers such business to that provider or affirmatively influences the selection of that provider. 12 USC §2602(7).

"Associate" means one who has one or more of the following relationships with a person in a position to refer settlement business: (A) a spouse, parent or child of such person; (B) a corporation or business entity that controls, is controlled by, or is under common control with such person; (C) an employer, officer, director, partner, franchisor or franchisee of such person; or (D) anyone who has an agreement, arrangement or understanding, with such person, the purpose or substantial effect of which is to enable the person in a position to refer settlement business to benefit financially from the referrals of such business. 12 USC §2602(8).

"Beneficial ownership" means the effective ownership of an interest in a provider of settlement services or the right to use and control the ownership interest involved even though legal ownership or title may be held in another person's name. 12 CFR §1024.

Please submit detailed written responses to the following questions along with the requested documentation to the Division of Insurance within twenty (20) calendar days of the date of this letter. An officer of the company must attest to the accuracy of the responses and sign the responses. Failure to supply complete, signed responses within the twenty (20) day time frame may subject your company to monetary or other penalties pursuant to _____ Division of Insurance Regulation_____.

Please note that in accordance with §_____ (cite state law), all working papers, claim files, recorded information and documents disclosed to the Division of Insurance will be given confidential treatment until the informal investigation is concluded. If documentation submitted to the Division of Insurance is additionally protected from disclosure under the exceptions to the _____ Open Records Act, you must mark each document as confidential. In addition, you must submit an index of the documents that describes the content of each document, the basis for the claim of confidentiality and the supporting rationale for the claim. This index must accompany the documentation.

For each of the following questions, please be sure to include all relevant dates and provide full and complete copies of all relevant written documents to the Division of Insurance with your responses.

Identify any and all AfBAs that exist or have existed between and among the title entity to which this letter is addressed and any other title entities or settlement producers. Indicate the dates of creation of all such AfBAs and provide full and complete copies of all written documents relating to affiliation with all such AfBAs to the _____ Division of Insurance with your responses, including all agreements of any kind between the title entity and the AfBAs.

If no such AfBAs exist or have existed between and among your title entity and any other title entities or settlement producers, please indicate this fact and you do not need to answer the remaining questions. If you are unsure whether AfBAs exist or have existed, please respond to the following questions:

Explain in detail how and when the title entity to which this letter is addressed was initially capitalized and state the net worth for each year from January 1, 2000, to the present, explaining how this figure was derived.

Provide a list of the names, addresses and occupations of all persons who contributed initial capital to the title entity to which this letter is addressed. Include the amount of capital obtained from each source and the respective capitalization ratios.

For each identified person, indicate whether this person took out a loan to cover any part of his/her contribution to the initial capital of the title entity to which this letter is addressed. Indicate the dollar amount and source of the loan.

For each identified person, state whether the title entity to which this letter is addressed has or has ever had any loan agreements with the identified person. Indicate the dates of all such loan agreements and provide full and complete copies of all written documents relating to all such loan agreements to the Division of Insurance with your responses.

Provide full and complete copies of any and all financial pro forma statements prepared by or for the title entity to which this letter is addressed. Indicate the date(s) on which each financial pro forma statement was prepared.

For each financial pro forma statement provided, explain in detail the reason(s) the financial pro forma statement was prepared.

For each financial pro forma statement provided, identify all persons who were involved in the preparation of the financial pro forma statement.

Has the title entity to which this letter is addressed ever owned or been owned, in whole or in part, by one or more settlement producers? If so, respond to the following:

Provide a list of the names, addresses and occupations of any and all settlement producers who have, in whole or in part, owned or been owned by the title entity to which this letter is addressed.

For each identified settlement producer, state the commencement date of the ownership arrangement(s) between the settlement producer and the title entity to which this letter is addressed. Provide full and complete copies of all written documents relating to the commencement of the ownership arrangement(s).

For each identified settlement producer, state the termination date of the ownership arrangement(s) between the settlement producer and the title entity to which this letter is addressed. Provide full and complete copies of all written documents relating to the termination of the ownership arrangement(s).

For each identified settlement producer whose ownership arrangement(s) with the title entity to which this letter is addressed was terminated or otherwise extinguished, state the reason(s) for the termination of the ownership arrangement(s) on the identified date(s). Provide full and complete copies of all written documents substantiating the reason(s) for the termination of the ownership arrangement(s).

For each identified settlement producer, indicate whether the ownership arrangement(s) between the settlement producer and the title entity to which this letter is addressed was adjusted or changed in any way. Indicate the date(s) on which the identified ownership arrangement(s) was adjusted or changed and provide full and complete copies of all written documents relating to any adjustments or changes that were made in the ownership arrangement(s).

For each identified settlement producer whose ownership arrangement(s) with the title entity to which this letter is addressed was adjusted or changed, state the reason(s) for the adjustment or change in the ownership arrangement(s) on the identified date(s). Provide complete copies of any and all written documents substantiating the identified reasons for the adjustments or changes in the ownership arrangement(s).

Provide a complete list of all employees who are currently or have ever been employed by the title entity to which this letter is addressed and indicate their dates of employment.

Respond to the following:

Provide a complete list of the names and job titles of all employees of the title entity to which this letter is addressed.

For each identified employee, identify any and all affiliated or associated businesses for which he/she performs services.

For each identified employee, identify any and all unaffiliated businesses for which he/she performs services.

Explain the proportion of time allotted by each such employee to each affiliated and/or unaffiliated business as a percentage of 100 percent.

Provide a complete list of the names and job titles of all employees who are not full-time employees of the title entity to which this letter is addressed.

For each identified part-time employee, identify any and all affiliated or associated businesses for which he/she performs services.

For each identified part-time employee, identify any and all unaffiliated businesses for which he/she performs services.

Explain the proportion of time allotted by each such employee to each affiliated and/or unaffiliated business as a percentage of 100 percent.

Explain in detail the specific job functions performed by each identified employee.

Explain in detail all services provided by the title entity to which this letter is addressed that have not already been identified as being performed by the identified employees of the title entity to which this letter is addressed.

Identify all employment-related licenses held by each identified person; e.g. title insurance producer, real estate agent, attorney, etc.

Provide full and complete copies of all 1096 (Annual Summary and Transmittal of U.S. Information Returns) forms filed with the IRS by or for the title entity to which this letter is addressed.

Provide full and complete copies of all Unemployment Insurance Quarterly Wage and Tax Reports filed with the State of _____ by or for the title entity to which this letter is addressed.

Provide a list of the names and job titles of all persons not listed above who manage or have ever managed the business affairs of the title entity to which this letter is addressed and indicate their dates of employment.

Respond to the following:

Describe when, how and by whom each identified person is compensated.

Describe the job-related duties performed by each identified person.

Identify any and all affiliated or associated businesses for which each identified person performs or has performed services, and describe those services.

Identify any and all unaffiliated businesses for which each identified person performs or has performed services, and describe those services.

Does the title entity to which this letter is addressed perform any of the following core title services: (1) title searches, (2) title examinations; (3) abstracts; (4) title evaluations to determine insurability; (5) prepare and/or issue title commitments and/or title policies; (6) maintain policy records; (7) receive premiums; (8) closing and settlement services; (9) solicit and negotiate for the issuance of your title commitments; (10) maintain escrow accounts? If so, please respond to the following questions for *each* of the above core title services:

Provide a list of the names and job titles of all persons who have performed each core title service for the title entity to which this letter is addressed from January 1, 2000, to the present.

For each identified person, state the number of each core title service performed per year by that person for the title entity to which this letter is addressed from January 1, 2000, to the present. In addition, state this number as a percentage of the total number of each core title service performed per year by the title entity to which this letter is addressed.

For each identified person, state the name of any and all employers of that person.

For each identified employer, state whether the employer is an affiliated or associated business.

For each identified employer, state whether the employer is a settlement producer and describe how they meet this definition as described in _____ Division of Insurance Regulation _____.

For each identified person, describe in detail the specific activity or activities performed to accomplish the identified core title services.

For each identified person, state the name of the business that appears on each person's paycheck and/or paystub.

Has the title entity to which this letter is addressed ever contracted out any part of its work relating to the performance of title services? If so, please respond to the following:

Provide a list of all persons to whom the title entity to which this letter is addressed has contracted out any part of its work relating to the performance of title services.

Identify all licensed producers who conduct or have conducted title insurance business for the title entity to which this letter is addressed. For each identified licensed producer, indicate the dates that the licensed producer conducted business for your title entity.

Identify all underwriters for whom the title entity to which this letter is addressed is or has been authorized to conduct title insurance business. For each identified underwriter, indicate the dates that your title entity was authorized to conduct title insurance business for the underwriter and provide full and complete copies of all underwriting agreements to the Division of Insurance with your responses.

For each identified person, state whether that person is or was an affiliate or associate of the title entity to which this letter is addressed.

For each identified person, state whether that person is or was a settlement producer, and describe how they meet this definition as described in _____ Division of Insurance Regulation _____.

Identify any and all agreements, written or oral, that the title entity to which this letter is addressed has made relating to the contracting out of any part of its work relating to the performance of title services. Indicate the date on which each agreement was made and provide full and complete copies of all such written agreements.

Identify any and all payments that the title entity to which this letter is addressed has made or received for the contracting out of any part of its work relating to the performance of title services. Indicate the date on which each payment was made and provide full and complete copies of all written documents relating to all such payments.

Has the title entity to which this letter is addressed ever rented office space, facilities, items or services *to* or *from* any other title entities or settlement producers? If so, respond to the following:

Describe in detail all rented spaces, facilities, items or services. Indicate the date(s) for which each identified space, facility, item or service was rented and provide full and complete copies of all written documents relating to all such rental agreements.

State the amount of rent paid for each identified space, facility, item or service and explain how the identified amount was derived.

State the name of the person(s) from whom each identified space, facility, item or service was rented.

Are any of the persons identified affiliates or associates of the title entity to which this letter is addressed? If so, please identify their affiliations or associations.

Are any of the identified persons settlement producers as defined in regulation _____ If yes, please identify in what capacity they are settlement producers.

Respond to the following questions concerning (1) affiliated settlement producers; (2) affiliated title entities; (3) unaffiliated settlement producers; and (4) unaffiliated title entities:

Since January 1, 2000, has the title entity to which this letter is addressed attempted to obtain business from one or more settlement producers and/or title entities affiliated or associated with the title entity to which this letter is addressed? If so, respond to the following:

Provide a list of all affiliated settlement producers and/or title entities that the title entity to which this letter is addressed has attempted to obtain business from since January 1, 2000.

For each identified affiliated settlement producer and/or title entities, describe in detail any and all marketing or advertising used from January 1, 2000, to the present by the title entity to which this letter is addressed in its attempt to obtain business from the affiliated settlement producer.

For each identified affiliated settlement producer and/or title entities, describe in detail any and all marketing or advertising agreements made with the affiliated settlement producer from January 1, 2000, to the present in its attempt to obtain business from the affiliated settlement producer.

Include all relevant dates and copies of all related documents.

Since January 1, 2000, has the title entity to which this letter is addressed received business from one or more settlement producers and/or title entities affiliated or associated with the title entity to which this letter is addressed? If so, respond to the following:

Provide a list of the names and addresses of all affiliated settlement producers and/or title entities that the title entity to which this letter is addressed has received business from since January 1, 2000.

For each identified affiliated settlement producer and/or title entities, indicate both the total number of customers and the total dollar amount of business received from the affiliated settlement producer and/or title entities from January 1, 2000, to the present.

Include all relevant dates and copies of all related documents.

Since January 1, 2000, has the title entity to which this letter is addressed sent business to one or more settlement producers and/or title entities affiliated or associated with the title entity to which this letter is addressed? If so, respond to the following:

Provide a list of the names and addresses of all affiliated settlement producers and/or title entities to which the title entity to which this letter is addressed has sent business since January 1, 2000.

For each identified affiliated settlement producer and/or title entities, indicate both the total number of customers and the total dollar amount of business sent to the affiliated settlement producer and/or title entities from January 1, 2000, to the present.

Include all relevant dates and copies of all related documents.

Does a settlement producer who refers business to the title entity to which this letter is addressed receive any services or products at a below market or discounted rate from an affiliate of the entity to which this letter is addressed?

Provide a list of the names and addresses of all settlement producers and affiliates of the entity to which this letter is addressed who receive or give services or products at a below market or discounted rate, as well as identification of which services or products are provided.

Identify all relevant documentation including documentation consulted to prepare your responses. In addition, you may provide any other documentation, including a position statement, which you feel is relevant to this inquiry.

Please attach the following attestation form to the back of your written responses. Electronic answers will NOT be accepted. Please mail or hand-deliver your written responses and supporting documents to:

_____ Division of Insurance

Please direct any inquiries concerning the above questions to:

Attn:

As an officer of the company to which this letter is addressed, who is authorized to sign on behalf of the company, I do hereby attest to the accuracy of the above responses.

Company Name (as licensed)	Company Address
Company Officer (print full name)	Title
Signature of Company Officer	Date

This letter commences an informal investigation of your company's practices. Your responses to these questions must be postmarked no later than twenty (20) calendar days from the date of this letter to avoid imposition of monetary penalties permitted under_____.

M. Sample Checklist

TITLE INSURANCE COMPANY CHECKLIST OF EXAMINATION REQUIREMENTS

All documents, lists and reference materials must be prepared for the period under examination and be ready at the commencement of the examination. If there were any substantive changes during the period under examination—i.e. a rate change or substantive underwriting rule change—your documents must so note and specifically describe how this change was implemented. Whenever possible, please supply the requested information in electronic format.

ADDITIONAL REQUESTS FOR INFORMATION MAY BE MADE BY THE EXAMINERS AT ANY TIME DURING THE EXAMINATION PROCESS.

1. Provide a brief narrative history of its business in general and specifically in _____ (state). Include, at a minimum, the state(s) in which the company is licensed to do business, when the company was licensed in (state), premium writings as of the last day of the examination period for the line of business being examined and any other historically significant detail pertinent to _____ (state). Provide an annual statement for the period(s) under examination.

2. Identify all internal audits performed by the company from the beginning date of the examination period to the present and provide a copy of same.

3. Provide a specimen of each policy and endorsement form in use during the examination period; include samples of manuscripted endorsements when applicable. Prepare a copy of all title insurance rate filings applicable to the period under examination and stamped by the _____ (state) Division of Insurance. Provide a schedule of fees and charges for closing and settlement services, which has been stamped by the _____ (state) Division of Insurance.

4. Provide a copy of the company's antifraud plan, if required by statute.

5. If the company possesses its own title plant, provide a detailed explanation of the company's procedures for the maintenance of this title plant.

6. Provide a copy of the underwriting rules, manual, guidelines, memoranda and directives and procedures manuals applicable to (state) business written during the period under examination.

7. Provide a copy of the (state) claims manual, guidelines, memoranda, directives and procedures for the processing of claims during the period under examination.

8. Provide a copy of all promotional and advertising materials utilized by the company or its agents during the period of examination.

9. Provide a list of all promotional and advertising activities—including, but not limited to, products, services, seminars, conventions, gifts and prizes—utilized by the company or its agents during the period of examination. Outline any incentive programs available to realtors, lenders, builders, et al., provided by the company or its agents during the period of examination.

10. Provide a list of policies issued during the period under examination. Include at least the policy number, effective date, named insured, named lender/mortagee, amount of coverage and premium.

11. Provide a list of claims made during the period under examination. Include at least the claim number, named insured, date claim made and status; i.e., open/amount reserved and closed/amount paid.

12. Provide a list of all affiliated entities.

13. Provide a list of all disbursements pertaining to advertising, sales and marketing and promotional activities.

Chapter 23—Conducting the Life and Annuity Examination

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

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

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

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

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

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

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

A. Operations/Management

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

STANDARDS
OPERATIONS/MANAGEMENT

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

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Insurance department records of certifications made by the regulated entity

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Advertisements of Life Insurance and Annuities Model Regulation (#570)
Life Insurance Illustrations Model Regulation (#582) and *Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest* (AG 49)

Review Procedures and Criteria

The illustration actuary should file a certification with the insurance department annually for all policies for which illustrations are used (Model #582, Section 11). For indexed universal life (IUL) illustrations, AG 49 expands upon and supersedes the illustration requirements in Model #582.

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

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

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

B. Complaint Handling

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

C. Marketing and Sales

1. Purpose

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

2. Techniques

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

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

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

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

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

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

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

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

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

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

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

Market regulators should also be aware that sales of products, such as fixed-index annuities (formerly referred to as equity-indexed annuities) and index life insurance products (such as universal index life insurance) continue to increase. These products typically include features that require an understanding of bonuses, guaranteed elements and an array of interest crediting methods. In some cases, existing NAIC model laws and regulations may not give specific guidance on all aspects of all products. In such instances, examiners may rely on general principles found in Model #880, the *Life Insurance Disclosure Model Regulation* (#580) and the *Annuity Disclosure Model Regulation* (#245).

Model #582 sets out a variety of requirements to prevent insurers from using misleading illustrations in the sale of life insurance. AG 49, originally adopted by the NAIC in 2015, expands upon and supersedes some of the illustration requirements of Model #582. It provides guidance and limitations for indexed universal life (IUL) illustrations. In simple terms, Section 4 and Section 5 of AG 49 set maximum crediting rates for illustrations. Section 6 addresses illustrations of policy loans, and Section 7 requires illustrations beyond those required in Model #582. The implementation of AG 49 was phased as follows:

- Section 4 and Section 5 shall be effective for all new business and in force life insurance illustrations of policies issued on or after Sept. 1, 2015;
- Effective March 1, 2017, Section 4 and Section 5 shall be effective for all in force life insurance illustrations of policies within the scope of this actuarial guideline, regardless of the date the policy was sold, and

- Section 6 and Section 7 shall be effective for all new business and in force life insurance illustrations on policies sold on or after March 1, 2016.

Testing the compliance of illustrations with Model #582 and AG 49 will be complex, and the examiner will likely seek assistance from an actuary familiar with and capable of testing compliance with Model #582 and AG 49. In such cases, the examiner should work with the actuary to determine the appropriate information to request from the insurer necessary to enable the actuary and examiner in testing the compliance of the illustrations.

Evaluation of compliance with annuity suitability may best be accomplished through a process and procedure review coupled with sampling. The process and procedure portion of the review is a good example of a function where states may wish to coordinate their reviews and share responsibilities. A continuum approach, such as use of a desk audit, may also be appropriate. Sampling enables examiners to evaluate whether the established processes have been clearly communicated and implemented rather than to function as a means to "second-guess" each individual suitability determination. Company programs for reviewing suitability may vary widely and should not be considered a "once-size-fits-all" approach. Annuity products can be designed or tailored to serve a wide variety of clientele and customer objectives.

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

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

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

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

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

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

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

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

3. Tests and Standards

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

STANDARDS
MARKETING AND SALES

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

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ All company advertising and sales materials, including radio and audiovisual items, such as television commercials, telemarketing scripts and pictorial materials

_____ Policy forms, including any required buyers' guides as they coincide with advertising and sales materials

_____ Producers' own advertising and sales materials

_____ All documents related to the development of crediting rates used in illustrations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Advertisements of Life Insurance and Annuities Model Regulation (#570), Section 5B
Risk-Based Capital (RBC) for Insurers Model Act (#312), Section 8B
Modified Guaranteed Annuity Model Regulation (#255), Section 4D
Life Insurance Disclosure Model Regulation (#580), Section 8C
Unfair Trade Practices Act (#880)
Annuity Disclosure Model Regulation (#245), Section 6 plus appendix
Long-Term Care Insurance Model Act (#640)
Life Insurance Illustrations Model Regulation (#582) and *Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index Based Interest* (AG 49)
Disclosure for Small Face Amount Life Insurance Policies Model Act (#605)
Suitability in Annuity Transactions Model Regulation (#275)
Suitability of Sales of Life Insurance and Annuities White Paper
Military Sales Practices Model Regulation (#528)

Review Procedures and Criteria

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

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

Review advertising materials in conjunction with the appropriate policy form.

Materials should not:

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

- State or imply that prospective insureds are or become members of a special class, group or quasi-group and enjoy special rates, dividends or underwriting privileges, unless that is a fact;
- Contain an assertion, representation or statement with regard to the risk-based capital levels of any insurer or of any component derived in the calculation;
- Use the existence of the insurance guaranty association for the purpose of sales, solicitation or inducement to purchase any form of insurance covered by the association;
- Misrepresent the dividends or share of the surplus to be received on any policy;
- Make a false or misleading statement as to the dividends or share of surplus previously paid on a policy;
- Misrepresent any policy as being shares of stock; and
- Illustrations of benefits payable under any modified guaranteed life insurance[28] shall not include projections of past investment experience. Hypothetical assumed interest credits may only be used if it is made clear that such are hypothetical only.

Materials should:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

For the review of Internet advertisements:

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

A summary of special requirements is available for the following:

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

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

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

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

Index products

For advertising for interest-sensitive products, review explanations of the crediting methods and terms. Review the functioning of the crediting methods to determine that the explanations are understandable and accurate. Verify that accurate information is provided regarding the options available to the consumer and the methods by which the consumer is to exercise the options.

In addition to reviewing the advertising of indexed products, the examiner should review the illustration for compliance with Model #582 to ensure that, among other things, unreasonable or deceptive crediting rates are not being used in the illustrations and that the illustrations provide the consumer with the information required by Model #582 and, for indexed universal life (IUL) products, AG 49. Determine whether the explanations and information provided regarding the options available to the consumer are consistent with the requirements and limitations of Model #582 in AG 49.

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

STANDARDS
MARKETING AND SALES

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

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Replacement register/Data

_____ Policy/Underwriting files

_____ Loan and surrender files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Life Insurance and Annuities Replacement Model Regulation (as adopted 19[illegible]) (#613)
Suitability in Annuity Transactions Model Regulation (#275)
Suitability of Sales of Life Insurance and Annuities White Paper
Military Sales Practices Model Regulation (#568)

Review Procedures and Criteria

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

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

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

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

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

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

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

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

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

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

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

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

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

STANDARDS
MARKETING AND SALES

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

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Replacement register/Data

_____ Policy/Underwriting files

_____ Agency correspondence file/Agency bulletins

_____ Agency procedural manual

_____ Claim files

_____ Agency sales/lapse records

_____ Regulated entity systems manual

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

Determine if the regulated entity has advised its producers of its replacement policy.

Determine if the regulated entity has provided timely notice to the existing insurer(s) of the replacement.

Examine for effectiveness the regulated entity's system of identifying undisclosed replacements.

Determine if the regulated entity has the capacity to produce data required by replacement regulation to assess producer replacement activity.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

STANDARDS
MARKETING AND SALES

Standard 4
An illustration used in the sale of a policy contains all required information and is delivered in accordance with statutes, rules and regulations.

Apply to: All life products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Actuarial records

_____ All documents related to the development of crediting rates used in illustrations

_____ Underwriting file

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Life Insurance Illustrations Model Regulation (#582) and *Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index Based Interest* (AG 49)
Universal Life Insurance Model Regulation (#585)
Variable Life Insurance Model Regulation (#270)
Life Insurance Disclosure Model Regulation (#580)
Disclosure for Small Face Amount Life Insurance Policies Model Act (#605)

Review Procedures and Criteria

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

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

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

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

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

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

Model #582 sets out a variety of requirements to prevent insurers from using unreasonable or misleading illustrations in the sale of life insurance. AG 49, originally adopted by the NAIC in 2015, expands upon and supersedes some of the illustration requirements of Model #582 for indexed universal life (IUL) illustrations. In simple terms, Section 4 and Section 5 of AG 49 set maximum crediting rates for illustrations. Section 6 addresses illustrations of policy loans, and Section 7 requires illustrations beyond those required in Model #582. The implementation of AG 49 was phased as follows:

- Section 4 and Section 5 shall be effective for all new business and in force life insurance illustrations on policies sold on or after Sept. 1, 2015;
- Effective March 1, 2017, Section 4 and Section 5 shall be effective for all in force life insurance illustrations on policies within the scope of this actuarial guideline, regardless of the date the policy was sold; and
- Section 6 and Section 7 shall be effective for all new business and in force life insurance illustrations on policies sold on or after March 1, 2016.

Testing the compliance of illustrations with Model #582 and AG 49 will be complex, and the examiner will likely seek assistance from an actuary familiar with and capable of testing compliance with Model #582 and AG 49. In such cases, the examiner should work with the actuary to determine the appropriate information to request from the insurer necessary to enable the actuary and examiner in testing the compliance of the illustrations.

The examiner may be able to test implementation compliance issues by confirming that IUL illustration changes were made on or before the effective dates set out above. For example:

- Did the insurer implement on or before Sept. 15, 2015, a compliant crediting rate methodology for new and in force illustrations on policies sold on or after Sept. 15, 2015?
- Did the insurer implement on or before March 1, 2016, a compliant credit rate methodology for all new illustrations produced on or after March 1, 2016, on in force policies?
- Did the insurer implement the policy loan and additional illustration scales requirement of Section 6 and Section 7 of AG 49 on or before March 1, 2016?

The following are more complex requirements of AG 49, which may require the assistance of an actuary or other person with expertise in evaluating illustration crediting methodologies and calculations:

- For new business and in force life insurance illustrations on policies sold on or after Sept. 1, 2015, determine whether the credited rate for the Illustrated Scale has been limited according to the requirements of Section 4;
- For new business and in force life insurance illustrations on policies sold on or after Sept. 1, 2015, determine whether the earned interest rate for the Disciplined Current Scale has been limited according to the requirements of Section 5;
- For new business and in force life insurance illustrations on policies sold on or after March 1, 2016, ensure that if the illustration includes a loan, the illustrated rate credited as compared to the illustrated loan charge has been limited according to the requirements of Section 6;
- For new business and in force life insurance illustrations on policies sold on or after March 1, 2016, ensure that the basic illustration includes a ledger using the Alternate Scale shown alongside a ledger using the illustrated scale with equal prominence according to the requirements of Section 7.A;

- For new business and in force life insurance illustrations on policies sold on or after March 1, 2016, ensure that the basic illustration includes a table showing the minimum and maximum of the geometric average annual credited rates as referenced in Section 7.B; and
- For new business and in force life insurance illustrations on policies sold on or after March 1, 2016, ensure that the basic illustration includes a table showing actual historical index changes and corresponding hypothetical interest rates using current index parameters for the most recent 20-year period for each Index Account illustrated, as required by Section 7.C.

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

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

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

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

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

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

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

STANDARDS
MARKETING AND SALES

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

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Producer records

_____ Training materials

_____ Procedure manuals

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

Determine whether marketing materials encour mul le issues of policies; e.g., use of existing policyholder list for additional sales of similar produc s to t ose he birth date solicitations, scare tactics, etc.

Determine if negative enrollment practic re pe ed and used.

Determine if the regulated entit has a system t discourage "over-insurance" of policyholders as defined by the regulated entity's underwriting re rements.

For annuity products, ensu the egulated entity maintains a written statement specifying the standards of suitability used by the insu r. The tandards should specify that an insurer's issuance of an annuity shall be reasonable under all the ircu stanc s actually known to the insurer at the time the annuity is issued.

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

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

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

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

STANDARDS
MARKETING AND SALES

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

Apply to: All preneed products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

A summary of special requirements for preneed disclosures is available.

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

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

STANDARDS
MARKETING AND SALES

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

Apply to: All individual and group life insurance

Priority: Essential

Documents to be Reviewed

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

_____ Claim procedure/underwriting manuals

_____ Claim files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Accelerated Benefits Model Regulation (#620)

Review Procedures and Criteria

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

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

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

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

STANDARDS
MARKETING AND SALES

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

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

All covered persons[29] as defined by the Gramm-Leach-Bliley Act. This includes any person who sells, solicits, advertises or offers an insurance product or annuity to a consumer at an office of the depository institution or on behalf of a depository institution.

Priority: Essential

Documents to be Reviewed

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

_____ Underwriting manuals

_____ Policy and contract application forms

_____ Policy files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

[29] Please refer to the Bulletin for a detailed explanation of what constitutes a covered person.

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

STANDARDS
MARKETING AND SALES

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

Apply to: All annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy/Other relevant files

_____ New business reports

_____ Policy/Underwriting files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

STANDARDS
MARKETING AND SALES

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

Apply to: All annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy/Underwriting files

_____ Agency correspondence file/Agency bulletins

_____ Agency procedural manual

_____ Claim files

_____ Complaint log

_____ Agency sales/lapse records

_____ Regulated entity's systems manual

_____ Regulated entity's producer training materials

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Examine the regulated entity's suitability policies and procedures to verify that the insurer maintains reasonable procedures to inform its insurance producers of the requirements of applicable state suitability statutes, rules and regulations. Verify that the requirements of applicable state suitability statutes, rules and regulations are incorporated into relevant insurance producer training manuals;
- Review the regulated entity's producer training materials to verify that the insurer establishes standards for insurance producer product training and maintains reasonable procedures to require its insurance producers to comply with the requirements of Section 7 of the *Suitability in Annuity Transactions Model Regulation* (#275). For more information on the requirements of Section 7 of Model #275, see Marketing and Sales Standard 11 in this chapter;
- Examine the regulated entity's producer training materials to ensure that the insurer provides adequate product-specific training and training materials which fully explain all material features of its annuity products to its insurance producers;
- Review the regulated entity's suitability policies and procedures to ensure that the insurer maintains adequate procedures for review of each recommendation prior to issuance of an annuity, that are designed to ensure that there is a reasonable basis to determine that a recommendation is suitable. An insurer's review procedures may apply a screening system for the purpose of identifying selected transactions for additional review and the insurer's review process may be accomplished electronically or through other means including, but not limited to, physical review. Such an electronic or other system may be designed to require additional review only of those transactions identified for additional review by the selection criteria;
- Verify that the insurer maintains reasonable procedures to detect recommendations that are not suitable. Insurer procedures may include, but are not limited to, confirmation of consumer suitability information, systematic customer surveys, interviews, confirmation letters and programs of internal monitoring. If there is no provision in applicable state suitability statutes, rules or regulations to the contrary, an insurer may demonstrate compliance in this area by applying sampling procedures, or by confirming suitability information after issuance or delivery of the annuity; and

- Verify that the insurer annually provides a report to senior management, including to the senior manager responsible for audit functions, which details a review, with appropriate testing, reasonably designed to determine the effectiveness of the supervision system, the exceptions found, and corrective action taken or recommended, if any.

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

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

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

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

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

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

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

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

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

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

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

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

STANDARDS
MARKETING AND SALES

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

Apply to: All annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity producer education/training files

_____ Producer continuing education files

_____ Producer new business/replacement log

_____ Regulated entity producer training materials

_____ Regulated entity standards for product training

_____ Regulated entity policies and procedures

_____ Complaint logs, complaint files and producer complaint logs/producer investigation files, if applicable

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

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

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

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

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

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

Examiners can review and trend this data for:

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

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

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

STANDARDS
MARKETING AND SALES

Standard 12
The insurer has product-specific training standards and materials designed to provide producers with adequate knowledge of the annuity products recommended prior to soliciting the sale of annuity products. The insurer also must have reasonable procedures in place to require its producers to comply with applicable producer training requirements.

Apply to: All annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Agency correspondence file/Agency bulletins

_____ Agency procedural manual

_____ Agency sales/lapse records

_____ Systems manuals

_____ Producer training materials

_____ Contracts with third-party vendors with compliance responsibilities

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Suitability in Annuity Transactions Model Regulation (#2
Unfair Trade Practices Act (#880)
Producer Licensing Model Act (#218)
Suitability of Sales of Life Insurance and Annuities W te Paper

Review Procedures and Criteria

Contact other regulators that may have conduc d a rec nt review of the insurer's training standards.

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

Determine if the insurer product-spe ific training materials are appropriate and accurately reflect the specific annuity being recommended. Rev w regulated entity's records to determine if, when and how product-specific training occurred prio to a p oducer ecommending an annuity.

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

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

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

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

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

STANDARDS
MARKETING AND SALES

Standard 13
The insurer has procedures in place to provide full disclosure to consumers regarding all sales of products involving fixed-index annuity products, and all sales are in compliance with applicable statutes, rules and regulations.

Apply to: All fixed-index annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy/Underwriting file

_____ Agency correspondence file/Agency bulletins

_____ Agency procedural manual

_____ Claim files

_____ Complaint log

_____ Agency sales/lapse records

_____ Systems manuals

_____ Producer training materials

_____ Contracts with third-party vendors with compliance responsibilities

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

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

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

STANDARDS
MARKETING AND SALES

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

Apply to: All index life products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy/Underwriting file

_____ Agency correspondence file/Agency bulletins

_____ Agency procedural manual

_____ All documentation demonstrating the development of crediting rates used in illustrations

_____ Claim files

_____ Complaint log

_____ Agency sales/lapse records

_____ Regulated entity's systems manual

_____ Regulated entity's producer training materials

_____ Contracts with third-party vendors with compliance responsibilities

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Advertisements of Life Insurance and Annuities Model Regulation (#570), Section 3B
Life Insurance Disclosure Model Regulation (#580), Section 8C
Unfair Trade Practices Act (#880)
Life Insurance Illustrations Model Regulation (#582) and *Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index Based Interest* (AG 49)

Review Procedures and Criteria

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

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

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

Review documentation to ensure compliance of the insurer's illustration methodologies with Model #582, generally, and with AG 49, specifically for indexed universal life (IUL) products. Review documentation to confirm implementation of AG 49 at required effective dates.

Review claim files for proper interest crediting and computation of death claims.

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

STANDARDS
MARKETING AND SALES

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

Apply to: All life products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Life insurance applications and related disclosure and consent forms

_____ Related questionnaires for applicants

_____ Underwriting guidelines and field underwriting guidelines for producers

_____ Review contracts with reinsurers of life insurance and all applicable guidelines from the reinsurer

_____ Regulated entity's guidelines regarding lawful travel

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Unfair Trade Practices Act (#880)

Review Procedures and Criteria

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

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

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

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

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

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

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

D. Producer Licensing

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

E. Policyholder Service

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

STANDARDS
POLICYHOLDER SERVICE

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

Apply to: All life products

Priority: Essential

Documents to be Reviewed

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

_____ Notice of reinstatement

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine that notices were sent out in a timely manner.

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

Reinstatements should be applied per policy provisions.

STANDARDS
POLICYHOLDER SERVICE

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

Apply to: All life products

Priority: Essential

Documents to be Reviewed

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

_____ Underwriting file

_____ Policy and contract history file

_____ Regulated entity's procedures manual

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Standard Nonforfeiture Law for Life Insurance (#808)
NAIC Procedure for Permitting Same Minimum Nonforfeiture Standards for Men and Women Insured Under 1980 CSO and 1980 CET Mortality Tables (#811)
Life Insurance Disclosure Model Regulation (#580)
Variable Life Insurance Model Regulation (#270)
Model Policy Loan Interest Rate Bill (#590)
Standard Nonforfeiture Law for Individual Deferred Annuities (#805)
Annuity Nonforfeiture Model Regulation (#806)

Review Procedures and Criteria

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

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

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

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

Cash Surrender Values

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

Extended Term Insurance (ETI)

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

Reduced Paid-Up (RPU)

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

Additional Paid-Up

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

Automatic Premium Loan (APL)

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

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

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

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

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

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

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

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

STANDARDS
POLICYHOLDER SERVICE

Standard 3
The regulated entity provides each policyowner with an annual report of policy values in accordance with statutes, rules and regulations and, upon request, an in force illustration or contract policy summary.

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

If required, ensure annual reports are being provided annually.

For universal life, ensure the report includes:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

STANDARDS
POLICYHOLDER SERVICE

Standard 4
Upon receipt of a request from a policyholder for accelerated benefit payment, the regulated entity must disclose to the policyholder the effect of the request on the policy's cash value, accumulation account, death benefit, premium, policy loans and liens. The regulated entity must also advise that the request may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements.

Apply to: All individual and group life products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files

_____ Policy files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

Unfair discrimination is prohibited.

F. Underwriting and Rating

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

STANDARDS
UNDERWRITING AND RATING

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

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

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

_____ All applications

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine if the requested coverage is issued.

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

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

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

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

Verify that supplemental applications are used, where appropriate.

STANDARDS
UNDERWRITING AND RATING

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

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Life insurance applications and related disclosure and consent forms

_____ Health questionnaires for applicants

_____ Medical underwriting guidelines

_____ Regulated entity's guidelines regarding the handling of AIDS-related test results, if such tests are allowed

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

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

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

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

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

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

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

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

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

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

G. Claims

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

STANDARDS
CLAIMS

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

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

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Claim procedure manuals

_____ Claim files

_____ Claim complaint records

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Accelerated Benefits Model Regulation (#620)

Review Procedures and Criteria

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

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

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

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

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

No restrictions are permitted on use of accelerated benefit proceeds.

STANDARDS
CLAIMS

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

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

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity's claim procedures manual and claim bulletins

_____ Claims training manual

_____ Claim files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Accelerated Benefits Model Regulation (#620)

Review Procedures and Criteria

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

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

STANDARDS
CLAIMS

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

Apply to: All life insurance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Claim procedure manuals/claim training manuals/claim bulletins

_____ Claim files

_____ Claim complaint records

_____ Disclosures provided to beneficiaries

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Retained Asset Accounts Sample Bulletin (#573)

Review Procedures and Criteria

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

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

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

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

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

b) Provided the beneficiary with a supplemental contract that clearly discloses the rights of the beneficiary and obligations of the regulated entity under the contract.

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

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

H. Supplemental Checklist for Marketing and Sales Standard #1

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

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

		An advertisement that includes any illustrations or statements containing or based upon non-guaranteed elements should set forth with equal prominence comparable illustrations or statements containing or based upon the guaranteed elements.
		If an advertisement refers to any non-guaranteed policy element, it should indicate that the insurer reserves the right to change any such element at any time and for any reason. However, if an insurer has agreed to limit this right in any way—such as, for example, if it has agreed to change these elements only at certain intervals or only if there is a change in the insurer's current or anticipated experience—the advertisement may indicate any such limitation on the insurer's right.
		An advertisement should not refer to dividends as "tax free" or use words of similar import, unless the tax treatment of dividends is fully explained, and the nature of the dividend as a return of premium is indicated clearly.
For policies sold to students:		
		The envelope in which insurance solicitation material is contained may be addressed to the parent(s) of students. The address may not include any combination of words which imply that the correspondence is from a school, college, university or other education or training institution, nor may it imply that the institution has endorsed the material or supplied the insurer with information about the student, unless such is a correct and truthful statement.
		All advertisements including, but not limited to, informational literature used in the solicitation of insurance must be identified clearly as coming from an insurer or insurance producer, if such is the case, and the entities must be clearly identified as such.
		The return address on the envelope may not imply that the soliciting insurer or insurance producer is affiliated with a university, college, school or other educational or training institution, unless true.
For individual deferred annuity products or deposit funds:		
		Any illustrations or statements containing or based upon interest rates higher than the guaranteed accumulation interest rates should set forth with equal prominence comparable illustrations or statements containing or based upon the guaranteed accumulation interest rates. The higher interest rates should not be greater than those currently being credited by the company, unless the higher rates have been publicly declared by the company with an effective date for new issues not more than 13 months subsequent to the date of declaration.

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

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

I. Supplemental Checklist for Marketing and Sales Standard #4

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

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

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

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

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

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

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

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

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

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

		The columns of the numeric summary should include: Bases 1: Policy guarantees Bases 2: Insurer's illustrated scale Bases 3: Insurer's illustrated scale used, but with the non-guaranteed elements reduced as follows: • Dividends at 50 percent of the dividends contained in the illustrated scale used; • Non-guaranteed credited interest at rates that are the average of the guaranteed rates and the rates contained in the illustrated scale used; and • All non-guaranteed charges, including, but not limited to, term insurance charges and mortality and expense charges, at rates that are the average of the guaranteed rates and the rates contained in the illustrated scale used.
		If coverage would cease before policy maturity or age 100, the year in which coverage ceases should be identified for each of the three bases.
		The following statement signed and dated by the applicant or policy owner: "I have received a copy of this illustration and understand that any non-guaranteed elements illustrated are subject to change and could be either higher or lower. The agent has told me they are not guaranteed."
		The following statement signed and dated by the insurance producer or other authorized representative of the insurer: "I certify that this illustration has been presented to the applicant, and that I have explained that any non-guaranteed elements illustrated are subject to change. I have made no statements that are inconsistent with the illustration."
		A basic illustration must include the following for at least each policy year from one to 10 and for every fifth policy year thereafter, ending at age 100, policy maturity or final expiration, and except for term insurance beyond the 20th year, for any year in which the premium outlay and contract premium, if applicable, is to change: • Premium outlay and mode the applicant plans to pay and the contract premium as applicable; • The corresponding guaranteed death benefit, as provided in the policy; • Corresponding guaranteed value available upon surrender, as provided in the policy; • Non-guaranteed elements may be shown if described in the contract. In the case of an illustration for a policy on which the insurer intends to credit terminal dividends, they may be shown if the insurer's current practice is to pay terminal dividends. If any non-guaranteed elements are shown, they must be shown at the same durations as the corresponding guaranteed elements, if any; and • If a guaranteed benefit value is available at any duration for which a non-guaranteed benefit or value is shown, a zero should be displayed in the guaranteed column.

"Basic illustration" means a ledger or proposal used in the sale of a life insurance policy that shows both guaranteed and non-guaranteed elements.

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

A *supplemental* illustration may be provided as long as:

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

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

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

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

Yes	No	Requirement
		Any statement of policy cost factors or benefits shall contain: • The corresponding guaranteed policy cost factors or benefits, clearly identified; • A statement explaining the non-guaranteed nature of any current interest rates, charges or other factors applied to the policy, including the insurer's right to alter any of these factors; • Any limitations on the crediting of interest, including identification of those portions of the policy to which a specified interest rate shall be credited; • Any illustration of the policy value shall be accompanied by the corresponding net cash surrender value; • Any statement regarding the crediting of a specific current interest rate shall also contain the frequency and timing by which such rate is determined; • If any statement refers to the policy being interest-indexed, the index shall be described. In addition, a description shall be given of the frequency and timing of determining the interest rate and of any adjustments made to the index in arriving at the interest rate credited under the policy; • Any illustrated benefits based upon non-guaranteed interest, mortality or expense factors shall be accompanied by a statement indicating that these benefits are not guaranteed; and • If the guaranteed cost factors or initial policy cost factor assumptions would result in policy values becoming exhausted prior to the policy's maturity date, such fact shall be disclosed, including notice that coverage will terminate under such circumstances.

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

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

Determine whether, in addition to all other illustration requirements, indexed universal life (IUL) illustrations contain or comply with the following requirements specified in *Actuarial Guideline XLIX— The Application of the Life Illustrations Model Regulation to Policies with Index Based Interest* (AG 49). (Section 4 and Section 5 apply to new business and in force illustrations for policies sold on or after Sept. 1, 2015, and Section 6 and Section 7 apply to new business and in force illustrations for policies sold on or after March 1, 2016.)

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

(*Actuarial Guideline XLIX— The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest*)

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

Ensure *variable life* illustrations contain or comply with the following:

Yes	No	Requirement
		The hypothetical interest rates used to illustrate accumulated policy values must be an annual effective gross rate after brokerage expenses and prior to any deduction for taxes, expenses and contract charges.
		If illustrations of accumulated policy values are shown, then for the highest interest rate used, one illustration must be based solely upon guarantees contained in the policy contract being illustrated.
		Except for illustrations contained in the prospectus, the pattern of premium payments used in an illustration should be the initial pattern requested by the proposed policyholder at inception or upon changes in face amount requested by the policyholder.
		If the illustrated policy contract provides for a variety of investment options, the illustration may either use an asset charge, which is reasonably representative, or use the asset charge of a particular option. The illustration should clearly identify the asset charge and either label it "hypothetical" or identify the fund.
		The illustration must disclose the transaction charges that will be levied against the contract because of transactions requested in accordance with rights and privileges specified in the policy contract. Any charge for the exercise of a right or privilege upon which the illustration is based must be reflected in the illustrated values. The nature of any other such charges must be disclosed in a clear statement accompanying such illustrations.
		A clear statement must be made following the table of illustrated accumulated policy values that use of hypothetical investment results does not in any way represent actual results or suggest that such results will be achieved and must indicate that the policy values which actually arise will differ from those shown, whenever the actual investment results differ from the hypothetical rates illustrated. Assumptions upon which illustrations are based must be clearly disclosed.
		Any sales illustration to a prospective policyholder must reflect the policy being presented accurately. Misleading statements or captions or other misrepresentations are prohibited.
		The requested sales illustration must be printed clearly and legibly on hard paper copy. An illustration displayed on a computer screen may be used in addition to, but not as a substitute for, hard paper copy.

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

	In connection with variable life insurance contracts offering both fixed and variable funding options: • An illustration of the variable funding option must comply with these guidelines; • If an illustration of the fixed funding option is shown, accumulated policy values must be shown on the basis of guaranteed rates. One or more additional rates may also be shown, but such rates may not exceed current rates; and • A summary illustration may be given in which results from comparable illustrated and hypothetical interest rates are combined. Such summary must cross-reference to the accompanying separate illustrations of the fixed and variable funding options.

(*Life Insurance Illustrations Model Regulation* (#582))

J. Supplemental Checklist for Marketing and Sales Standard #8

Yes	No	Requirement
Ensure the disclosures include:		
		The fact that a life insurance policy is involved or being used to fund a prearrangement.
		The nature of the relationship among the soliciting agent or agents, the provider of the funeral or cemetery merchandise or services, the administrator and any other person.
		The relationship of the life insurance policy to the funding of the prearrangement and the nature and existence of any guarantees relating to the prearrangement.
		The impact on the prearrangement of the following: • Any changes in the life insurance policy including, but not limited to, changes in the assignment, beneficiary designation or use of the proceeds; • Any penalties to be incurred by the policyholder as a result of failure to make premium payments; • Any penalties to be incurred or monies to be received as a result of cancellation or surrender of the life insurance policy; • A list of the merchandise and services which are applied or contracted for in the prearrangement and all relevant information concerning the price of the funeral services, including an indication that the purchase price is either guaranteed at the time of purchase or to be determined at the time of need; • All relevant information concerning what occurs and whether any entitlements or obligations arise, if there is a difference between the proceeds of the life insurance policy and the amount actually needed to fund the prearrangement; • Any penalties or restrictions, including, but not limited to, geographic restrictions or the inability of the provider to perform, on the delivery of merchandise, services or the prearrangement guarantee; and The fact that a sales commission or other form of compensation is being paid and, if so, the identity of such individuals or entities to whom it is paid.

Chapter 24—Conducting the Health Examination

Introduction

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

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

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

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

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

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

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

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

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

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

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

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

Exempt Benefit Plans

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

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

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

HIPAA—Federal Minimum Requirements

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

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

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

Federally Mandated Benefits

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

Federally mandated benefits include:

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

IIPRC-Approved Products

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

A. Operations/Management

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

B. Complaint Handling

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

C. Marketing and Sales

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

STANDARDS
MARKETING AND SALES

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

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

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Replacement register

_____ Underwriting file

_____ Replacement comparison form (if external replacement)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

Review replacement forms for compliance.

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

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

STANDARDS
MARKETING AND SALES

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

Apply to: All health products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Actuarial records

_____ Underwriting file

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

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

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

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

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

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

STANDARDS
MARKETING AND SALES

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

Apply to: All health products

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Producer records

_____ Training materials

_____ Procedure manuals

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

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

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

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

Determine if negative enrollment practices are permitted and used.

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

D. Producer Licensing

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

E. Policyholder Service

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

STANDARDS
POLICYHOLDER SERVICE

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

Apply to: All health products
Disability income products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Notice of reinstatement

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine that notice was sent in a timely manner.

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

Verify that reinstatement was applied per policy provisions.

STANDARDS
POLICYHOLDER SERVICE

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

Apply to: All health plans

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy history file

_____ Regulated entity procedures manual

Others Reviewed

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

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

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

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

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

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

Certificates should automatically be issued to:

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

Creditable coverage certificates should include:

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

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

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

Duplicate certificates should be provided free of charge.

F. Underwriting and Rating

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

STANDARDS
UNDERWRITING AND RATING

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

Apply to: All health products
Disability income products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy contract

_____ Underwriter's file or notes on a system log

_____ Insured's request (if applicable)

_____ Regulated entity cancellation/nonrenewal guidelines

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

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

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

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

STANDARDS
UNDERWRITING AND RATING

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

Apply to: All health products
Disability income products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ All applications

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Group Health Insurance Standards Model Act (#100)

Review Procedures and Criteria

Determine if the coverage is issued as applied for.

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

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

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

Verify that supplemental applications are used, where appropriate.

STANDARDS
UNDERWRITING AND RATING

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

Apply to: All health products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy forms

_____ Regulated entity guidelines

_____ Regulated entity marketing materials dealing with continuation of benefits

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

Review continuation of benefit files.

Review declinations/cancellations of continuation of benefits insureds.

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

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

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

STANDARDS
UNDERWRITING AND RATING

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

Apply to: All group health products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting guidelines and producer guidelines related to group health insurance

_____ Rating guidelines related to group health insurance

Others Reviewed

Genetic Information Nondiscrimination Act of 2008 (GINA)

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

STANDARDS
UNDERWRITING AND RATING

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

Apply to: All health products
Disability income products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Written policies, standards and procedures

_____ Regulated entity guidelines

_____ Rights of individual applicant to access and amend health information

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

Review medical/lifestyle questions and underwriting guidelines for AIDS.

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

STANDARDS
UNDERWRITING AND RATING

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

Apply to: All group health products
Disability income products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy forms and endorsements

_____ Regulated entity guidelines

_____ Regulated entity materials dealing with HIPAA

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

Continuous coverage is required as follows:

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

Waiting periods:

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

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

Individual Market

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

STANDARDS
UNDERWRITING AND RATING

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

Apply to: All health products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files of denied policies

_____ Regulated entity guidelines

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

For group coverage:

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

For individual coverage:

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

"Eligible individual" includes a person that:

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

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

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

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

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

STANDARDS
UNDERWRITING AND RATING

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

Apply to: All small group health products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files of denied policies

_____ Regulated entity guidelines

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

STANDARDS
UNDERWRITING AND RATING

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

Apply to: All health products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files of denied policies

_____ Regulated entity guidelines

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

STANDARDS
UNDERWRITING AND RATING

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

Apply to: All group health plans

Priority: Essential

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

_____ Applicable statutes, rules and regulations

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

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

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

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

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

_____ Applicable statutes, rules and regulations

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

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

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

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

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

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

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

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

G. Claims

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

STANDARDS
CLAIMS

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

Apply to: All health products
Disability income products

Priority: Essential

Documents to be Reviewed

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

_____ Company claim procedure manuals

_____ Claim training manuals

_____ Internal company claim audit reports

_____ Claim bulletins, UCR guidelines and procedure manuals

_____ Company claim forms manual

_____ Claim files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

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

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

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

Determine if claim files are handled according to policy provisions.

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

Determine if claim handling includes proper referral of suspicious claims.

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

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

For disability income insurance claims:

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

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

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

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

STANDARDS
CLAIMS

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

Apply to: All health lines offering maternity coverage

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Company claim procedure manuals

Others Reviewed

Newborns' and Mothers' Health Protection Act of 1996

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

STANDARDS
CLAIMS

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

Apply to: Certain group health plans offering mental health coverage

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Company claim procedure manuals

_____ Claim training manuals

_____ Internal company claim audit reports

_____ Claim bulletins, UCR guidelines and procedure manuals

_____ Company claim forms manual

_____ Claim files

Others Reviewed

Mental Health Parity Act of 1996

Mental Health Parity and Addiction Equity Act of 2008

_____ _____

NAIC Model References

Review Procedures and Criteria

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

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

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

STANDARDS
CLAIMS

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

Apply to: Certain group health plans offering mastectomy coverage

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Company claim procedure manuals

_____ Claim training manuals

_____ Internal company claim audit reports

_____ Claim bulletins and procedure manuals

_____ Company claim forms manual

_____ Claim files

Others Reviewed

Women's Health and Cancer Rights Act of 1998

_____ _____

NAIC Model References

Review Procedures and Criteria

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

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

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

STANDARDS
CLAIMS

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

Apply to: Replacement or replaced group health plans

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Company claim procedure manuals

_____ Claim files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Group Coverage Discontinuance and Replacement Model Regulation (#110)

Review Procedures and Criteria

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

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

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

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

H. Grievance Procedures

1. Purpose

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

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

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

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

2. Techniques

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

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

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

3. Tests and Standards

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

STANDARDS
GRIEVANCE PROCEDURES

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

Apply to: All health carriers offering a health benefit plan

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Sample documents and files (including electronic correspondence)

_____ Member evidence of coverage

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

STANDARDS
GRIEVANCE PROCEDURES

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

Apply to: All health carriers offering a health benefit plan

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Company's grievance handling policies and procedures

_____ Sample of grievances

_____ Member evidence of coverage

_____ Company's grievance register

_____ Company's annual grievance report to the insurance department

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

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

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

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

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

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

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

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

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

STANDARDS
GRIEVANCE PROCEDURES

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

Apply to: All health carriers offering a health benefit plan

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Grievance procedures

_____ All forms used to process a grievance

_____ Company approval register

_____ Grievance procedure filings filed with the insurance department

_____ Certificates of compliance filed with the insurance department

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

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

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

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

STANDARDS
GRIEVANCE PROCEDURES

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

Apply to: All health carriers offering a health benefit plan

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

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

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

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

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

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

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

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

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

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

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

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

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

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

STANDARDS
GRIEVANCE PROCEDURES

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

Apply to: All health carriers offering a health benefit plan

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Sample of grievances

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

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

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

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

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

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

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

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

STANDARDS
GRIEVANCE PROCEDURES

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

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

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Sample of voluntary review grievances

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

STANDARDS
GRIEVANCE PROCEDURES

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

Apply to: All health carriers offering a health benefit plan

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Sample of expedited appeals

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I. Network Adequacy

1. Purpose

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

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

2. Techniques

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

3. Tests and Standards

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

STANDARDS
NETWORK ADEQUACY

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

Apply to: Health carriers with network plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Selection criteria

_____ Documents related to physician recruitment

_____ Provider directory

_____ Reports of out-of-network service denials

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

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

_____ List of providers by specialty

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

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

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

Reasonable criteria include, but are not limited to:

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

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

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

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

A health carrier shall demonstrate that it monitors its providers, provider groups and intermediaries with which it contracts on an ongoing basis to ensure their ability, clinical capacity, financial capability and legal authority, including applicable licensure requirements, to furnish all contracted benefits to covered persons. There are no standards pertinent to provider licensing in Section J Provider Credentialing in this chapter.

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

STANDARDS
NETWORK ADEQUACY

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

Apply to: Health carriers with network plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

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

_____ Member materials referencing access plans

_____ Provider manual

_____ Provider contract

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

The access plan shall describe or contain the following:

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

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

STANDARDS
NETWORK ADEQUACY

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

Apply to: Health carriers with network plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Sample of provider contracts

_____ Credentialing file

_____ Directory of providers

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

Determine if the forms and endorsements have been filed.

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

STANDARDS
NETWORK ADEQUACY

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

Apply to: Health carriers with network plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Provider manual

_____ Provider contracts

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

STANDARDS
NETWORK ADEQUACY

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

Apply to: Health carriers with network plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Provider contracts

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

STANDARDS
NETWORK ADEQUACY

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

Apply to: Health carriers with network plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Intermediary contracts

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Benefit Plan Network Access and Network Adequacy Model Act (#74), Section 7
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

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

- Intermediaries and participating providers with whom they contract shall comply with all applicable requirements for health carriers and participating providers, as indicated in state provisions equivalent to the *Health Benefit Plan Network Access and Network Adequacy Model Act* (#74) and accompanying regulations;
- A health carrier's statutory responsibility to monitor the offering of covered benefits to covered persons shall not be delegated or assigned to the intermediary;
- A health carrier shall have the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering covered benefits to the carrier's covered persons;
- A health carrier shall maintain copies of all intermediary health care subcontracts at its principal place of business in the state, or ensure that it has access to all intermediary subcontracts, including the right to make copies to facilitate regulatory review, upon 10 days' prior written notice from the health carrier;
- If applicable, an intermediary shall transmit utilization documentation and claims paid documentation to the health carrier. The carrier shall monitor the timeliness and appropriateness of payments made to providers and health care services received by covered persons;
- If applicable, an intermediary shall maintain the books, records, financial information and documentation of services provided to covered persons at its principal place of business in the state and preserve them according to applicable statutory duration, in a manner that facilitates regulatory review;
- An intermediary shall allow the insurance commissioner access to the intermediary's books, records, financial information and any documentation of services provided to covered persons, as necessary to determine compliance; and

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

STANDARDS
NETWORK ADEQUACY

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

Apply to: Health carriers with network plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Provider contracts

_____ Provider manuals

_____ Complaints made by providers

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

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

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

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

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

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

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

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

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

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

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

STANDARDS
NETWORK ADEQUACY

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

Apply to: Health carriers with network plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Provider directory and updates

_____ Provider contracts

_____ Credentialing documentation

_____ Internet directory

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

J. Provider Credentialing

1. Purpose

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

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

2. Techniques

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

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

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

3. Tests and Standards

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

STANDARDS
PROVIDER CREDENTIALING

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

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Credentialing policies and procedures

_____ Credentialing plan

_____ Minutes of the credentialing committee

_____ Credentialing plan evaluation reports (if any)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

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

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

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

STANDARDS
PROVIDER CREDENTIALING

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

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Provider directory

_____ Provider credentialing files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

STANDARDS
PROVIDER CREDENTIALING

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

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Checklist for credentialing

_____ Checklist and forms for site visits (if any)

_____ Reports made from site visits (if any)

_____ Sample of credentialing files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

STANDARDS
PROVIDER CREDENTIALING

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

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Checklist for credentialing

_____ Checklist and forms for site visits (if any)

_____ Reports made from site visits (if any)

_____ Sample of credentialing files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

STANDARDS
PROVIDER CREDENTIALING

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

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Checklist for credentialing

_____ Checklist and forms for site visits (if any)

_____ Reports made from site visits (if any)

_____ Sample of credentialing files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

STANDARDS
PROVIDER CREDENTIALING

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

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Credentialing policies and procedures

_____ Provider contracts

_____ Credentialing files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

STANDARDS
PROVIDER CREDENTIALING

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

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Credentialing policies and procedures

_____ Provider manual

_____ Listing of providers (active and terminated)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

STANDARDS
PROVIDER CREDENTIALING

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

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

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Credentialing policies and procedures

_____ Intermediary contracts

_____ Periodic reports from intermediaries

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

_____ Minutes of the health carrier's credentialing committee

_____ Minutes of the health carrier's board of directors

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

K. Quality Assessment and Improvement

1. Purpose

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

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

2. Techniques

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

3. Tests and Standards

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

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

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

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Quality assessment policies and procedures

_____ Quality assessment plan (if any)

_____ Minutes of the health carrier's quality assessment committee

_____ Minutes of the health carrier's board of directors

_____ Evaluations of the quality assessment program

_____ Job descriptions for the chief medical officer or clinical director

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

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

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

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

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

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

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

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

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Written description of the quality assessment program

_____ Signed certification by a corporate officer

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

Determine if the forms have been filed.

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

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

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

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Quality improvement policies and procedures

_____ Quality improvement plan

_____ Minutes of the health carrier's quality improvement committee

_____ Minutes of the health carrier's board of directors

_____ Evaluations of the quality improvement program

_____ Job descriptions for the chief medical officer or clinical director

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

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

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

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

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

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

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

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

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

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

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

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

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

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Quality assessment and improvement policies and procedures

_____ Reports made to the licensing authority

_____ Terminated and suspended provider contract files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

Determine that policies and procedures address reporting requirements.

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

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

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

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Quality assessment and improvement policies and procedures

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

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

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

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

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

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Certification filings

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

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

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

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

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

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Quality assessment and improvement policies and procedures

_____ Contracts with entities

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

_____ Periodic reports from the entity

_____ Minutes from the health carrier's board of directors

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

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

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

L. Utilization Review

1. Purpose

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

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

2. Techniques

The review of utilization review activities should include an overview of the health plan's written utilization review policies, procedures and scripts, in addition to an overview of how utilization review activities are applied to individual cases. Utilization review issues may also surface during the examiners' review of claims, complaints and grievance procedures.

a. Examiners should request a written overview of the insurer's utilization review program. The overview should include the names and positions of individuals responsible for overseeing the program, along with the qualifications of the utilization review director and staff. Examiners may request an interview of appropriate personnel, to supplement information obtained in the written overview. During this process, examiners should also determine how the insurer maintains corporate oversight of the utilization review process. When applicable, the examiner should obtain copies of any required utilization review licenses or certifications. Review the scope of the utilization review program. Utilization review functions for some specialized services are occasionally delegated to other entities. Examiners should request copies of applicable reports required for regulatory purposes.

b. Examiners should also obtain the program materials and scripts to ascertain the source of guidelines used, how frequently the materials are updated and whether they are supported by reliable sources of data and medical protocols. In addition, obtain standards used by applicable accreditation entities, if any. A review of the time guidelines for responding to utilization review and reconsideration requests should be conducted. An evaluation of the methods used to communicate utilization review decisions to medical providers, subscribers and other applicable divisions within the company should be completed.

c. Evaluate the availability of, and access to, the utilization review program to plan members or subscribers. Review adequacy of staffing and hours of operation.

d. Ascertain whether utilization review requirements are consistent with and supported by language in the policy, certificate of coverage and marketing materials.

e. Obtain listings of utilization review approvals or certifications, denials and requests for reconsideration. Use sampling techniques to review specific cases. Evaluate handling for adherence to written guidelines and standards.

3. Tests and Standards

The utilization review assessment includes, but is not limited to, the following standards related to the performance of utilization review activities by the health carrier. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
UTILIZATION REVIEW

Standard 1
The health carrier establishes and maintains a utilization review program in compliance with applicable statutes, rules and regulations.

Apply to: Health carriers offering a health benefit plan providing or performing utilization review services

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations, including those related to mandated benefits and services

_____ Utilization review policies and procedures

_____ Utilization review program or plan documentation

_____ Medical criteria used to make utilization review determinations

_____ Job description of the staff position functionally responsible for day-to-day management

_____ Minutes of the health carrier's board of directors

_____ Minutes of the health carrier's utilization review committee

_____ Documentation of clinical staff credentialing maintenance and education requirements

_____ Program assessment reports

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Utilization Review and Benefit Determination Model Act (#73), Sections 5, 7 & 12

Review Procedures and Criteria

Verify that the health carrier implements procedures to ensure effective corporate oversight of its utilization review program.

Verify that a health carrier that requires a request for benefits under the covered person's health benefit plan to be subjected to utilization review implements a written utilization review program that describes all review activities, both delegated and nondelegated for:

- The filing of benefit requests;
- The notification of utilization review and benefit determinations; and
- The review of adverse determinations in accordance with applicable state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72).

Verify that the health carrier's written utilization review program document describes all of the following:

- Procedures to evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services;
- Data sources and clinical review criteria used in decision-making;
- Mechanisms to ensure consistent application of clinical review criteria and compatible decisions;
- Data collection processes and analytical methods used in assessing utilization of health care services;
- Provisions for ensuring confidentiality of clinical and proprietary information;
- The organizational structure (e.g., utilization review committee, quality assurance or other committee) that periodically assesses utilization review activities and reports to the health carrier's governing body; and
- The staff position functionally responsible for day-to-day program management.

Verify that the health carrier ensures that appropriate personnel have operational responsibility for conducting the carrier's utilization review program.

The health carrier shall annually certify in writing to the commissioner that the utilization review program of the health carrier complies with all applicable state and federal laws establishing confidentiality and reporting requirements.

The health carrier shall comply with all applicable state provisions equivalent to the *Utilization Review and Benefit Determination Model Act* (#73) and accompanying regulations not expressly covered by any other of these standards.

STANDARDS
UTILIZATION REVIEW

Standard 2
The health carrier operates its utilization review program in accordance with applicable state statutes, rules and regulations.

Apply to: Health carriers offering a health benefit plan providing or performing utilization review services

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Utilization review policies and procedures

_____ Form letters

_____ Activity reports

_____ Provider manual

_____ Files with utilization review requests (Verify that all levels of authorized, appealed and disapproved requests are reviewed)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Utilization Review and Benefit Determination Model Act (#73), Section 8

Review Procedures and Criteria

Verify that the health carrier's utilization review program uses documented clinical review criteria that are based on sound clinical evidence and evaluated periodically to assure ongoing efficacy.

Note: The health carrier may develop its own clinical review criteria or may purchase or license clinical review criteria from qualified vendors.

Verify that the health carrier makes its clinical review criteria available upon request to authorized government agencies.

Verify that the health carrier ensures that qualified health care professionals administer the utilization review program and oversee review decisions. Verify that the health carrier has appointed clinical peers to evaluate the clinical appropriateness of adverse determinations.

Verify that the health carrier issues utilization review decisions and benefit determinations in a timely and efficient manner pursuant to the requirements set forth in applicable state statutes, rules and regulations.

Verify that the health carrier has a process to ensure that utilization reviewers apply clinical review criteria in conducting utilization review consistently.

Verify that the health carrier conducts routine assessments of the effectiveness and efficiency of its utilization review program.

Verify that the health carrier's data systems are sufficient to support utilization review program activities and to generate management reports to enable the health carrier to monitor and manage health care services effectively.

If a health carrier delegates any utilization review activities to a utilization review organization, verify that the health carrier maintains adequate oversight, to include all of the following:

- A written description of the utilization review organization's activities and responsibilities, including reporting requirements;
- Evidence of formal approval of the utilization review organization program by the health carrier; and
- A process by which the health carrier evaluates the performance of the utilization review organization.

Verify that the health carrier coordinates its utilization review program activities with other medical management activity conducted by the health carrier—such as quality assurance, credentialing, provider contracting, data reporting, grievance procedures, claims adjudication, processes for assessing member satisfaction, and risk management.

Verify that the health carrier provides covered persons, or, if applicable, the covered person's authorized representatives and participating providers with access to its utilization review staff via a toll-free number or collect call telephone line.

Verify that the health carrier, when conducting utilization review, collects only the information necessary, including pertinent clinical information, to make the utilization review or benefit determination.

STANDARDS
UTILIZATION REVIEW

Standard 3
The health carrier discloses information about its utilization review and benefit determination procedures to covered persons, or, if applicable, the covered person's authorized representative, in compliance with applicable statutes, rules and regulations.

Apply to: Health carriers offering a health benefit plan providing or performing utilization review services

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Member materials

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Utilization Review and Benefit Determination Model Act (#73), Section 13

Review Procedures and Criteria

Verify that the health carrier provides a clear and accurate summary of its utilization review and benefit determination procedures to prospective covered persons, or, if applicable, to the covered person's authorized representative.

Verify that the health carrier provides a clear and comprehensive description of its utilization review procedures, including the procedures for obtaining adverse review determinations, and a statement of rights and responsibilities of covered persons, or, if applicable, the covered person's authorized representative, with respect to those procedures, in the certificate of coverage or member handbook provided to covered persons.

Verify that the health carrier prints on its membership cards a toll-free telephone number to call for utilization review and benefit determination decisions.

STANDARDS
UTILIZATION REVIEW

Standard 4
The health carrier makes standard utilization review and benefit determinations in a timely manner and as required by applicable state statutes, rules and regulations, as well as the provisions of HIPAA.

Apply to: Health carriers offering a health benefit plan providing or performing utilization review services

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Utilization review policies and procedures

_____ Form letters

_____ Activity reports

_____ Provider manual

_____ Files with utilization review requests (Verify that all levels of authorized, appealed and disapproved requests are reviewed)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Utilization Review and Benefit Determination Model Act (#73), Section 9

Review Procedures and Criteria

Verify that the health carrier maintains written procedures pursuant to applicable state statutes, rules and regulations, for making standard utilization review and benefit determinations on requests submitted to the health carrier by the covered person, or, if applicable, the covered person's authorized representative, for benefits and for notifying the covered person, and, if applicable, the covered person's authorized representative, of its determinations with respect to these requests within the specified time frames required pursuant to applicable state statutes, rules and regulations.

For prospective review determinations, verify that the health carrier makes the determination and notifies the covered person, or, if applicable, the covered person's authorized representative, of the determination, whether the carrier certifies the provision of the benefit or not, within a reasonable period of time appropriate to the covered person's medical condition, but in no event later than 15 days after the date the health carrier receives the request.

Whenever the determination is an adverse determination, verify that the health carrier makes the notification of the adverse determination in accordance with state statutes, rules and regulations regarding procedures for standard utilization review and benefit determination.

Verify that if the health carrier extends the time period for making a determination and notifying the covered person, or, if applicable, the covered person's authorized representative, of the determination one time for up to 15 days pursuant to applicable state statutes, rules and regulations, the health carrier has:

- Determined that the extension was necessary due to matters beyond the health carrier's control; and
- Notified the covered person, or, if applicable, the covered person's authorized representative, prior to the expiration of the initial 15-day time period, of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.

If the extension referenced above is necessary due to the failure of the covered person, or, if applicable, the covered person's authorized representative, to submit information necessary to reach a determination on the request, verify that the health carrier issues a notice of extension that:

- Specifically describes the required information necessary to complete the request; and
- Gives the covered person, or, if applicable, the covered person's authorized representative, at least 45 days from the date of receipt of the notice to provide the specified information.

Whenever the health carrier receives a prospective review request from a covered person, or, if applicable, the covered person's authorized representative, that fails to meet the health carrier's filing procedures, verify that the health carrier notifies the covered person, or, if applicable, the covered person's authorized representative, of the failure and provides in the notice information on the proper procedures to be followed for filing a request.

Verify that the notice referenced in the previous paragraph is provided by the health carrier as soon as possible, but in no event later than five days following the date of the failure.

Verify that the health carrier provides the notice orally or, if requested by the covered person or, if applicable, the covered person's authorized representative, in writing.

Note: The provisions regarding the covered person's, or, if applicable, the covered person's authorized representative's, failure to meet the health carrier's filing procedures apply only in the case of a failure that:

- Is a communication by a covered person, or, if applicable, the covered person's authorized representative, that is received by a person or organizational unit of the health carrier responsible for handling benefit matters; and
- Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment or provider for which certification is being requested.

For concurrent review determinations, if a health carrier has certified an ongoing course of treatment to be provided over a period of time or number of treatments, examiners need to be aware that:

- Any reduction or termination by the health carrier during the course of treatment before the end of the period or number of treatments, other than by health benefit plan amendment or termination of the health benefit plan, constitutes an adverse determination; and
- The health carrier shall notify the covered person, or, applicable, the covered person's authorized representative, of the adverse determination in accordance with applicable state statutes, rules and regulations regarding procedures for standard utilization review and benefit determination at a time sufficiently in advance of the reduction or termination to allow the covered person, or, if applicable, the covered person's authorized representative, to file a grievance to:
    - Request a review of the adverse determination pursuant to state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72); and
    - Obtain a determination with respect to that review of the adverse determination before the benefit is reduced or terminated.

Verify that the health care service or treatment that is the subject of the adverse determination is continued by the health carrier without liability to the covered person with respect to the internal review request made pursuant to state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72).

For retrospective review determinations, verify that the health carrier makes the determination within a reasonable period of time, but in no event later than 30 working days after the date of receiving the benefit request.

If the retrospective review determination is an adverse determination, verify that the health carrier provides notice of the adverse determination to the covered person, or, if applicable, the covered person's authorized representative, in accordance with applicable state statutes regarding procedures for standard utilization review and benefit determination.

Verify that if the health carrier extends the time period for making a determination and notifying the covered person, or, if applicable, the covered person's authorized representative, of the determination one time for up to 15 days pursuant to applicable state statutes, rules and regulations, the health carrier has:

- Determined that the extension was necessary due to matters beyond the health carrier's control; and
- Notified the covered person, or, if applicable, the covered person's authorized representative, prior to the expiration of the initial 30 day time period, of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.

If the extension referenced above is necessary due to the failure of the covered person, or, if applicable, the covered person's authorized representative, to submit information necessary to reach a determination on the request, verify that the health carrier issues a notice of extension that:

- Specifically describes the required information necessary to complete the request; and
- Gives the covered person, or, if applicable, the covered person's authorized representative at least 45 days from the date of receipt of the notice to provide the specified information.

Verify that the health carrier calculates the time periods, within which a prospective or retrospective determination is required to be made pursuant to applicable state statutes, rules and regulations, to begin on the date the request is received by the health carrier in accordance with the health carrier's procedures established pursuant to applicable state statutes, rules and regulations for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

If the time period for making a prospective or retrospective determination is extended due to the covered person's, or, if applicable, the covered person's authorized representative's, failure to submit the information necessary to make the determination, verify that the health carrier calculates the time period for making the determination to begin on the date on which the health carrier sends the notification of the extension to the covered person, or, if applicable, the covered person's authorized representative, until the earlier of:

- The date on which the covered person, or, if applicable, the covered person's authorized representative, responds to the request for additional information; or
- The date on which the specified information was to have been submitted.

Unless the state has a specific exemption because of an alternative law, HIPAA requires that all group health plans, insurance companies and HMOs offering health coverage for hospital stays in connection with the birth of a child must provide health coverage for a minimum of 48 hours for a normal vaginal delivery and 96 hours for a cesarean section. (Coverage is required for both the mother and the newborn.) Deductibles, coinsurance and other cost-sharing methods may be applied.

Verify that the company does not engage in incentive arrangements to circumvent the requirements of the law. Such incentive requirements could include: making monetary payments or rebates to mothers to encourage them to accept a shorter length of stay; penalizing or reducing or limiting reimbursement of an attending provider because they provided care to an individual for the above minimum time frames; or providing incentives to induce a provider to provide care in a manner inconsistent with the law.

STANDARDS
UTILIZATION REVIEW

Standard 5
The health carrier provides written notice of an adverse determination of standard utilization review and benefit determinations in compliance with applicable statutes, rules and regulations.

Apply to: Health carriers offering a health benefit plan providing or performing utilization review services

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Utilization review policies and procedures

_____ Form letters

_____ Utilization review files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Utilization Review and Benefit Determination Model Act (#73), Section 9F

Review Procedures and Criteria

Verify that the health carrier issues notification of an adverse determination in a manner calculated to be understood by the covered person, to include all of the following:

- The specific reason or reasons for the adverse determination;
- Reference to the specific plan provisions on which the determination is based;
- A description of any additional material or information necessary for the covered person, or, if applicable, the covered person's authorized representative, to perfect the benefit request, including an explanation of why the material or information is necessary to perfect the request;
- A description of the health carrier's grievance procedures established pursuant to applicable state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72), including any time limits applicable to those procedures;
- If the health carrier relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion, or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person, or, if applicable, the covered person's authorized representative, upon request;
- If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person, or, if applicable, the covered person's authorized representative, free of charge upon request;

- A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination;
- The written statement of the scientific or clinical rationale for the adverse determination; and
- A statement explaining the availability of and the right of the covered person, or, if applicable, the covered person's authorized representative, as appropriate, to contact the insurance commissioner's office at any time for assistance or, upon completion of the health carrier's grievance procedure process as provided under state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72), to file a civil suit in a court of competent jurisdiction. The statement shall include contact information for the insurance commissioner's office.

Verify that the health carrier provides the notice in writing or electronically.

STANDARDS
UTILIZATION REVIEW

Standard 6
The health carrier conducts expedited utilization review and benefit determinations in a timely manner and in compliance with applicable statutes, rules and regulations.

Apply to: Health carriers offering a health benefit plan providing or performing utilization review services

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Utilization review policies and procedures

_____ Form letters

_____ Utilization review files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Utilization Review and Benefit Determination Model Act (#73), Section 10

Review Procedures and Criteria

Verify that the health carrier has established written procedures pursuant to applicable state statutes, rules and regulations for receiving benefit requests from covered persons, or, if applicable, their authorized representatives, and for making and notifying the covered person, or, if applicable, the covered person's authorized representative, of expedited utilization review and benefit determinations with respect to urgent care requests and concurrent review urgent care requests.

Verify that the health carrier, in the case of a failure by a covered person, or, if applicable, the covered person's authorized representative, to follow the health carrier's procedures for filing an urgent care request, notifies the covered person, or, if applicable, the covered person's authorized representative, of the failure and the proper procedures to be followed for filing the request.

Verify that the health carrier's notice regarding a covered person's, or, if applicable, the covered person's authorized representative's, failure to follow the health carrier's procedures for filing an urgent care request:

- Is provided to the covered person, or, if applicable, the covered person's authorized representative, as appropriate, as soon as possible, but not later than 24 hours after receipt of the request; and
- May be oral, unless the covered person, or, if applicable, the covered person's authorized representative, requests the notice in writing.

Note: The provisions regarding the covered person's, or, if applicable, the covered person's authorized representative's, failure to follow the health carrier's procedures for filing an urgent care request apply only in the case of a failure that:

- Is a communication by a covered person, or, if applicable, the covered person's authorized representative, that is received by a person or organizational unit of the health carrier responsible for handling benefit matters; and
- Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment or provider for which approval is being requested.

For an urgent care request, unless the covered person, or, if applicable, the covered person's authorized representative, has failed to provide sufficient information for the health carrier to determine whether, or to what extent, the benefits requested are covered benefits or payable under the health carrier's health benefit plan, verify that the health carrier notifies the covered person, or, if applicable, the covered person's authorized representative, of the health carrier's determination with respect to the request, whether or not the determination is an adverse determination, as soon as possible, taking into account the medical condition of the covered person, but in no event later than 72 hours after the receipt of the request by the health carrier.

If the health carrier's determination is an adverse determination, verify that the health carrier provides notice of the adverse determination in accordance with applicable state statutes, rules and regulations regarding procedures for expedited utilization review and benefit determination.

If the covered person, or, if applicable, the covered person's authorized representative, has failed to provide sufficient information for the health carrier to make a determination, verify that the health carrier notifies the covered person, or, if applicable, the covered person's authorized representative, either orally or, if requested by the covered person, or, if applicable, the covered person's authorized representative, in writing of this failure and states what specific information is needed as soon as possible, but in no event later than 24 hours after receipt of the request.

Verify that the health carrier provides the covered person, or, if applicable, the covered person's authorized representative, a reasonable period of time to submit the necessary information, taking into account the circumstances, but in no event less than 48 hours after notifying the covered person, or, if applicable, the covered person's authorized representative, of the failure to submit sufficient information, pursuant to applicable state statutes, rules and regulations.

Verify that the health carrier notifies the covered person, or, if applicable, the covered person's authorized representative, of its determination with respect to the urgent care request as soon as possible, but in no event more than 48 hours after the earlier of:

- The health carrier's receipt of the requested specified information; or
- The end of the period provided for the covered person, or, if applicable, the covered person's authorized representative, to submit the requested specified information.

If the health carrier's determination is an adverse determination, verify that the health carrier provides notice of the adverse determination accordance with applicable state statutes, rules and regulations regarding procedures for expedited utilization review and benefit determination.

For concurrent review urgent care requests involving a request by the covered person, or, if applicable, the covered person's authorized representative, to extend the course of treatment beyond the initial period of time or the number of treatments, if the request is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, verify that the health carrier makes a determination with respect to the request and notifies the covered person, or, if applicable, the covered person's authorized representative, of the determination, whether it is an adverse determination or not, as soon as possible, taking into account the covered person's medical condition, but in no event more than 24 hours after the health carrier's receipt of the request.

If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with applicable state statutes, rules and regulations regarding procedures for expedited utilization review and benefit determination.

Verify that the health carrier calculates the time period within which a determination is required to be made pursuant to applicable state statutes, rules and regulations, to begin on the date the request is filed with the health carrier in accordance with the health carrier's procedures established pursuant to applicable state statutes, rules and regulations for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

Verify that the health carrier's notification of an adverse determination pursuant to an expedited utilization review and benefit determination is set forth in a manner calculated to be understood by the covered person, or, if applicable, the covered person's authorized representative, to include all of the following:

- The specific reason or reasons for the adverse determination;
- Reference to the specific plan provisions on which the determination is based;
- A description of any additional material or information necessary for the covered person, or, if applicable, the covered person's authorized representative, to complete the request, including an explanation of why the material or information is necessary to complete the request;
- A description of the health carrier's internal review procedures established pursuant to applicable state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72), including any time limits applicable to those procedures;
- A description of the health carrier's expedited review procedures established pursuant to applicable state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72);
- If the health carrier relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person, or, if applicable, the covered person's authorized representative upon request;
- If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person, or, if applicable, the covered person's authorized representative, free of charge upon request;
- If applicable, instructions for requesting:
    - A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination, as set forth in applicable state statutes, rules and regulations; or
    - The written statement of the scientific or clinical rationale for the adverse determination, as set forth in applicable state statutes, rules and regulations; and
- A statement explaining the availability of and the right of the covered person, or, if applicable, the covered person's authorized representative, as appropriate, to contact the insurance commissioner's office at any time for assistance or, upon completion of the health carrier's grievance procedure process as provided under applicable state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72), to file a civil suit in a court of competent jurisdiction. The statement shall include contact information for the insurance commissioner's office.

Verify that the health carrier provides the notice orally, in writing or electronically.

If the health carrier provides the notice of adverse determination orally, verify that the health carrier also provides written or electronic notice of the adverse determination within three days following the oral notification.

STANDARDS
UTILIZATION REVIEW

Standard 7
The health carrier monitors the activities of the utilization review organization or entity with which the carrier contracts and ensures that the contracting organization complies with applicable state provisions equivalent to the *Utilization Review and Benefit Determination Model Act* (#73) and accompanying regulations.

Apply to: Health carriers offering a health benefit plan contracting out utilization review services

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Utilization review policies and procedures

_____ Contracts with organizations or entities

_____ Reports of entity reviews and audits (if any) by health carrier

_____ Periodic reports from the organization or entity

_____ Minutes of the health carrier's board of directors

_____ Minutes of the health carrier's utilization review committee

_____ Policies and procedures for oversight

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Utilization Review and Benefit Determination Model Act (#73), Sections 6 & 12

Review Procedures and Criteria

Whenever a health carrier contracts to have a utilization review organization or other entity perform the utilization review functions required by the *Utilization Review and Benefit Determination Model Act* (#73) or applicable state statutes, rules and regulations, the health carrier is responsible for monitoring the activities of the utilization review organization or entity with which the health carrier contracts and for ensuring that the requirements of the *Utilization Review and Benefit Determination Model Act* (#73) and applicable state statutes, rules and regulations are met.

Verify that the health carrier has policies and procedures in place that ensure the utilization review programs of designees comply with all applicable state and federal laws establishing confidentiality and reporting requirements.

The health carrier shall annually certify in writing to the commissioner that the utilization review program of its designee complies with all applicable state and federal laws establishing confidentiality and reporting requirements.

M. External Review

Use the standards set forth below.

STANDARDS
EXTERNAL REVIEW

Standard 1
Companies covered under the *Health Carrier External Review Model Act* (#75) will be in compliance with the following procedures and criteria, as well as with other applicable statutes, rules and regulations.

Apply to: Health insurance carriers under the *Health Carrier External Review Model Act* (#75)

Priority: Essential

Documents to be Reviewed

_____ Certificates, policies and company procedures

_____ Applicable statutes, rules and regulations

_____ Reports on external review requests

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Carrier External Review Model Act (#75), Section 4
Health Maintenance Organization Model Act (#430)
Issues Involving External Review Procedures White Paper

Review Procedures and Criteria

The *Health Carrier External Review Model Act* (#75) shall apply to all health carriers that provide or perform utilization review, except for the following:

> "The provisions of this Act shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, as defined by [insert appropriate reference to state law that defines long-term care insurance], vision care or any other limited supplemental benefit or to a Medicare supplement policy of insurance, as defined by the commissioner by regulation, coverage under a plan through Medicare, Medicaid or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis."

The health carrier shall notify covered persons in writing of the right to request an external review and shall:

- Include in the notice what circumstances constitute sufficient grounds for a standard, expedited or experimental/investigational review, and what procedures must be followed to request a review;
- Include an authorization form that allows the health carrier to disclose protected health information;
- Pay the cost of the independent review to the organization conducting the external review; and
- Include the telephone number and address of the insurance commissioner.

The health carrier shall include a description of the external review procedures in or attached to the policy, certificate, membership booklet, an outline of coverage or other evidence of coverage it provides to covered persons.

The health carrier shall maintain written records in the aggregate and for each type of health benefit plan offered by the health carrier on all requests for external review. This information must be submitted to the insurance commissioner, at least annually, via a report in a format specified by the insurance commissioner.

STANDARDS
EXTERNAL REVIEW

Standard 2
In jurisdictions that choose Option 1 or Option 2 under the *Health Carrier External Review Model Act* (#75) for providing an external review process, companies will be in compliance with the following requirements, whether the request for the review is for a standard, expedited or experimental/investigational review.

Apply to: Health insurance carriers in jurisdictions where the *Health Carrier External Review Model Act* (#75) has been adopted

Priority: Essential

Documents to be Reviewed

_____ Certificates, policies and company procedures

_____ Applicable statutes, rules and regulations

_____ Reports on external review requests

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Carrier External Review Model Act (#75), Section 4
Health Maintenance Organization Model Act (#430)
Issues Involving External Review Procedures White Paper

Review Procedures and Criteria (Option 1, Option 2)

The *Health Carrier External Review Model Act* (#75) shall apply to all health carriers that provide or perform utilization review, except for the following:

> "The provisions of this Act shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, as defined by [insert the reference to state law that defines long-term care insurance], vision care or any other limited supplemental benefit or to a Medicare supplement policy of insurance, as defined by the commissioner by regulation, coverage under a plan through Medicare, Medicaid or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis."

External Review Process, Option 1
The external review process resides in the office of the insurance commissioner and requires that covered persons file all requests for external review with the commissioner. This option also provides that the commissioner will conduct a preliminary review of the request for external review to ensure that it meets all of the requirements to be eligible for external review. If the request for external review is determined to be eligible for external review, the commissioner is required to assign an independent review organization to conduct the external review. This option requires the assigned independent review organization to provide the commissioner with a written recommendation on whether to uphold or reverse the adverse determination or final adverse determination. After reviewing the recommendation, the commissioner is required to notify the covered person, if applicable, the covered person's authorized representative and the health carrier of the external review decision.

External Review Process, Option 2
This alternative is the same as Option 1, except the independent review organization assigned to conduct the review makes the determination, if the company's decision is to be reversed.

Standard Review Procedures
Provide within 7 days the documents and any information considered in making the adverse determination or the final adverse determination to the assigned independent review organization.

Notify the covered person, if applicable, the covered person's authorized representative, the assigned independent review organization and the commissioner in writing of its decision upon making the decision to reverse its adverse determination or final adverse determination.

Approve the coverage that was the subject of the adverse determination or final adverse determination upon receipt of a notice of a decision reversing the adverse determination or final adverse determination.

Expedited External Review Procedures
Provide in an expeditious manner all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization upon receipt of notice that the case has been accepted for an expedited external review.

Approve the coverage that was the subject of the adverse determination or final adverse determination upon receipt of the notice of a decision reversing the original determination.

Experimental or Investigational Treatment Procedures
Provide or transmit in an expeditious manner all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization.

Provide within 7 days the documents and any information considered in making the adverse determination or the final adverse determination to the assigned independent review organization.

Approve the coverage that was the subject of the adverse determination or final adverse determination upon receipt of the notice of a decision reversing the original determination.

STANDARDS
EXTERNAL REVIEW

Standard 3
In states that choose Option 3 under the *Health Carrier External Review Model Act* (#75) for providing an external review process, companies will be in compliance with the following requirements, whether the request for the review is a standard, expedited or experimental/investigational review.

Apply to: Health insurance carriers in jurisdictions where the *Health Carrier External Review Model Act* (#75) has been adopted

Priority: Essential

Documents to be Reviewed

_____ Certificates, policies and company procedures

_____ Applicable statutes, rules and regulations

_____ Reports on external review requests

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Carrier External Review Model Act (#75)
Health Maintenance Organization Model Act (#430)
Issues Involving External Review Procedures White Paper

Review Procedures and Criteria

The *Health Carrier External Review Model Act* (#75) shall apply to all health carriers that provide or perform utilization review, except for the following:

> "The provisions of this Act shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, as defined by [insert the reference to state law that defines long-term care insurance], vision care or any other limited supplemental benefit or to a Medicare supplement policy of insurance, as defined by the commissioner by regulation, coverage under a plan through Medicare, Medicaid or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis."

External Review Process, Option 3
This option makes it the responsibility of the health carrier to provide for an external review process and requires that covered persons file requests for external review with the health carrier. The health carrier must also assign an independent review organization, from the list of approved independent review organizations compiled by the insurance commissioner, to conduct a preliminary review of the request and conduct an external review of the request, if the request has satisfied specified requirements to be eligible for external review.

Standard Review Procedures
Send a copy of the request for an external review to the insurance commissioner.

Assign an independent review organization, upon receiving a request for an expedited external review, from the list compiled and maintained pursuant to Section 13 of this Act, to determine whether the request meets the reviewability requirements set forth in Section 8B of this Act and conduct the external review, if the request meets the reviewability requirements of Section 8B of this Act.

Provide within 7 days the documents considered in making the adverse determination or the final adverse determination to the assigned independent review organization.

Notify the covered person, if applicable, the covered person's authorized representative, the assigned independent review organization and the commissioner in writing of its decision upon making the decision to reverse the adverse determination or final adverse determination before a determination by the independent review organization.

Approve the coverage that was the subject of original adverse determination or final adverse determination upon receipt of a notice of a decision reversing the original determination.

Expedited External Review
Assign an independent review organization, from the list compiled and maintained pursuant to Section 13 of the Act, to determine whether the request meets the reviewability requirements set forth in the Act and conduct the external review if the request meets the reviewability requirements of the Act and send a copy of the request to the commissioner.

Send a copy of the request for an external review to the commissioner.

Provide or transmit in an expeditious manner all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization.

Approve the coverage that was the subject of original adverse determination or final adverse determination upon receipt of a notice of a decision reversing the original determination.

Expedited Experimental or Investigational Review
Assign an independent review organization from the list of approved independent review organizations to determine whether the request meets the reviewability requirements and, if the request meets those requirements, conduct the review.

Provide or transmit in an expeditious manner all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization.

Standard Experimental or Investigational Review
Send a copy of the request for external review to the commissioner.

Assign an independent review organization, from the list of approved independent review organizations compiled and maintained by the insurance commissioner pursuant to the Act, to conduct a preliminary review of the request to determine whether

Note: The independent review organization can deny the request for an external review.

Not choose or control the choice of the physicians or other health care professionals to be selected to conduct the external review.

Approve the coverage that was the subject of original adverse determination or final adverse determination upon receipt of a notice of a decision reversing the original determination.

N. Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (#40)

Applies to State?	Review Criteria	Pass	Fail	N/A
	This regulation shall apply to individual and group accident and sickness insurance (except Medicare supplement insurance or any other insurance that is covered by a separate state statute) "advertisement," as that term is defined in Section 3B, G, H and I, unless otherwise specified in this regulation. **(Section 2A)**			
	Every insurer shall establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All of the insurer's advertisements, regardless of by whom written, created, designed or presented, shall be the responsibility of the insurer whose policies are advertised. **(Section 2B)**			
	Advertising materials that are reproduced in quantity shall be identified by form numbers or other identifying means. The identification shall be sufficient to distinguish an advertisement from any other advertising materials, policies, applications or other materials used by the insurer. **(Section 2C)**			
	All information, exceptions, limitations, reductions and other restrictions required to be disclosed by this regulation shall be set out conspicuously and in close conjunction to the statements to which the information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisements so as to be confusing or misleading. This regulation permits, but is not limited to, the use of either of two methods of disclosure listed in this Section **(Section 4)**			
	The format and content of an advertisement of an accident or sickness insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Format means the arrangement of the text and the captions. **(Section 5A)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	Distinctly different advertisements are required for publication in different media, such as newspapers or magazines of general circulation as compared to scholarly, technical or business journals and newspapers. Where an advertisement consists of more than one piece of material, each piece of material must, independent of all other pieces of material, conform to the disclosure requirements of this regulation. **(Section 5B)**			
	Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the commissioner from the overall impression that the advertisement may be reasonably expected to create within the segment of the public to which it is directed. **(Section 5C)**			
	Advertisements shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology, shall not be used. **(Section 5D)**			
	An insurer shall clearly identify its accident and sickness insurance policy as an insurance policy. A policy trade name shall be followed by the words "insurance policy" or similar words clearly identifying the fact that an insurance policy or health benefits product (in the case of health maintenance organizations, prepaid health plans and other direct service organizations) is being offered. **(Section 5E)**			
	An advertisement that is an invitation to contract[30] shall disclose the provisions relating to renewability, cancellability and termination and any modification of benefits, losses covered, or premiums because of age or for other reasons, in a manner that shall not minimize or render obscure the qualifying conditions. **(Section 7A)**			

[30] An advertisement providing details about specific products and intended to promote consumer purchase of insurance. An advertisement that includes an application is generally considered an invitation to contract. Such an advertisement would be regarded as an offer to contract if it contains some language of commitment or some invitation to take action without further communication.

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	Advertisements of cancelable accident and sickness insurance policies shall state that the contract is cancelable or renewable at the option of the company, as the case may be, in language substantially similar to the following: A policy that is renewable at the option of the insurance company shall be advertised in a manner similar to, "This policy is renewable at the option of the company," "The company has the right to refuse renewal of this policy," "Renewable at the option of the insurer" or "This policy can be cancelled by the company at any time." **(Section 7B)**			
	Advertisements of insurance policies that are guaranteed renewable, cancelable or renewable at the option of the company shall disclose that the insurer has the right to increase premium rates, if the policy so provides. **(Section 7C)**			
	Qualifying conditions that constitute limitations on the permanent nature of the coverage shall be disclosed in advertisements of insurance policies that are guaranteed renewable, cancelable or renewable at the option of the company. Examples of qualifying conditions are (1) age limits, (2) reservation of a right to increase premiums and (3) the establishment of aggregate limits. (1) Provisions for reduction of benefits at stated ages shall be set forth. For example, a policy may contain a provision that reduces benefits 50 percent after age 60, although it is renewable to age 65. Such a reduction shall be set forth. Also, a provision for the elimination of certain hazards at any specific ages or after the policy has been in force for a specified time shall be set forth. (2) An advertisement for a policy that provides for step-rated premium rates based upon the policy year or the insured's attained age shall disclose the rate increases and the times or ages at which the premiums increase. **(Section 7D)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	An insurer, directly or through its agents or brokers, shall: (1) Establish marketing procedures to assure that any comparison of policies by its agents or brokers will be fair and accurate; (2) Establish marketing procedures assuring excessive insurance is not sold or issued, except this requirement does not apply to group major medical expense coverage and disability income coverage; and (3) Establish auditable procedures for verifying compliance with this subsection. **(Section 8A)**			
	In addition to the practices prohibited in [insert reference to state law equivalent to the *Unfair Trade Practices Act* (#880)], the following acts and practices are prohibited: (1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of insurance policies or insurers for the purpose of inducing, or intending to induce, a person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert an insurance policy, or to take out a policy of insurance with another insurer; (2) High Pressure Tactics. Employing a method of marketing that has the effect of inducing the purchase of insurance, or tends to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance; and (3) Cold Lead Advertising. Making use directly or indirectly of any method of marketing that fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company. **(Section 8B)**			
	Testimonials and endorsements used in advertisements shall be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced. The insurer, in using a testimonial or endorsement, makes as its own all of the statements contained in it, and the advertisement, including the statement, is subject to all the provisions of this regulation. When a testimonial or endorsement is used more than one year after it was originally given, a confirmation must be obtained. **(Section 9A)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	A person shall be deemed a "spokesperson" if the person making the testimonial or endorsement: (1) Has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee or otherwise; (2) Has been formed by the insurer, is owned or controlled by the insurer, its employees or the person or persons who own or control the insurer; (3) Has any person in a policy-making position who is affiliated with the insurer in any of the above described capacities; or (4) Is in any way directly or indirectly compensated for making a testimonial or endorsement. **(Section 9B)**			
	The fact of a financial interest or the proprietary or representative capacity of a spokesperson shall be disclosed in an advertisement and shall be accomplished in the introductory portion of the testimonial or endorsement in the same form and with equal prominence. If a spokesperson is directly or indirectly compensated for making a testimonial or endorsement, the fact shall be disclosed in the advertisement by language substantially as follows: "Paid Endorsement." The requirement of this disclosure may be fulfilled by use of the phrase "Paid Endorsement" or words of similar import in a type style and size at least equal to that used for the spokesperson's name or the body of the testimonial or endorsement, whichever is larger. In the case of television or radio advertising, the required disclosure shall be accomplished in the introductory portion of the advertisement and shall be given prominence. **(Section 9C)**			
	The source of any statistics used in an advertisement shall be identified in the advertisement. **(Section 10C)**			
	When a choice of the amount of benefits is referred to in an advertisement that is an invitation to contract shall disclose that the amount of benefits provided depends upon the plan selected, and that the premium will vary with the amount of the benefits selected. **(Section 11B)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	When an advertisement that is an invitation to contract refers to various benefits that may be contained in two (2) or more policies, other than group master policies, the advertisement shall disclose that the benefits are provided only though a combination of policies. **(Section 11C)**			
	The name of the actual insurer shall be stated in all of its advertisements. The form number or numbers of the policy advertised shall be stated in an advertisement that is an invitation to contract. An advertisement shall not use a trade name, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device that without disclosing the name of the actual insurer, would have the capacity and tendency to mislead or deceive as to the true identity of the insurer. **(Section 14A)**			
	Advertisements used by agents, producers, brokers or solicitors of an insurer shall have prior written approval of the insurer before they may be used. **(Section 14L)**			
	An agent who makes contact with a consumer, as a result of acquiring that consumer's name from a lead-generating device, shall disclose that fact in the initial contact with the consumer. An agent or insurer may not use names produced from lead-generating devices that do not comply with the requirements of this regulation. **(Section 14M)**			
	An advertisement to join an association, trust or discretionary group that is also an invitation to contract for insurance coverage shall clearly disclose that the applicant will be purchasing both membership in the association, trust or discretionary group and insurance coverage. The insurer shall solicit insurance coverage on a separate and distinct application that requires a separate signature. The separate and distinct application required need not be on separate documents or contained in a separate mailing. The insurance program shall be presented so as not to conceal the fact that the prospective members are purchasing insurance as well as applying for membership, if that is the case. Similarly, it is prohibited to use terms such as "enroll" or "join" to imply group or blanket insurance coverage, when that is not the fact. **(Section 15D)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	Advertising File. Each insurer shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of its individual policies and typical printed, published or prepared advertisements of its blanket, franchise and group policies hereafter disseminated in this or any other state, whether or not licensed in an other state, with a notation attached to each advertisement that indicates the manner and extent of distribution and the form number of any policy advertised. The file shall be subject to regular and periodical inspection by the commissioner. All of these advertisements shall be maintained in a file for a period of either 4 years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time. **(Section 18A)**			
	Certificate of Compliance. Each insurer required to file an annual statement shall file with the commissioner, with its annual statement, a certificate of compliance executed by an authorized officer of the insurer that states that, to the best of the officer's knowledge, information and belief, the advertisements that were disseminated by the insurer during the preceding statement year complied or were made to comply in all respects with the provisions of this regulation and the insurance laws of this state as implemented and interpreted by this regulation. **(Section 18B)**			
	An insurer, agent, broker, producer, solicitor or other person shall not solicit a resident of this state for the purchase of accident and sickness insurance in connection with or as the result of the use of advertisement by the person or any other persons, where the advertisement: (1) Contains any misleading representations or misrepresentations, or is otherwise untrue, deceptive or misleading with regard to the information imparted, the status, character or representative capacity of the person or the true purpose of the advertisement; or (2) Otherwise violates the provisions of this regulation. **(Section 5F)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	An insurer, agent, broker, producer, solicitor or other person shall not solicit residents of this state for the purchase of accident and sickness insurance through the use of a true or fictitious name that is deceptive or misleading with regard to the status, character or proprietary or representative capacity of the person or the true purpose of the advertisement. **(Section 5G)**			
	Covered Benefits. (1) The use of deceptive words, phrases or illustrations in advertisements of accident and sickness insurance is prohibited. **(Section 6A)**			
	(2) An advertisement that fails to state clearly the type of insurance coverage being offered is prohibited. **(Section 6A)**			
	(3) An advertisement shall not omit information or use words, phrases, statements, references or illustrations if the omission of information or use of words, phrases, statements, references or illustrations has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements. **(Section 6A)**			
	(4) An advertisement shall not contain or use words or phrases such as "all," "full," "complete" "comprehensive," "unlimited," "up to," "as high as," "this policy will help fill some of the gaps that Medicare and your present insurance leave out," "this policy will help to replace your income" (when used to express loss of time benefits) or similar words and phrases, in a manner that exaggerates a benefit beyond the terms of the policy. **(Section 6A)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	(5) An advertisement of a hospital or other similar facility confinement benefit that makes reference to the benefit being paid directly to the policyholder is prohibited unless, in making the reference, the advertisement includes a statement that the benefits may be paid directly to the hospital or other health care facility, if an assignment of benefits is made by the policyholder. An advertisement of medical and surgical expense benefits shall comply with this regulation in regard to the disclosure of assignments of benefits to providers of services. Phrases such as "you collect," "you get paid," "pays you" or other words or phrases of similar import may be used so long as the advertisement indicates that it is payable to the insured or someone designated by the insured. **(Section 6A)**			
	(6)(a) An advertisement for basic hospital expense coverage, basic medical-surgical expense coverage, basic hospital/medical-surgical expense coverage, hospital confinement indemnity coverage, accident only coverage, specified disease coverage, specified accident coverage or limited benefit health coverage or for coverage that covers only a certain type of loss is prohibited, if: (i) The advertisement refers to a total benefit maximum limit payable under the policy in any headline, lead-in or caption without also in the same headline, lead-in or caption specifying the applicable daily limits and other internal limits; (ii) The advertisement states a total benefit limit without stating the periodic benefit payment, if any, and the length of time the periodic benefit would be payable to reach the total benefit limit; or (iii) The advertisement prominently displays a total benefit limit that would not, as a general rule, be payable under an average claim. (b) This paragraph does not apply to individual major medical expense coverage, individual basic medical expense coverage or disability income insurance. **(Section 6A)**			
	(7) Advertisements that emphasize total amounts payable under hospital, medical or surgical accident and sickness insurance coverage or other benefits in a policy, such as benefits for private duty nursing, are prohibited, unless the actual amounts payable per day for the indemnity or benefits are stated. **(Section 6A)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	(8) Advertisements that include examples of benefits payable under a policy shall not use examples in a way that implies that the maximum payable benefit payable under the policy will be paid, when less than maximum benefits are paid in an average claim. **(Section 6A)**			
	(9) When a range of benefit levels is set forth in an advertisement, it shall be clear that the insured will receive only the benefit level written or printed in the policy selected and issued. Language that implies that the insured may select the benefit level at the time of filing claims is prohibited. **(Section 6A)**			
	(10) Language in an advertisement that implies that the amount of benefits payable under a loss-of-time policy may be increased at the time of claim or disability according to the needs of the insured is prohibited. **(Section 6A)**			
	(11) Advertisements for policies with premiums that are modest because of their limited coverage or limited amount of benefits shall not describe premiums as "low," "low cost," "budget" or use qualifying words of similar import. The use of words such as "only" and "just" in conjunction with statements of premium amounts when used to imply a bargain is prohibited. **(Section 6A)**			
	(12) Advertisements that state or imply that premiums will not be changed in the future are prohibited, unless the advertised policies expressly provide that the premiums will not be changed in the future. **(Section 6A)**			
	(13) An advertisement for a policy that does not require the premium to accompany the application shall not overemphasize that fact and shall clearly indicate under what circumstances coverage will become effective. **(Section 6A)**			
	(14) An advertisement that exaggerates the effect of statutorily-mandated benefits or required policy provisions or that implies that the provisions are unique to the advertised policy is prohibited. **(Section 6A)**			
	(15) An advertisement that implies that a common type of policy or a combination of common benefits is "new," "unique," "a bonus," "a breakthrough" or is otherwise unusual is prohibited. The addition of a novel method of premium payment to an otherwise common plan of insurance does not render it new. **(Section 6A)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	(16) Language in an advertisement that states or implies that each member under a family contract is covered as to the maximum benefits advertised, where that is not the fact, is prohibited. **(Section 6A)**			
	(17) An advertisement that contains statements such as "anyone can apply" or "anyone can join," other than with respect to a guaranteed-issue policy, for which administrative procedures exist to assure that the policy is issued within a reasonable period of time after the application is received by the insurer, is prohibited. **(Section 6A)**			
	(18) An advertisement that states or implies immediate coverage of a policy is prohibited, unless administrative procedures exist so that the policy is issued within 15 working days after the insurer receives the completed application. **(Section 6A)**			
	(19) An advertisement that contains statements such as "here is all you do to apply," "simply" or "merely" to refer to the act of applying for a policy that is not a guaranteed- issue policy is prohibited, unless it refers to the fact that the application is subject to acceptance or approval by the insurer. **(Section 6A)**			
	(20) An advertisement of accident and sickness insurance sold by direct response shall not state or imply that because no insurance agent will call and no commissions will be paid to agents that it is a low cost plan, or use other similar words or phrases because the cost of advertising and servicing the policies is a substantial cost in the marketing by direct response. **(Section 6A)**			
	(21) Applications, request forms for additional information and similar related materials are prohibited if they resemble money currency, bonds, stock certificates, etc., or use any name, service mark, slogan, symbol or device in a manner that implies that the insurer or the policy advertised is connected with a government agency, such as the Social Security Administration or the Department of Health and Human Services. **(Section 6A)**			
	(22) An advertisement that implies in any manner that the prospective insured may realize a profit from obtaining hospital, medical or surgical insurance coverage is prohibited. **(Section 6A)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	(23) An advertisement that uses words such as "extra," "special" or "added" to describe a benefit in the policy is prohibited. No advertisement of a benefit for which payment is conditioned upon confinement in a hospital or similar facility shall use words or phrases such as "tax-free," "extra cash," "extra income," "extra pay" or substantially similar words or phrases, because these words and phrases have the capacity, tendency or effect of misleading the public into believing that the policy advertised will, in some way, enable them to make a profit from being hospitalized. **(Section 6A)**			
	(24) An advertisement of a hospital or other similar facility confinement benefit shall not advertise that the amount of the benefit is payable on a monthly or weekly basis when, in fact, the amount of the benefit payable is based upon a daily pro rata basis relating to the number of days of confinement, unless the statements of the monthly or weekly benefit amounts are in juxtaposition with equally prominent statements of the benefit payable on a daily basis. The term "juxtaposition" means side by side or immediately above or below. When the policy contains a limit on the number of days of coverage provided, the limit shall appear in the advertisement. **(Section 6A)**			
	(25) An advertisement of a policy covering only one disease or a list of specified diseases shall not imply coverage beyond the terms of the policy. Synonymous terms shall not be used to refer to any disease so as to imply broader coverage than is the fact. **(Section 6A)**			
	(26) An advertisement that is an invitation to contract for a specified disease policy that provides lesser benefit amounts for a particular subtype of disease, shall clearly disclose the subtype and its benefits. This provision shall not apply to institutional advertisements.[31] **(Section 6A)**			

[31] An advertisement that is intended to provide general information about an insurer or company that does not include detailed product or policy specific information. Such an advertisement may, for example, be intended to promote company name recognition or generate good will.

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	(27) An advertisement of a specified disease policy providing expense benefits shall not use the term "actual" when the policy only pays up to a limited amount for expenses. Instead, the term "charges" or substantially similar language should be used that does not create the misleading impression that there is full coverage for expenses. **(Section 6A)**			
	(28) An advertisement that describes any benefits that vary by age shall disclose that fact. **(Section 6A)**			
	(29) An advertisement that uses a phrase such as "no age limit," if benefits or premiums vary by age or if age is an underwriting factor, shall disclose that fact. **(Section 6A)**			
	(30) A television, radio, mail or newspaper advertisement or lead-generating device that is designed to produce leads either by use of a coupon, a request to write or to call the company or a subsequent advertisement prior to contact shall include information disclosing that an agent may contact the applicant. **(Section 6A)**			
	(31) Advertisements, applications, requests for additional information and similar materials are prohibited if they state or imply that the recipient has been individually selected to be offered insurance or has had his or her eligibility for the insurance individually determined in advance when the advertisement is directed to all persons in a group or to all persons whose names appear on a mailing list. **(Section 6A)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	(32) An advertisement, including invitations to inquire[32] or invitations to contract, shall not employ devices that are designed to create undue fear or anxiety in the minds of those to whom they are directed. Examples of prohibited devices are: (a) The use of phrases such as "cancer kills somebody every two minutes" and "total number of accidents," without reference to the total population from which the statistics are drawn; (b) The exaggeration of the importance of diseases rarely or seldom found in the class of persons to whom the policy is offered; (c) The use of phrases such as "the finest kind of treatment," implying that the treatment would be unavailable without insurance; (d) The reproduction of newspaper articles, magazine articles, information from the Internet or other similar published material containing irrelevant facts and figures; (e) The use of images that unduly emphasize automobile accidents, disabled persons or persons confined in beds who are in obvious distress, persons receiving hospital or medical bills or persons being evicted from their homes due to their medical bills; (f) The use of phrases such as "financial disaster," "financial distress," "financial shock" or another phrase implying that financial ruin is likely without insurance is only permissible in an advertisement for major medical expense coverage, individual basic medical expense coverage or disability income coverage, and only if the phrase does not dominate the advertisement; (g) The use of phrases or devices that unduly exploit fear of dependence upon relatives or charity; and (h) The use of phrases or devices that imply that long sicknesses or hospital stays are common among the elderly. **(Section 6A)**			

[32] An advertisement intended to promote inquiries to the insurer or its producers about a specific product or line of products. Such an advertisement would not be intended to induce an express undertaking to contract without further information, comparison or inquiry. Such advertisement may be an invitation to enter into negotiations, which may subsequently result in an offer and acce

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	Exceptions, Reductions and Limitations (1) An advertisement shall not contain descriptions of policy limitations, exceptions or reductions, worded in a positive manner to imply that it is a benefit, such as describing a waiting period as a "benefit builder" or stating, "even preexisting conditions are covered after two years." Words and phrases used in an advertisement to describe the policy limitations, exceptions and reductions shall fairly and accurately describe the negative features of the limitations, exceptions and reductions of the policy offered. **(Section 6B)**			
	(2) An advertisement that is an invitation to contract shall disclose those exceptions, reductions and limitations affecting the basic provisions of the policy. **(Section 6B)**			
	(3) When a policy contains a waiting, elimination, probationary or similar time period between the effective date of the policy and the effective date of coverage under the policy or at a time period between the date a loss occurs and the date benefits begin to accrue for the loss, an advertisement that is subject to the requirements of the preceding paragraph shall prominently disclose the existence of the periods. **(Section 6B)**			
	(4) An advertisement shall not use the words "only," "just," "merely," "minimum," "necessary" or similar words or phrases to describe the applicability of any exceptions, reductions, limitations or exclusions such as: "This policy is subject to the following minimum exceptions and reductions." **(Section 6B)**			
	(5) An advertisement that is an invitation to contract that fails to disclose the amount of any deductible or the percentage of any coinsurance factor is prohibited. **(Section 6B)**			
	(6) An advertisement for loss-of-time coverage that is an invitation to contract that sets forth a range of amounts of benefit levels is prohibited unless it also states that eligibility for the benefits is based upon condition of health, income or other economic conditions, or other underwriting standards of the insurer if that is the fact. **(Section 6B)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	(7) An advertisement that refers to "hospitalization for injury or sickness" omitting the word "covered" when the policy excludes certain sicknesses or injuries, or that refers to "whenever you are hospitalized," "when you go to the hospital" or "while you are confined in the hospital" omitting the phrase "for covered injury or sickness." if the policy excludes certain injuries or sickness, is prohibited. Continued reference to "covered injury or sickness" is not necessary where this fact has been prominently disclosed in the advertisement, and where the description of sicknesses or injuries not covered is prominently set forth. **(Section 6B)**			
	(8) An advertisement that fails to disclose that the definition of "hospital" does not include certain facilities that provide institutional care such as a nursing home, convalescent home or extended care facility, when the facilities are excluded under the definition of hospital in the policy, is prohibited. **(Section 6B)**			
	(9) The term "confining sickness" shall be explained in an advertisement containing the term. The explanation might be as follows: "Benefits are payable for total disability due to confining sickness only so long as the insured is necessarily confined indoors." Captions such as "Lifetime Sickness Benefits" or "Five-Year Sickness Benefits" are incomplete, if the benefits are subject to confinement requirements. When sickness benefits are subject to confinement requirements, captions such as "Lifetime House Confining Sickness Benefits" or "Five-Year House Confining Sickness Benefits" would be permissible. **(Section 6B)**			
	(10) An advertisement that fails to disclose any waiting or elimination periods for specific benefits is prohibited. **(Section 6B)**			
	(11) An advertisement for a policy providing benefits for specified illnesses only, such as cancer, or for specified accidents only, such as automobile accidents, or other policies providing benefits that are limited in nature, shall clearly and conspicuously in prominent type state the limited nature of the policy. The statement shall be worded in language identical to or substantially similar to the following: "This Is A Limited Policy," "This Policy Provides Limited Benefits," "This Is A Cancer Only Policy" or "This Is An Automobile Accident Only Policy." **(Section 6B)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	Preexisting Conditions (1) An advertisement that is an invitation to contract shall, in negative terms, disclose the extent to which any loss is not covered, if the cause of the loss is traceable to a condition existing prior to the effective date of the policy. The use of the term "preexisting condition" without an appropriate definition or description shall not be used. **(Section 6C)**			
	(2) When an accident and sickness insurance policy does not cover losses resulting from preexisting conditions, an advertisement of the policy shall not state or imply that the applicant's physical condition or medical history will not affect the issuance of the policy or payment of a claim under the policy. This regulation prohibits the use of the phrase "no medical examination required" and phrases of similar import, but does not prohibit explaining "automatic issue." If an insurer requires a medical examination for a specified policy, the advertisement, if it is an invitation to contract, shall disclose that a medical examination is required. **(Section 6C)**			
	(3) When an advertisement contains an application form to be completed by the applicant and returned by mail, the application form shall contain a question or statement that reflects the preexisting condition provisions of the policy immediately preceding the blank space for the applicant's signature. For example, the application form shall contain a question or statement substantially as follows: "Do you understand that this policy will not pay benefits during the first [insert number] [years, months] after the issue date for a disease or physical condition that you now have or have had in the past? YES" Or substantially the following statement: "I understand that the policy applied for will not pay benefits for any loss incurred during the first [insert number] [years, months] after the issue date on account of disease or physical condition that I now have or have had in the past." **(Section 6C)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	The disclosure requirements of this regulation shall not apply where the sole financial interest or compensation of a spokesperson, for all testimonials or endorsements made on behalf of the insurer, consists of the payment of union scale wages required by union rules, and if the payment is actually the scale for TV or radio performances. **(Section 9D)**			
	An advertisement shall not state or imply that an insurer or an accident and sickness insurance policy has been approved or endorsed by any individual, group of individuals, society, association or other organizations, unless that is the fact, and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial has been formed by the insurer or is owned or controlled by the insurer or the person or persons who own or control the insurer, the fact shall be disclosed in the advertisement. If the insurer or an officer of the insurer formed or controls the association, or holds any policy-making position in the association, that fact must be disclosed. **(Section 9E)**			
	When a testimonial refers to benefits received under an accident and sickness insurance policy, the specific claim data, including claim number, date of loss and other pertinent information shall be retained by the insurer for inspection for a period of 4 years or until the filing of the next regular report of examination of the insurer, whichever is the longer period of time. The use of testimonials that do not correctly reflect the present practices of the insurer or that are not applicable to the policy or benefit being advertised is not permissible. **(Section 9F)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	An advertisement relating to the dollar amounts of claims paid, the number of people insured, or similar statistical information relating to an insurer or policy shall not use irrelevant facts, and shall not be used, unless it accurately reflects all of the current and relevant facts. The advertisement shall not imply that the statistics are derived from the policy advertised, unless that is the fact, and when applicable to other policies or plans shall specifically so state. (1) An advertisement shall specifically identify the accident and sickness insurance policy to which statistics relate and where statistics are given that are applicable to a different policy, it shall be stated clearly that the data do not relate to the policy being advertised. (2) An advertisement using statistics that describe an insurer, such as assets, corporate structure, financial standing, age, product lines or relative position in the insurance business, may be irrelevant and, if used at all, shall be used with extreme caution because of the potential for misleading the public. As a specific example, an advertisement for accident and sickness insurance that refers to the amount of life insurance which the company has in force or the amounts paid out in life insurance benefits is not permissible, unless the advertisement clearly indicates the amount paid out for each line of insurance. **(Section 10A)**			
	An advertisement shall not represent or imply that claim settlements by the insurer are "liberal," "generous" or use words of similar import, or that claim settlements are or will be beyond the actual terms of the contract. An unusual amount paid for a unique claim for the policy advertised is misleading and shall not be used. **(Section 10B)**			
	An advertisement that uses the word "plan" without prominently identifying it as an accident and sickness insurance policy is prohibited. **(Section 11A)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	An advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits or comparisons of non-comparable policies of other insurers, shall not disparage competitors, their policies, services or business methods and shall not disparage or unfairly minimize competing methods of marketing insurance. An advertisement shall not contain statements such as "no red tape" or "here is all you do to receive benefits." **(Section 12A)**			
	Advertisements that state or imply that competing insurance coverages customarily contain certain exceptions, reductions or limitations not contained in the advertised policies are prohibited, unless the exceptions, reductions or limitations are contained in a substantial majority of the competing coverages. **(Section 12B)**			
	Advertisements that state or imply that an insurer's premiums are lower or that its loss ratios are higher because its organizational structure differs from that of competing insurers are prohibited. **(Section 12C)**			
	An advertisement that is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits. **(Section 13A)**			
	An advertisement shall not create the impression directly or indirectly that the insurer, its financial condition or status, or the payment of its claims, or the merits, desirability, or advisability of its policy forms or kinds or plans of insurance are approved, endorsed or accredited by any division or agency of this state or the federal government. Terms such as "official" or words of similar import, used to describe any policy or application form are prohibited because of the potential for deceiving or misleading the public. **(Section 13B)**			
	An advertisement shall not imply that approval, endorsement or accreditation of policy forms or advertising has been granted by any division or agency of the state or federal government. Approval of either policy forms or advertising shall not be used by an insurer to imply or state that a governmental agency has endorsed or recommended the insurer, its policies, advertising or its financial condition. **(Section 13C)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	An advertisement shall not use any combination of words, symbols, or physical materials that by their content, phraseology, shape, color or other characteristics are so similar to combination of words, symbols or physical materials used by agencies of the federal government or of this state, or otherwise appear to be of such a nature that it tends to confuse or mislead prospective insureds into believing that the solicitation is in some manner connected with an agency of the municipal, state or federal government. **(Section 14B)**			
	Advertisements, envelopes or stationery that employ words, letters, initials, symbols or other devices that are similar to those used in governmental agencies or by other insurers are not permitted, if they may lead the public to believe: (1) That the advertised coverages are somehow provided by or are endorsed by the governmental agencies or the other insurers; (2) That the advertiser is the same, connected with or is endorsed by the governmental agencies or the other insurers. **(Section 14C)**			
	An advertisement shall not use the name of a state or political subdivision of a state in a policy name or description. **(Section 14D)**			
	An advertisement in the form of envelopes or stationery of any kind may not use any name, service mark, slogan, symbol or any device in a manner that implies that the insurer or the policy advertised, or that any agent who may call upon the consumer in response to the advertisement, is connected with a governmental agency, such as the Social Security Administration. **(Section 14E)**			
	An advertisement may not incorporate the word "Medicare" in the title of the plan or policy being advertised unless, whenever it appears, the word is qualified by language differentiating it from Medicare. The advertisement, however, shall not use the phrase "[…] Medicare Department of the […] Insurance Company" or language of similar import. **(Section 14F)**			
	An advertisement may not imply that the reader may lose a right or privilege or benefit under federal, state or local law if he or she fails to respond to the advertisement. **(Section 14G)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	The use of letters, initials or symbols of the corporate name or trademark that would have the tendency or capacity to mislead or deceive the public as to the true identity of the insurer is prohibited, unless the true, correct and complete name of the insurer is in close conjunction and in the same size type as the letters, initials or symbols of the corporate name or trademark. **(Section 14H)**			
	The use of the name of an agency or "[ ] Underwriters" or "[ ] Plan" in type, size and location, so as to have the capacity and tendency to mislead or deceive as to the true identity of the insurer, is prohibited. **(Section 14I)**			
	The use of an address so as to mislead or deceive as to the true identity of the insurer, its location or licensing status is prohibited. **(Section 14J)**			
	An insurer shall not use, in the trade name of its insurance policy, any terminology or words so similar to the name of a governmental agency or governmental program as to have the tendency to confuse, deceive or mislead the prospective purchaser. **(Section 14K)**			
	An advertisement of a particular policy shall not state or imply that prospective insureds become group or quasi-group members covered under a group policy and as members, enjoy special rates or underwriting privileges, unless that is the fact. **(Section 15A)**			
	This regulation prohibits the solicitations of a particular class, such as governmental employees, by use of advertisements which state or imply that their occupational status entitles them to reduced rates on a group or other basis when, in fact, the policy being advertised is sold only on an individual basis at regular rates. **(Section 15B)**			
	Advertisements that indicate that a particular coverage or policy is exclusively for "preferred risks" or a particular segment of the population or that a particular segment of the population is an acceptable risk, when the distinctions are not maintained in the issuance of policies, are prohibited. **(Section 15C)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	An advertisement to join an association, trust or discretionary group that is also an invitation to contract for insurance coverage shall clearly disclose that the applicant will be purchasing both membership in the association, trust or discretionary group and insurance coverage. The insurer shall solicit insurance coverage on a separate and distinct application that requires a separate signature. The separate and distinct applications required need not be on separate documents or contained in a separate mailing. The insurance program shall be presented so as not to conceal the fact that the prospective members are purchasing insurance as well as applying for membership, if that is the case. Similarly, it is prohibited to use terms such as "enroll" or "join" to imply group or blanket insurance coverage, when that is not the fact. **(Section 15D)**			
	Advertisements for group or franchise group plans that provide a common benefit or a common combination of benefits shall not imply that the insurance coverage is tailored or designed specifically for that group, unless that is the fact. **(Section 15E)**			
	(1) An advertisement of an individual policy shall not directly or by implication represent that a contract or combination of contracts is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless that is the fact. An advertisement shall not contain phrases describing an enrollment period as "special," "limited" or similar words or phrases when the insurer uses the enrollment periods as the usual method of marketing accident and sickness insurance. **(Section 16A)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	(2) An enrollment period during which a particular insurance product may be purchased on an individual basis shall not be offered within this state, unless there has been a lapse of not less than [insert number] months between the close of the immediately preceding enrollment period for the same product and the opening of the new enrollment period. The advertisement shall indicate the date by which the applicant must mail the application, which shall be not less than 10 days and not more than 40 days from the date that the enrollment period is advertised for the first time. This regulation applies to all advertising media, i.e., mail, newspapers, the Internet, radio, television, magazines and periodicals, by any one insurer. It is inapplicable to solicitations of employees or members of a particular group or association that otherwise would be eligible under specific provisions of the insurance code for group, blanket or franchise insurance. The phrase "any one insurer" includes all the affiliated companies of a group of insurance companies under common management or control. **(Section 16A)**			
	(3) This regulation prohibits any statement or implication to the effect that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy, unless that is the fact. **(Section 16A)**			
	The phrase "a particular insurance product" in Paragraph (2) of this subsection means an insurance policy that provides substantially different benefits than those contained in any other policy. Different terms of renewability; an increase or decrease in the dollar amounts of benefits; an increase or decrease in any elimination period or waiting period from those available during an enrollment period for another policy shall not be sufficient to constitute the product being offered as a different product eligible for concurrent or overlapping enrollment periods. **(Section 16A)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	B. An advertisement shall not offer a policy that utilizes a reduced initial premium rate in a manner that overemphasizes the availability and the amount of the initial reduced premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, the advertisement shall not display the amount of the reduced initial premium either more frequently or more prominently than the renewal premium, and both the initial reduced premium and the renewal premium must be stated in juxtaposition in each portion of the advertisement where the initial reduced premium appears. **(Section 16B)**			
	C. Special awards, such as a "safe driver's award," shall not be used in connection with advertisements of accident and sickness insurance. **(Section 16C)**			
	An advertisement shall not contain statements that are untrue in fact, or by implication misleading, with respect to the assets, corporate structure, financial standing, age or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system, unless it clearly indicates the purpose of the recommendation and the limitations of the scope and extent of the recommendations. **(Section 17)**			

Chapter 24A—Conducting the Affordable Care Act (ACA) Related Examination

Introduction

The intent of Chapter 24A—Conducting the Affordable Care Act (ACA) Related Examination in the *Market Regulation Handbook* is primarily to provide guidance when reviewing insurers whose business includes major medical policies that are intended to serve as Qualified Health Plans (QHPs) as defined by the Affordable Care Act (ACA). In its current form, Chapter 24A is not intended to fully provide guidance on which standards are applicable to Minimum Essential Coverage (MEC) policies that are not designated as QHPs. Where possible, reference to the applicability of the standards to MEC policies has been included.

The examination standards in Chapter 24—Conducting the Health Examination of the *Market Regulation Handbook* provide guidance specific to all health plans that may or may not include MEC, as defined by the ACA, whereas Chapter 24A applies only to QHPs; NAIC models related to the ACA are set forth separately under each examination standard in Chapter 24A. When developing an examination or review plan related to MEC or ACA compliance, it is important to consider examination standards as applicable from both Chapter 24 and Chapter 24A. In the event of duplication or conflict of examination standards between the chapters, the examination standards and review criteria located in Chapter 24A—Conducting the Affordable Care Act (ACA) Related Examination will generally take precedence for QHP and ACA-related compliance, barring applicable state or federal laws to the contrary.

Regardless of which chapter is used in the *Market Regulation Handbook,* the examiner will also need to reference Chapter 20—General Examination Standards for general examination standards that apply to all insurers.

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. To help ensure strong consumer protections remain in place, state insurance regulators are developing new tools and methods for comprehensive oversight of the health insurance marketplace. Examination standards continue to be developed for the health reform-related requirements that became effective Jan. 1, 2014.

Examination Standards

States are developing examination standards for the immediate mandates of health reform. Since the immediate mandates are new to the marketplace and regulators, each examination standard includes introductory language setting forth the appropriate health reform provision title, citation, effective date, summary of the provision, background and cross-references to FAQs. The introductory language is followed by the examination standards for the health reform mandate formatted for the *Market Regulation Handbook*.

Examination Checklist

Once the examination standards are finalized, the standards will be placed into an examination checklist for use by state insurance regulators and health carriers. The examination checklist will serve as a uniform tool through which states and health carriers can measure compliance.

Additional Data Collection

As the examination standards and checklists are developed, additional data may need to be collected for monitoring and oversight of the marketplace.

Collaboration Methodology

The final component of state market conduct compliance tools for health reform is enhanced state collaboration, which would provide consistent interpretation and review of the health reform standards.

Health Reform Complaint Codes and Complaint Code Definitions
At the NAIC 2014 Spring National Meeting, the NAIC adopted complaint codes and complaint code definitions related to the ACA to be added to the NAIC Complaints Database System (CDS). Recognizing jurisdictions have varying policy directions regarding the enforcement of the ACA, the purpose of the adopted health reform complaint coding is to provide a uniform manner, regardless of the mechanism of administration of the ACA in each state, for jurisdictions to classify, process and track consumer complaints relating to the health reform mandates of the ACA.

The health reform complaint codes and definitions are provided as reference documents to the *Market Regulation Handbook*, and regulators may access these documents via myNAIC at **StateNet** >> **Market Regulation Handbook, Handbook Updates and Reference Documents** >> **Market Regulation Handbook Reference Documents**. The NAIC Standard Complaint Data Form as well as the CDS Definitions and Basics Manual on StateNet were also updated to include the adopted health reform complaint codes and their corresponding definitions.

For non-regulators, the health reform complaint codes and complaint code definitions are available on the NAIC Account Manager web page at *https://www.naic.org/account_manager.htm*.

Health Reform Survey, Health Reform Standardized Data Request and Corresponding Standardized Data Request Definitions
The NAIC adopted a health reform survey, health reform standardized data request and corresponding standardized data request definitions at the NAIC 2015 Spring National Meeting. The survey, standardized data request and the corresponding definitions were developed to assist states in gathering the data needed to monitor regulated entity compliance with the provisions of the ACA**.**

The NAIC health reform survey, standardized data request and standardized data request definitions are provided as reference documents to the *Market Regulation Handbook*; regulators may access these documents via myNAIC at **StateNet** >> **Market Regulation Handbook, Handbook Updates and Reference Documents** >> **Market Regulation Handbook Reference Documents** >> **Standardized Data Requests**.

Non-regulators may access the health reform survey, health reform standardized data request and corresponding standardized data request definitions on the NAIC Account Manager web page at *https://www.naic.org/account_manager.htm*.

ACA-RELATED MARKET CONDUCT EXAMINATION STANDARDS

ACA Provision	PHSA Citation
(Coverage for Individuals Participating in Approved) Clinical Trials	PHSA §2709
(Extension of) Dependent Coverage to Age 26	PHSA §2714
Direct Access to Providers	PHSA §2719A
Essential Health Benefits	PHSA §2707 & §1302
(Prohibition on) Excessive Waiting Periods	PHSA §2708
Grievance Procedures	PHSA §2719
Guaranteed Availability of Coverage	PHSA §2702
Guaranteed Renewability of Coverage	PHSA §2703
Lifetime/Annual Benefit Limits	PHSA §2711
Network Adequacy	PHSA §2702
(Prohibition on) Preexisting Condition Exclusions	PHSA §2704 & §1255
Preventive Health Services	PHSA §2713
Rescissions	PHSA §2712
Summary of Benefits and Coverage (SBC) and Uniform Glossary	PHSA §2715
Utilization Review	PHSA §2719

PROVISION TITLE: Coverage for Individuals Participating in Approved Clinical Trials

CITATION: PHSA §2709

EFFECTIVE DATE: Plan years and, in the individual market, policy years beginning on or after Jan. 1, 2014

PROVISION: The provisions of the federal Affordable Care Act (ACA) set forth requirements that if a group health plan or health carrier provides coverage to a "qualified individual," then the plan or health carrier:

- May not deny the individual participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition;
- May not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; or
- May not discriminate against the individual on the basis of the individual's participation in such trial.

BACKGROUND: Regulations and associated FAQs issued by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury) set forth the requirement that if a group health plan or health insurance issuer in the group and individual health insurance market provides coverage to a qualified individual (as defined under PHSA §2709(b)), then such plan or issuer: 1) may not deny the qualified individual participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition; 2) may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and 3) may not discriminate against the individual on the basis of the individual's participation in the trial.

A qualified individual under PHSA §2709(b) is generally a participant or beneficiary who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition; and either: 1) the referring health care professional is a participating provider and has concluded that the individual's participation in such trial would be appropriate; or 2) the participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

This provision applies to all health carriers in the individual market and to small group employer plans. This provision applies to non-grandfathered group health plans.

FAQs: See the HHS website for federal guidance.

NOTES:

STANDARDS
COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS

Standard 1
A health carrier may not deny coverage or restrict coverage for qualified individuals, as defined in applicable statutes, rules and regulations, who participate in approved clinical trials.

Apply to: All group health products (non-grandfathered products) for plan years beginning on or after Jan. 1, 2014

All individual health products (non-grandfathered products) for policy years beginning on or after Jan. 1, 2014

Priority: Essential

Documents to be Reviewed

_____ Health carrier claim handling policies and procedures related to individuals participating in approved clinical trials

_____ Claim files and supporting documentation regarding coverage of individuals participating in approved clinical trials, including letters, notices, telephone scripts, etc.

_____ Complaint register/logs/files

_____ Health carrier complaint records concerning coverage denial or restriction of coverage of individuals participating in approved clinical trials (supporting documentation, including but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Claim files

_____ Health carrier prior authorization policies

_____ Internal appeals/grievances files

_____ Applicable external appeals related to individuals participating in approved clinical trials, external appeal resolution and associated documentation

_____ Health carrier form approvals (policy language, enrollment materials and advertising materials, as required under state statutes, rules and regulations)

_____ Health carrier marketing and sales policies and procedures' references to coverage of individuals participating in approved clinical trials

_____ Health carrier communication and educational materials related to coverage of individuals participating in approved clinical trials, provided to applicants, enrollees, policyholders, certificateholders and beneficiaries

_____ Training materials

_____ Producer records

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Individual Market Health Insurance Coverage Model Act (#36)
Small Group Market Health Insurance Coverage Model Act (#106)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding the prohibition of denial and restriction of coverage for qualified individuals participating in approved clinical trials in accordance with statute and regulatory guidance established by HHS, the DOL and the Treasury.

Review health carrier underwriting policies and procedures related to coverage of individuals participating in clinical trials to verify adequate and appropriate policies/procedures are in place to ensure the health carrier does not deny or impose restrictions on coverage for qualified individuals participating in approved clinical trials in compliance with statute and regulatory guidance established by HHS, the DOL and the Treasury.

Review health carrier claim files to verify the health carrier does not:

- Deny participation by a qualified individual in an approved clinical trial;
- Deny, limit or impose additional conditions on the coverage of routine patient costs for items or services furnished in connection with participation in a trial; or
- Discriminate against an individual on the basis of the individual's participation in an approved clinical trial.

Note: Examiners need to be aware that a network plan may require a qualified individual who wishes to participate in an approved clinical trial that is offered through a health care provider who is part of the network plan if the provider is participating in the trial and the provider accepts the individual as a participant in the trial.

This provision applies to any qualified individual who participates in an approved clinical trial that is conducted outside of the state in which the individual resides.

A health carrier is not required to offer individual market or small group market health insurance coverage through a network plan to provide benefits for routine patient costs if the services are provided outside of the plan's network unless the out-of-network benefits are otherwise provided under the coverage.

Review complaint register/logs and complaint files to identify complaints pertaining to coverage denial/restriction of coverage imposed upon individuals participating in approved clinical trials.

Review complaint records to verify that when a health carrier has inappropriately restricted or denied coverage for a qualified individual who participated in an approved clinical trial, the health carrier has taken appropriate corrective action/adjustments in a timely and accurate manner.

Ascertain if any health carrier error could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to an individual for whom coverage for participation in an approved clinical trial was inappropriately restricted or denied.

Review health carrier claim files to identify any coverage denials for claimants for whom coverage of participation in an approved clinical trial was inappropriately restricted or denied.

Review prior authorization policies to verify that insurers are not inappropriately denying or restricting coverage for qualified individuals participating in approved clinical trials.

Review health carrier internal appeals/grievance files to identify any coverage denials for individuals for whom coverage of participation in an approved clinical trial was inappropriately restricted or denied.

Review procedures should also require review of any external appeal requests and of the conclusions of external appeals addressing coverage of participation in approved clinical trials.

Review policy form files to ensure approval(s) from the applicable state and (if applicable) from the Marketplace.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about coverage for individuals participating in approved clinical trials.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about coverage for individuals participating in approved clinical trials.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and Treasury provisions and statute and regulatory guidance pertaining to coverage for individuals participating in approved clinical trials.

Review health carrier training materials to verify that information provided is complete and accurate with regard to coverage for individuals participating in approved clinical trials.

Determine if the health carrier monitors producer-generated coverage denials/restrictions of coverage pertaining to qualified individuals participating in approved clinical trials. Review any such producer records of coverage denials/restrictions of coverage for compliance with statute and regulatory guidance established by HHS, the DOL and the Treasury.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

PROVISION TITLE: Extension of Dependent Coverage to Age 26

CITATION: PHSA §2714

EFFECTIVE DATE: Plan years and, in the individual market, policy years beginning on or after Sept. 23, 2010

PROVISION: The provisions of the federal Affordable Care Act (ACA) established a requirement that a health carrier that makes available dependent coverage of children must make that coverage available for children until attainment of 26 years of age.

BACKGROUND: Regulations and associated FAQs, issued by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury) set forth the requirement that group health plans and health carriers offering dependent coverage must make that coverage available until a child reaches the age of 26. This is the case even if a young adult no longer lives with his or her parents, is not a dependent on a parent's tax return or is no longer a student. These provisions apply to both married and unmarried children; affected children's spouses and children do not qualify for this coverage extension.

This provision applies to all health carriers in the individual market and to small group employer plans. This provision applies to both grandfathered and non-grandfathered group health plans.

DENTAL & VISION PLANS: The extension of dependent coverage to age 26 provision applies to medical, behavioral and pharmacy benefits. The provision does not apply to employer-sponsored dental or vision benefits if they are in a separate dental or vision policy. If the dental or vision plan is not a separate plan, but part of the employer-sponsored medical plan, the health reform provisions apply to the entire plan, including the dental and vision coverage.

FAQs: See the HHS website for federal guidance.

NOTES:

STANDARDS
EXTENSION OF DEPENDENT COVERAGE TO AGE 26

Standard 1
A group health plan, or a health carrier offering group or individual health insurance coverage, that makes available dependent coverage of children shall make such coverage available for children until attainment of 26 years of age.

Apply to: All group health products (grandfathered and non-grandfathered products) for plan years beginning on or after Sept. 23, 2010

All individual health products (grandfathered and non-grandfathered products) for policy years beginning on or after Sept. 23, 2010

Priority: Essential

Documents to be Reviewed

_____ Health carrier underwriting policies and procedures related to extension of dependent coverage for individuals to age of 26

_____ Underwriting files and supporting documentation regarding extension of dependent coverage for individuals to age of 26, including letters, notices, telephone scripts, etc.

_____ Health carrier notices issued addressing opportunity to enroll in dependent coverage to age 26

_____ Complaint register/logs/files

_____ Health carrier complaint records concerning extension of dependent coverage for individuals to age of 26 (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Claim files

_____ Internal appeals/grievances

_____ Health carrier form approvals (policy language, enrollment materials and advertising materials, as required under state statutes, rules and regulations)

_____ Health carrier marketing and sales policies and procedures, references to extension of dependent coverage for individuals to age of 26

_____ Health carrier communication and educational materials related to extension of dependent coverage for individuals to age of 26, provided to applicants, enrollees, policyholders, certificateholders and beneficiaries

_____ Training materials

_____ Producer records

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Individual Market Health Insurance Coverage Model Act (#36)
Small Group Market Health Insurance Coverage Model Act (#106)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding extension of dependent coverage for individuals to age 26 in accordance with final regulations established by HHS, the DOL and the Treasury.

Review health carrier underwriting policies and procedures related to extension of dependent coverage for individuals to age 26 to verify adequate and appropriate policies/procedures are in place to ensure the health carrier extends dependent coverage for individuals to age 26 in compliance with final regulations established by HHS, the DOL and the Treasury.

Review health carrier underwriting policies and procedures regarding extension of dependent coverage for individuals to age 26 to verify the health carrier does not define dependent, for the purposes of eligibility for dependent coverage of children, other than in the terms of a relationship between a child and the plan participant, and in the individual market, a primary subscriber.

Review health carrier underwriting and claim files regarding extension of dependent coverage for individuals to age 26 to verify the health carrier does not deny or restrict coverage for a dependent child, who has not attained 26 years of age, based upon the following factors:

- The presence or absence of the child's financial dependency upon the plan participant, primary subscriber or any other person;
- Residency with the plan participant and, in the individual market, the primary subscriber, or with any other person;
- Marital status;
- Student status;
- Employment; or
- Any combination thereof.

Review health carrier underwriting files to verify that the terms of coverage in a health benefit plan offered by a health carrier providing dependent coverage of children do not vary based upon age, except for dependent children who are 26 years of age or older.

Note: Examiners need to be aware that:

- A health carrier is not required to make coverage available for a child of a child receiving dependent coverage, unless a grandparent becomes the legal guardian or adoptive parent of that grandchild; and
- HHS, DOL and Treasury preemption standards permit states to establish more stringent consumer protection requirements, such as requiring health carriers who provide dependent coverage to extend dependent coverage to unmarried disabled unmarried dependent children who are over the age of 26. Applicable state statutes, rules and regulations regarding extension of coverage, including, but not limited to, extension of coverage to disabled unmarried dependent children who are over the age of 26 may apply.

Individuals Whose Coverage Ended by Reason of Cessation of Dependent Status

Review health carrier underwriting files and claim files to verify that the health carrier does not deny or restrict coverage for a dependent child:

- Whose coverage ended;
- Who was denied coverage; or
- Who was not eligible for group health insurance coverage or individual health insurance coverage under a health benefit plan because, under the terms of coverage, the availability of dependent coverage for a child ended before the child attained of 26 years of age.

Review health carrier underwriting files and claim files to verify the health carrier does not deny or restrict coverage for any individual who became eligible, or were required to become eligible, for coverage on the first day of the first plan year and, in the individual market, the first day of the first policy year, beginning on or after Sept. 23, 2010, in accordance with final regulations established by HHS, the DOL and the Treasury.

Review health carrier underwriting files to verify the health carrier provides a dependent child with at least a 30-day written notice of the opportunity to enroll in a health benefit plan. Verify that the 30-day written notice is provided in the following instances:

- To any child whose coverage ended, or who was denied coverage, or was not eligible for group health insurance coverage or individual health insurance coverage under a health benefit plan, because, under the terms of coverage, the availability of dependent coverage of a child ended before the child attained 26 years of age; and
- To any child who becomes eligible, or is required to become eligible, for coverage on the first day of the first plan year, and, in the individual market, the first day of the first policy year, beginning on or after Sept. 23, 2010.

Review the health carrier's underwriting files to verify the health carrier provides a dependent child with a written notice of opportunity to enroll, beginning, in the group health plan market, not later than the first day of the first plan year and, in the individual market, the first day of the first policy year, beginning on or after Sept. 23, 2010.

Review the health carrier's written notices to verify that each written notice of opportunity to enroll includes a statement that dependent children whose coverage ended, who were denied coverage or who were not eligible for coverage, because the availability of dependent coverage of children ended, before the dependent child attained 26 years of age, are eligible to enroll in health coverage.

Note: Examiners need to be aware that:

- The health carrier written notice of opportunity to enroll may be provided to an employee on behalf of the employee's child, and in the individual market, to the primary subscriber on behalf of the primary subscriber's child; and
- With regard to group health insurance coverage:
  - The written notice of opportunity to enroll may be included with other enrollment materials that the health carrier distributes to employees, provided the statement is prominent; and
  - If a written notice satisfying the requirements of HHS, DOL and Treasury final regulations is provided to an employee whose child is entitled to an enrollment opportunity under HHS, DOL and Treasury provisions, the obligation to provide the notice of enrollment opportunity with respect to that child is satisfied for both the plan and health carrier.

Review the health carrier's written notices of opportunity to enroll to verify notices are provided beginning not later than the first day of the first plan year and, in the individual market, the first day of the first policy year, beginning on or after Sept. 23, 2010.

Review the health carrier's underwriting files to verify that for any dependent child who enrolls under the provisions of HHS, the DOL and the Treasury, the coverage for that dependent child takes effect no later than the first day of the first plan year and, in the individual market, the first day of the first policy year, beginning on or after Sept. 23, 2010.

Individuals Whose Coverage Ended by Reason of Cessation of Dependent Status—Group Health Plan Special Enrollees

Review the health carrier's underwriting files to verify that a dependent child enrolling in group health insurance coverage is treated as a special enrollee, as provided under final regulations established by HHS, the DOL and the Treasury.

Review the health carrier's underwriting files to verify that a dependent child, and, if the child would not be a participant once enrolled, the participant or primary subscriber through whom the child is otherwise eligible for coverage under the plan, is offered all the benefit packages available to similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

Note: Examiners need to be aware that any difference in benefits or cost sharing requirements offered by the health carrier to plan participants or, in the individual market, primary subscribers constitutes a different benefits package.

Review the health carrier's underwriting files to verify that the health carrier does not require a child to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

Grandfathered Group Health Plans—Applicability

Note: Examiners need to be aware that:

- For plan years beginning before Jan. 1, 2014, a group health plan providing group health insurance coverage that is a grandfathered plan and makes available dependent coverage of children may exclude an adult child who has not attained 26 years of age from coverage only if the adult child is eligible to enroll in an eligible employer-sponsored group health plan, as defined in Section §5000A(f)(2) of the Internal Revenue Code, other than the group employer-sponsored health plan of a parent; and

- For plan years beginning on or after Jan. 1, 2014, a group health plan providing group health insurance coverage that is a grandfathered plan shall comply with the requirements of HHS, DOL and Treasury final regulations regarding extension of dependent coverage for individuals to age of 26. Applicable state statutes, rules and regulations including, but not limited to, extension of coverage to disabled unmarried dependent children who are over the age of 26 may apply. For plan years beginning on or after Jan. 1, 2014, a group health plan may no longer exclude an adult child who is eligible to enroll in an eligible employer-sponsored group health plan.

General Review Procedures and Criteria

Review complaint register/logs and complaint files to identify complaints pertaining to extension of dependent coverage to age 26.

Review complaint records to verify that if the health carrier has inappropriately denied or restricted coverage for a dependent child, the health carrier has taken appropriate corrective action/adjustments regarding the reinstatement of coverage in a timely and accurate manner.

Ascertain if any health carrier error could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to a dependent child whose coverage ended, or who was denied coverage, or was not eligible for group health insurance coverage or individual insurance coverage under a health benefit plan because, under the terms of coverage, the availability of dependent coverage of a child ended before the child attained 26 years of age.

Review health carrier claim files to identify any inappropriate coverage denials for claimants whose coverage ended by reason of cessation of dependent status.

Review health carrier internal appeals/grievance files to identify any inappropriate coverage denials for claimants whose coverage ended by reason of cessation of dependent status.

Review policy form files to ensure approval(s) from the applicable state and (if applicable) from the Marketplace.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about extension of dependent coverage for individuals to age 26.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about extension of dependent coverage for individuals to age of 26.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and Treasury provisions and final regulations pertaining to extension of dependent coverage for individuals to age 26.

Review health carrier training materials to verify that information provided is complete and accurate with regard to extension of dependent coverage for individuals to age 26.

Determine if the health carrier monitors producer-generated coverage denials/restrictions of coverage for dependent children. Review producer records of coverage denials/restrictions of coverage for dependent children for compliance with final regulations established by HHS, the DOL and the Treasury.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

PROVISION TITLE: Direct Access to Providers

CITATION: PHSA §2719A

EFFECTIVE DATE: Plan years, and in the individual market, policy years beginning on or after Sept. 23, 2010

PROVISION: The provisions of the health reform act require that non-grandfathered small and large group employer plans and individual plans, which require or provide for designation by a covered person of a participating primary health care professional, shall permit covered individuals to designate any participating primary health care professional who is available to accept the covered person.

The provisions of the health reform act also require that a covered individual may, on behalf of a covered child, designate any participating pediatric physician as the child's primary care health care professional, if the health care professional is available to accept the child.

The provisions of the health reform act prohibit a health carrier that requires the designation of a primary care health care professional from imposing prior authorization or referral requirements for access to an obstetrical or gynecological health care professional.

The health carrier shall provide a notice to a covered person that satisfies the requirements of U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury final regulations regarding a covered individual's right to designate a participating primary health care professional, including the designation of pediatric and obstetrical and gynecological specialists and the prohibition of a health carrier from imposing prior authorization or referral for a female covered person seeking access to an obstetrical or gynecological health care professional.

BACKGROUND: Regulations and associated FAQs, issued by HHS, the DOL and Treasury set forth the requirement that for group health benefit plans, individual health plans or health carriers that require a participant to choose a participating primary care provider, the health benefit plan or health carrier must allow the participant to choose any participating primary care provider who is available to accept the participant.

With respect to a child, a health benefit plan or health carrier must allow the designation of a pediatrician as a child's primary care provider if the provider participates in the health carrier's health benefit plan network.

A health benefit plan or health carrier that requires the designation of a primary health care professional may not impose prior authorization or referral requirements for access to obstetrical and gynecological health care professionals for a female plan participant who seeks access to an obstetrical or gynecological health care professional.

A health benefit plan or health carrier must provide a notice informing the participants of the terms of the plan regarding designation of a primary care provider.

This provision applies to all health carriers in the individual market and to small and large group employer plans. This provision applies to non-grandfathered individual market, small group and large group market health plans.

FAQs: See the HHS website for federal guidance.

NOTES:

STANDARDS
DIRECT ACCESS TO PROVIDERS

Standard 1
A health carrier providing individual, small group and large group market health coverage under a health benefit plan that requires or provides for designation of a participating primary health care professional: 1) shall permit a covered person to choose any participating primary care health care professional; 2) shall allow a covered individual, on behalf of a child, to designate any participating pediatric physician as the child's primary care health care professional; and 3) for health carriers providing coverage for obstetrical or gynecological care, shall be precluded from imposing upon an insured prior authorization or referral requirements with respect to access to participating health care professionals who specialize in obstetrics or gynecology.

Apply to: All group health products, (non-grandfathered products) for plan years beginning on or after Sept. 23, 2010

All individual health products, (non-grandfathered products) for policy years beginning on or after Sept. 23, 2010

Priority: Essential

Documents to be Reviewed

_____ Health carrier policyholder service, complaint handling, claim handling, and utilization management policies and procedures related to designation of participating primary health care professionals, including the designation of pediatric and obstetrical and gynecological specialists and prior authorization or referral regarding access to an in-network obstetrical and gynecological health care professional

_____ Policyholder files and supporting documentation, including a copy of the issued certificate of coverage or policy, letters, notices, telephone scripts, etc., regarding designation of participating primary health care professionals, pediatric, obstetrical and gynecological specialists, and prior authorization or referral regarding access to an in-network obstetrical and gynecological health care professional

_____ Complaint register/logs/files

_____ Health carrier complaint records concerning designation of participating primary health care professionals, pediatric, obstetrical and gynecological specialists, and prior authorization or referral regarding access to an in-network obstetrical and gynecological health care professional (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Internal appeals/grievance files and adverse utilization review determinations concerning designation of participating primary health care professionals, pediatric, obstetrical and gynecological specialists, and prior authorization or referral regarding access to an in-network obstetrical and gynecological health care professional

_____ Applicable external appeals register/logs/files, external appeal resolution and associated documentation related to designation of participating primary health care professionals, pediatric, obstetrical and gynecological specialists, and prior authorization or referral regarding access to an in-network obstetrical and gynecological health care professional

_____ Health carrier form approvals (policy language, enrollment materials and advertising materials, as required under state statutes, rules and regulations)

_____ Health carrier marketing and sales policies and procedures' references to designation of participating primary health care professionals, pediatric, obstetrical and gynecological specialists, and prior authorization or referral regarding access to an in-network obstetrical and gynecological health care professional

_____ Health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries related to designation of participating primary health care professionals, pediatric, obstetrical and gynecological, and prior authorization or referral regarding access to an in-network obstetrical and gynecological health care professional

_____ Training materials

_____ Producer records

_____ Applicable state and federal statutes, rules and regulations, and guidances

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Individual Market Health Insurance Coverage Model Act (#36)
Small Group Market Health Insurance Coverage Model Act (#106)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Student health coverage is subject to the direct access requirements of Section 2719A. However, federal regulations permit a student health insurance plan to designate providers at a student health center as its in-network providers, thus allowing students to choose from among the student health center's providers for purposes of satisfying Section 2719A, provided that the center has sufficient provider capacity and range of services available to support this designation and provides students with a choice of providers while away from campus. Examiners are encouraged to review CMS–9981–F with regard to federal regulations pertaining to student health insurance coverage.

Verify that a health carrier, which requires the designation by an insured of a participating primary care health care professional, has established and implemented policies and procedures regarding: 1) an insured's right to designate any participating primary health care professional who is willing to accept the covered person; 2) an insured's right to designate, for a covered child, any participating pediatric physician as the child's primary care health care professional; and 3) for health carriers providing coverage for obstetrical or gynecological care, the prohibition by a health carrier of imposing upon an insured prior authorization or referral requirements with respect to the insured's access to participating health care professionals who specialize in obstetrics or gynecology, in accordance with final regulations established by HHS, the DOL and the Treasury.

Review health carrier policyholder service, complaint handling, claim handling and utilization management policies and procedures related to the designation of a primary health care professional to verify adequate and appropriate policies/procedures are in place to ensure that a health carrier permits an insured to designate any participating primary health care professional who is available to accept the covered person, as required under final regulations established by HHS, the DOL and the Treasury.

Review health carrier policyholder service, complaint handling, and claim handling policies and procedures related to the designation of a primary health care professional to verify adequate and appropriate policies/procedures are in place to ensure that a health carrier permits an insured, on behalf of a child, to designate any participating physician who specializes in pediatrics as the child's primary care health care professional and who is available to accept the child.

Note: Examiners need to be aware that this provision shall not be construed to waive any exclusions of coverage under the terms and conditions of the health benefit plan with respect to coverage of pediatric care.

If a health carrier provides individual market, small group or large group market health insurance coverage under a health benefit plan for obstetrical or gynecological care and requires the designation by a covered person of a participating primary care health care professional, review health carrier policyholder service, complaint handling and claim handling policies and procedures related to the designation of a primary health care professional to verify that the health carrier:

- Does not require any insured's, including a primary care health care professional's, authorization or referral in the case of a female covered person who seeks access to a participating health care professional who specializes in obstetrics or gynecology; and
- Treats the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care health care professional.

Note: Examiners need to be aware that the health carrier may require the health care professional to agree to otherwise adhere to the health carrier's policies and procedures, including procedures for obtaining prior authorization and provider services in accordance with a treatment plan, if any, approved by the health carrier. A health care professional who specializes in obstetrics or gynecology means any individual, including an individual other than a physician, who is authorized under state law to provide obstetrical or gynecological care. This provision shall not be construed to waive any exclusions of coverage under the terms and conditions of the health benefit plan with respect to coverage of obstetrical or gynecological care, or preclude the health carrier involved from requiring that the participating health care professional providing obstetrical or gynecological care notify the primary care health care professional or the health carrier of treatment decisions.

Review complaint register/logs and complaint files to identify complaints pertaining to coverage denial/restriction relating to designation of participating primary health care professional and prior authorization or referral requirements regarding access to an in-network obstetrical and gynecological health care professional.

Review complaint records to verify that when an individual has been the subject of a restriction of health benefits coverage or has been denied health benefits coverage due to the health carrier having restricted the insured's ability to designate a participating primary health care professional, pediatric or obstetrical/gynecological specialist, or the health carrier having imposed prior authorization or referral requirements upon the insured regarding access to an in-network obstetrical and gynecological health care professional, the health carrier has taken appropriate corrective action/adjustments in a timely and accurate manner.

Ascertain if any health carrier error could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to an individual for whom coverage of health benefits were inappropriately restricted or denied due to the health carrier having restricted the insured's ability to designate a participating primary health care professional, pediatric or obstetrical/gynecological specialist, or due to the health carrier having imposed prior authorization or referral requirements upon the insured regarding access to an in-network obstetrical and gynecological health care professional.

Review health carrier claim files to identify any coverage denials for claimants for whom coverage was improperly restricted or denied, due to the health carrier having restricted the insured's ability to designate a participating primary health care professional, pediatric or obstetrical/gynecological specialist, or due to the health carrier having imposed prior authorization or referral requirements upon the insured regarding access to an in-network obstetrical and gynecological health care professional.

Review health carrier internal appeals/grievance register/logs/files, as well as records of appeals of adverse utilization review determinations, to identify any individuals for whom coverage of was improperly restricted or denied due to the health carrier restricting the insured's ability to designate a participating primary health care professional, pediatric or obstetrical/gynecological specialist, or the health carrier imposing prior authorization or referral requirements regarding access to an in-network obstetrical and gynecological health care professional.

Review of procedures should also require review of any external appeal requests and of the conclusions of external appeals addressing improper denial/restriction of coverage due to the health carrier restricting the insured's ability to designate a participating primary health care professional, pediatric or obstetrical/gynecological specialist, or the health carrier imposing prior authorization or referral requirements regarding access to an in-network obstetrical and gynecological health care professional.

Review policy form files to verify approval(s) from the applicable state and (if applicable) from the Marketplace and compare against the issued certificate or policy provided in the sample.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about the insured's right to designate a participating primary health care professional, pediatric, or obstetrical/gynecological specialist, and the prohibition of the health carrier from imposing prior authorization or referral requirements regarding access to an in-network obstetrical and gynecological health care professional.

Verify that health carrier communication and education materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about the insured's right to designate a participating primary health care professional, pediatric or obstetrical/gynecological specialist, and the prohibition of the health carrier from imposing prior authorization or referral requirements regarding access to an in-network obstetrical and gynecological health care professional.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and Treasury provisions and final regulations pertaining to notices required to be provided to the insured regarding the insured's right to designate a participating primary health care professional, pediatric or obstetrical/gynecological specialist, and the prohibition of the health carrier from imposing prior authorization or referral requirements regarding access to an in-network obstetrical and gynecological health care professional.

Review health carrier training materials to verify that information provided is complete and accurate with regard to the insured's right to designate a participating primary health care professional, pediatric or obstetrical/gynecological specialist, and the prohibition of the health carrier from imposing prior authorization or referral requirements regarding access to an in-network obstetrical and gynecological health care professional.

Note: With regard to conflicts of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

STANDARDS
DIRECT ACCESS TO PROVIDERS

Standard 2
A health carrier shall provide a notice to covered persons, addressing terms and conditions of the health benefit plan relating to: 1) the insured's right to designate a participating primary health care professional, pediatric or obstetrical/gynecological specialist; and 2) for health carriers providing coverage for obstetrical or gynecological care, which require the designation of a primary care health professional, the prohibition of the health carrier from imposing prior authorization or referral requirements regarding access to an in-network obstetrical and gynecological health care professional, in compliance with final regulations issued by HHS, the DOL and the Treasury.

Apply to: All group health products, (non-grandfathered products) for plan years beginning on or after Sept. 23, 2010

All individual health products, (non-grandfathered products) for policy years beginning on or after Sept. 23, 2010

Priority: Essential

Documents to be Reviewed

_____ Health carrier policyholder service, complaint handling, claim handling, and new business-related policies and procedures related to health carrier-issued notices regarding the insured's right to designate a participating primary health care professional, pediatric or obstetrical/gynecological specialist, and prior authorization or referral regarding access to an in-network obstetrical and gynecological health care professional

_____ Consumer notice-related requests and health carrier delivery logs, or other related information or protocols

_____ Samples of notices, including any web-based forms

_____ Health carrier complaint handling policies and procedures related to incorrectly issued and/or missing notices

_____ Health carrier complaint records regarding notices (supporting documentation including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Health carrier marketing and sales policies and procedures' references to notices

_____ Training materials

_____ Producer records

_____ Applicable state and federal statutes, rules and regulations, and guidances

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Individual Market Health Insurance Coverage Model Act (#36)
Small Group Market Health Insurance Coverage Model Act (#106)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding the issuance and delivery of notices to insureds regarding: 1) an insured's right to designate a participating primary health care professional, pediatric or obstetrical/gynecological specialist; and 2) for health carriers providing coverage for obstetrical or gynecological care, the prohibition of the health carrier from imposing prior authorization or referral requirements regarding access to an in-network obstetrical and gynecological health care professional, in accordance with final regulations established by HHS, the DOL and the Treasury.

Review health carrier policyholder service, complaint handling, claim handling, and new business-related policies and procedures to verify that the health carrier provides notice to covered persons of the terms and conditions of the health benefit plan and a covered person's rights with respect to the following: 1) the designation of a participating health care professional, pediatric or obstetrical/gynecological specialist; and 2) for health carriers providing coverage for obstetrical or gynecological care, the requirement, as set forth under final regulations established by HHS, the DOL and the Treasury, that a health carrier shall not impose prior authorization or referral requirements regarding access to an in-network obstetrical and gynecological health care professional.

For group health insurance coverage, verify that the health carrier provides notices whenever the health carrier provides a participant with a summary plan description or other similar description of benefits under a health benefit plan, in accordance with final regulations established by HHS, the DOL and the Treasury.

For individual health insurance, verify that the health carrier provides notices whenever the health carrier provides a primary subscriber with a policy, certificate or contract of health insurance in accordance with final regulations established by HHS, the DOL and the Treasury.

Note: Examiners need to be aware that federal regulations (45 CFR §147.138(a)(4)(iii) provide templates of notices for health carriers to use to provide insureds with notices of rights with regard to direct access to providers.

Review notices issued: 1) to verify that when a health carrier has not made available or has improperly issued such notice, the health carrier has taken appropriate corrective action/adjustments in a timely and accurate manner; and 2) to ascertain if any health carrier error could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete, accurate and current information about the issuance and delivery of such notices.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and Treasury provisions and regulations pertaining to issuance and delivery of such notices.

Review the health carrier's training materials to verify that the information provided is complete and accurate with regard to the issuance and delivery of such notices.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

PROVISION TITLE: Essential Health Benefits

CITATION: PHSA §2707 & §1302

EFFECTIVE DATE: Plan years, and in the individual market, policy years beginning on or after Jan. 1, 2014

PROVISION: The provisions of the health reform act require that non-grandfathered small group employer plans and individual plans provide a core package of health care services, known as essential health benefits (EHB).

BACKGROUND: Regulations and associated FAQs, issued by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury set forth the requirement that Qualified Health Plans (QHPs) in the Marketplace, as well as individual and small group employer plans offered outside of the Marketplace, provide EHB, to include the following general categories of services:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services, and chronic disease management; and
- Pediatric services, including oral and vision care.

The provisions of the health reform act require that states define EHB for policies issued in a state. To meet this requirement, each jurisdiction selected an existing health plan as a "benchmark" to establish services and items included in that jurisdiction's EHB package.

Nothing in the health reform act prohibits a QHP from providing benefits in excess of the essential benefits package.

This provision applies to all health carriers in the individual market and to small group employer plans. This provision applies to non-grandfathered individual market and small group health plans.

FAQs: See the HHS website for federal guidance.

NOTES:

STANDARDS
ESSENTIAL HEALTH BENEFITS

Standard 1
A health carrier offering health benefit plans providing individual market health insurance coverage and small group market health insurance coverage plans shall provide coverage for a core package of health care services, known as "essential health benefits" (EHB).

Apply to: All group health products, (non-grandfathered products) for plan years beginning on or after Jan. 1, 2014

All individual health products, (non-grandfathered products) for policy years beginning on or after Jan. 1, 2014

Priority: Essential

Documents to be Reviewed

_____ Health carrier underwriting, complaint handling, and claim handling policies and procedures related to EHB

_____ Underwriting files and supporting documentation regarding EHB, including letters, notices, telephone scripts, etc.

_____ Complaint register/logs/files

_____ Health carrier complaint records concerning EHB (supporting documentation including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Internal appeals/grievance files

_____ Applicable external appeals register/logs/files related to EHB, external appeal resolution and associated documentation

_____ Health carrier form approvals (policy language, enrollment materials and advertising materials, as required under state statutes, rules and regulations)

_____ Health carrier marketing and sales policies and procedures' references to EHB

_____ Health carrier communication and educational materials related to EHB, provided to applicants, enrollees, policyholders, certificateholders and beneficiaries

_____ Training materials

_____ Producer records

_____ Applicable state and federal statutes, rules and regulations, and guidances

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Individual Market Health Insurance Coverage Model Act (#36)
Small Group Market Health Insurance Coverage Model Act (#106)
Individual Market Health Insurance Coverage Model Regulation (#26)
Small Group Market Health Insurance Coverage Model Regulation (#126)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding the mandate of coverage for essential health benefits in accordance with final regulations established by HHS, the DOL and the Treasury.

Review health carrier underwriting, complaint handling, and claim handling policies and procedures related to EHB to verify adequate and appropriate policies/procedures are in place to ensure a health carrier that offers health benefit plans providing individual market health insurance coverage or small group market health insurance coverage includes an EHB package required under final regulations established by HHS, the DOL and the Treasury.

Review the health carrier's underwriting, complaint and claim files to verify that the health carrier does not deny or restrict EHB coverage.

Examiners need to be aware that EHB means that a health benefit plan provides health benefits that:

- Are substantially equal to the EHB-benchmark plan including:
  - Covered benefits;
  - Limitations on coverage, including coverage of benefit amount, duration and scope; and
  - Prescription drug benefits that meet the requirements of the final regulations established by HHS, the DOL and the Treasury;
- With the exception of the EHB category of coverage for pediatric services, do not exclude an enrollee from coverage in an EHB category;
- With respect to the mental health and substance use disorder services, including behavioral health treatment services, comply with the requirements of the final regulations established by HHS, the DOL and the Treasury related to parity in mental health and substance use disorder benefits;
- Include preventive health services, as defined in applicable statutes, rules and regulations;
- If the EHB benchmark plan does not include coverage for habilitative services, include habilitative services in a manner that meets one of the following:
  - Provides parity by covering habilitative services benefits that are similar in scope, amount and duration to benefits covered for rehabilitative services;
  - Is determined by the health carrier and reported to HHS; or
  - As determined by the state.

Examiners need to be aware that a health carrier offering a health benefit plan in the individual or small group market providing EHB may substitute benefits if the health carrier meets the following conditions:

- The health carrier substitutes a benefit that:
  - Is actuarially equivalent to the benefit that is being replaced;
  - Is made only within the same EHB category; and
  - Is not a prescription drug benefit; and
- The health carrier also submits evidence of actuarial equivalence that is:
  - Certified by a member of the American Academy of Actuaries;
  - Based on an analysis performed in accordance with generally accepted actuarial principles and methodologies;
  - Based on a standardized plan population; and
  - Determined regardless of cost sharing.

A health benefit plan does not fail to provide essential health benefits solely because it does not offer the services described in 45 CFR §156.280(d).

A health carrier offering a health benefit plan in the individual or small group market providing EHB may not include routine non-pediatric dental services, routine non-pediatric eye exam services, long-term custodial nursing home care benefits or nonmedically necessary orthodontia as EHB.

Review the health carrier's claim handling procedures to verify that a health carrier offering health benefit plans in the individual market or small group market providing EHB does not impose annual and lifetime dollar limits on EHB, in accordance with final regulations established by HHS, the DOL and the Treasury.

Review the health carrier's health benefit plans to verify that the coverage, in accordance with final regulations established by HHS, the DOL and the Treasury:

- Provides for EHB;
- Limits annual cost-sharing charges under such coverage to specified limits; and
- Provides bronze, silver, gold or platinum level of coverage as follows:
  - A health benefit plan in the bronze level has an actuarial value of 60%;
  - A health benefit plan in the silver level has an actuarial value of 70%;
  - A health benefit plan in the gold level has an actuarial value of 80%;
  - A health benefit plan in the platinum level has an actuarial value of 90%; and
  - If a plan does not provide coverage at the bronze, silver, gold or platinum level, that it meets the standards established for catastrophic plans.

Examiners need to be aware that a health carrier may convert an annual dollar limit that is imposed in the state's EHB benchmark plan to an actuarial equivalent visit limit.

Review the health carrier's health benefit plans to verify that EHB coverage includes the following general categories of services:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services, and chronic disease management; and
- Pediatric services, including oral and vision care.

EHB vary by state, based on the EHB benchmark plan selection process described in 45 CFR §156.100 and 156.110. The HHS has provided additional guidance on how states will supplement a benchmark plan with coverage for habilitative services and pediatric dental and vision services, as these types of services are not traditionally offered in health plans today. The process for determining EHB may change in 2016, as the HHS plans to revisit the benchmark approach at that time.

A health carrier offering a health benefit plan providing individual market health insurance coverage or small group market health insurance coverage does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life or other health conditions. The design of benefits includes covered benefits, cost-sharing charges, exclusions, medical necessity definitions, drug formularies, visit limits, benefit substitutions and utilization management. Therefore, review the health carrier's health benefit plans to ensure these benefit design elements are consistent with reasonable medical management techniques and are not discriminatory. In addition, review the health carrier's underwriting, complaint and claim files to verify the heath carrier does not discriminate against an individual with regard to the aforementioned bases.

Review health carrier underwriting, complaint and claim files to verify the health carrier, in providing EHB, or in coverage denials/restrictions of coverage of EHB, does not discriminate against an individual on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.

With regard to coverage of emergency services health benefits, review health carrier's underwriting, complaint and claim files to verify that coverage for emergency services is provided as follows:

- Without imposing any requirement under the health benefit plan for prior authorization of services or any limitation on coverage where the provider of services is out of network that is more restrictive than the requirements or limitations that apply to emergency services received in network; and
- If such services are provided out of network, cost-sharing must be limited as provided in applicable federal and state statutes, rules and regulations.

With regard to mental health and substance use disorder health benefits, review the health carrier's underwriting, complaint and claim files to ensure that coverage for mental health and substance use disorder services, including behavioral health treatment, is provided as follows:

- The provisions of 45 CFR §146.136 relating to parity in mental health and substance use disorder benefits apply to a health carrier offering a health benefit plan providing individual market health insurance coverage and small group market health insurance coverage. The provisions of 45 CFR §146.136 also apply to the same extent to health insurance coverage offered in connection with a group health insurance plan in the large group market, as defined in 45 CFR §146.103; and
- The provisions of 45 CFR §146.136 relating to parity in mental health and substance use disorder benefits apply to non-grandfathered health plan coverage and grandfathered health plan coverage. Per 45 CFR §156.115(a)(3), for the mental health and substance use disorder benefit, EHB plans must comply with parity standards set forth in the federal Mental Health Parity and Addiction Equity Act of 2008.

Note: Examiners need to be aware that Section 1304 of the federal act gives states the option, prior to Jan. 1, 2016, to define a "small employer" as an employer that employed an average of at least one, but not more than 50 employees on business days during the preceding calendar year and that employs at least one employee on the first day of the plan year. On or after Jan. 1, 2016, a "small employer" must be defined as an employer that employed an average of at least one but not more than 100 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. As such, the small employer exemption provided in PPACA §2726 and implementing regulations will continue to apply to employers with 51 or more employees in 2016, when the upper limit of the small employer size increases in accordance with Section §1304 of the federal act. For more information, examiners can refer to page 68248 of the final rules published in the Federal Register (78 FR 68240), Nov. 13, 2013.

With regard to prescription drug EHB, review the health carrier's underwriting, complaint and claim files to verify that the health carrier's health benefit plan:

- Except as provided in the asterisked paragraph below, covers at least the greater of:
  - One drug in every United States Pharmacopeia (USP) category and class; or
  - The same number of prescription drugs in each category and class as the EHB-benchmark plan; and
- Submits its drug list to the state.

Note: A health benefit plan does not fail to provide EHB prescription drug benefits solely because it does not offer drugs approved by the U.S. Food and Drug Administration as a service described in 45 CFR §156.280(d).

A health benefit plan providing EHB must have procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not covered by the health benefit plan:

- The procedures must include a process for an enrollee, the enrollee's designee, or the enrollee's prescribing physician or other prescriber to request an expedited review based on exigent circumstances;
- Exigent circumstances exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug;
- A health benefit plan must make its coverage determination on an expedited review request based on exigent circumstances and notify the enrollee or the enrollee's designee and the prescribing physician or other prescriber, as appropriate, of its coverage determination no later than 24 hours after it receives the request; and
- A health benefit plan that grants an exception based on exigent circumstances must provide coverage of the non-formulary drug for the duration of the exigency.

Examiners need to be aware that the provisions regarding prescriptions above reference health benefit plans having procedures, including an expedited review process as part of those procedures, in place to allow enrollees to request and gain access to clinically appropriate drugs not covered by the health benefit plan. In considering what procedures, if any, states may want to require health carriers to have in place for their health benefit plans to carry out the provisions of Subsection C, states may want to review procedures in the NAIC models concerning internal and external review. In addition, states may want to review the provisions of the *Health Carrier Prescription Drug Benefit Management Model Act* (#22), particularly Section 7—Medical Exceptions Approval Process Requirements and Procedures.

Review complaint register/logs and complaint files to identify complaints pertaining to coverage denial/restriction of coverage of EHB.

Review complaint records to verify that when an individual has been the subject of a restriction of health benefits coverage or denied EHB coverage, the health carrier has taken appropriate corrective action/adjustments in a timely and accurate manner.

Ascertain if any health carrier error could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to an individual for whom coverage of EHB were inappropriately restricted or denied.

Review health carrier claim files to identify any coverage denials for claimants for whom coverage for EHB was improperly restricted or denied.

Review health carrier internal appeals/grievance register/logs/files to identify any individuals for whom coverage of EHB was improperly restricted or denied.

Review procedures should also require review of any external appeal requests and of the conclusions of external appeals addressing improper denial/restriction of coverage for EHB.

Review policy form files to ensure approval(s) from the applicable state and (if applicable) from the Marketplace.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about coverage of EHB.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about coverage of EHB.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and Treasury provisions and final regulations pertaining to coverage of EHB.

Review health carrier training materials to verify that information provided is complete and accurate with regard to coverage of EHB.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

PROVISION TITLE: Prohibition on Excessive Waiting Periods

CITATION: PHSA §2708

EFFECTIVE DATE: Plan years beginning on or after Jan. 1, 2014

PROVISION: A group health plan and a health carrier offering group health insurance coverage shall not apply to any waiting period (as defined in PHSA §2704(b)(4)) that exceeds 90 days.

BACKGROUND: Regulations and associated FAQs, issued by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury set forth the requirement that a group health plan or health insurance issuer offering group health insurance coverage shall not apply to any waiting period (as defined in PHSA §2704(b)(4)) that exceeds 90 days.

PHSA §2704(b)(4), ERISA Section 701(b)(4) and 26 U.S. Code Section 9801(b)(4) define a waiting period to be the period that must pass with respect to an individual before the individual is eligible to be covered for benefits under the terms of the plan.

The provisions in PHSA §2708 prevent an otherwise eligible individual from being required to wait more than 90 days before coverage becomes effective.

The final regulations implementing PHSA §2708 set forth rules governing the relationship between a plan's eligibility criteria and the 90-day waiting period limitation. Specifically, the final regulations provide that being otherwise eligible to enroll in a plan means having met the plan's substantive eligibility conditions (for example, being in an eligible job classification, achieving job-related licensure requirements specified in the plan's terms, or satisfying a reasonable and bona fide employment-based orientation period). Under the final regulations, after an individual is determined to be otherwise eligible for coverage under the terms of the plan, any waiting period may not extend beyond 90 days, and all calendar days are counted beginning on the enrollment date, including weekends and holidays.

HHS guidance states that plans that must provide the essential health benefits (EHB) may not impose benefit-specific waiting periods except for reasonable waiting periods for the coverage of pediatric orthodontia.

This provision applies to all health carriers offering group health insurance plans. This provision applies to both grandfathered and non-grandfathered group health plans.

FAQs: See the HHS website for federal guidance.

NOTES:

STANDARDS
PROHIBITION ON EXCESSIVE WAITING PERIODS

Standard 1
A health carrier may not impose excessive waiting periods, as defined in applicable statutes, rules and regulations, to individuals determined by the health carrier to be otherwise eligible for coverage under the terms of the plan.

Apply to: All group health products, (grandfathered and non-grandfathered products) for plan years beginning on or after Jan. 1, 2014

Priority: Essential

Documents to be Reviewed

_____ Health carrier underwriting policies and procedures related to waiting periods

_____ Underwriting files and supporting documentation regarding waiting periods, including letters, notices, telephone scripts, etc.

_____ Complaint register/logs/files

_____ Health carrier complaint records concerning waiting periods (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Internal and external appeals register/logs/files

_____ Health carrier form approvals (policy language, enrollment materials and advertising materials, as required under state statutes, rules and regulations)

_____ Health carrier marketing and sales policies and procedures' reference to waiting periods

_____ Health carrier communication and educational materials related to waiting periods, provided to applicants, enrollees, policyholders, certificateholders and beneficiaries

_____ Training materials

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Small Group Market Health Insurance Coverage Model Regulation (#126)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding the prohibition of excessive waiting periods in accordance with final regulations established by HHS, the DOL and the Treasury.

Review health carrier underwriting policies and procedures related to waiting periods to verify adequate and appropriate policies/procedures are in place to ensure the length of waiting periods imposed by the health carrier to otherwise eligible individuals is in compliance with final regulations and guidance established by HHS, the DOL and the Treasury.

Review policies to verify that the health carrier does not apply waiting periods longer than 90 days, and for health carriers that must provide EHB, to verify that the health carrier does not impose benefit-specific waiting periods.

Review health carrier underwriting policies and procedures to ensure that the health carrier does not consider the period before an individual's late or special enrollment date as a waiting period.

Verify that if an individual loses eligibility for coverage under a health benefit plan and subsequently becomes eligible for coverage, a health carrier only considers the individual's most recent period of eligibility in determining whether the individual is a late enrollee under the plan with respect to the most recent period coverage.

Verify that the health carrier does not apply a waiting period longer than 90 days to an individual who became eligible for coverage under the health benefit plan after a suspension of coverage that applied generally under the plan.

Note: Examiners need to be aware that, except as noted below, an individual is otherwise eligible to enroll under the terms of a health benefit plan if the individual has met the plan's substantive eligibility conditions, such as being in an eligible job classification, achieving job-related licensure requirements specified in the plan's terms or satisfying a reasonable bona fide employment-based orientation period.

A health carrier is not required to offer small group market health insurance coverage to any particular individual or class of individuals despite an individual being otherwise eligible to enroll under the plan, but individuals otherwise eligible for coverage under the plan may not be required to wait more than 90 days before coverage is effective.

Conditions of eligibility to enroll for coverage under the terms of a health benefit plan may be based solely on the lapse of a time period, but only for a time period of no more than 90 days.

Other conditions of eligibility to enroll for coverage under the terms of a health benefit plan are permitted unless the condition is designed to avoid compliance with applicable statutes, rules and regulations regarding excessive waiting periods, as determined in accordance with the following provisions:

- If eligibility is based on an employee having a specified number of hours of service per pay period, or working full-time, and it cannot be determined that a newly hired employee is reasonably expected to regularly work that number of hours per period, or work full-time, the terms of the health benefit plan may allow a reasonable time period of time, not to exceed 12 months and beginning on any date between the employee's employment start date and the first day of the first calendar month following the employee's start date, to determine whether the employee meets the plan's eligibility condition; or
- If eligibility is based on an employee having completed a number of cumulative hours of service, the eligibility condition is not considered to be designed to avoid compliance with the 90-day waiting period limitation, if the cumulative hours of service required does not exceed 1,200 hours.

Except for cases in which the health benefit plan imposes a waiting period exceeding a 90-day period in addition to a measurement period, as described in applicable statutes, rules and regulations, the time period for determining whether the employee meets the plan's eligibility requirements will not be considered to be designed to avoid compliance with the 90-day waiting period limitation if coverage is made effective no more than 13 months after the employee's employment start date plus the time remaining until the first day of the next calendar month, if the employee 's employment start date is not the first day of a calendar month.

To ensure that an orientation period is not used as a subterfuge for the passage of time, or designed to avoid compliance with the 90-day waiting period limitation, an orientation period is permitted only if it does not exceed one month. For the purposes of calculating one month, as described above, one month is determined by adding one calendar month and subtracting one calendar day, measured from an employee's start date in a position otherwise eligible for small group market health insurance coverage under a health benefit plan.

A health carrier may treat an employee whose employment has terminated and then rehired as newly eligible to enroll for coverage upon rehire and, therefore, required to meet the health benefit plan's eligibility requirements and waiting period anew, if reasonable under the circumstances and the termination and rehiring is not used or designed as a subterfuge to avoid compliance with the 90-day waiting period limitation.

For the purpose of calculating waiting periods, all calendar days are counted beginning on the enrollment date, including weekends and holidays.

For administrative convenience, a health carrier that imposes a 90-day waiting period may choose to permit coverage to become effective earlier than the 91st day if the 91st day is a weekend or holiday.

A health carrier satisfies the requirements set forth regarding excessive waiting periods in applicable statutes, rules and regulations if, under the terms of the health benefit plan, an individual employee elects coverage that begins on a date before the end of a 90-day waiting period and the health carrier is also not considered to be in violation of applicable statutes, rules and regulations if an individual employee takes, or is permitted to take, additional time beyond any 90-day waiting period to elect coverage.

A health carrier that relies on the eligibility information reported to it by the small group employer will not be considered to have violated the requirements set forth in applicable statutes, rules and regulations regarding excessive waiting periods with respect to the health carrier's administration of any waiting period, if the following is satisfied:

- The health carrier requires the small group to make a representation and update this representation with any changes regarding the terms of any eligibility conditions or waiting periods imposed before an individual is eligible for coverage under the health benefit plan; and
- The health carrier has no specific knowledge of a waiting period imposed that exceeds the permitted 90-day period.

Review complaint register/logs and complaint files to identify complaints pertaining to excessive waiting periods.

Review complaint records to verify that when an excessive waiting period has been inappropriately applied, the health carrier has taken appropriate corrective action/adjustments in a timely and accurate manner.

Ascertain if any health carrier error could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective actions provided to an individual upon whom a waiting period longer than 90 days was inappropriately imposed.

Review internal and external appeals register/logs/files to determine if there have been any appeals based on excessive waiting periods

Review policy form files to ensure approval(s) from the applicable state and (if applicable) from the Marketplace.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about the prohibition of excessive waiting periods.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about the prohibition of excessive waiting periods.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and Treasury provisions and final regulations pertaining to the prohibition of excessive waiting periods.

Review health carrier training materials to verify that information provided is complete and accurate with regard to excessive waiting periods.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

PROVISION TITLE: Grievance Procedures

CITATION: PHSA §2719

EFFECTIVE DATE: Plan years and, in the individual market, policy years beginning on or after Sept. 23, 2010

PROVISION: The provisions of the federal Affordable Care Act (ACA) set forth requirements with respect to internal claims and appeals and external review processes for group health plans and health carriers that are not grandfathered health plans under 45 CFR §147.140.

BACKGROUND: Regulations and associated FAQs, issued by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury) set forth the requirement that a health carrier offering health insurance coverage in the individual and small group market in a state must implement an effective appeals process for appeals of coverage determinations and claims, under which the plan or issuer shall, at a minimum:

- Have in effect an internal claims appeal process;
- For health carriers offering individual health insurance coverage, maintain for six years records of all claims and notices associated with the internal claims and appeals process, and must make such records available for examination by the claimant or state or federal oversight agency upon request;
- Have an independent and impartial review process;
- Provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman established under PHSA §2793 to assist such enrollees with the appeals processes; and
- Allow an enrollee to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

This provision applies to all health carriers in the individual market and to small group employer plans. This provision applies to non-grandfathered group health plans.

FAQs: See the HHS website for federal guidance.

NOTES:

STANDARDS
GRIEVANCE PROCEDURES

Standard 1
A health carrier offering individual health insurance coverage shall maintain records of all claims and notices associated with the internal claims and appeals process for the length of time specified in the final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Apply to: The provisions of this section apply to policy years beginning on or after Sept. 23, 2010

This provision does not apply to grandfathered health plans

Priority: Essential

Documents to be Reviewed

_____ Health carrier grievance handling policies and procedures

_____ Sample of grievances

_____ Health carrier grievance records

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Carrier Grievance Procedure Model Act (#72)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented written policies and procedures regarding grievance records handling in accordance with final regulations established by HHS, the DOL and the Treasury.

Verify the health carrier maintains grievance records for at least six years for first level grievances involving an adverse determination and for expedited reviews of grievances involving an adverse determination.

Verify the health carrier makes grievance records available for examination by covered persons, or, if applicable, the covered person's authorized representative, or the appropriate state or federal oversight agencies upon request.

Note: With regard to conflicts of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

STANDARDS
GRIEVANCE PROCEDURES

Standard 2
The health carrier shall comply with grievance procedures requirements, in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Apply to: The provisions of this section apply to plan years (in the individual market, policy years) beginning on or after Sept. 23, 2010

This provision does not apply to grandfathered health plans

Priority: Essential

Documents to be Reviewed

_____ Health carrier grievance handling policies and procedures

_____ Sample of grievances

_____ Health carrier grievance records

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Carrier Grievance Procedure Model Act (#72)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier utilizes written procedures for receiving and resolving first level review of grievances involving an adverse determination; standard review of grievances not involving an adverse determination; and voluntary review of grievances from covered persons, or, if applicable, the covered person's authorized representative, in accordance with final regulations in accordance with final regulations established by HHS, the DOL and the Treasury.

Note: Examiners need to be aware that whenever a health carrier fails to adhere to the requirements set forth in applicable state statutes, rules and regulations with respect to receiving and resolving first level review of grievances involving an adverse determination and expedited review of grievances involving an adverse determination, the covered person or, if applicable, the covered person's authorized representative, shall be deemed to have exhausted the provisions of applicable state statutes, rules and regulations and may file a request for external review in accordance with the procedures outlined in applicable state statutes, rules and regulations equivalent to the *Uniform Health Carrier External Review Model Act* (#76).

The provisions of applicable state statutes, rules and regulations regarding first level review of grievances involving an adverse determination and expedited review of grievances involving an adverse determination shall not be deemed exhausted based on a *de minimis* violation that does not cause, and is not likely to cause, prejudice or harm to the covered person as long as the health carrier demonstrates that the violation was for good cause or due to matters beyond the control of the health carrier and that the violation occurred in the context of an ongoing, good faith exchange of information between the health carrier and the covered person.

The exception noted above does not apply if the violation is part of a pattern or practice of violations by the health carrier.

A covered person, or, if applicable, the covered person's authorized representative, may request a written explanation of the violation from the health carrier. Verify that the health carrier has:

- Provided the written explanation within 10 days of receiving the request; and
- Included in the written explanation a specific description of its bases, if any, for asserting that the violation does not deem the provisions of applicable state statutes, rules and regulations to be exhausted.

Note: Examiners need to be aware that if an independent reviewer or a court of competent jurisdiction rejects the grievance involving an adverse determination for immediate review on the basis that the health carrier met the requirements of the exception outlined above, the covered person, or, if applicable, the covered person's authorized representative, has the right to resubmit and pursue a review of the grievance under applicable state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72).

In this case, verify that the health carrier has provided to the covered person, or, if applicable, the covered person's authorized representative, notice, within a reasonable period of time, but not to exceed 10 days after the independent reviewer or the court rejects the grievance involving an adverse determination for immediate review, of the opportunity to resubmit and, as appropriate, pursue a review of the grievance under applicable state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72).

For purposes of calculating the time period for refiling the benefit request or claim, verify that the health carrier calculates the time period to begin upon the covered person's, or, if applicable, the covered person's authorized representative's receipt of the notice of opportunity to resubmit.

Verify that the health carrier's grievance procedure documents include a statement of a covered person's, or, if applicable, the covered person's authorized representative's, right to contact the insurance commissioner's office or ombudsman's office for assistance at any time. Verify that the statement includes the telephone number and address of the insurance commissioner or ombudsman's office.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

STANDARDS
GRIEVANCE PROCEDURES

Standard 3
The health carrier shall conduct first level reviews of grievances involving an adverse determination in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Apply to: The provisions of this section apply to plan years (in the individual market, policy years) beginning on or after Sept. 23, 2010

This provision does not apply to grandfathered health plans

Priority: Essential

Documents to be Reviewed

_____ Health carrier grievance handling policies and procedures

_____ Sample of first level reviews of grievances involving an adverse determination

_____ Health carrier grievance records

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Carrier Grievance Procedure Model Act (#72)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented written policies and procedures regarding receiving and resolving first level review of grievances involving an adverse determination in accordance with final regulations established by HHS, the DOL and the Treasury.

Verify that the health carrier ensures that the first level review is conducted in a manner to ensure the independence and impartiality of the individuals involved in making the first level review decision.

To verify the independence and impartiality of individuals involved in making the first level review decision, verify that the health carrier does not make decisions related to such individuals regarding hiring, compensation, termination, promotion or other similar matters based upon the likelihood that the individual will support the denial of benefits.

Verify that, prior to issuing a decision regarding a first level review of a grievance involving an adverse determination, the health carrier provides free of charge to the covered person, or, if applicable, the covered person's authorized representative, any new or additional evidence, relied upon or generated by the health carrier, or at the direction of the health carrier, in connection with the grievance, sufficiently in advance of the date the decision is required to be provided, to permit the covered person, or, if applicable, the covered person's authorized representative, a reasonable opportunity to respond prior to that date.

Verify that, before the health carrier issues or provides notice of a final adverse determination in accordance with the time frames set forth in applicable state statutes, rules and regulations that is based on new or additional rationale, the health carrier provides the new or additional rationale to the covered person, or, if applicable, the covered person's authorized representative, free of charge as soon as possible and sufficiently in advance of the date the notice of final adverse determination is to be provided, to permit the covered person, or, if applicable, the covered person's authorized representative, a reasonable opportunity to respond prior to that date.

Verify that the health carrier's decision of a first level review of a grievance involving an adverse determination is set forth in a manner calculated to be understood by the covered person, or, if applicable, the covered person's authorized representative, to include all of the following:

- Information sufficient to identify the claim involved with respect to the grievance, including the date of service, the health care provider and, if applicable, the claim amount;
- A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning. Verify that the health carrier:
    - Provides to the covered person, or, if applicable, the covered person's authorized representative, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse determination;
    - Does not consider a request for the diagnosis code and treatment information, by itself, to be a request for external review pursuant to applicable state statutes, rules and regulations equivalent to the *Uniform Health Carrier External Review Model Act* (#75); and
- For a first level review decision that upholds the grievance:
    - The specific reason or reasons for the final adverse determination, including the denial code and its corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in reaching the denial; and
    - Notice of the covered person's, or, if applicable, the covered person's authorized representative's, right to contact the insurance commissioner's office or ombudsman's office for assistance with respect to any claim, grievance or appeal at any time, including the telephone number and address of the insurance commissioner's office or ombudsman's office.

Verify that the health carrier provides the notice in a culturally and linguistically appropriate manner in accordance with federal regulations.

Verify that the health carrier:

- Provides oral language services, such as a telephone assistance hotline, that include answering questions in any applicable non-English language and providing assistance with filing benefit requests and claims and appeals in any applicable non-English language;
- Provides, upon request, a notice in any applicable non-English language; and
- Includes in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the health carrier.

With respect to any United States county to which a notice is sent, a non-English language is an applicable non-English language if 10 percent or more of the population residing in the county is literate only in the same non-English language, as determined in published federal guidance.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

STANDARDS
GRIEVANCE PROCEDURES

Standard 4
The health carrier shall conduct expedited reviews of urgent care requests of grievances involving an adverse determination in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Apply to: The provisions of this section apply to plan years (in the individual market, policy years) beginning on or after Sept. 23, 2010

This provision does not apply to grandfathered health plans

Priority: Essential

Documents to be Reviewed

_____ Health carrier grievance handling policies and procedures

_____ Sample of expedited appeals

_____ Health carrier grievance records

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Carrier Grievance Procedure Model Act (#72)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented written policies and procedures regarding receiving and resolving expedited review of urgent care requests of grievances involving an adverse determination in accordance with final regulations established by HHS, the DOL and the Treasury.

Verify that the health carrier's decision of an expedited review of urgent care requests of a grievance involving an adverse determination is set forth in a manner calculated to be understood by the covered person, or, if applicable, the covered person's authorized representative, to include all of the following:

- Information sufficient to identify the claim involved with respect to the grievance, including the date of service, the health care provider and, if applicable, the claim amount;
- A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning. Verify that the health carrier:
    - Provides to the covered person, or, if applicable, the covered person's authorized representative, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse determination; and
    - Does not consider a request for the diagnosis code and treatment information, in itself, to be a request for external review pursuant to applicable state statutes, rules and regulations equivalent to the *Uniform Health Carrier External Review Model Act* (#75); and
- If the decision involves a final adverse determination, the notice shall provide:
    - The specific reason or reasons for the final adverse determination, including the denial code and its corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in reaching the denial; and
    - Notice of the covered person's, or, if applicable, the covered person's authorized representative's right to contact the insurance commissioner's office or ombudsman's office for assistance with respect to any claim, grievance or appeal at any time, including the telephone number and address of the insurance commissioner's office or ombudsman's office.

Verify that the health carrier provides the notice in a culturally and linguistically appropriate manner in accordance with federal regulations.

Verify that the health carrier:

- Provides oral language services, such as a telephone assistance hotline, that include answering questions in any applicable non-English language and providing assistance with filing benefit requests and claims and appeals in any applicable non-English language;
- Provides, upon request, a notice in any applicable non-English language; and
- Includes in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the health carrier.

With respect to any United States county to which a notice is sent, a non-English language is an applicable non-English language if 10 percent or more of the population residing in the county is literate only in the same non-English language, as determined in published federal guidance.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

PROVISION TITLE: Guaranteed Availability of Coverage (Individual and Group Market Health Insurance)

CITATION: PHSA §2702

EFFECTIVE DATE: Plan years and, in the individual market, policy years beginning on or after Jan. 1, 2014

PROVISION: The provisions of the federal Affordable Care Act (ACA) established a requirement that a health carrier offering health insurance coverage in the individual or group markets in a state must offer to any individual or employer in the applicable state all products approved for sale in the applicable market, and must accept any eligible individual or employer applying for any of those products.

BACKGROUND: Regulations and associated FAQs, issued by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury) set forth the requirement that a health carrier offering health insurance coverage in the individual and group markets in a state must accept for coverage, in the applicable state, every individual and group employer that: 1) applies for the plan; 2) agrees to make the required premium payments; and 3) meets other reasonable conditions consistent with federal and state law.

Health carriers are permitted to limit enrollment to designated annual open and special enrollment periods.

This provision applies to all health carriers in the individual market and group employer plans. This provision applies to non-grandfathered group health plans. This provision also applies to grandfathered small group health plans, which were already required to comply with guaranteed availability of coverage requirements under HIPAA.

FAQs: See the HHS website for federal guidance.

NOTES:

STANDARDS
GUARANTEED AVAILABILITY OF COVERAGE
(INDIVIDUAL MARKET)

Standard 1
A health carrier offering individual market health insurance coverage shall issue any applicable health benefit plan to any individual who: 1) applies for the plan; 2) agrees to make the required premium payments; and 3) meets other reasonable conditions consistent with federal and state law.

Apply to: All individual health products (non-grandfathered products) for policy years beginning on or after Jan. 1, 2014

This standard does not apply to grandfathered health plans in accordance with §147.140

This standard does not apply to transitional plans

Priority: Essential

Documents to be Reviewed

_____ Health carrier underwriting policies and procedures related to guaranteed availability of coverage

_____ Underwriting files and supporting documentation regarding guaranteed availability of coverage, including letters, notices, telephone scripts, etc.

_____ Complaint register/logs/files

_____ Health carrier complaint records concerning guaranteed availability of coverage (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Health carrier form approvals (policy language, enrollment materials and advertising materials, as required under state statutes, rules and regulations)

_____ Health carrier marketing and sales policies and procedures, references to guaranteed availability of coverage

_____ Health carrier communication and educational materials related to guaranteed availability of coverage provided to applicants, enrollees, policyholders, certificateholders and beneficiaries, including communications with producers

_____ Training materials

_____ Producer records

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Individual Market Health Insurance Coverage Model Regulation (#26)
Individual Market Health Insurance Coverage Model Act (#36)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding guaranteed availability of individual market health insurance coverage in accordance with final regulations established by HHS, the DOL and the Treasury.

Review health carrier underwriting policies and procedures related to guaranteed availability to verify adequate and appropriate policies and procedures are in place to ensure the health carrier makes individual market health insurance coverage available on a guaranteed availability basis to plan applicants in compliance with final regulations established by HHS, the DOL and the Treasury and does not place unallowable conditions on such availability.

A health carrier may restrict enrollment in coverage as described above to open or special enrollment periods, and coverage issued during an open or special enrollment period must become effective consistent with the dates set forth in federal regulations. Verify that a carrier has complied with any requirements that would allow for continuous open enrollment based upon certain circumstances of failing to file rates and forms and have them approved prior to open enrollment period.

Individual Health Insurance Coverage—Open Enrollment Period
A health carrier in the individual market must allow an individual to purchase health insurance coverage during the annual open enrollment period described in 45 CFR §155.410(e).

Individual Health Insurance Coverage—Special Enrollment Periods
Verify that a health carrier allows enrollment during defined enrollment periods, including open enrollment periods, limited open enrollment periods and special enrollment periods, and provides those periods pursuant to 45 CFR §147.104 and §155.420, as well as in accordance with state specific requirements.

Verify that a health carrier provides for a special enrollment period that is not less than 60 calendar days pursuant to 45 CFR §147.104 and §155.420 for qualified individuals (and their dependents, when applicable) in the following circumstances:

- Loss of minimum essential coverage (including employer plans, Medicaid, CHIP and COBRA coverage, as well as loss of coverage due to divorce, legal separation, loss of dependent status or death of the policyholder);
- Addition of a dependent through marriage, birth, adoption, placement for adoption or placement in foster care (including gaining a dependent through a child support order or other court order);
- Unintentional, inadvertent or erroneous enrollment in a plan that results from error, misrepresentation, misconduct or inaction of an officer, employee or agent of the exchange or HHS or its instrumentalities, or a non-exchange entity (including a health carrier or its representative) that provides enrollment assistance or conducts enrollment activities;
- Health carrier substantially violated a material provision of its contract in relation to the enrollee;
- Enrollee (or dependent of an enrollee) is determined newly eligible or ineligible for an advance premium tax credit or experiences a change in eligibility for cost-sharing reductions;
- A person terminates employer coverage as a result of being determined newly eligible for premium tax credits due to becoming ineligible for qualifying coverage in an eligible employer-sponsored plan;

- A person in a state that has not expanded Medicaid who was previously ineligible for premium tax credits due to having income below the federal poverty line experiences a change in household income that makes the person newly eligible for premium tax credits; or
- Permanent move that results in access to new individual market plans (including release from incarceration).

Verify that a health carrier that offers qualified health plans through an insurance exchange or marketplace serving the individual insurance market also provides for a special enrollment period that is not less than 60 days for qualified individuals in the following circumstances:

- Gain of status as a citizen, national or lawfully present individual;
- Status as federally recognized American Indian tribe or Alaska Native; or
- Person demonstrates to the exchange in the state, in accordance with federal guidelines, that the individual meets other exceptional circumstances as the exchange may provide.

Verify that a health carrier provides for a special enrollment period with effective coverage dates that begin the first day of the month following enrollment if the plan is selected between the 1st and 15th of the month or the first day of the second month following enrollment if the plan is selected between the 16th and the last day of the month with the following exceptions:

- In the case of marriage, not later than the first day of the month following plan selection;
- In the case of a dependent's birth, adoption, placement for adoption, or placement in foster care, the date of the birth, adoption, placement for adoption, or placement in foster care; or
- For loss of minimum essential coverage, the first day of the month following the loss of previous coverage if the qualified health plan is selected before or on the day of the loss. If the plan is selected after the date of coverage loss, then coverage is effective the first day of the month following plan selection.

Note: In some circumstances, federal rules permit states or the marketplace in a state to implement alternative coverage effective dates. Examiners should verify that health carriers are complying with any state-specific requirements that may apply.

Note: Examiners need to be aware that a health carrier subject to the guaranteed availability provisions of the final regulations established by HHS, the DOL and the Treasury is not required to provide coverage if:

- For any period of time the carrier demonstrates, and the commissioner determines, the health carrier does not have the financial reserves necessary to underwrite additional coverage; and
- The health carrier cannot offer coverage for reason of lack of financial reserves and is applying that reason uniformly to all individuals in the individual market in the applicable state—consistent with applicable state statutes, rules and regulations—and without regard to the claims experience of an individual and his or her dependents or any health status-related factor relating to such individual and his or her dependents.

With regard to a health carrier denying coverage for reason of lack of financial reserves, review the health carrier underwriting files to verify the health carrier does not offer coverage in the individual market in the applicable state until the later of:

- A period of 180 days after the date the coverage is denied; or
- Until the health carrier has demonstrated to the commissioner that it has sufficient financial reserves to underwrite additional coverage.

Network Plans

Note: Examiners need to be aware that with respect to coverage offered through a network plan, a health carrier is not required to offer individual market health insurance coverage under that plan or accept applications for that plan in the case of the following:

- To an individual, when the individual does not live or reside within the health carrier's established geographic service area for such network plan; or
- Within the geographic service area for such network plan where the health carrier reasonably anticipates, and demonstrates to the satisfaction of the commissioner, that it will not have the capacity within its established geographic service area to deliver service adequately to any additional individuals because of its obligations to existing enrollees.

Review health carrier underwriting files to verify that a health carrier, that cannot offer coverage for reason of lack of network capacity, does not offer coverage in the individual market in the applicable geographic service to new individuals or to any enrollees until the later of 180 days following each such refusal or the date on which the health carrier notifies the commissioner of the applicable state that it has regained capacity to deliver services.

Review health carrier underwriting files to verify that the health carrier is applying its noncompliance with guaranteed availability requirements for reason of lack of network capacity, on a uniform basis, to all individuals without regard to the claims experience of those individuals and their dependents or any health status-related factor relating to such individuals and their dependents.

Note: Examiners need to be aware that:

- The provisions set forth in the final regulations established by HHS, the DOL and the Treasury should not be construed to require that a health carrier offering group health benefit plans must offer health benefit plans in the individual market;
- A health carrier offering only student health insurance coverage is not required to otherwise offer coverage in the individual market so long as the health carrier is offering student health insurance coverage consistent with the HHS, DOL and the Treasury definition of "student health insurance coverage." In accordance with 45 CFR §147.145, student health insurance is exempt from the requirement to establish open enrollment periods and coverage effective dates based on a calendar policy year; and
- A health carrier, at the time of renewal, may modify coverage under a health benefit plan offering individual market health insurance coverage so long as such modification is consistent with applicable state statutes, rules and regulations and effective on a uniform basis among all individuals covered under the health benefit plan.

Review complaint register/logs and complaint files to identify complaints pertaining to restriction of guaranteed availability of coverage.

Review complaint records to verify that if the health carrier has not offered health insurance coverage on a guaranteed availability basis to eligible plan applicants the above reasons for noncompliance notwithstanding, the health carrier has taken appropriate corrective action/adjustments regarding making an offer of coverage in a timely and accurate manner.

Ascertain if any health carrier error could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to an eligible plan applicant who was not offered health insurance coverage on a guaranteed availability basis.

Review policy form files to ensure approval(s) from the applicable state and (if applicable) from the Marketplace.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about guaranteed availability of individual market health insurance coverage.

Verify that a health carrier and its officials, employees, agents and representatives comply with any applicable statutes, rules and regulations regarding marketing by health carriers and do not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminating based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life or other health conditions.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about guaranteed availability of individual market health insurance coverage.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and Treasury provisions and final regulations pertaining to guaranteed availability of individual market health insurance coverage.

Review health carrier training materials to verify that information provided is complete and accurate with regard to guaranteed availability of individual market health insurance coverage.

Review producer records and health carrier communication with producers to verify that information provided by producers to applicants/proposed insureds is complete and accurate with regard to guaranteed availability and does not discourage the enrollment of applicants/proposed insureds. Review commission schedules and related commission filing information to verify that commissions do not have the effect of discouraging enrollment, when applicable.

Determine if the health carrier monitors producer-generated notices that deny or restrict coverage. Review producer records of such notices for compliance with the guaranteed availability provisions in final regulations established by HHS, the DOL and the Treasury.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

STANDARDS
GUARANTEED AVAILABILITY OF COVERAGE
(GROUP MARKET)

Standard 2
A health carrier offering group market health insurance coverage shall issue any applicable health benefit plan to any eligible employer that: 1) applies for the plan; 2) agrees to make the required premium payments; and 3) meets other reasonable conditions consistent with state and federal law.

Apply to: All group health products (non-grandfathered products) for policy years beginning on or after Jan. 1, 2014

This standard does not apply to grandfathered health plans in accordance with §147.140. However, grandfathered small group health plans were already required to comply with guaranteed availability of coverage requirements under HIPAA

This standard does not apply to transitional plans

Priority: Essential

Documents to be Reviewed

_____ Health carrier underwriting policies and procedures related to guaranteed availability of coverage

_____ Underwriting files and supporting documentation regarding guaranteed availability of coverage, including letters, notices, telephone scripts, etc.

_____ Complaint register/logs/files

_____ Health carrier complaint records concerning guaranteed availability of coverage (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Health carrier form approvals (policy language, enrollment materials and advertising materials, as required under state statutes, rules and regulations)

_____ Health carrier marketing and sales policies and procedures references to guaranteed availability of coverage

_____ Health carrier communication and educational materials related to guaranteed availability of coverage provided to applicants, enrollees, policyholders, certificateholders and beneficiaries, including communications with producers

_____ Training materials

_____ Producer records

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Small Group Market Health Insurance Coverage Model Act (#106)
Small Group Market Health Insurance Coverage Model Regulation (#126)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding guaranteed availability of group market health insurance coverage in accordance with final regulations provided by HHS, the DOL and the Treasury.

Review health carrier underwriting policies and procedures related to guaranteed availability to verify that adequate and appropriate policies and procedures are in place to ensure the health carrier makes group market health insurance coverage available on a guaranteed availability basis to eligible employers in compliance with final regulations provided by HHS, the DOL and the Treasury, and that the carrier does not place unallowable conditions on such availability.

Review health carrier underwriting policies and procedures to verify the health carrier:

- Offers coverage to all eligible employees of the eligible employer and their dependents who apply for enrollment during the period in which the employee first becomes eligible to enroll under the terms of the plan; and
- Does not limit the offer of coverage to only certain individuals or dependents in the group or to only part of the group.

A health carrier may restrict enrollment in coverage as described above to open or special enrollment periods.

Group Plans—Special Enrollment Periods
Verify that a health carrier offering coverage in the small group market provides for an annual open enrollment period from Nov. 15 through Dec. 15, during which time employees may enroll in coverage effective Jan. 1 of the subsequent year without meeting any minimum participation or minimum contribution requirements.

Verify that a health carrier offering coverage in the small group market permits employers to enroll at any time during the year, including outside of the annual group open enrollment period, and that the carrier does not place any unallowable enrollment restrictions on employers.

Verify that any enrollment restrictions that may be allowable outside of the annual group enrollment period (such as minimum participation and minimum contribution requirements) are applied by the carrier in a consistent manner to all employers seeking coverage.

Note: Different enrollment standards may apply depending on whether small group coverage is being offered within a small group exchange (also known as a SHOP marketplace) or in the small group market outside of an exchange or SHOP. For example, the minimum participation requirement may be calculated differently. Examiners should be aware of such differences and also of whether the carrier being examined is offering coverage within a SHOP, outside the SHOP, or both.

Verify that a health carrier permits an employee, or a dependent of the employee, who is eligible, but not enrolled, to enroll for coverage under the terms of any health benefit package under the plan of the employer during a special enrollment period if:

- The employee or dependent was covered under a group health plan or had coverage under a health benefit plan at the time coverage was previously offered to the employee or dependent;
- The employee's or dependent's coverage:
    - Was under a COBRA continuation provision and the coverage under this provision has been exhausted; or
    - Was not under a COBRA continuation provision and that other coverage has been terminated as a result of loss of eligibility for coverage, including as a result of a legal separation, divorce, cessation of dependent status, death, termination of employment, reduction in the number of hours of employment or employer contributions towards that other coverage having been terminated, or loss of coverage because an individual no longer resides, lives or works in the service area of HMO coverage;
- The employee stated in writing at the time coverage was previously offered that coverage under a group health plan or other health benefit plan was the reason for declining enrollment, but only if the plan sponsor or carrier, if applicable, required such a statement at the time coverage was previously offered and provided notice to the employee of the requirement and the consequences of the requirement at that time; or
- Under the terms of the health benefit plan, the employee requests enrollment not later than 30 days after the triggering event.

Verify that the health carrier provides a special enrollment period to all covered employees that experience the following qualifying events that result in the loss of coverage of a qualified beneficiary pursuant to 29 USC §1163:

- The death of the covered employee;
- The termination (other than by reason of such employee's gross misconduct), or reduction of hours of the covered employee's employment;
- The divorce or legal separation of the covered employee from the employee's spouse;
- The covered employee becomes entitled to benefits under Title XVIII of the Social Security Act;
- A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan; or
- A proceeding in a case under Title XI of the Social Security Act, commencing on or after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time.

Verify that if an employee requests enrollment the health carrier provides for enrollment effective not later than the first day of the first calendar month beginning after the date the health carrier received the completed request for enrollment.

Verify that, with respect to dependents of employees, the health carrier provides for a dependent special enrollment period during which the dependent, and if not otherwise enrolled, the employee, may be enrolled under a health benefit plan, if a person becomes a dependent of the employee/participant through marriage, birth, adoption, or placement for adoption.

Verify that the health carrier's special enrollment period for qualified individuals provides a period of time not less than 30 days from the date of the marriage, birth, adoption, or placement for adoption (or, if dependent coverage is not generally made available, at least 30 days after the date the plan makes dependent coverage generally available).

Verify that the health carrier, for an employee who seeks to enroll a dependent during a special enrollment period, provides for the coverage of the dependent effective upon:

- In the case of marriage, not later than the first day of the first month beginning after the health carrier receives the completed request for special enrollment;
- In the case of a dependent's birth, the date of the child's birth; and
- In the case of a dependent's adoption or placement for adoption, not later than the date of the adoption or placement for adoption.

Verify that the health carrier permits an employee or a dependent of the employee, who is eligible but not enrolled, to enroll in coverage under the terms of the health benefit plan if:

- The employee or dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under the state children's health plan under Title XXI of the Social Security Act and coverage of the employee or dependent under the plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under the plan not later than 60 days after the date of termination of such coverage; or
- The employee or dependent becomes eligible for assistance, with respect to coverage under the plan under a Medicaid plan under Title XIX of the Social Security Act or under the state child health plan under Title XXI of the Social Security Act, including any waiver or demonstration project conducted under or in relation to such a plan, if the employee requests coverage under the plan not later than 60 days after the employee or dependent is determined to be eligible for such assistance.

Verify that the health carrier provides adequate written notice of special enrollment rights and the requirement furnished to an individual declining coverage (if the plan requires the reason for declining coverage to be in writing). 29 CFR §2590.701-6 includes model language for informing employees of their special enrollment rights.

Verify that the health carrier does not treat special enrollees as late enrollees and offers the same benefit package as is offered to similarly situated individuals who enroll when first eligible. Any differences in benefits or cost-sharing requirements for different individuals constitute a different benefit package, and a special enrollee cannot be required to pay more for coverage or to enroll in different coverage than a similarly situated individual who enrolls in the same coverage when first eligible.

Verify that the health carrier is in compliance with 45 CFR §147.108 and 45 CFR §146.111, including the examples identified in federal regulations.

Review health carrier underwriting policies and procedures to verify the health carrier does not apply any waiting period (consistent with the HHS, DOL and Treasury definition of "waiting period") that exceeds 90 days.

Review the health carrier's underwriting files to verify the requirements used by a health carrier in determining whether to provide coverage to an employer are applied uniformly among all employers applying for coverage or receiving coverage from the health carrier.

In states that have adopted the *Small Group Market Health Insurance Coverage Model Act* (#106), review health carrier underwriting files to verify that any minimum participation level that a health carrier establishes for employers applying for coverage outside of the Nov. 15 through Dec. 15 group open enrollment period is not greater than:

- 100% of eligible employees working for groups of three or fewer employees; and
- 75% of eligible employees working for groups with more than three employees.

Minimum participation requirements are permitted outside the annual enrollment period from Nov. 15 through Dec. 15 to the extent permitted by state law. Examiners should review health carrier underwriting files to verify that any minimum participation rules applied by the health carrier comply with any state-specific requirements.

In states that have adopted the *Small Group Market Health Insurance Coverage Model Act* (#106), review health carrier underwriting files to verify the health carrier, in applying minimum participation requirements with respect to an employer, that applies for coverage outside of the Nov. 15 through Dec. 15 time period, does not consider employees or dependents of employees who have creditable coverage in determining whether the applicable percentage of participation is met.

"Creditable coverage" is defined in the *Small Group Market Health Insurance Coverage Model Act* (#106) as follows. "Creditable coverage" means, with respect to an individual, health benefits or coverage provided under any of the following:

(1) A group health plan;
(2) A health benefit plan;
(3) Part A or Part B of Title XVIII of the Social Security Act (Medicare);
(4) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 (the program for distribution of pediatric vaccines);
(5) Chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services, and for their dependents. For purposes of Title 10, USC Chapter 55, "uniformed services" means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service);
(6) A medical care program of the Indian Health Service or of a tribal organization;
(7) A state health benefits risk pool;
(8) A health plan offered under Chapter 89 of Title 5, United States Code (Federal Employees Health Benefits Program (FEHBP);
(9) A public health plan, which for purposes of this act, means a plan established or maintained by a state, the United States government or a foreign country or any political subdivision of a state, the United States government or a foreign country that provides health insurance coverage to individuals enrolled in the plan;
(10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 USC 2504(e)); or
(11) Title XXI of the Social Security Act (State Children's Health Insurance Program).

In states that have not adopted the *Small Group Market Health Insurance Coverage Model Act* (#106), examiners need to be aware that HHS guidance regarding the applicability of group participation rules provide for different ways in which the state and/or health carrier may calculate minimum participation requirements, as such variations are deemed permissible by HHS.

In applying minimum participation requirements with respect to an employer, review health carrier underwriting files to verify the health carrier does not consider individuals eligible for coverage under a COBRA continuation provision as eligible employees in determining whether the applicable percentage of participation is met.

Review health carrier underwriting files to verify the health carrier does not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to an employer at any time after the employer has been accepted for coverage.

Examiners should verify that health carriers are complying with any state-specific requirements that may apply.

Note: Examiners need to be aware that a health carrier subject to the guaranteed availability provisions of the final regulations established by HHS, the DOL and the Treasury is not required to provide coverage if:

- For any period of time the health carrier demonstrates, and the commissioner determines, the health carrier does not have the financial reserves necessary to underwrite additional coverage; and
- The health carrier cannot offer coverage for reason of lack of financial reserves and is applying that reason uniformly to all employers in the group market in the applicable state consistent with applicable state statutes, rules and regulations and without regard to the claims experience of an employer and its employees and their dependents or any health status-related factor relating to such employees and their dependents.

With regard to a health carrier that denies coverage for reason of lack of financial reserves, review the health carrier underwriting files to verify the health carrier does not offer coverage in the group market in the applicable state until the later of:

- A period of 180 days after the date the coverage is denied; or
- Until the health carrier has demonstrated to the commissioner that it has sufficient financial reserves to underwrite additional coverage.

Network Plans

Note: Examiners need to be aware that with respect to coverage offered through a network plan, a health carrier is not required to offer group market health insurance coverage under that plan or accept applications for that plan in the case of the following:

- In an area outside of the health carrier's established geographic service area for such network plan;
- To an employee when the employee does not live, work or reside within the health carrier's established geographic service area for such network plan; or
- Within the geographic service area for such network plan where the health carrier reasonably anticipates, and demonstrates to the satisfaction of the commissioner, that it will not have the capacity within its established geographic service area to deliver service adequately to the members of such groups because of its obligations to existing group certificateholders and covered persons.

Review health carrier underwriting files to verify that a health carrier that cannot offer coverage for reason of lack of network capacity does not offer coverage in the group market in the applicable geographic service area to new cases of employer groups or to any employer groups until the later of 180 days following each such refusal or the date on which the carrier notifies the commissioner that it has regained capacity to deliver services.

Review health carrier underwriting files to verify the health carrier is applying its noncompliance with guaranteed availability requirements for reason of lack of network capacity on a uniform basis, to all employers without regard to the claims experience of the employer and its employees and their dependents or any health status-related factor relating to such employees and their dependents and their dependents or any health status-related factor relating to such individuals and their dependents.

Note: Examiners need to be aware that:

- A health carrier subject to the guaranteed availability provisions of the final regulations established by HHS, the DOL and the Treasury is not required by such regulations to provide group market health insurance coverage if the health carrier elects not to offer new coverage to group employers in the applicable state; and
- A health carrier that elects not to offer new coverage may be allowed, as determined by the commissioner, to maintain its existing policies in the applicable state;

Review health carrier underwriting files to verify that a health carrier that elects not to offer new coverage to employers in the applicable state has provided notice of its election to the commissioner and does not write new business in the group market in the applicable state for a period of 5 years beginning on the date the carrier ceased offering new coverage in the applicable state.

General Review Procedures and Criteria

Review complaint register/logs and complaint files to identify complaints pertaining to restriction of guaranteed availability of coverage.

Review complaint records to verify that if the health carrier has not offered health insurance coverage on a guaranteed availability basis to an eligible employer, the above reasons for noncompliance notwithstanding, the health carrier has taken appropriate corrective action/adjustments regarding making an offer of coverage in a timely and accurate manner.

Ascertain if any health carrier error could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to an eligible employer that was not offered health insurance coverage on a guaranteed availability basis.

Review policy form files to ensure approval(s) from the applicable state and (if applicable) from the Marketplace.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about guaranteed availability of group market health insurance coverage.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about guaranteed availability of group market health insurance coverage.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and Treasury provisions and final regulations pertaining to guaranteed availability of group market health insurance coverage.

Review health carrier training materials to verify that information provided is complete and accurate with regard to guaranteed availability of group market health insurance coverage.

Review producer records and health carrier communication with producers to verify that information provided by producers to applicants/proposed insureds is complete and accurate with regard to guaranteed availability and does not discourage the enrollment of applicants/proposed insureds. Review commission schedules and related commission filing information to verify that commissions do not have the effect of discouraging enrollment, when applicable.

Determine if the health carrier monitors producer-generated notices that deny or restrict coverage. Review producer records of such notices for compliance with the guaranteed availability provisions in final regulations established by HHS, the DOL and the Treasury.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

PROVISION TITLE: Guaranteed Renewability of Coverage (Individual and Small Group Market Health Insurance)

CITATION: PHSA §2703

EFFECTIVE DATE: Plan years and, in the individual market, policy years beginning on or after Jan. 1, 2014

PROVISION: The provisions of the federal Affordable Care Act (ACA) established a requirement that a health carrier offering health insurance coverage in the individual and small group market in a state is required to renew or continue in force the coverage at the option of the individual or small employer, as applicable.

BACKGROUND: Regulations and associated FAQs, issued by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury) set forth the requirement that a health carrier offering health insurance coverage in the individual, small group or large group market is required to renew or continue in force the coverage at the option of the plan sponsor.

There are numerous exceptions to the guaranteed renewability requirements, such as failure to pay premiums or contributions, fraud, violation of participation or contribution rules, termination of the plan, enrollees' movement outside of the service area, cessation of association membership, discontinuation of a particular product, or the discontinuance of all coverage.

This provision applies to all health carriers in the individual market and to small group employer plans. This provision applies to non-grandfathered group health plans.

FAQs: See the HHS website for federal guidance.

NOTES:

STANDARDS
GUARANTEED RENEWABILITY OF COVERAGE

Standard 1
A health carrier offering individual market health insurance coverage shall renew or continue in force the coverage, at the option of the policyholder, subject to final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Apply to: All individual health products (non-grandfathered products) for policy years beginning on or after Jan. 1, 2014

This standard does not apply to grandfathered health plans in accordance with §147.140

This standard does not apply to transitional plans

Priority: Essential

Documents to be Reviewed

_____ Health carrier underwriting policies and procedures related to guaranteed renewability of coverage

_____ Underwriting files and supporting documentation regarding guaranteed renewability of coverage, including letters, notices, telephone scripts, etc.

_____ Complaint register/logs/files

_____ Health carrier complaint records concerning guaranteed renewability of coverage (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Health carrier form approvals (policy language, enrollment materials and advertising materials, as required under state statutes, rules and regulations)

_____ Health carrier marketing and sales policies and procedures relative to guaranteed renewability of coverage

_____ Health carrier communication and educational materials related to guaranteed renewability of coverage provided to applicants, enrollees, policyholders, certificateholders and beneficiaries

_____ Training materials

_____ Producer records

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Individual Market Health Insurance Coverage Model Regulation (#26)
Individual Market Health Insurance Coverage Model Act (#36)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding guaranteed renewability of individual market health insurance coverage in accordance with final regulations established by HHS, the DOL and the Treasury.

Review health carrier underwriting policies and procedures related to guaranteed renewability to verify adequate and appropriate policies and procedures are in place to ensure the health carrier renews, or continues in force at the option of the policyholder, individual market health insurance coverage, in compliance with final regulations established by HHS, the DOL and the Treasury.

Review health carrier underwriting files to verify that health carrier nonrenewal or discontinuance of coverage of a health benefit plan, subject to guaranteed renewability provisions established by HHS, the DOL and the Treasury final regulations, are performed only as follows:

- The policyholder has failed to pay premiums or contributions in accordance with the terms of the health benefit plan, or the health carrier has not received timely premium payments;
- The policyholder or the policyholder's representative has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of coverage;
- The health carrier elects to cease offering individual market health insurance coverage in the applicable state in accordance with HHS, the DOL and the Treasury final regulations and other applicable state law;
- In the case of a health carrier that offers coverage through a network plan, the policyholder no longer lives or resides within the health carrier's established geographic service area, and the health carrier would deny enrollment in the plan pursuant to lack of capacity as defined in final regulations established by HHS, the DOL and the Treasury.
- The commissioner, in accordance with state law:
    - Finds that the continuation of the coverage would not be in the best interests of the covered persons or would impair the health carrier's ability to meet its contractual obligations; and
    - Assists affected covered persons in finding replacement coverage (Note: Examiners need to be aware that health carriers that fail to renew coverage under this exception must do so in a nondiscriminatory fashion); or
- In the case of health benefit plans that are made available in the individual market only through one or more bona fide associations, the membership of a policyholder in the association on the basis of which the coverage is provided ceases, provided that coverage is terminated for reason of lack of policyholder association membership uniformly, without regard to any health status-related factor related to any covered person.
- In the case of health benefit plans that are made available in the individual market as student health insurance coverage, the student policyholder covered under the coverage ceases to be a student at the institution of higher education through which the student health insurance coverage is offered, provided the coverage for reason of cessation of student status is terminated uniformly without regard to any health status-related factor related to any covered person; or

- The commissioner finds that the product form is obsolete and is being replaced with comparable coverage and the health carrier decides to discontinue offering that particular type of health benefit plan (obsolete product form) in the applicable state's individual market, only if the health carrier:
    - Provides advance notice of its decision to discontinue offering the obsolete health benefit plan to the commissioner in the applicable state in which it is licensed;
    - Provides notice of the decision to nonrenew coverage at least 180 days prior to the nonrenewal of any health benefit plans to:
        - All affected policyholders; and
        - The commissioner in the applicable state in which an affected policyholder is known to reside, provided the notice is sent to the commissioner at least three working days prior to the date the notice is sent to the affected policyholders;
    - Provides notice to each enrollee issued that particular type of health benefit plan (obsolete product form) that the policyholder has the option to purchase all other health benefit plans currently being offered by the health carrier in the individual market in the applicable state; and
    - In exercising the option to discontinue that particular type of health benefit plan (obsolete product form) and in offering the option of coverage to purchase all other health benefit plans currently being offered by the health carrier in the individual market in the applicable state, acts uniformly, without regard to the claims experience of those covered persons or any other health status-related factor relating to any covered person who may become eligible for coverage.

Review health carrier underwriting files to verify that if a health carrier decides to discontinue offering a particular type of health benefit plan of individual market health insurance coverage, the health carrier discontinues coverage only in accordance with applicable state statutes, rules and regulations and only if the health carrier:

- Provides advance notice of its decision to discontinue offering a health benefit plan to the commissioner in the applicable state in which it is licensed;
- Provides notice of the decision to nonrenew coverage at least 90 days prior to the nonrenewal of the health benefit plan to:
    - All affected policyholders; and
    - The commissioner in the applicable state in which an affected policyholder is known to reside, provided the notice to the commissioner is sent at least three working days prior to the date the notice is sent to affected policyholders;
- Provides notice to each enrollee issued that particular type of health benefit plan that the policyholder has the option to purchase all other health benefit plans providing individual market health insurance coverage currently being offered by the health carrier in the applicable state; and
- In exercising the option to discontinue that particular type of health benefit plan and in offering the option of coverage to purchase all other health benefit plans providing individual market health insurance coverage currently being offered by the health carrier in the applicable state, acts uniformly without regard to the claims experience of those policyholders or any health status-related factor relating to any policyholder or dependent of a policyholder or new policyholders and their dependents who may become eligible for coverage.

Review health carrier underwriting files to verify that if a health carrier elects to discontinue offering health insurance coverage under health benefit plans in the individual market, or all markets, in the applicable state, the health carrier discontinues such coverage only in accordance with applicable state statutes, rules and regulations and only if the health carrier:

- Provides advance notice of its decision to discontinue offering health insurance coverage under health benefit plans in the individual market, or all markets, to the commissioner in each state in which it is licensed; and

- Provides notice of the decision to nonrenew coverage at least 180 days prior to the nonrenewal of any health benefit plans to:
    - All affected policyholders; and
    - The commissioner in each state in which an affected policyholder is known to reside, provided the notice sent to the commissioner at least three working days prior to the date the notice is sent to affected policyholders.

Review health carrier underwriting files to verify that in the case of a discontinuance, the health carrier has ceased writing new business in the market in the applicable state for a period of five years beginning on the date the health carrier ceased offering new coverage in the applicable state. Depending upon the state, if a plan that is guaranteed renewable is modified by the health carrier, then that plan typically would need to have been reviewed and approved by the state insurance department.

Review health carrier underwriting files to verify that in the case of a discontinuance, the health carrier, as determined by the commissioner, may renew its existing business in the market in the applicable state or may be required to nonrenew all of its existing business in the market in the applicable state.

Note: Examiners need to be aware that, in the case of a health carrier doing business in one established geographic service area of the applicable state, the guaranteed renewability provisions established by HHS, the DOL and the Treasury shall apply only to the health carrier's operations in that service area. Examiners should also be aware of the rating areas and the service areas that have been approved by the applicable state.

General Review Procedures and Criteria

Review complaint register/logs and complaint files to identify complaints pertaining to restriction of guaranteed renewability of coverage.

Review complaint records to verify that if the health carrier has improperly nonrenewed or discontinued a health benefit plan providing individual market health insurance coverage, the health carrier has taken appropriate corrective action/adjustments regarding renewal of coverage, or continuation of coverage, in a timely and accurate manner.

Ascertain if any health carrier error could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to a policyholder whose health benefit plan providing individual market health insurance coverage was nonrenewed or discontinued.

Review policy form files to ensure approval(s) from the applicable state and (if applicable) from the Marketplace.

Verify that any marketing materials provided to insureds, prospective purchasers and policyholders by the health carrier provide complete and accurate information about guaranteed renewability of individual market health insurance coverage.

Verify that health carrier communications and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about guaranteed renewability of individual market health insurance coverage.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and Treasury provisions and final regulations pertaining to guaranteed renewability of individual market health insurance coverage.

Review health carrier training materials to verify that information provided is complete and accurate with regard to guaranteed renewability of individual market health insurance coverage.

Determine if the health carrier monitors producer-generated notices that nonrenew or discontinue coverage. Review producer records of such notices for compliance with the guaranteed renewability provisions in final regulations established by HHS, the DOL and the Treasury.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

STANDARDS
GUARANTEED RENEWABILITY OF COVERAGE

Standard 2
A health carrier offering small group market health insurance coverage shall renew or continue in force the coverage, at the option of the small employer subject to final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Apply to: All small group health products (non-grandfathered products) for plan years beginning on or after Jan. 1, 2014

This standard does not apply to grandfathered health plans in accordance with §147.140

This standard does not apply to transitional plans

Priority: Essential

Documents to be Reviewed

_____ Health carrier underwriting policies and procedures related to guaranteed renewability of coverage

_____ Underwriting files and supporting documentation regarding guaranteed renewability of coverage, including letters, notices, telephone scripts, etc.

_____ Complaint register/logs/files

_____ Health carrier complaint records concerning guaranteed renewability of coverage (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Health carrier form approvals (policy language, enrollment materials and advertising materials, as required under state statutes, rules and regulations)

_____ Health carrier marketing and sales policies and procedures references to guaranteed renewability of coverage

_____ Health carrier communication and educational materials related to guaranteed renewability of coverage provided to applicants, enrollees, policyholders, certificateholders and beneficiaries

_____ Training materials

_____ Producer records

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Small Group Market Health Insurance Coverage Model Act (#106)
Small Group Market Health Insurance Coverage Model Regulation (#126)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding guaranteed renewability of small group market health insurance coverage in accordance with final regulations established by HHS, the DOL and the Treasury.

Review health carrier underwriting policies and procedures related to guaranteed renewability to verify that adequate and appropriate policies and procedures are in place to ensure the health carrier renews, or continues in force, at the option of the small employer, small group market health insurance coverage, in compliance with final regulations established by HHS, the DOL and the Treasury.

Review health carrier underwriting files to verify that health carrier nonrenewal or discontinuance of coverage of a health benefit plan, subject to guaranteed renewability provisions established by HHS, the DOL and Treasury final regulations, are performed only as follows:

- The plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health benefit plan, or the health carrier has not received timely premium payments;
- The plan sponsor has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of coverage;
- There has been noncompliance with the health carrier minimum participation requirements;
- There has been noncompliance with the health carrier's employer contribution requirements;
- The health carrier elects to cease offering small group market health insurance coverage in the applicable state in accordance with HHS, DOL and the Treasury final regulations and other applicable state law;
- In the case of a health carrier that offers coverage through a network plan, there is no longer any employee living, working or residing within the health carrier's established geographic service area, and the health carrier would deny enrollment in the plan pursuant to lack of capacity as set forth in HHS, DOL and Treasury final regulations;
- In the case of a health carrier that offers coverage in the small group market only through one or more bona fide associations, the membership of the small employer in the association (on the basis of which the coverage is provided) ceases, but only if such coverage is terminated for reason of lack of policyholder association membership uniformly, without regard to any health status-related factor relating to any covered person;
- The commissioner, in accordance with state law:
    - Finds that the continuation of the coverage would not be in the best interests of the certificateholders or would impair the health carrier's ability to meet its contractual obligations; and
    - Assists affected covered persons in finding replacement coverage (Note: Examiners need to be aware that health carriers that fail to renew coverage under this exception must do so in a nondiscriminatory fashion); or

- The commissioner finds that the product form is obsolete and is being replaced with comparable coverage, and the health carrier decides to discontinue offering that particular type of health benefit plan (obsolete product form) in the applicable state's small group market, if the health carrier:
    - Provides advance notice of its decision to discontinue offering that particular type of health benefit plan (obsolete product form) in the applicable state's small group market, to the commissioner, in the applicable state in which it is licensed;
    - Provides notice of the decision to nonrenew coverage at least 180 days prior to the nonrenewal of any health benefit plans to:
        - All affected plan sponsors and employees and their dependents; and
        - The commissioner in the applicable state in which an affected insured individual is known to reside, provided the notice is sent to the commissioner at least three working days prior to the date the notice is sent to the affected plan sponsors and employees and their dependents;
    - Provides notice to each plan sponsor issued that particular type of health benefit plan (obsolete product form) that the plan sponsor has the option to purchase all other health benefit plans currently being offered by the health carrier in the small group market in the applicable state; and
    - In exercising the option to discontinue that particular type of health benefit plan (obsolete product form), acts uniformly without regard to the claims experience of any small employer or any other health status-related factor relating to any employee or dependent of an employer or new employees and their dependents who may become eligible for coverage.

Note: Examiners need to be aware that a health carrier that elects to nonrenew small group market health insurance coverage under a health benefit plan because of the plan sponsor's fraud or intentional misrepresentation of material fact under the terms of coverage, may choose not to issue a health benefit plan to that plan sponsor for one year after the date of nonrenewal. This provision shall not be construed to affect guaranteed renewability requirements pertaining to other health carriers to issue coverage under any health benefit plan to the plan sponsor.

Review health carrier underwriting files to verify that if a health carrier decides to discontinue offering a particular type of health benefit plan of small group market health insurance coverage, the health carrier discontinues coverage only in accordance with applicable state statutes, rules and regulations and only if the health carrier:

- Provides advance notice of its decision to discontinue offering a particular type of health benefit plan of small group market health insurance coverage to the commissioner in each state in which it is licensed;
- Provides notice of the decision to nonrenew coverage at least 90 days prior to the nonrenewal of the health benefit plan to:
    - All affected plan sponsors and employees and their dependents; and
    - The commissioner in the applicable state in which an affected insured individual is known to reside, provided the notice to the commissioner is sent at least three working days prior to the date the notice is sent to affected plan sponsors and employees and their dependents;
- Provides notice to each plan sponsor issued that particular type of health benefit plan that the plan sponsor has the option to purchase all other health benefit plans providing small group market health insurance coverage currently being offered by the health carrier in the applicable state; and
- In exercising the option to discontinue that particular type of health benefit plan, acts uniformly without regard to the claims experience of any small employer or any health status-related factor relating to any employee or dependent of an employer or new employees and their dependents who may become eligible for coverage.

Review health carrier underwriting files to verify that if a health carrier elects to discontinue offering small group market health insurance coverage in the small group market, or all markets, in the applicable state, the health carrier discontinues such coverage only in accordance with applicable state law and only if:

- The health carrier provides advance notice of its decision to discontinue offering small group market health insurance coverage in the small group market, or all markets, to the commissioner in each state in which it is licensed;
- Provides notice of the decision to nonrenew coverage at least 180 days prior to the nonrenewal of any health benefit plans to:
    - All affected plan sponsors and employees and their dependents; and
    - The commissioner in each state in which an affected insured individual is known to reside, provided the notice sent to the commissioner is sent at least three working days prior to the date the notice is sent to affected plan sponsors and employees and their dependents.
- In the case of a discontinuance, the health carrier shall be prohibited from writing new business in the market in the applicable state for a period of five years beginning on the date the health carrier ceased offering new coverage in the applicable state; and
- In the case of a discontinuance, the health carrier, as determined by the commissioner, may renew its existing business in the market in the applicable state or may be required to nonrenew all of its existing business in the market in the applicable state.

Review health carrier underwriting policies and procedures to verify that at the time of coverage renewal, a health carrier may modify the coverage for a product offered in the small group market if, for coverage that is available in such market other than only through one or more bona fide associations, such modification is consistent with applicable state law and effective on a uniform basis among small group health plans within that market.

Note: Examiners need to be that, in the case of a health carrier doing business in an established geographic service area of the applicable state, the guaranteed renewability provisions established by HHS, the DOL and the Treasury shall apply only to the health carrier's operations in that service area. Examiners should also be aware of the rating areas and the service areas that have been approved by the applicable state.

General Review Procedures and Criteria

Review complaint register/logs and complaint files to identify complaints pertaining to restriction of guaranteed renewability of coverage.

Review complaint records to verify that if the health carrier has improperly nonrenewed, or discontinued a health benefit plan providing small group market health insurance coverage, the health carrier has taken appropriate corrective action/adjustments regarding renewal of coverage, or continuation of coverage, in a timely and accurate manner.

Ascertain if any health carrier error could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to a policyholder whose health benefit plan providing small group market health insurance coverage was nonrenewed or discontinued.

Review policy form files to ensure approval(s) from the applicable state and (if applicable) from the Marketplace.

Verify that any marketing materials provided to insureds, prospective purchasers and policyholders by the health carrier provide complete and accurate information about guaranteed renewability of small group market health insurance coverage.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about guaranteed renewability of small group market health insurance coverage.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and Treasury provisions and final regulations pertaining to guaranteed renewability of small group market health insurance coverage.

Review health carrier training materials to verify that information provided is complete and accurate with regard to guaranteed renewability of small group market health insurance coverage.

Determine if the health carrier monitors producer-generated notices that nonrenew or discontinue coverage.

Review producer records of such notices for compliance with the guaranteed renewability provisions in final regulations established by HHS, the DOL and the Treasury.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

PROVISION TITLE: Lifetime/Annual Benefit Limits

CITATION: PHSA §2711

EFFECTIVE DATE: Plan years and, in the individual market, policy years beginning on or after Sept. 23, 2010

PROVISION: The provisions of the federal Affordable Care Act (ACA) established a requirement that a health carrier offering health insurance coverage in the individual and small group market in a state is prohibited from establishing lifetime limits and annual limits on the dollar value of essential health benefits.

BACKGROUND: Regulations and associated FAQs, issued by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury) set forth the requirement that a health carrier offering health insurance coverage in the individual market and small group market is prohibited from establishing lifetime limits and annual limits on the dollar value of essential health benefits.

Starting in 2014, the Affordable Care Act banned annual dollar limits. Until that time, annual limits were restricted under the Department of Health and Human Services (HHS) regulations published in June 2010. For plan years starting between Sept. 23, 2010 and Sept. 22, 2011, plans may not limit annual coverage of essential benefits such as hospital, physician and pharmacy benefits to less than $750,000. The restricted annual limit is $1.25 million for plan years starting on or after Sept. 23, 2011, and $2 million for plan years starting between Sept. 23, 2012 and Jan. 1, 2014. For plans issued or renewed beginning Jan. 1, 2014, all annual dollar limits on coverage of essential health benefits is prohibited.

This provision applies to all health carriers in the individual market and to small group employer plans. This provision applies to grandfathered and non-grandfathered group health plans, and non-grandfathered individual health benefit plans. This provision does not apply to grandfathered individual health insurance coverage.

FAQs: See the HHS website for federal guidance.

NOTES:

STANDARDS
LIFETIME/ANNUAL BENEFIT LIMITS

Standard 1
A health carrier shall not establish any lifetime or annual limit on the dollar amount of essential health benefits (EHB)s for any individual, in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Apply to: Restriction on the dollar amount of lifetime limits applies to all group health products (grandfathered and non-grandfathered products) for plan years beginning on or after Sept. 23, 2010, and all individual health products (non-grandfathered products) for policy years beginning on or after Sept. 23, 2010

Restriction on the dollar amount of annual limits applies to all group health products (grandfathered and non-grandfathered products) for plan years beginning on or after Jan. 1, 2014 and all individual health products (non-grandfathered products) for policy years beginning on or after Sept. 23, 2010

Not applicable to grandfathered individual health insurance coverage

Documents to be Reviewed

_____ Health carrier complaint handling policy/procedures

_____ Health carrier complaint register/logs/files

_____ Complaint letter or email and health carrier's complaint response

_____ Supporting documentation (claim files, underwriting files, etc.)

_____ Health carrier correspondence

_____ Health carrier policyholder service policy/procedures

_____ Health carrier policy files

_____ Health carrier marketing materials

_____ Health carrier policy forms and filings

_____ Health carrier claim handling policies/procedures

_____ Claims training manuals

_____ Health carrier internal claims audit reports

_____ Claim bulletins

_____ Health carrier claim forms manual

_____ Health carrier claim files

_____ Health carrier grievance handling policies/procedures

_____ Health carrier grievance procedure training manuals

_____ Health carrier grievance register

_____ Health carrier grievance records/files

_____ Health carrier internal grievance audit reports

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Individual Market Health Insurance Coverage Model Act (#36)
Small Group Market Health Insurance Coverage Model Act (#106)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented written complaint handling policies and procedures regarding compliance with restrictions on establishing lifetime/annual limits on the dollar amount of essential health benefits for any individual, in accordance with final regulations established by HHS, the DOL and the Treasury.

Review complaint logs/files to verify that, when improper application of lifetime/annual limits on the dollar amount of essential health benefits upon an individual occurs, the health carrier has taken appropriate corrective action/adjustments a timely and accurate manner.

Verify that the health carrier maintains proper documentation for all correspondence supporting the corrective action provided to the insured, including website notification.

Verify that the health carrier has established and implemented written policyholder service policies and procedures regarding compliance with restrictions on establishing lifetime/annual limits on the dollar amount of essential health benefits for any individual, in accordance with final regulations established by HHS, the DOL and the Treasury.

Verify that, for plan or policy years beginning prior to Jan. 1, 2014, for any individual, the health carrier has established, for its health benefit plans, the following minimum annual limits on the dollar amount of benefits that are essential health benefits:

- $750,000, for a plan or policy year beginning on or after Sept. 22, 2010, but before Sept. 23, 2011;
- $1,250,000, for a plan or policy year beginning on or after Sept. 22, 2011, but before Sept. 23, 2012; and
- $2,000,000, for a plan or policy year beginning on or after Sept. 22, 2012, but before Jan. 1, 2014.

With regard to U.S. Department of Health and Human Services (HHS) waivers, examiners need to be aware that for plan or policy years beginning prior to Jan. 1, 2014, a health benefit plan is exempt from annual limit requirements if the plan is approved for a waiver from such requirements by the HHS, but such exemption only applies for the specified period of time that the HHS waiver is applicable.

Verify that, when a health benefit plan receives a waiver from the HHS, the health carrier notifies prospective applicants, affected policyholders and the commissioner in each state where prospective applicants and any affected insured are known to reside.

Verify that, when an applicable HHS waiver expires or is otherwise no longer in effect, the health carrier notifies affected policyholders and the commissioner in each state where any affected insured is known to reside.

With regard to reinstatement of coverage, verify that the health carrier reinstates coverage for any individual:

- Whose coverage or benefits under a health benefit plan ended by reason of reaching a lifetime limit on the dollar value of all benefits for the individual; and
- Who becomes eligible, or is required to become eligible, for benefits not subject to a lifetime limit on the dollar value of all benefits under the health benefit plan:
    - For group health insurance coverage, on the first day of the first plan year beginning on or after Sept. 23, 2010; or
    - For individual health insurance coverage, on the first day of the first policy year beginning on or after Sept. 23, 2010.

Note: Examiners need to be aware that, for individual health insurance coverage, an individual is not entitled to reinstatement under a health benefit plan if the individual has reached his or her lifetime limit and the contract is not renewed or is otherwise no longer in effect. However, the requirement for reinstatement of coverage does apply to a family member who has reached his or her lifetime limit in a family plan and other family members remain covered under the plan.

With regard to reinstatement of coverage, if an individual is eligible for benefits or is required to become eligible for benefits under the health benefit plan, verify that the health carrier provides the individual with written notice that:

- The lifetime limit on the dollar value of all benefits no longer applies; and
- The individual, if still covered under the plan, is again eligible to receive benefits under the plan.

If an individual is not enrolled in the health benefit plan but for whom enrolled individual is eligible for, but not enrolled in any benefit package under a health benefit plan, verify that the health carrier provides an individual with an opportunity of at least 30 days to enroll in the health benefit plan.

Verify that the health carrier provides applicable notices and an enrollment opportunity beginning not later than:

- For group health insurance coverage, the first day of the first plan year beginning on or after Sept. 23, 2010; or
- For individual health insurance coverage, the first day of the first policy year beginning on or after Sept. 23, 2010.

Verify that the health carrier provides the notices as follows:

- For group health insurance coverage, to an employee on behalf of the employee's dependent;
- For individual health insurance coverage, to the primary subscriber on behalf of the primary subscriber's dependent;
- For group health insurance coverage, the notices may be included with other enrollment materials that a health benefit plan distributes to employees, provided the statement is prominently displayed on the notice; and
- For group health insurance coverage, if a notice is provided to an individual, a health carrier's requirement to provide the notice with respect to that individual is satisfied.

For any individual, who is eligible for benefits or who is required to become eligible for benefits under the health benefit plan, that enrolls in a health benefit plan, verify that coverage provided by the health carrier under the plan takes effect not later than:

- For group health insurance coverage, the first day of the first plan year beginning on or after Sept. 23, 2010; or
- For individual health insurance coverage, the first day of the first policy year beginning on or after Sept. 23, 2010.

Examiners need to be aware that, with regard to reinstatement of coverage, an individual enrolling in a health benefit plan for group health insurance coverage is to be treated by the health carrier as if the individual were a special enrollee in the plan, as provided under federal regulations 45 CFR §146.117(d).

With regard to reinstatement of coverage, verify that the health carrier:

- Offers the individual all of the benefit packages available to similarly situated individuals who did not lose coverage under the plan by reason of reaching a lifetime limit on the dollar value of all benefits; and
- Does not require the individual to pay more for coverage than similarly situated individuals who did not lose coverage by reason of reaching a lifetime limit on the dollar value of all benefits.

Examiners need to be aware that any difference in benefits or cost-sharing provided to the individual by the health carrier constitutes a different benefit package.

Verify that the health carrier's marketing materials provided to insureds and prospective insureds provides complete, accurate information about lifetime and annual limits.

Verify that the health carrier has established written claim handling policies and procedures regarding compliance with ACA-related restrictions on establishing lifetime/annual limits on the dollar amount of essential health benefits for any individual, in accordance with final regulations established by HHS, the DOL and the Treasury.

Verify that the health carrier's system of ACA-related oversight is reasonably designed to:

- Detect improper application of lifetime/annual limits on the dollar amount of essential health benefits for any individual;
- Identify exceptions found;
- Set forth recommended next steps; and
- Provide for appropriate corrective action/adjustments to be performed by the health carrier regarding incorrectly applied lifetime/annual limits, in a timely and accurate manner.

Review claim handling files to verify that the health carrier properly applies lifetime/annual limits on the dollar amount of essential health benefits for any individual, in accordance with final regulations established by HHS, the DOL and the Treasury.

Review claim handling files to verify that the health carrier does not improperly establish a <u>lifetime</u> limit on the dollar amount of essential health benefits for any individual.

Examiners need to be aware that:

- A health carrier is not prohibited from placing <u>annual</u> or <u>lifetime</u> dollar limits for any individual on specific covered benefits that are not essential health benefits to the extent that such limits are otherwise permitted under applicable federal or state law; and
- The provisions of the final regulations established by HHS, the DOL and the Treasury do not prohibit a health carrier from excluding all benefits for a given condition. However, examiners need to be aware that other state/federal laws or regulations, such as state laws regarding mandatory coverage for certain conditions, may prohibit such exclusions of all benefits for a given condition and may have been adopted as part of a state's essential health benefit package.

Verify that the health carrier does not establish an annual limit on the dollar amount of essential health benefits for any individual, with the following exceptions:

- Health flexible spending arrangements (FSA), as defined in Section 106(a)(2)(i) of the Internal Revenue Code;
- Medical savings accounts (MSA), as defined in Section 220 of the Internal Revenue Code; and
- Health savings accounts (HSA), as defined in Section 223 of the Internal Revenue Code.

Verify that the health carrier has taken into account only essential health benefits, in determining whether an individual has received benefits that meet or exceed the allowable limits.

Verify that the health carrier has established written grievance handling policies and procedures regarding compliance with ACA-related restrictions on establishing lifetime/annual limits on the dollar amount of essential health benefits for any individual, in accordance with final regulations established by HHS, the DOL and the Treasury.

Review grievance procedures files/records to verify that, when improper application of lifetime/annual limits on the dollar amount of essential health benefits upon an individual occurs, the health carrier has taken appropriate corrective action/adjustments a timely and accurate manner.

Verify that the health carrier maintains proper documentation for all correspondence supporting the corrective action provided to the insured, including website notifications.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

PROVISION TITLE: Network Adequacy

CITATION: PHSA §2702 (45 CFR §156.230)

EFFECTIVE DATE: Plan years and, in the individual market, policy years beginning on or after Jan. 1, 2014

PROVISION: The NAIC established network adequacy standards as set forth in the revised *Health Benefit Plan Network Access and Adequacy Model Act* (#74) for the creation and maintenance of networks by health carriers and to assure the adequacy, accessibility, transparency and quality of health care services offered under a network plan. In addition, provisions of the ACA established a requirement that a health carrier offering qualified health plans in the individual or group markets in a state must meet minimum criteria for the adequacy of provider networks delivering covered services to covered persons.

BACKGROUND: In Nov. 2015, the NAIC adopted a substantially revised network adequacy model, the *Health Benefit Plan Network Access and Adequacy Model Act* (#74). The NAIC established standards for the creation and maintenance of networks by health carriers and assures the adequacy, accessibility, transparency and quality of health care services offered under a network plan. Based upon the Affordable Care Act, federal regulatory agencies, including the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury), have issued regulations and associated regulatory guidance, including frequently asked questions (FAQs) that set forth minimum criteria for network adequacy that health carriers' network plans must meet in order to be certified as Qualified Health Plans (QHP's) and stand-alone dental plans (SADPs).

Pursuant to 45 CFR §156.230(a)(2), a health carrier which issues a QHP or SADP that uses a provider network must "maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to assure that all services will be accessible to enrollees without unreasonable delay." All health carriers applying for QHP certification need to attest that they meet this standard as part of the certification/recertification process.

Note: State regulators need to determine whether these examination standards are to apply to all health carriers in the individual market and to group plans, including non-grandfathered group health plans, or to only a subset of health insurance markets and policies, in accordance with state statute and regulations.

FAQs: See the HHS website for federal guidance.

NOTES: Examiners should obtain specific direction from the insurance commissioner ordering the examination as to whether there are provisions for which examiners are to apply federal statutes and regulations in addition to, or in place of, state statutes and regulations when applying these examination standards. Examiners should familiarize themselves with specific state and federal statutes and regulations as they pertain to network adequacy. States have considerable flexibility in determining how they want to address network adequacy issues, and the federal regulatory agencies have traditionally deferred to that inherent state authority. States may therefore require examiners to refer to specific state and federal law and regulations instead of the language found in the *Health Benefit Plan Network Access and Adequacy Model Act* (#74).

STANDARDS
NETWORK ADEQUACY

Standard 1
A health carrier offering individual and group market health insurance network plans shall develop and file an access plan with the insurance commissioner in accordance with requirements regarding content and filing of network access plans set forth in applicable state statutes, rules and regulations.

Apply to: Those individual and group health products and related provider networks as set forth in the state's statutes and regulations. For state examinations, in the absence of state statutes and regulations addressing ACA provisions, to all Qualified Health Plan products that use a provider network

Priority: Essential

Documents to be Reviewed

_____ State statutes and regulations and exchange requirements, addressing filing and approval of network adequacy or access plans

_____ Federal statutes and regulations as they pertain to network adequacy

_____ Approved network access plan(s)

_____ Health carrier policies and procedures related to the implementation of access plans

_____ Health carrier policies and procedures related to filing of access plans and material changes to access plans

_____ Policies and/or incentives that restrict, or unduly burden an enrollee's access to network providers, including provider specialists

_____ Health carrier communication and educational materials related to access plans provided to applicants, enrollees, policyholders, certificateholders and beneficiaries, including communications with producers

_____ Health carrier employees' and appointed agent training materials

_____ State exchange filing requirements

Others Reviewed

_____ _____

_____ _____

NAIC References

Health Benefit Plan Network Access and Adequacy Model Act (#74)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented written policies and procedures regarding the health carrier's filing of access plans at the time it files a newly offered provider network

Verify that a health carrier has filed a network access plan in a compliant manner and form and obtained all necessary approvals from the appropriate state regulators prior to or at the same time it files a newly offered network.

Verify that the health carriers' network(s) comply(ies) with approved access plan(s). This verification can be performed by directly confirming active provider participation, "secret shopping," reviewing regulatory or health carrier customer service inquiries and/or complaints, surveying policyholders and enrollees, or by other tools generally employed or otherwise utilized by examiners to verify a health carrier's compliance with filings.

Verify that the health carrier makes access plans, absent [proprietary, competitive or trade secret] information, available online, at its business premises, and to any person upon request.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

STANDARDS
NETWORK ADEQUACY

Standard 2
A health carrier offering individual and group market health insurance network plans shall maintain a network that is sufficient in number and types of providers, including those that serve predominantly low-income, medically underserved individuals, to assure that all covered services to covered persons will be accessible, without unreasonable travel or delay and that emergency services are accessible 24 hours per day, 7 days per week.

Apply to: Those individual and group health products and related provider networks as set forth in the state's statutes and regulations. For state examinations being conducted in the absence of state statutes and regulations addressing ACA provisions, to all Qualified Health Products that use a provider network

Priority: Essential

Documents to be Reviewed

_____ State statutes and regulations addressing network adequacy and plan design

_____ Federal statutes and regulations as they pertain to network adequacy

_____ Approved health carrier network access plan

_____ Health carrier policies and procedures related to implementing and maintaining network adequacy and access plans

_____ Health carrier correspondence with state regulators addressing issues related to maintaining network adequacy

_____ Health carrier policies and procedures related to filings for material changes to access plans

_____ Provider selection [tiering] criteria and supporting documentation regarding selection [tiering] criteria for maintaining network adequacy and access plans

_____ Documents related to recruitment and selection of providers including following approval of network access plan

_____ Provider directory/ies

_____ Provider/member location reports (e.g. by ZIP code)

_____ List of providers by specialty

_____ Any policies or incentives that restrict access to subsets of network specialists

_____ Health carrier complaint records concerning network adequacy, plan design and out of network service denials (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Health carrier marketing and sales policies and procedures that reference to network adequacy and plan design

_____ Health carrier marketing and educational materials related to network adequacy and plan design created for insureds, beneficiaries and prospective purchasers including communications with producers

_____ Health carrier employee training materials related to network adequacy maintenance activities

Others Reviewed

_____ _____

_____ _____

NAIC References

Health Benefit Plan Network Access and Adequacy Model Act (#74)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify the health carrier has maintained its provider network(s) in accordance with terms of the approved network access plan(s) and state [and federal] statutes and regulations, as applicable.

Verify the health carrier has implemented the administrative functions necessary to meet the size and performance requirements of its provider network(s), including any reasonable criteria in accordance with its approved access plan and state [and federal] statutes and regulations, as applicable.

Verify that the health carrier has established and implemented written policies and procedures regarding filings of amended access plans when necessitated by materials in its provider networks.

Verify as required by the approved access plan, and by state [and federal] statutes and regulations, that the health carrier's established network(s) address(es) at least the following:

- The use of telemedicine or telehealth or other technology to meet network access standards, if applicable; procedures for making and authorizing referrals within and outside its network, if applicable; factors used by the health carrier to build its provider network, including a description of the network and the criteria used to select [and/or tier] providers;
- The health carrier's efforts to address the needs of covered persons, including, but not limited to children and adults, including those with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, physical or mental disabilities, and serious chronic or complex medical conditions. This includes the carrier's efforts, when appropriate, to include various types of essential community providers (ECPs) in its network;
- The health carrier's system for ensuring the coordination and continuity of care in situations where the health carrier, or its intermediary, due to insolvency or other cessation of operations, and when a participating provider is being removed or leaving the network with or without cause:
    - For covered persons referred to specialty physicians; and
    - For covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;
- The health carrier's process for enabling covered persons to change primary care professionals, if applicable;
- The health carrier's process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, hospitalist care and pathology/laboratory services at the health carrier's participating hospitals.

Verify the health carrier monitors the performance of its provider network(s) in accordance with its approved access plan and state statutes and regulations, as applicable, and records such activities.

Verify the health carrier has implemented necessary provider network changes, including but not limited to contracting with additional or replacement providers for its provider network(s) required to maintain its provider network(s), as established within its approved access plan(s) and as required under applicable state [and federal] statutes and regulations.

Verify that the health carrier has notified the state insurance department [or other state regulator] of material changes to its access plan.

Verify the health carrier has received any required approvals necessitated by changes to the health carrier's provider network(s) or enrollment.

Verify the health carrier has implemented any requirements established by the state insurance department required by any changes to the access plan or the health carrier's enrolled policyholder and enrolled life membership counts, including any insured, beneficiary, prospective purchaser, or provider notice, education, or other communication(s).

Review health carrier policies and procedures related to network adequacy and plan design to verify that the health carrier maintains a network that is sufficient in number and appropriate types of providers, including providers who serve predominantly low-income, medically underserved individuals, to assure that all covered services to covered persons, including children and adults will be accessible without unreasonable travel or delay, and that emergency services are accessible 24 hours per day, 7 hours per week, in compliance with state [and federal] statutes and regulations.

Verify that the health carrier has established and implemented a process, including written policies and procedures, to assure that a covered person obtains a covered benefit at an in-network level of benefits, including an in-network level of cost-sharing, from a non-participating provider, or shall make other arrangements acceptable to the insurance commissioner as required under state statutes and regulations.

Verify that the health carrier specifies and informs covered persons of the process a covered person may use to request access to obtain a covered benefit from a non-participating provider and that such requests are documented, processed in a timely fashion and, for approved requests, that cost-sharing and out-of-pocket maximums are accurately applied, as required under state statutes and regulations.

Verify that the health carrier has a system in place that documents all requests to obtain a covered benefit from a non-participating provider and verify that the health carrier provides this information to the insurance commissioner of the applicable state upon request as required under state statutes and regulations.

Verify that that the health carrier monitors, on an ongoing basis, the ability, clinical capacity and legal authority of its participating providers to furnish all contractual covered benefits to covered persons.

Review complaint records to determine if the health carrier has not met minimum network adequacy standards contained within its access plan or required under applicable state [or federal] statutes and regulations or has improperly applied network adequacy standards and whether the health carrier has taken appropriate corrective action/adjustments for the covered person(s) in a timely and accurate manner.

Ascertain if any examination adverse determination finding could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence supporting corrective action provided to a covered person, including website notifications, as applicable.

Verify that health carrier communication and educational and marketing materials provided to insureds, beneficiaries and prospective purchasers provide complete and accurate information about network adequacy.

Verify that the health carrier has established training programs designed to inform its employees and agents about applicable state [and federal] laws and regulations.

Review health carrier employee training materials to verify that information provided is complete and accurate with regard to network adequacy.

Review producer records and health carrier communication with producers to verify that information provided by producers to applicants/proposed insureds is complete and accurate with regard to network adequacy.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

STANDARDS
NETWORK ADEQUACY

Standard 3
A health carrier's contractual arrangements with participating providers shall comply with requirements regarding health carrier/participating provider contractual requirements set forth in applicable state statutes and regulations.

Apply to: Those individual and group health products and related provider networks as set forth in the state's statutes and regulations. For state examinations being conducted in the absence of state statutes and regulations addressing ACA provisions, to Qualified Health Plan products that use a provider network

Priority: Essential

Documents to be Reviewed

_____ State statutes and regulations addressing network adequacy and plan design

_____ Federal statutes and regulations as they pertain to network adequacy

_____ Approved health carrier network access plan(s)

_____ Health carrier policies and procedures related to applicable contractual arrangements between health carriers and participating providers

_____ Health carrier contracts with providers

____ Health carrier complaint records relating to complaints or other disputes made by providers, policyholders or enrollees relating to network provider contractual matters

_____ Health carrier communication, education and training materials provided to participating providers

_____ Health carrier employee and agent training materials related to network provider contractual matters

Others Reviewed

_____ _____

_____ _____

NAIC References

Health Benefit Plan Network Access and Adequacy Model Act (#74)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier's network provider contracts comply with state [and federal] statutes and regulations and with approved network access plan(s).

Review how the health carrier markets or represents its network plans to consumers, particularly for those health carriers that market or represent to consumers as using quality as at least one method of assessing whether to include providers in the network. In addition, for such network plans, review the health carrier's provider selection standards to verify that quality is actually being used to assess whether to include providers in the network.

Verify that the health carrier has established and implemented written policies and procedures regarding compliance health benefit network plans with state [and federal] requirements relating to health carrier/participating provider contractual arrangements. Review records related to the written policies and procedures for any instances, indicating health carrier performance, that did not comply with such policies and procedures.

Verify that the health carrier has established a process by which contracting network providers will be notified of the specific covered health care services for which the provider will be responsible, including any limitations or conditions on services, on an ongoing basis. Review process records to confirm that the health carrier in fact provides such notifications in a timely manner.

Verify that contracts between a health carrier and a participating provider set forth a hold harmless provision specifying protection for covered persons in the event of nonpayment or insolvency of the health carrier or its intermediary, as required under state statutes or regulations.

Verify that contracts between the health carrier and a participating provider set forth that in the event of a health carrier or intermediary insolvency or other cessation of operations, the provider's obligation to deliver covered services to covered persons without balance billing will continue as required under state statutes or regulations.

Verify that the participating provider does not collect or attempt to collect from a covered person any money owed to the provider by the health carrier. Review the contract provisions within the health carrier/participating provider contract with regard to periodic reconciliation/audit of itemized bills related to claims to health carrier reimbursement amounts. Review explanation of benefits (EOB) documents to verify that the provider is collecting the appropriate amount from the covered person.

Verify that the health carrier has developed, for providers and each health care professional specialty, selection standards for selecting [and tiering], as applicable, of participating providers as required under the health carrier's approved access plan and in accordance with state statutes and regulations. Verify that the health carrier uses the selection standards in determining the selection [and tiering] of participating providers by the health carrier and its intermediaries with which it contracts.

Verify that the health carrier does not establish selection [and tiering] criteria in a manner:

- That would allow a health carrier to discriminate against high-risk populations by excluding [and tiering] providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health care services utilization; or
- That would exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health care services utilization.

Verify that the health carrier's selection criteria do not discriminate, with respect to participation under the health benefit plan, against any provider who is acting within the scope of the provider's license or certification under applicable state law or regulations.

Verify that consistent with state statutes and regulations, the health carrier makes its standards for selection and tiering, as applicable, of participating providers for its network(s)available for review [and approval] by the insurance commissioner.

Verify, if applicable, that a description in plain language of the standards the health carrier uses for selecting and tiering, as applicable, for its network providers is made available to the public.

Verify that the health carrier notifies participating providers of the providers' responsibilities with respect to the health carrier's applicable administrative policies and programs, including but not limited to payment terms; utilization review; quality assessment and improvement programs; credentialing; grievance and appeals procedures; data reporting requirements; reporting requirements for timely notice of changes in practice, such as discontinuance of accepting new patients; confidentiality requirements; and any applicable federal or state programs.

Review health carrier policies, procedures, programs, provider communications and other materials that may document or record health carrier activities related to provider networks, and policy provisions to identify if a health carrier offers an inducement to a provider that would encourage or otherwise incentivize the provider to deliver less than medically necessary services to a covered person.

Verify that the health carrier does not prohibit a participating provider from discussing any specific or all treatment options with covered persons irrespective of the health carrier's position on the treatment options or from advocating on behalf of covered persons within the utilization review or grievance or appeals processes established by the health carrier or a person contracting with the health carrier or in accordance with any rights or remedies available under applicable state [and federal] law and regulations. Examiners may need to review network provider contract forms and network provider communications, policies and other written materials. Review health carrier network provider records including communications that could contain complaints from network providers raising such concerns.

Verify that contracts between a health carrier and a participating provider require the provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of covered persons, and to comply with applicable state and federal laws related to the confidentiality of medical and health records and the covered person's right to see, obtain copies of or amend their medical and health records.

Verify that the health carrier and participating provider provide the requisite advance written notice to each other as required under state [and federal] statutes and regulations before the provider is removed or leaves a network without cause.

Verify that the health carrier maintains network provider participation records, including records pertaining to former network providers, to include records documenting provider status, status notices, renewals and terminations as required by state statutes and regulations.

Verify that the health carrier makes a good faith effort to provide written notice of a provider's removal or leaving the network within state [and federal] statutory or regulatory time frames for health carrier notices to all persons entitled to such notice under state [and federal] statutes or regulations.

Verify that when a provider who is a primary care professional has been removed, or has left a provider network, the provider provides the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier, as required by the health carrier's contract with the participating provider. If the list is not provided to the health carrier by the primary care physician who has been removed or who has left a provider network, ascertain why the health carrier has not enforced the contractual provision regarding such notice.

Verify that when the provider being removed or leaving the network is a primary care professional, the health carrier provides notice related to the termination to all covered persons who are patients of that primary care professional.

When a covered person's provider leaves or is removed from the network, verify that the health carrier establishes reasonable procedures addressing those covered persons who are in an active course of treatment, including procedures to assist transitions to participating providers in a manner that provides for continuity of care, in accordance with applicable state [and federal] statutes or regulations.

Verify that the health carrier makes available to the covered person information concerning available participating providers in the same geographic area who are of the same provider type, and information about how the covered person may request continuity of care.

Verify that the health carrier's procedures outlining how a covered person may request continuity of care include all provisions required under state [and federal] statutes or regulations, including:

- Individuals eligible to request continuity of care on behalf of patients;
- Individuals eligible to receive continuity of care;
- The length of the continuity of care period;
- Health carrier decision-making processes on continuity of care requests; and
- Enrollee grievance and appeal rights regarding continuity of care decisions.

Verify that the health carrier's procedures for continuity of care ensure that providers agree in writing to accept the same payment from and abide by the same terms and conditions with respect to the health carrier for that patient as provided in the original provider contract, and the provider agrees in writing not to seek any payment from the covered person for any amount for which the covered person would not have been responsible if the provider were still a participating provider.

Verify that health carrier contractual arrangements with participating providers ensure that the rights and responsibilities under a contract between a health carrier and a participating provider are not assigned or delegated by either party without the prior written consent of the other party.

Verify that the health carrier has written policies and procedures in place to ensure that a participating provider furnishes covered benefits to all covered persons without regard to the covered person's enrollment in the plan as a private purchaser of the plan or as a participant in publicly-financed programs of health care services. This requirement does not apply to circumstances when the provider should not render services due to limitations arising from lack of training, experience, skill or licensing restrictions.

Verify that the health carrier assumes responsibility for notifying participating providers (1) of their obligations, if any, to collect applicable coinsurance, copayments or deductibles from covered persons pursuant to the evidence of coverage, and (2) of their obligations, if any, to notify covered persons of their personal financial obligations for non-covered services.

Verify that a health carrier does not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare.

Verify that the health carrier has established a mechanism by which a participating provider may determine in a timely manner, at the time services are provided, whether or not an individual is a covered person or is within a grace period for payment of premium during which the health carrier may hold a claim for services rendered, pending receipt of payment of premium.

Verify that the health carrier has established written policies and procedures for resolution of administrative, payment or other disputes between providers and the health carrier for plans that use a provider network.

Review contractual arrangements between the health carrier and participating providers to ascertain if such contracts contain provisions that conflict with the provisions contained in the approved access plan(s) and/or the requirements of applicable state [and federal] statutes and regulations regarding network adequacy.

Verify that, at the time a contract is signed, the network provider receives a copy of or access to the network contract in a timely manner including all documents incorporated by reference. The provider contract shall define what is to be considered timely notice.

Verify that, while a provider contract is in force, the health carrier notifies a participating provider in a timely manner, of any changes to those provisions or documents that would result in material changes in the contract. The language of the contract shall define what is to be considered timely notice and what is to be considered a material change.

Verify that a health carrier informs a provider of the provider's network participation status, in a timely manner, on any health benefit plan in which the health carrier has included the provider as a participating provider.

Review complaint/dispute records to determine if the health carrier has not complied with the contractual provisions of the health carrier/participating provider contract, and whether the health carrier has provided appropriate corrective action/adjustments to the participating provider(s) in a timely and accurate manner.

Ascertain if any examination adverse determination finding could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence related to any corrective action provided to a participating provider.

Verify that health carrier communication and educational materials provided to participating providers provide complete and accurate information about health carrier/participating provider contractual arrangements.

Review health carrier training materials to verify that information provided is complete and accurate with regard to health carrier/participating provider contractual arrangements and state [and federal] statutes and regulations.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

STANDARDS
NETWORK ADEQUACY

Standard 4
A health carrier offering individual and group market health insurance network plans shall comply with requirements regarding balance billing in accordance with applicable state statutes and regulations.

Apply to: Those individual and group health products and related provider networks as set forth in the state's laws and regulations. For state examinations being conducted in the absence of state statutes and regulations addressing ACA provisions, to all Qualified Health Plan products that use a provider network

Note: Standard 4 is based on the section titled "Requirements for Participating Facilities with Non-Participating Facility-Based Providers" of the *Health Benefit Plan Network Access and Adequacy Model Act* (#74). In states that have not adopted this section of the Model Act, examiners should look at the state statutes and regulations that pertain to balance billing

Priority: Essential

Documents to be Reviewed

_____ State statutes and regulations addressing balance billing within health carrier provider networks

_____ Approved health carrier network access plan(s)

_____ Health carrier policies and procedures related to balance billing, including contractual arrangements between health carriers and participating providers

_____ Health carrier policyholder service policies and procedures related to balance billing

_____ Policyholder service files and supporting documentation regarding balance billing, including letters, notices, telephone scripts, etc., within health carrier provider network plans

_____ Non-emergency out-of-network services written disclosures issued by facility-based providers, if set forth in state statutes or regulations for health carrier provider networks

_____ Out-of-network emergency services billing notices issued by facility-based providers, if set forth in state statutes or regulations for health carrier provider networks

_____ Non-participating facility-based provider-issued payment responsibility notices/billing statements, if set forth in state statute or regulations for health carrier provider networks

_____ Health carrier's provider mediation processes, including policies and procedures, if set forth in state statutes or regulations for health carrier provider networks

_____ Records of open and completed provider mediations, if set forth in state statutes or regulations for health carrier provider network plans

_____ Health carrier complaint records concerning balance billing (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response) for health carrier provider network plans

_____ Health carrier communication and educational materials related to balance billing provided to insureds, beneficiaries and prospective purchasers of health carrier provider network plans

_____ Employee training materials related to balance billing for health carrier provider network plans

Others Reviewed

_____ _____

_____ _____

NAIC References

Health Benefit Plan Network Access and Adequacy Model Act (#74)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented written policies and procedures regarding compliance of network plans with requirements in approved provider networks and as set forth in applicable state statutes and regulations regarding balance billing.

Verify for non-emergency out-of-network services, at the time a participating facility schedules a procedure or seeks prior authorization from a health carrier for the provision of non-emergency services to a covered person, the facility provides the covered person with an out-of-network services written disclosure, in accordance with any requirements set forth in state statutes or regulations.

Verify that at the time of admission in the participating facility where the non-emergency services are to be performed on the covered person, the facility provides a covered person with a written disclosure and obtains the covered person's or the covered person's authorized representative's signature on the disclosure document acknowledging that the covered person received the disclosure document before the time of admission.

Verify for out-of-network emergency services, a non-participating facility-based provider includes a statement on any billing notice sent to a covered person for services provided, informing the covered person that he or she is responsible for paying the applicable in-network cost-sharing amount, but has no legal obligation to pay the remaining balance. Such statement also shall inform the covered person of his or her obligation to forward the bill to their health carrier for consideration under a provider mediation process as set forth in state statutes or regulations.

Verify that where a non-participating facility-based provider sends a billing notice directly to a covered person for the non-participating facility-based provider's service(s), the billing notice includes the Payment Responsibility Notice as set forth in state statutes or regulations.

Verify that non-participating facility-based providers do not attempt to collect payment, excluding appropriate cost-sharing, from covered persons when the provider has elected to trigger the health carrier's non-participating facility-based provider billing process.

Verify that non-participating facility-based providers who do not provide a covered person with a Payment Responsibility Notice may not balance bill the covered person.

Verify that for health carrier out-of-network facility-based provider payments, health carriers develop a program for payment of non-participating facility-based provider bills and may elect to pay non-participating facility-based provider bills as submitted or the health carrier may pay in accordance with the benchmark for non-participating facility-based provider payments established in applicable state statutes and regulations, and that non-participating

facility-based providers who object to such payment(s) may elect the provider mediation process described in applicable state statutes and regulations. Payments to non-participating facility-based providers shall be presumed to be reasonable if a payment is based on the higher of the health carrier's contracted rate or [XX] percentage of the Medicare payment rate for the same or similar services in the same geographic area.

Verify that the health carrier has established a provider mediation process for payment of non-participating facility-based provider bills for providers objecting to the application of the established payment rate outlined in applicable state statutes and regulations or that the health carrier otherwise complies with any state statutes and regulations regarding mediation or arbitration processes for payment of non-participating provider bills. The health carrier's provider mediation process shall be established in accordance with mediation standards as set forth under state statute and regulations.

Verify that following completion of the provider mediation process, the cost of mediation is split evenly and paid by the health carrier and the non-participating facility-based provider or that the health carrier otherwise follows any state statutes or regulations regarding its share of the cost for the process.

Verify that a health carrier provider mediation process is not used when the health carrier and the non-participating facility-based provider agree to a separate payment arrangement or when the covered person agrees to accept and pay the non-participating facility-based provider's charges for the out-of-network service(s).

Verify that a health carrier maintains records on all requests for mediation and completed mediations during a calendar year and, upon request, submits a report to the insurance commissioner in the format specified by the insurance commissioner.

Review complaint records (including complaint records to other state agencies, if applicable) to verify that if a non-participating facility-based provider attempts to collect payment, excluding appropriate cost-sharing, from a covered person for health care services, the non-participating facility-based provider has taken appropriate corrective action/adjustments regarding the removal of the requirement of the covered person's payment for health care services, in a timely and accurate manner.

Ascertain if any examination adverse determination finding could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, supporting corrective action provided to a covered person(s), including website notifications.

Verify that health carrier communication and educational materials provided to insureds, beneficiaries and prospective purchasers provide complete and accurate information about balance billing.

Verify that the health carrier has established training programs designed to inform its employees and producers about state [and federal] statutes and regulations pertaining to balance billing.

Review health carrier training materials for its employees and appointed agents to verify that information provided is complete and accurate with regard to balance billing.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek legal advice and assistance from the state insurance department.

STANDARDS
NETWORK ADEQUACY

Standard 5
A health carrier offering individual and group market health insurance network plans shall develop and issue written disclosures or notices to be provided to covered persons regarding balance billing, in accordance with applicable state statutes and regulations.

Apply to: Those individual and group health products and related provider networks as set forth in the state's laws and regulations. For state examinations conducted in the absence of state statutes and regulations addressing ACA provisions, to all Qualified Health Plan products that use a provider network

Note: Standard 5 is based on the section titled "Disclosure and Notice Requirements" of the *Health Benefit Plan Network Access and Adequacy Model Act* (#74). In states that have not adopted this section of the Model Act, examiners should look at the state's statutes and regulations that pertain to written disclosures or notices regarding balance billing

Priority: Essential

Documents to be Reviewed

_____ State statutes and regulations addressing balance billing within health carrier provider networks

_____ Federal statutes and regulations as they pertain to network adequacy

_____ Approved health carrier network access plan provisions related to written disclosures and notices regarding balance billing

_____ Provisions within health carrier contracts with network providers related to written disclosures and notices regarding balance billing

_____ Health carrier policyholder service policies and procedures related to written disclosures and notices of balance billing

_____ Policyholder service files and supporting documentation regarding balance billing, including letters, notices, telephone scripts, etc.

_____ Written disclosures for out-of-network services provided by health carriers regarding balance billing

_____ If set forth in state statutes or regulations, written disclosures for non-emergency services provided by facility-based providers regarding balance billing

_____ Health carrier complaint records concerning balance billing (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Health carrier communication and educational materials related to written disclosures/notices of balance billing provided to insureds/beneficiaries, prospective purchasers and producers

_____ Training materials for health carrier employees and appointed agents related to balance billing

Others Reviewed

_____ _____

_____ _____

NAIC References

Health Benefit Plan Network Access and Adequacy Model Act (#74)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that, as set forth in state [or federal] statute or regulation, the health carrier develops a written disclosure or notice to be provided to a covered person or the covered person's authorized representative at the time of pre-certification and other time frame(s) as set forth in state [or federal] statutes or regulations for a covered benefit to be provided at a facility that is in the covered person's health benefit plan network, that there is the possibility that the covered person could be treated by a health care professional that is not in the same network as the covered person's network.

Verify, as set forth in state [and federal] statutes or regulations, that the health carrier has established and implemented written policies and procedures regarding the content and issuance of written disclosures or notices to covered persons regarding balance billing.

Verify, as set forth in state [and federal] statutes or regulations, that the health carrier's disclosure or notice indicates that the covered person may be subject to higher cost-sharing, as described in the covered person's plan summary of coverage and benefits documents, including balance billing, if the covered services are performed by a health care professional, who is not in the covered person's plan network even though the covered person is receiving the covered services at a participating facility, and that information on what the covered person's plan will pay for the covered services provided by a non-participating health care professional is available on request from the health carrier. Verify that the notice includes other content as set forth in state [or federal] statutes or regulations pertaining to the treatment of costs incurred due to services provided by out-of-network providers. Verify that the disclosure or notice also informs the covered person or the covered person's authorized representative of options available to access covered services from a participating provider.

Verify, as set forth in statutes or regulations, that for non-emergency services, as a requirement of its provider contract with a health carrier, a facility develops a written disclosure or notice to be provided to a covered person of the carrier within ten (10) days of an appointment for in-patient or outpatient services at the facility or at the time of a non-emergency admission at the facility that confirms that the facility is a participating provider of the covered person's network plan and informs the covered person that a health care professional, such as an anesthesiologist, pathologist or radiologist, who may provide services to the covered person while at the facility may not be a participating provider in the same network as the covered person's network.

Verify that the health carrier has established processes to count the cost sharing paid by a covered person for an essential health benefit provided by an out-of-network provider in an in-network setting towards the enrollee's annual limitation on cost sharing in instances in which the carrier does not provide requisite notice to the covered person, as required under state [and federal] statutes and regulations.

Review complaint records to verify that if the health carrier has issued a written notice or disclosure of balance billing not in compliance with the content requirements of applicable state [and federal] statutes and regulations and the approved access plan has improperly issued such notice or has not issued such notice, the health carrier has taken appropriate corrective action/adjustments regarding the issuance of a proper written notice or disclosure to the covered person(s).

Ascertain if any examination adverse determination finding could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains correspondence, records documenting corrective actions taken on behalf of a covered person(s), including website notifications.

Verify that health carrier communication and educational materials provided to insureds, beneficiaries, prospective purchasers and producers provide complete and accurate information about content and issuance of written notices or disclosures pertaining to balance billing.

Verify that the health carrier has established training programs designed to inform its employees and appointed agents about state [and federal] and regulations regarding content and issuance of written notices or disclosures pertaining to balance billing. Review the health carrier's training materials to verify that the information provided is complete and accurate.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

STANDARDS
NETWORK ADEQUACY

Standard 6
A health carrier offering individual and group market health insurance network plans shall comply with requirements set forth in applicable state statutes and regulations regarding content, accessibility, transparency, accuracy, and completeness of printed and electronic provider directories.

Apply to: Those individual and group health products and related provider networks as set forth in the state's laws and regulations. For state examinations being conducted in the absence of state statutes and regulations addressing ACA provisions, to all Qualified Health Plan products that use a provider network

Priority: Essential

Documents to be Reviewed

_____ State statutes and regulations related to network provider directories

_____ Federal statutes and regulations as they pertain to network adequacy

_____ Approved health carrier network access plan(s)

_____ Hard copies and web-based copies of network provider directories

_____ Provisions within health carrier network provider contract(s) entered into pursuant to the approved network access plan(s) addressing provider directories

_____ Health carrier policies and procedures related to network provider directories, including policies and procedures for maintaining accurate and timely directories

_____ Files and supporting documentation regarding frequency of network provider directory revisions and updates

_____ Health carrier self-audits of provider directories, in accordance with state statutes and regulations

_____ Health carrier complaint records concerning the accessibility, accuracy and completeness of network provider directories as well as supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response

_____ Health carrier marketing and sales policies and procedures that refer to provider directories and networks

_____ Health carrier marketing and educational materials related to provider directories and networks provided to insureds, beneficiaries and prospective purchasers, including communications with producers

_____ Health carrier training materials for employees and appointed agents

_____ Producer records related to network provider directories

Others Reviewed

_____ _____

_____ _____

NAIC References

Health Benefit Plan Network Access and Adequacy Model Act (#74)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented written policies and procedures regarding compliance of all network plans with provider directory requirements in accordance with state [and federal] requirements.

Verify that the health carrier posts electronically a current and accurate provider directory for each of its network plans, including specified information required under state [and federal] statutes and regulations for health care professionals, hospitals and other facilities. To the extent required under state statutes and regulations, verify that this information is available in a searchable format.

Verify for electronic provider directories for each network plan, that the health carrier makes available specified additional information required under state statutes or regulations for health care professionals, hospitals and other facilities.

Verify that in making a provider directory available electronically, the health carrier ensures that the general public is able to view all of the current providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number.

Verify that the health carrier makes it clear for both its electronic and print directories what provider directory applies to which network plan, such as including the specific name of the network plan as marketed and issued in the applicable state.

Verify that the health carrier updates each network plan provider directory at least monthly or within the specified time frame stated under applicable state statutes or regulations.

Verify that the health carrier periodically audits at least a reasonable sample size of its provider directories for accuracy and retains documentation of such an audit to be made available to the insurance commissioner of the applicable state upon request or complies with any other provider directory audit requirements as applicable under state statutes or regulations.

Verify that the health carrier provides a print copy, or a print copy of the requested directory information, of a current provider directory with specified information for health care professionals, hospitals and other facilities, in accordance with state [and federal] statutes and regulations, upon request of a covered person or a prospective covered person.

Verify, via sample testing of the provider directory relative to network providers, that the network provider:

- Is still practicing;
- Is currently participating in the health carrier's network;
- Office is located at the address designated in the provider directory;
- Is practicing in accordance with the designation (i.e. pediatrics, nurse midwife, cardiology) as listed in the provider directory;
- Is currently accepting new patients;
- Has not been sanctioned or prohibited from participation in federal health care programs under Section 1128 or Section 1128A of the Social Security Act; and
- Has not had his/her license suspended or revoked by a state agency.

With regard to residential treatment facilities (mental health treatment and substance use disorder), verify that residential treatment facilities for mental health treatment and substance use disorder are included in the provider directory on the health carrier's website and in hardcopy.

Verify that for each network plan, a health carrier includes in plain language in both the electronic and print directory, general information, if applicable, describing the criteria the health carrier has used to build its provider network; describing the criteria the health carrier has used to tier providers; describing how the health carrier designates the different provider tiers or levels in the network and identifies for each specific provider, hospital or other type of facility in the network which tier each is placed, for example by name, symbols or grouping, in order for a covered person or a prospective covered person to be able to identify the provider tier; and noting that authorization or referral may be required to access some providers.

Verify that the health carrier includes in both its electronic and print directories a customer service email address and telephone number or electronic link that covered persons or the general public may use to notify the health carrier of inaccurate provider directory information.

Verify that for all of the pieces of information required to be included in a printed or electronic provider directory pertaining to a health care professional, a hospital or a facility other than a hospital, the health carrier makes available through the directory the source of the information and any limitations, if applicable.

Verify that the health carrier's provider directory, whether in electronic or print format, accommodates the communication needs of individuals with disabilities, and includes a link to or information regarding available assistance for persons with limited English proficiency, or otherwise complies with state statutes and regulations regarding accessibility.

Note: State regulators should be aware that a Qualified Health Plan (QHP) must comply with language accessibility requirements under federal regulations 45 CFR § 155.205 in order to be offered on a health insurance exchange under the federal Affordable Care Act (ACA) and implementing regulations.

Verify that the health carrier makes available in print, upon request, specified information about health care professionals, hospitals and other facilities required under state statute and regulations, for the applicable network plan.

Verify that the health carrier includes a disclosure in the printed directory that the information included in the directory is accurate as of the date of printing and that insureds, beneficiaries, prospective purchasers and producers should consult the health carrier's electronic provider directory on its website or call the health carrier's customer service telephone number to obtain current provider directory information.

Review complaint register/logs and complaint files to identify complaints pertaining to accessibility, accuracy and completeness of provider directories.

Review complaint records to verify that if the health carrier has issued a provider directory not in compliance with the content requirements of applicable state [and federal] statutes and regulations, has improperly issued such a directory or has not issued such a directory, the health carrier has taken appropriate corrective action/adjustments regarding the issuance of a proper provider directory to covered person(s).

Ascertain if any examination adverse determination finding could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains correspondence documenting the corrective action taken on behalf of a covered person(s), including website notifications related to provider directories.

Verify that any marketing materials, communication and educational materials provided to insureds, beneficiaries and potential purchasers by the health carrier provide complete and accurate information about the network based on evaluation of the content, accessibility, transparency, accuracy, and completeness of provider directories.

Verify that the health carrier has established training programs designed to inform its employees and appointed agents about applicable state [and federal] statutes and regulations pertaining to content, accessibility, transparency, accuracy, and completeness of provider directories.

Review health carrier training materials to verify that information provided is complete and accurate with regard to requirements for content, accessibility, transparency, accuracy, and completeness of provider directories.

Review producer records and health carrier communication with producers to verify that the provider directory information provided by producers to insureds, beneficiaries and prospective purchasers is complete and accurate with regard to provider networks.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

PROVISION TITLE: Prohibition on Preexisting Condition Exclusions

CITATION: PHSA §2704 and §1255

EFFECTIVE DATE: For grandfathered and non-grandfathered group health insurance coverage, plan years beginning on or after Jan. 1, 2014; grandfathered plans must also comply with other federal and state requirements related to preexisting condition exclusions, including HIPAA

For non-grandfathered individual health insurance coverage, policy years beginning, or applications denied on or after Jan. 1, 2014

For individuals under 19 years of age enrolled in transitional coverage, policy or plan years beginning on or after Sept. 23, 2010

PROVISION: The provisions of the federal Affordable Care Act (ACA) prohibit health carriers from denying coverage, limiting benefits or denying benefits to any individual, based upon a preexisting condition.

BACKGROUND: "Preexisting condition exclusion" means a limitation or exclusion on benefits (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan or group or individual health insurance coverage (or other coverage provided to federally eligible individuals pursuant to 45 CFR §148), whether medical advice, diagnosis, care or treatment was recommended or received before that day.

A preexisting condition exclusion includes any limitation or exclusion of benefits (including denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan, or group or individual health insurance coverage (or other coverage provided to federally eligible individuals pursuant to 45 CFR §148), such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period).

Note: The standards for Section 2704 are closely related to other provisions of the ACA regarding guaranteed issue, waiting periods and nondiscrimination. For instance, health carriers are prohibited from denying eligibility for benefits or from charging more for coverage on the basis of health status related factors, including health status, medical condition (both physical and mental illness) and claims experience, among other factors. It is important to review other areas of Chapter 24A for further guidance regarding other applicable health reform provisions.

Examiners should also refer to guidance provided by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury) final regulations, including FAQs and other guidance issued by HHS, the DOL and the Treasury with regard to the prohibition of preexisting condition exclusions and special enrollment period provisions.

FAQs: See the HHS website for federal guidance.

NOTES: For additional examination standards related to preexisting condition exclusions, please review the section of Chapter 24—Conducting the Health Examination in the *Market Regulation Handbook* related to HIPAA.

STANDARDS
PROHIBITION ON PREEXISTING CONDITION EXCLUSIONS

Standard 1
A health carrier may not deny coverage to applicants/proposed insureds, based on any preexisting condition exclusion or preexisting condition limitation.

Apply to: All group health products (grandfathered and non-grandfathered products) for plan years beginning on or after Jan. 1, 2014. Grandfathered plans must also comply with other federal and state requirements related to preexisting condition exclusions, including HIPAA

All individual health products (non-grandfathered products) for policy years beginning, or applications denied on or after Jan. 1, 2014

All transitional products (non-grandfathered products) for policy or plan years beginning on or after Sept. 23, 2010 for individuals under age 19

This does not apply to individual health insurance coverage grandfathered health plans. However, other federal and state requirements related to preexisting condition exclusions, including HIPAA, may apply

Priority: Essential

Documents to be Reviewed

_____ Data request for all applications for coverage during the relevant period, including the underwriting and rating characteristics of the applicant and the outcome of the application

_____ Health carrier underwriting, policyholder service, and complaint handling policies and procedures related to eligibility and coverage for applicants/proposed insureds with preexisting conditions

_____ Underwriting files

_____ Policyholder service files and supporting documentation, letters, notices, telephone scripts, etc., regarding preexisting conditions

_____ Complaint register/logs/files

_____ Health carrier complaint records (supporting documentation including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Applications for coverage and pre-enrollment questionnaires

_____ Questionnaires or assessments related to wellness or disease-management programs and health carrier policies and procedures for using this information

_____ Health carrier form approvals (policy language, enrollment materials and advertising materials, as required under state statutes, rules and regulations)

_____ Health carrier marketing and sales policies and procedures' references to preexisting conditions

_____ Health carrier communication and educational materials related to preexisting conditions provided to applicants and enrollees, including communications with producers

_____ Any information that health carriers request before an individual is accepted for coverage, including, but not limited to, claims history, family history, genetic information and credit information

_____ Training materials

_____ Producer records

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC References

Individual Market Health Insurance Coverage Model Regulation (#26)
Individual Market Health Insurance Coverage Model Act (#36)
Small Group Market Health Insurance Coverage Model Act (#106)
Nondiscrimination in Health Insurance Coverage in the Group Market Model Regulation (#107)
Small Group Market Health Insurance Coverage Model Regulation (#126)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Review health carrier underwriting, policyholder service and complaint handling policies and procedures for provisions addressing applicants/proposed insureds to verify that the health carrier has adequate and appropriate policies and procedures in place to ensure that coverage is not denied to applicants/proposed insureds on the basis of a preexisting condition. Such review should include examination of applications for coverage and pre-enrollment questionnaires, questionnaires or assessments related to wellness or disease-management programs, the collection of any other information that health carriers request before an individual is accepted for coverage, and health carrier policies and procedures for using this information.

Verify that the health carrier does not limit or exclude coverage under an individual or group health insurance benefit plan for an individual via the health carrier's issuance of a preexisting condition exclusion or preexisting condition limitation on that individual.

Note: HIPAA explicitly limits the use of preexisting condition exclusions and prohibits health carriers from denying eligibility for benefits or from charging more for coverage because of any health factor, including health status, medical condition (both physical and mental illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability and disability. For additional examination standards related to these requirements, please review the section of Chapter 24—Conducting the Health Examination in the *Market Regulation Handbook*.

Review health carrier underwriting files/records for denials of coverage for applicants/proposed insureds on the basis of a preexisting condition.

Review health carrier policyholder service files to identify inquiries regarding coverage denials for applicants/proposed insureds on the basis of a preexisting condition.

Analyze data on applications and the outcome of applications to assess whether there are unusual frequencies related to denials of coverage and the reasons for denials. An unusual frequency for a certain type of denial could indicate failure to comply with the prohibition against preexisting condition exclusions or limitations.

Review health carrier enrollment policies and procedures to verify that the health carrier has adequate and appropriate policies and procedures in place regarding applications for coverage for individuals, to include provisions addressing open enrollments and renewals:

- Verify that during an open enrollment period, a health carrier does not deny or unreasonably delay the issuance of a policy, refuse to issue a policy or issue a policy with any preexisting condition exclusion rider or endorsement to an applicant or insured on the basis of a preexisting condition; and
- Verify that the coverage offered by the health carrier is effective for those applying during an open enrollment period on the same basis as any applicant qualifying for coverage on an underwritten basis.

Verify that the health carrier:

- Provides prior prominent public notice on its Internet website and written notice of open enrollment rights for individuals to each of its policyholders at least 90 days before any open enrollment period; and
- Provides information as to how an individual may enroll in coverage with the health carrier during an open enrollment period.

Individual Health Insurance Coverage—Special Enrollment Periods

Verify that a health carrier that restricts enrollment to defined enrollment periods, including open enrollment periods, limited open enrollment periods and special enrollment periods, and provides those periods pursuant to 45 CFR §147.104 and §155.420, as well as in accordance with state-specific requirements.

Verify that a health carrier provides for a special enrollment period that is not less than 30 calendar days, pursuant to 45 CFR §147.104 and §155.420 for qualified individuals (and their dependents, when applicable) in the following circumstances:

- Loss of minimum essential coverage (including employer plans, Medicaid, CHIP and COBRA coverage, as well as loss of coverage due to divorce, legal separation, loss of dependent status or death of the policyholder);
- Addition of a dependent through marriage, birth, adoption, placement for adoption, or placement in foster care (including gaining a dependent through a child support order or other court order);
- Unintentional, inadvertent, or erroneous enrollment in a plan that results from error, misrepresentation, misconduct, or inaction of an officer, employee or agent of the exchange or HHS or its instrumentalities, or a non-exchange entity (including a health carrier or its representative) that provides enrollment assistance or conducts enrollment activities;
- Health carrier substantially violated a material provision of its contract in relation to the enrollee;
- Enrollee or dependent of an enrollee is determined newly eligible or ineligible for an advance premium tax credit or experiences a change in eligibility for cost-sharing reductions;
- A person terminates employer coverage as a result of being determined newly eligible for premium tax credits due to becoming ineligible for qualifying coverage in an eligible employer-sponsored plan;
- A person in a state that has not expanded Medicaid who was previously ineligible for premium tax credits due to having income below the federal poverty line experiences a change in household income that makes the person newly eligible for premium tax credits; or
- A permanent move that results in access to new individual market plans (including release from incarceration).

Verify that a health carrier that offers qualified health plans through an insurance exchange or marketplace serving the individual insurance market also provides for a special enrollment period that is not less than 60 days for qualified individuals in the following circumstances:

- Gain of status as a citizen, national, or lawfully present individual;
- Status as federally recognized American Indian tribe or Alaska Native; or
- Person demonstrates to the exchange in the state, in accordance with federal guidelines, that the individual meets other exceptional circumstances as the exchange may provide.

Verify that a health carrier provides for a special enrollment period with effective coverage dates that begin the first day of the month following enrollment if the plan is selected between the 1st and 15th of the month or the first day of the second month following enrollment if the plan is selected between the 16th and the last day of the month with the following exceptions:

- In the case of marriage, not later than the first day of the month following plan selection;
- In the case of a dependent's birth, adoption, placement for adoption, or placement in foster care, the date of the birth, adoption, placement for adoption or placement in foster care; or
- For loss of minimum essential coverage, the first day of the month following the loss of previous coverage if the qualified health plan is selected before or on the day of the loss. If the plan is selected after the date of coverage loss, then coverage is effective the first day of the month following plan selection.

Note: In some circumstances, federal rules permit states or the marketplace in a state to implement alternative coverage effective dates. Examiners should verify that health carriers are complying with any state-specific requirements that may apply.

Note: Examiners should be aware that in some cases, individuals having prior group health plan coverage may be eligible for special enrollment in a health benefit plan if the individual was under a COBRA continuation provision and the coverage under such provision was exhausted or the individual was not under a COBRA continuation provision, but the coverage was terminated as a result of a COBRA qualifying event resulting in the loss of eligibility of coverage, including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment or employer contributions toward such coverage were terminated.

Group Plans—Special Enrollment Periods

Verify that a health carrier offering coverage in the group market provides for an annual open enrollment period from Nov. 15 through Dec. 15, during which time employers may enroll in coverage without meeting any minimum participation or minimum contribution requirements.

Verify that a health carrier offering coverage in the group market permits employers to enroll at any time during the year, including outside of the annual group open enrollment period, and that the carrier does not place any unallowable enrollment restrictions on employers.

Verify that any enrollment restrictions that may be allowable outside of the annual group enrollment period (such as minimum participation and minimum contribution requirements) are applied by the carrier in a consistent manner to all employers seeking coverage.

Note: Different enrollment standards may apply depending on whether group coverage is being offered within a group exchange (also known as a SHOP marketplace) or in the group market outside of an exchange or SHOP. For example, the minimum participation requirement may be calculated differently. Examiners should be aware of such differences and also of whether the carrier being examined is offering coverage within a SHOP, outside the SHOP, or both.

Verify that a health carrier permits an employee, or a dependent of the employee, who is eligible, but not enrolled, to enroll for coverage under the terms of any health benefit plan of the employer during a special enrollment period if:

- The employee or dependent was covered under a group health plan or had coverage under a health benefit plan at the time coverage was previously offered to the employee or dependent;
- The employee's or dependent's coverage:
    - Was under a COBRA continuation provision and the coverage under this provision has been exhausted; or
    - Was not under a COBRA continuation provision and that other coverage has been terminated as a result of loss of eligibility for coverage, including as a result of a legal separation, divorce, cessation of dependent status, death, termination of employment, or reduction in the number of hours of employment or employer contributions towards that other coverage have been terminated, or loss of coverage because an individual no longer resides, lives or works in the service area of HMO coverage;
- The employee stated in writing at the time coverage was previously offered that coverage under a group health plan or other health benefit plan was the reason for declining enrollment, but only if the plan sponsor or carrier, if applicable, required such a statement at the time coverage was previously offered and provided notice to the employee of the requirement and the consequences of the requirement at the time; and
- Under the terms of the health benefit plan, the employee requests enrollment not later than 30 days after the triggering event.

Verify that the health carrier provides a special enrollment period to all covered employees that experience the following qualifying events that result in the loss of coverage of a qualified beneficiary pursuant to 29 USC §1163:

- The death of the covered employee;
- The termination (other than by reason of such employee's gross misconduct) or reduction of hours of the covered employee's employment;
- The divorce or legal separation of the covered employee from the employee's spouse;
- The covered employee becomes entitled to benefits under Title XVIII of the Social Security Act;
- A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan; or
- A proceeding in a case under Title XI of the Social Security Act, commencing on or after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time.

Verify that if an employee requests enrollment, the health carrier provides for enrollment effective not later than the first day of the first calendar month beginning after the date the health carrier received the completed request for enrollment.

Verify that, with respect to dependents of employees, the health carrier provides for a dependent special enrollment period during which the dependent, and if not otherwise enrolled, the employee, may be enrolled under a health benefit plan, if a person becomes a dependent of the employee/participant through marriage, birth adoption or placement for adoption.

Verify that the health carrier's special enrollment period for qualified individuals provides a period of time not less than 30 days from the date of the marriage, birth, adoption or placement for adoption (or, if dependent coverage is not generally made available, at least 30 days after the date the plan makes dependent coverage generally available).

Verify that the health carrier, for an employee who seeks to enroll a dependent during a special enrollment period, provides for the coverage of the dependent effective upon:

- In the case of marriage, not later than the first day of the first month beginning after the date the health carrier receives the completed request for special enrollment;
- In the case of a dependent's birth, as of the child's birth; and
- In the case of a dependent's adoption or placement for adoption, not later than the date of the adoption or placement for adoption.

Verify that the health carrier permits an employee or a dependent of the employee, who is eligible, but not enrolled, to enroll in coverage under the terms of the health benefit plan of the employer during a special enrollment period if:

- The employee or dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under the state child health plan under Title XXI of the Social Security Act and coverage of the employee or dependent under the plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under the plan not later than 60 days after the date of termination of such coverage; or
- The employee or dependent becomes eligible for assistance, with respect to coverage under the plan under a Medicaid plan under Title XIX of the Social Security Act or under the state child health plan under Title XXI of the Social Security Act, including any waiver or demonstration project conducted under or in relation to such a plan, if the employee requests coverage under the plan not later than 60 days after the employee or dependent is determined to be eligible for such assistance.

Verify that the health carrier provides adequate written notice of special enrollment rights and the requirement furnished to an individual declining coverage (if the plan requires the reason for declining coverage to be in writing). 29 CFR §2590.701-6 includes model language for informing employees of their special enrollment rights.

Verify that the health carrier does not treat special enrollees as late enrollees and offers the same benefit package as is offered to similarly situated individuals who enroll when first eligible. Any differences in benefits or cost-sharing requirements for different individuals constitute a different benefit package, and a special enrollee cannot be required to pay more for coverage or to enroll in different coverage than a similarly situated individual who enrolls in the same coverage when first eligible.

Verify that the health carrier is in compliance with 45 CFR §147.108 and 45 CFR §146.111, including the examples identified in federal regulations.

Review complaint register/logs and complaint files to identify complaints pertaining to coverage denial/restriction relating to the health carrier having imposed preexisting condition exclusions or preexisting condition limitations.

Review complaint records to verify that, when an applicant/proposed insured has been the subject of a restriction of health benefits coverage or has been denied health benefits coverage, due to the health carrier having imposed a preexisting condition exclusion or preexisting condition limitation, the health carrier has taken appropriate corrective action/adjustments in a timely and accurate manner.

Ascertain if any health carrier error could be the result of some systemic issue (e.g. programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to an applicant/proposed insured for whom coverage of health benefits were inappropriately restricted or denied due to the health carrier having imposed a preexisting condition exclusion or preexisting condition limitation.

Review policy form files to verify approval(s) from the applicable state and (if applicable) from the Marketplace, and compare against the issued certificate or policy provided in the sample.

Verify that any marketing materials provided to prospective purchasers by the health carrier provide complete and accurate information about the prohibition of the health carrier from imposing any preexisting condition exclusion or preexisting condition limitation.

Verify that health carrier communication and educational materials provided to applicants and enrollees provide complete and accurate information about the prohibition of the health carrier from imposing any preexisting condition exclusion or preexisting condition limitation.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and Treasury provisions and final regulations pertaining to prohibition of the health carrier from imposing any preexisting condition exclusion or preexisting condition limitation.

Review health carrier training materials to verify that information provided is complete and accurate with regard to limitations and restrictions regarding the issuance of preexisting condition exclusions or preexisting condition limitations.

Review producer records and health carrier communication with producers to verify that information provided by producers to applicants/proposed insureds is complete and accurate with regard to limitations and restrictions regarding the issuance of preexisting condition exclusions or preexisting condition limitations and does not encourage the exclusion of applicants/proposed insureds on the basis of preexisting conditions.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

STANDARDS
PROHIBITION ON PREEXISTING CONDITION EXCLUSIONS

Standard 2
A health carrier may not deny coverage to any insured, based on any preexisting condition exclusion or other preexisting condition limitation.

Apply to: All group health products (grandfathered and non-grandfathered products) for plan years beginning on or after Jan. 1, 2014. Grandfathered plans must also comply with other federal and state requirements related to preexisting condition exclusions, including HIPAA

All individual health products (non-grandfathered products) for policy years beginning, or applications denied on or after Jan. 1, 2014

All transitional products (non-grandfathered products) for policy or plan years beginning on or after Sept. 23, 2010 for individuals under age 19

This does not apply to individual health insurance coverage grandfathered health plans. However, other federal and state requirements related to preexisting condition exclusions, including HIPAA, may apply

Priority: Essential

Documents to be Reviewed

_____ Data request for all claims presented by policyholders during the relevant period including a description of the benefit requested and the outcome of the claim

_____ Health carrier policyholder service, complaint handling, claim handling and grievance policies and procedures related to coverage for insureds with preexisting conditions

_____ Policyholder service files, and supporting documentation, including claim denial letters and explanation of benefits, letters, notices, telephone scripts, etc., regarding preexisting conditions

_____ Complaint register/logs/files

_____ Health carrier complaint records (supporting documentation including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Claim files/register/logs

_____ Informal/formal grievances/register/logs

_____ Health carrier utilization management policies and procedures

_____ Applicable external appeals files/register/logs/external appeal resolutions and associated documentation

_____ Applications for coverage and pre-enrollment questionnaires

_____ Questionnaires or assessments related to wellness or disease-management programs and health carrier policies and procedures for using this information

_____ Health carrier form approvals (policy language, enrollment materials, and advertising materials, as required under state statutes, rules and regulations)

_____ Health carrier communication and educational materials related to preexisting conditions provided to policyholders, certificateholders and beneficiaries, including communication with producers

_____ Training materials

_____ Producer records

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC References

Individual Market Health Insurance Coverage Model Regulation (#26)
Individual Market Health Insurance Coverage Model Act (#36)
Small Group Market Health Insurance Coverage Model Act (#106)
Nondiscrimination in Health Insurance Coverage in the Group Market Model Regulation (#107)
Small Group Market Health Insurance Coverage Model Regulation (#126)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Review health carrier policyholder service, complaint handling, utilization management policies and procedures, claim handling and grievance procedures policies and procedures for provisions addressing insureds, to verify that a health carrier has adequate and appropriate policies and procedures in place to ensure that coverage is not denied to insureds on the basis of a preexisting condition or preexisting condition limitation.

Verify that the health carrier does not limit or exclude coverage for any insured under an individual or group health insurance benefit plan via the health carrier's issuance of a preexisting condition exclusion or preexisting condition limitation on that individual.

Review health carrier policyholder service files/records for inquiries regarding denial of coverage to insureds on the basis of a preexisting condition.

Review health carrier complaint register/logs and complaint records to identify complaints relating to denial of coverage to insureds on the basis of a preexisting condition.

Review health carrier claim files/register/logs and formal and informal grievances to identify insureds for whom coverage of health benefits was improperly restricted or denied, due to the health carrier having imposed a preexisting condition exclusion or preexisting condition limitation.

Review health carrier claim files/register and formal and informal grievances, as well as records of appeals of adverse utilization review determinations to verify that when a health carrier has improperly applied limitations or exclusions of coverage through the issuance of a preexisting condition exclusion or preexisting condition limitation on any insured, the health carrier has taken appropriate corrective action/adjustments regarding the removal of the limitations/exclusions in a timely and accurate manner.

Analyze data on claims presented and claim outcomes to assess whether there are unusual frequencies related to denials of claims and the reasons for denials. An unusual frequency for a certain type of claim denial could indicate failure to comply with the prohibition against preexisting condition exclusions or limitations.

Ascertain if any health carrier error could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented any corrective actions, including remediation and interest payments. The examiner should include this information in the examination report. If it appears financial harm occurred to consumers and the health carrier did not provide remediation, the examiner should make a recommendation for remediation to all affected consumers in the examination report.

Verify that the health carrier maintains proper documentation for all correspondence supporting corrective action provided to the insured, including website notifications.

Review of procedures should also require review of any external appeal requests and of the conclusions of external appeals addressing improper denial/restriction of coverage due to the health carrier having imposed a preexisting condition exclusion or preexisting condition limitation on an insured.

Review policy form files to verify approval(s) from the applicable state and, (if applicable) from the Marketplace and compare against the issued certificate or policy provided in the sample.

Note: Examiners need to be aware that other plan elements may result in the imposition of a preexisting condition exclusion or limitation on the insured or discourage the enrollment of individuals with significant health needs. These elements may include cost-sharing; narrow or tiered provider networks; drug formularies; restrictive medical necessity definitions; utilization management; waiting periods; and benefit substitution. Therefore, examiners should review the health carrier's health benefit plans to verify that these benefit design elements are consistent with reasonable medical management techniques and are not discriminatory.

Verify that health carrier communication and educational materials provided to policyholders, certificateholders and beneficiaries provide complete and accurate information about the prohibition of the health carrier from imposing any preexisting condition exclusion or preexisting condition limitation.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and Treasury provisions and final regulations pertaining to prohibition of the health carrier from imposing any preexisting condition exclusion or preexisting condition limitation.

Review health carrier training materials to verify that information provided is complete and accurate with regard to the prohibition of health carrier issuance of preexisting condition exclusions and preexisting condition limitations.

Review producer records and health carrier communications with producers to verify that information provided by producers to insureds and claimants is complete and accurate with regard to the prohibition of health carrier issuance of preexisting condition exclusions and preexisting condition limitations and does not encourage the exclusion of applicants/proposed insureds on the basis of preexisting conditions.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

PROVISION TITLE: Preventive Health Services

CITATION: PHSA §2713

EFFECTIVE DATE: Plan years and, in the individual market, policy years beginning on or after Sept. 23, 2010

PROVISION: The provisions of the federal Affordable Care Act (ACA) set forth established a requirement that a health carrier that provides coverage in the individual and small group market in a state must provide a minimum level of preventive benefits. PHSA §2713 contains guidelines for determining what services are considered "preventive." A health carrier may not impose cost sharing requirements on preventive health services.

BACKGROUND: Under the Patient Protection and Affordable Care Act (ACA), covered persons are eligible for a variety of "preventive services," without cost-sharing, or at no additional cost to the covered person. These preventive health services are among those designed to help identify health problems earlier, manage those problems more effectively, and treat those problems before they develop into more complicated and serious illness.

The U.S. Department of Health and Human Services (HHS) has provided several lists of covered preventive health services for different groups, including evidence-based screening and counseling, preventive services for adults, preventive services for children and youth, and preventive services for women, including pregnant women.

This provision applies to all health carriers in the individual market and to small group employer plans. This provision does not apply to grandfathered health insurance coverage.

FAQs: See the HHS website for federal guidance.

NOTES:

STANDARDS
PREVENTIVE HEALTH SERVICES

Standard 1
A health carrier shall not impose cost sharing requirements upon preventive services, as defined in, and in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Apply to: All group health products (non-grandfathered products) for plan years beginning on or after Sept. 23, 2010

Individual health products (non-grandfathered products) for policy years beginning on or after Sept. 23, 2010

Not applicable to grandfathered health insurance coverage

Priority: Essential

Documents to be Reviewed

_____ Health carrier complaint handling policy/procedures

_____ Health carrier complaint register/logs/files

_____ Health carrier complaint register

_____ Complaint letter or email and health carrier's complaint response

_____ Supporting documentation (claim files, underwriting files, etc.)

_____ Health carrier correspondence

_____ Health carrier policyholder service policy/procedures

_____ Health carrier policy files

_____ Health carrier marketing materials

_____ Health carrier policy forms and filings

_____ Health carrier claim handling policies/procedures

_____ Claims training manuals

_____ Health carrier internal claims audit reports

_____ Claim bulletins

_____ Health carrier claim forms manual

_____ Health carrier claim files

_____ Health carrier grievance handling policies/procedures

_____ Health carrier grievance procedure training manuals

_____ Health carrier grievance register

_____ Health carrier grievance records/files

_____ Health carrier internal grievance audit reports

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Individual Market Health Insurance Coverage Model Act (#36)
Small Group Market Health Insurance Coverage Model Act (#106)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established written complaint handling policies and procedures regarding compliance with ACA-related restrictions on the assessment of cost-sharing upon insureds for preventive items and services, in accordance with final regulations established by HHS, the DOL and the Treasury.

Review complaint logs/files to verify that, when improper assessment of cost-sharing upon insureds occurs, the health carrier has taken the appropriate corrective action/adjustment of the insured's policy deductibles, copayments, coinsurance and other cost-sharing mechanisms in a timely and accurate manner.

Verify that the health carrier maintains proper documentation for all correspondence supporting the corrective action provided to the insured, including website notifications.

Verify that the health carrier has established written policyholder service policies and procedures regarding compliance with ACA-related restrictions on the assessment of cost-sharing upon insureds for preventive items and services, in accordance with final regulations established by HHS, the DOL and the Treasury.

Note: Examiners need to be aware that other provisions of state or federal law may apply in connection with a health carrier's ceasing to provide coverage for any such items or services including Section §2715(d)(4) of the Public Health Services Act, which requires a health carrier to give 60 days' advance notice to a covered person before any material modification will become effective.

The USPSTF recommendations regarding breast cancer screening, mammography and prevention issued in or around November 2009 are not considered to be current. A health carrier would therefore not need to provide coverage in accordance with the November 2009 USPSTF guidelines. However, the examiner should check the USPSTF recommendations regarding breast cancer screening, mammography and prevention periodically to see if the recommendations have been updated.

Verify that the health carrier, at least annually at the beginning of each new plan year or policy year, whichever is applicable, revises the preventive services covered under its health benefit plans in accordance with final regulations established by HHS, the DOL and the Treasury and that are consistent with the recommendations of the USPSTF, the ACIP of the CDC and the guidelines with respect to infants, children, adolescents and women evidence-based preventive care and screenings supported by the HRSA in effect at the time.

Verify that the health carrier's marketing materials provided to insureds and prospective insureds provides complete, accurate information about the restriction of cost-sharing methods the health carrier may impose on the insured for preventive items and services described in the final regulations established by HHS, the DOL and the Treasury.

Verify that the health carrier has established written claim handling policies and procedures regarding compliance with ACA-related restrictions on the assessment of cost-sharing upon insureds for preventive items and services, in accordance with final regulations established by HHS, the DOL and the Treasury.

Verify that the health carrier's system of ACA-related oversight is reasonably designed to:

- Detect improper assessment of cost-sharing upon insureds for preventive items and services;
- Identify exceptions found;
- Set forth recommended next steps; and
- Provide for appropriate corrective action/adjustments to be performed by the health carrier on the insured's policy deductibles, copayments, coinsurance and other cost sharing mechanisms in a timely and accurate manner.

Review claim handling files to verify that the health carrier properly applies deductibles, copayments, coinsurance and other methods of cost-sharing on preventive items and services, in accordance with final regulations established by HHS, the DOL and the Treasury.

Review claim handling files to verify that the health carrier does not improperly impose any cost-sharing requirements, such as a co-payment, coinsurance or deductible with respect to any of the following items or services:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force (USPSTF) as of Sept. 23, 2010, with respect to the insured;
- Note: Examiners need to be aware that the listing of recommended items/services in the USPSTF may change over time. Examiners need to review the health carrier's claim practices procedures to verify that the health carrier is utilizing the USPSTF recommendations in effect at the time that the items/services are rendered to the insured. The website for verification of the aforementioned is, as of September 2012, located at *www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date*;
- Immunizations for routine use in children, adolescents and adult insureds that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved. A recommendation from the ACIP of the CDC is considered in effect after it has been adopted by the Director of the CDC, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the CDC. Note: The recommended immunizations for children, adolescents and adults referenced above can be found at *www.cdc.gov/vaccines/schedules*;
- With respect to infants, children and adolescent insureds, evidence-informed preventive care, and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- With respect to insured women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA.

Examiners need to be aware that a health carrier may impose cost-sharing requirements with respect to an office visit, if an item or service described in final regulations established by HHS, the DOL and the Treasury is billed separately or is tracked as individual encounter data separately from the insured's office visit.

Review the health carrier's claim handling files to verify that the health carrier does not improperly impose any cost-sharing requirements with respect to an office visit if a preventive item or service is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the insured's office visit is the delivery of the item or service.

If an item or service described in in final regulations established by HHS, the DOL and the Treasury is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is not the delivery of the item or service, then the carrier may impose cost sharing requirements.

Examiners need to be aware that with regard to preventive items and services delivered by out-of network providers:

- A health carrier that has a network of providers is not required to provide benefits for items and services described in final regulations established by HHS, the DOL and the Treasury that are delivered by an out-of-network provider; and
- A health carrier that has a network of providers is not precluded from imposing cost-sharing requirements for items or services described in final regulations established by HHS, the DOL and the Treasury that are delivered by an out-of-network provider.

Examiners need to be aware that nothing prevents a health carrier from using medical management techniques to determine frequency, method, treatment or setting described in final regulations established by HHS, the DOL and the Treasury to the extent not specified in the recommendation(s) or guideline(s).

Examiners need to be aware that with regard to additional services, a health carrier is not prohibited from providing coverage for items and services in addition to those recommended by the USPSTF or the ACIP of the CDC, or provided by guidelines supported by the HRSA, or from denying coverage for items and services that are not recommended by the USPSTF, the ACIP or the HRSA. A health carrier may impose cost-sharing requirements for a treatment not described in final regulations established by HHS, the DOL and the Treasury even if the treatment results from an item or service described in final regulations established by HHS, the DOL and the Treasury.

Verify that the health carrier has established written grievance handling policies and procedures regarding compliance with ACA-related restrictions on the assessment of cost sharing upon insureds for preventive items and services, in accordance with final regulations established by HHS, the DOL and the Treasury.

Review grievance procedures files/records to verify that, when improper assessment of cost-sharing upon insureds occurs, the health carrier has taken the appropriate corrective action/adjustments on the insured's policy deductibles, copayments, coinsurance and other cost sharing mechanisms in a timely and accurate manner.

Verify that the health carrier maintains proper documentation for all correspondence supporting the corrective action provided to the insured, including website notifications.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

PROVISION TITLE: Rescissions

CITATION: PHSA §2712

EFFECTIVE DATE: Plan years and, in the individual market, policy years beginning on or after Sept. 23, 2010

PROVISION: The provisions of the federal Affordable Care Act (ACA) prohibit health carriers from rescinding policies unless a rescission is based upon fraud or intentional misrepresentation of material fact.

BACKGROUND: Regulations and associated FAQs issued by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury) set forth the requirement that a rescission is a cancellation or discontinuance of coverage that has a retroactive effect; this includes a cancellation that treats a policy as void from the time of the group's enrollment or a cancellation that voids benefits paid up to one year before the cancellation. A rescission is not the cancellation or discontinuance of coverage that has only a prospective effect, nor the cancellation or discontinuance of coverage if effective retroactively to the extent it is based on a failure to timely pay required premiums or contributions towards the cost of coverage.

This provision applies to all health carriers in the individual market and to small group employer plans. This provision applies to both grandfathered and non-grandfathered group health plans.

A group health benefit plan and a health carrier offering group or individual health insurance coverage may not rescind such plan or coverage with respect to a plan enrollee (in the individual market, primary subscriber) once the enrollee (or subscriber) is covered under such plan or coverage, except that provision shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage.

Such plan or coverage may not be canceled except with prior notice to the plan enrollee (in the individual market, primary subscriber) and only as permitted under applicable sections of HHS, DOL and Treasury regulations.

FAQs: See the HHS website for federal guidance.

NOTES:

STANDARDS
RESCISSIONS

Standard 1
A health carrier may not retrospectively rescind individual or group coverage (including family coverage in which the individual is included) unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact.

Apply to: All group health products (grandfathered and non-grandfathered products) for plan years beginning on or after Sept. 23, 2010

All individual health products (grandfathered and non-grandfathered products) for policy years beginning on or after Sept. 23, 2010

Priority: Essential

Documents to be Reviewed

_____ Health carrier underwriting policies and procedures related to rescissions

_____ Underwriting files and supporting documentation regarding rescissions, including letters, notes, telephone scripts, etc.

_____ Rescinded policies

_____ Reformations/counteroffers

_____ Complaint register/logs/files

_____ Health carrier complaint records concerning rescissions (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complaint correspondence and health carrier response)

_____ Claim files

_____ Internal appeals/grievances files

_____ Applicable external appeals based on rescissions, external appeal resolution and associated documentation

_____ Health carrier form approvals (policy language, enrollment materials and advertising materials, as required under state statutes, rules and regulations)

_____ Health carrier marketing and sales policies and procedures' references to rescissions

_____ Health carrier communication and educational materials related to rescissions, provided to applicants, enrollees, policyholders, certificateholders and beneficiaries

_____ Training materials

_____ Producer records

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Individual Market Health Insurance Coverage Model Act (#36)
Small Group Market Health Insurance Coverage Model Act (#106)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding the prohibition of rescissions in accordance with final regulations established by HHS, the DOL and the Treasury.

Review health carrier underwriting policies and procedures related to rescissions to verify adequate and appropriate policies/procedures are in place to ensure rescissions issued by the health carrier are in compliance with final regulations established by HHS, the DOL and the Treasury.

Review rescinded policies to verify that the health carrier does not inappropriately rescind coverage.

Review reformations and/or counteroffers to determine if the reformation or counteroffer resulted in any inappropriate rescissions of coverage.

Note: Examiners need to be aware that carrier rescissions should be reviewed to ensure that carrier rescissions are not based on actions taken or statements made by enrollees on the basis of errors or misrepresentations on the part of carriers, exchanges, producers, navigators or assisters. (See the federal Centers for Medicare & Medicaid Services (CMS) guidance on errors and misrepresentations.)

Review rescission notices to verify that notices sent out clearly state the specific fraudulent act, practice, or omission or intentional misrepresentation of material fact on which the rescission is based, the terms of the plan or coverage that supports the rescission, and the factual basis for rescinding coverage.

Review complaint register/logs and complaint files to identify complaints pertaining to rescission.

Review complaint records to verify that when coverage has been rescinded inappropriately, the health carrier has taken appropriate corrective action/adjustments regarding the reinstatement of coverage in a timely and accurate manner.

Ascertain if any health carrier error could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to the individual whose coverage was inappropriately rescinded.

Review health carrier claim files to identify any coverage denials for claimants on inappropriately rescinded coverage.

Review health carrier internal appeals/grievance files to identify any coverage denials for individuals on inappropriately rescinded coverage.

Review procedures should also require review of any external appeal requests and of the conclusions of external appeals addressing rescissions.

Review policy form files to ensure approval(s) from the applicable state and (if applicable) from the Marketplace.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about rescissions.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about rescissions.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and Treasury provisions and final regulations pertaining to rescissions.

Review health carrier training materials to verify that information provided is complete and accurate with regard to rescissions.

Determine if the health carrier monitors producer-generated rescissions. Review producer records of rescissions for compliance with final regulations established by HHS, the DOL and the Treasury.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

STANDARDS
RESCISSIONS

Standard 2
A health carrier offering group or individual health insurance coverage shall provide at least 30 days' advance written notice to each plan enrollee (in the individual market, primary subscriber) who would be affected before coverage may be rescinded.

Apply to: All group health products (grandfathered and non-grandfathered products) for plan years beginning on or after Sept. 23, 2010

All individual health products (grandfathered and non-grandfathered products) for policy years beginning on or after Sept. 23, 2010

Priority: Essential

Documents to be Reviewed

_____ Health carrier underwriting policies and procedures related to rescissions

_____ Underwriting files and supporting documentation regarding rescissions, including letters, notices, telephone scripts, etc.

_____ Rescinded policies

_____ Complaint register/logs/files

_____ Health carrier complaint records concerning rescissions (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Training materials

_____ Producer records

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Individual Market Health Insurance Coverage Model Act (#36)
Small Group Market Health Insurance Coverage Model Act (#106)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding providing advance notice of rescissions in accordance with final regulations established by HHS, the DOL and the Treasury.

Review health carrier's underwriting policies and procedures related to advance written notice of rescissions to verify that adequate and appropriate policies/procedures are in place to ensure the health carrier issues advance written notice of rescissions in compliance with final regulations established by HHS, the DOL and the Treasury.

Review rescinded policies to verify that the health carrier provides 30-day advance written notice to a plan enrollee or, in the individual market, a primary subscriber.

Review complaint register/logs and complaint files to identify complaints pertaining to improper advance written notice of rescission.

Review complaint records to verify that when 30 days' advance written notice of rescission has not been provided, the health carrier has taken appropriate corrective action/adjustments regarding the reinstatement of coverage in a timely and accurate manner.

Ascertain if any health carrier error could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to an individual where advance written notice of rescission was inappropriately performed.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and Treasury provisions and final regulations pertaining to advance written notice of rescissions.

Review health carrier training materials to verify that information provided is complete and accurate with regard to advance written notice of rescissions.

Determine if the health carrier monitors producer-generated rescissions. Review producer records of rescissions for compliance with advance written notice provisions set forth in final regulations established by HHS, the DOL and the Treasury.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

PROVISION TITLE: Summary of Benefits and Coverage (SBC) and Uniform Glossary

CITATION: PHSA §2715

EFFECTIVE DATE: Policy years beginning on or after Sept. 23, 2012

PROVISION: The provisions of the federal Affordable Care Act (ACA) established a requirement that the U.S. Department of Health and Human Services (HHS) develop standards—for use by a group health plan and a health carrier offering group or individual health insurance coverage, in compiling and providing to applicants, enrollees, policyholders or certificateholders and beneficiaries a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage. HHS was also directed to develop standards for definitions for commonly used insurance-related and medical terms and such other terms that will help consumers understand and compare the terms of coverage and the extent of medical benefits (including any exceptions and limitations).

Regulations issued by HHS, the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury) established a framework for the production and distribution of SBCs, which include coverage examples and a uniform glossary of health insurance and medical definitions. These documents are designed to provide consumers—both individuals who purchase their own coverage and those who obtain coverage through their place of work—with consistent, understandable and comparable information regarding both available health coverage options and purchased or elected coverage.

BACKGROUND: The SBC and the uniform glossary are designed to provide consumers—both individuals who purchase their own coverage and those who obtain coverage through their place of work—with consistent, understandable and comparable information regarding health coverage options. While HHS interim regulations appear to require strict compliance with SBC format—including approved font, wording, and document layout and length—subsequent final regulations by HHS, the DOL and the Treasury have established a number of enforcement safe harbors for insurance carriers that are working diligently and in good faith to understand and come into compliance with health reform law.

With regard to compliance, "[t]he Departments' [HHS, DOL, and Treasury] basic approach to health reform implementation, as stated in associated HHS, DOL and Treasury FAQs, is: "[to work] together with employers, issuers, States, providers and other stakeholders to help them come into compliance with the new law and [to work] with families and individuals to help them understand the new law and benefit from it, as intended. Compliance assistance is a high priority for the Departments. Our approach to implementation is and will continue to be marked by an emphasis on assisting (rather than imposing penalties on) plans, issuers and others that are working diligently and in good faith to understand and come into compliance with the new law."

In addition, federal guidance is set forth in associated FAQs that "[t]o the extent a plan's terms do not reasonably correspond to these instructions, the template should be completed in a manner that is as consistent with the instructions as possible, while still accurately reflecting the plan's terms."

FAQs: See the HHS website for federal guidance.

NOTES:

STANDARDS
SUMMARY OF BENEFITS AND COVERAGE (SBC) AND UNIFORM GLOSSARY

Standard 1
The appearance, language, form and content of a summary of benefits and coverage (SBC) and uniform glossary issued by a health carrier shall be in compliance with final regulations issued by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Apply to: All individual health and group health products (grandfathered and non-grandfathered products) for plan years beginning on or after Sept. 23, 2012

Priority: Essential

Documents to be Reviewed

_____ Health carrier policyholder service and new business-related policies and procedures related to SBCs and uniform glossaries

_____ Health carrier SBC and uniform glossary implementation plan (first review year)

_____ Health carrier SBC template

_____ Health carrier documentation for SBC template variations

_____ Health carrier SBC-related communication and education materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries

_____ Samples of SBC forms, uniform glossaries and related forms, including the applicable health plans, policy forms, certificates and coverage endorsements

_____ Health carrier complaint handling policies and procedures related to incomplete, inaccurate and out-of-date SBC forms and uniform glossaries

_____ Health carrier complaint records regarding SBCs and uniform glossaries (supporting documentation including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Health carrier marketing and sales policies and procedures related to SBCs

_____ Producer records

_____ Training materials

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Individual Market Health Insurance Coverage Model Regulation (#26)
Individual Market Health Insurance Coverage Model Act (#36)
Small Group Market Health Insurance Coverage Model Act (#106)
Small Group Market Health Insurance Coverage Model Regulation (#126)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established policies and procedures regarding the appearance, language, form and content of SBCs and uniform glossaries in accordance with final regulations provided by HHS, the DOL and the Treasury.

Review the health carrier's policyholder service and new business-related policies and procedures to verify that the health carrier has adequate and appropriate policies and procedures in place to ensure that the appearance, language, form and content of SBCs and uniform glossaries is in compliance with final regulations provided by HHS, the DOL and the Treasury.

For both group health plans and individual health plans, review SBCs and copies of uniform glossaries issued by a health carrier, together with the applicable health plan, policy forms, certificates and coverage documents for consistency and accuracy of the SBC in describing the benefits and coverage of the plan.

For both group health plans and individual health plans, review SBCs and copies of uniform glossaries issued by a health carrier for compliance with HHS, the DOL and the Treasury requirements, in the following areas:

- Length of document limited to eight sides or four sheets;
- Twelve-point font size;
- Language (culturally and linguistically appropriate and understandable language);
- Content (required content elements and coverage examples); and
- Health carrier contact information.

Note: Examiners need to be aware that HHS guidance permits carriers to exceed the four-page length limit if the carrier determines it is necessary to allow for the accurate portrayal of required information.

Review health carrier's SBCs and uniform glossaries for compliance with HHS, the DOL and the Treasury safe-harbor requirements.

In instances where a health carrier has issued an SBC that is at variance with applicable health carrier instructions, review health carrier documentation for SBC variations to obtain an explanation for the variance.

Review complaint records to verify that when an SBC or uniform glossary is provided in error, the health carrier has taken appropriate corrective action/adjustment regarding the issuance of a revised SBC and/or uniform glossary in a timely and accurate manner.

Ascertain if any health carrier error could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence supporting corrective action provided to the recipient of an SBC and/or a uniform glossary, including website notifications.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about SBCs and uniform glossaries.

Review the health carrier's training materials to verify that information provided is complete and accurate with regard to the appearance, language, form and content of SBCs and uniform glossaries.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

STANDARDS
SUMMARY OF BENEFITS AND COVERAGE (SBC) AND UNIFORM GLOSSARY

Standard 2
A health carrier shall make a summary of benefits and coverage (SBC) available in compliance with final regulations issued by the U.S. Department of Health and Human Services (HHS), U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Apply to: All individual health and group health products (grandfathered and non-grandfathered products) for plan years beginning on or after Sept. 23, 2012

Priority: Essential

Documents to be Reviewed

_____ Health carrier policyholder service and new business-related policies and procedures related to SBCs and uniform glossaries

_____ Health carrier SBC and uniform glossary implementation plan (first review year)

_____ Health carrier SBC-related communication and education materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries

_____ Consumer SBC requests and health carrier delivery logs or other related information or protocols

_____ Samples of SBC forms, uniform glossaries including any web-based forms

_____ Health carrier complaint handling policies and procedures related to incorrectly issued and/or missing SBC forms and uniform glossaries

_____ Health carrier complaint records regarding SBCs and uniform glossaries (supporting documentation including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Health carrier marketing and sales policies and procedures related to SBCs

_____ Producer records

_____ Training materials

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Individual Market Health Insurance Coverage Model Regulation (#26)
Individual Market Health Insurance Coverage Model Act (#36)
Small Group Market Health Insurance Coverage Model Act (#106)
Small Group Market Health Insurance Coverage Model Regulation (#126)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established policies and procedures regarding the availability of SBCs and uniform glossaries in accordance with final regulations provided by HHS, the DOL and the Treasury.

Note: Examiners need to be aware that an SBC must be provided in several different circumstances, such as upon application for coverage, by the first day of coverage (if information in the SBC has materially changed), upon renewal or re-issuance, and upon request. Health carrier requirements regarding availability and method of delivery of the SBC and uniform glossary vary based upon HHS, DOL and Treasury final regulations regarding group (initial enrollment and renewals) or individual health insurance coverage. Review HHS, DOL and Treasury final regulations for requirements pertaining to health carrier production, issuance and delivery of SBCs and uniform glossaries to applicants, enrollees, policyholders or certificateholders, and beneficiaries.

Note: Examiners need to be aware that HHS/DOL/Treasury rules permit carriers to establish procedures designed to prevent the delivery of multiple identical SBCs to covered individuals residing at the same location.

Verify that the health carrier makes SBCs available without cost to consumers, when "shopping," upon application for insurance or during a plan or policy year.

Review complaint records to: 1) verify that when a health carrier has not made available or has improperly issued an SBC and/or a uniform glossary, the health carrier has taken appropriate corrective action/adjustments in a timely and accurate manner; and 2) ascertain if any health carrier error could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence supporting corrective action provided to the recipient of an SBC and/or a uniform glossary, including website notifications.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete, accurate and current information about the availability of SBCs and uniform glossaries.

Review the health carrier's training materials to verify that information provided is complete and accurate with regard to the availability of SBCs and uniform glossaries.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

PROVISION TITLE: Utilization Review

CITATION: PHSA §2719

EFFECTIVE DATE: Plan years and, in the individual market, policy years beginning on or after Sept. 23, 2010

PROVISION: The provisions of the federal Affordable Care Act (ACA) set forth requirements with respect to internal claims and appeals and external review processes for group health plans and health carriers that are not grandfathered health plans under 45 CFR §147.140.

BACKGROUND: Regulations and associated FAQs, issued by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury) set forth the requirements with respect to internal claims and appeals and external review processes for health carriers offering health insurance coverage in the individual and small group market.

Paragraph (b) of 45 CFR §147.136 provides requirements for internal claims and appeals processes. Paragraph (c) of 45 CFR §147.136 sets forth rules governing the applicability of state external review processes. Paragraph (d) of 45 CFR §147.136 sets forth a federal external review process for plans and issuers not subject to an applicable state external review process. Paragraph (e) of 45 CFR §147.136 prescribes requirements for ensuring that notices required to be provided under this section are provided in a culturally and linguistically appropriate manner. Paragraph (f) of this section describes the authority of HHS to deem certain external review processes in existence on March 23, 2010 as in compliance with paragraph (c) or (d) of 45 CFR §147.136. Paragraph (g) of 45 CFR §147.136 sets forth the applicability date for this section.

PHSA §2719 and the interim final regulations implementing §2719 require that group health plans and health carriers offering coverage in the group and individual markets comply with a state's external review process, if that process includes, at a minimum, the consumer protections set forth in the *Uniform Health Carrier External Review Model Act* (#75). The *Uniform Health Carrier External Review Model Act* (#75) references the procedures and time frames in the *Utilization Review and Benefit Determination Model Act* (#73). The *Health Carrier Grievance Procedure Model Act* (#72) sets out a process, including time frames, for covered persons to file a grievance requesting a review of an adverse determination made by a health carrier made under the *Utilization Review and Benefit Determination Model Act* (#73).

This provision applies to all health carriers in the individual market and to small group employer plans. This provision applies to non-grandfathered group health plans.

FAQs: See the HHS website for federal guidance.

NOTES:

STANDARDS
UTILIZATION REVIEW

Standard 1
The health carrier shall operate its utilization review program in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Apply to: Health carriers offering a health benefit plan providing or performing utilization review services

This provision does not apply to grandfathered health plans

Priority: Essential

Documents to be Reviewed

_____ Health carrier utilization review policies and procedures

_____ Form letters

_____ Activity reports

_____ Provider manual

_____ Files with utilization review requests (Verify all levels of authorized, appealed and denied/approved requests are reviewed)

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Utilization Review and Benefit Determination Model Act (#73)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented written policies and procedures regarding the operation of its utilization review program, in accordance with final regulations established by HHS, the DOL and the Treasury.

Note: Examiners need to be aware that whenever a health carrier fails to adhere to the requirements set forth in applicable state statutes, rules and regulations with respect to making standard or expedited utilization review and benefit determinations of a benefit request or claim, the covered person, or, if applicable, the covered person's authorized representative, shall be deemed to have exhausted the provisions of applicable state statutes, rules and regulations equivalent to the *Utilization Review and Benefit Determination Model Act* (#73) and may take action as outlined in applicable state statutes, rules and regulations relating to the *Uniform Health Carrier External Review Model Act* (#76).

The provisions of applicable state statutes, rules and regulations regarding standard or expedited utilization review and benefit determinations shall not be deemed exhausted based on a *de minimis* violation that does not cause, and is not likely to cause, prejudice or harm to the covered person as long as the health carrier demonstrates that the violation was for good cause or due to matters beyond the control of the health carrier and that the violation occurred in the context of an ongoing, good faith exchange of information between the health carrier and the covered person, or, if applicable, the covered person's authorized representative.

The exception noted above does not apply if the violation is part of a pattern or practice of violations by the health carrier.

A covered person, or, if applicable, the covered person's authorized representative, may request a written explanation of the violation from the health carrier. Verify that the health carrier has:

- Provided the written explanation within 10 days of receiving the request; and
- Included in the written explanation a specific description of its bases, if any, for asserting that the violation does not deem the provisions of applicable state statutes, rules and regulations to be exhausted.

Note: Examiners need to be aware that if an independent reviewer or a court of competent jurisdiction rejects the benefit request or claim for immediate review on the basis that the health carrier met the requirements of the exception outlined above, the covered person, or, if applicable, the covered person's authorized representative, has the right to resubmit and, as appropriate, pursue a review of the benefit request or claim under applicable state statutes, rules and regulations equivalent to the *Utilization Review and Benefit Determination Model Act* (#73) or file a grievance pursuant to applicable state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72).

In this case, verify that the health carrier has provided to the covered person or, if applicable, the covered person's authorized representative, notice, within a reasonable period of time, but not to exceed 10 days after the independent reviewer or the court rejects the benefit request or claim for immediate review, of the opportunity to resubmit and, as appropriate, pursue a review of the benefit request or claim under applicable state statutes, rules and regulations equivalent to the *Utilization Review and Benefit Determination Model Act* (#73) or file a grievance pursuant to applicable state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72).

For purposes of calculating the time period for refiling the benefit request or claim, verify that the health carrier calculates the time period shall begin upon the covered person's, or, if applicable, the covered person's authorized representative's, receipt of the notice of opportunity to resubmit.

Verify that the health carrier, in conducting utilization review, ensures that the review is conducted in a manner to ensure the independence and impartiality of the individuals involved in making the utilization review or benefit determination.

Verify that the health carrier, in ensuring the independence and impartiality of individuals involved in making the utilization review or benefit determination, does not make decisions regarding hiring compensation, termination, promotion or other similar matters based upon the likelihood that the individual will support the denial of benefits.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

STANDARDS
UTILIZATION REVIEW

Standard 2
The health carrier shall provide written notice of an adverse determination of standard utilization review and benefit determinations, in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Apply to: Health carriers offering a health benefit plan providing or performing utilization review services

This provision does not apply to grandfathered health plans

Priority: Essential

Documents to be Reviewed

_____ Health carrier utilization review policies and procedures

_____ Form letters

_____ Utilization review files

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Utilization Review and Benefit Determination Model Act (#73)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented written policies and procedures in regard to providing written notice of an adverse determination of standard utilization review and benefit determinations, in accordance with final regulations established by HHS, the DOL and the Treasury.

Verify that the health carrier issues notification of an adverse determination in a manner calculated to be understood by the covered person, or, if applicable, the covered person's authorized representative, to include all of the following:

- Information sufficient to identify the benefit request, or claim involved, including the date of service, if applicable, the health care provider and the claim amount, if applicable;

- A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning. Verify that the health carrier:
    - Provides to the covered person, or, if applicable, the covered person's authorized representative, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse determination;
    - Does not consider a request for the diagnosis code and treatment information, in itself, to be a request to file a grievance for review of an adverse determination pursuant to applicable state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72);
    - The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in denying the benefit request or claim; and
    - A statement explaining the availability of and the right of the covered person, or, if applicable, the covered person's authorized representative, as appropriate, to contact the insurance commissioner's office or ombudsman's office at any time for assistance or, upon completion of the health carrier's grievance procedure process as provided under state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72), to file a civil suit in a court of competent jurisdiction. The statement shall include contact information for the insurance commissioner's office or ombudsman's office.

Verify that the health carrier provides the notice in a culturally and linguistically appropriate manner in accordance with federal regulations.

Verify that the health carrier:

- Provides oral language services, such as a telephone assistance hotline, that include answering questions in any applicable non-English language and providing assistance with filing benefit requests and claims and appeals in any applicable non-English language;
- Provides, upon request, a notice in any applicable non-English language; and
- Includes in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the health carrier.

With respect to any United States county to which a notice is sent, a non-English language is an applicable non-English language if 10 percent or more of the population residing in the county is literate only in the same non-English language, as determined in published federal guidance.

If the adverse determination is a rescission, verify that the health carrier provides in the advance notice of the rescission determination required to be provided under applicable state statutes, rules and regulations related to the advance notice requirement of a proposed rescission, in addition to any applicable disclosures required pursuant to other applicable state statutes, rules and regulations:

- Clear identification of the alleged fraudulent act, practice or omission or the intentional misrepresentation of material fact;
- An explanation as to why the act, practice or omission was fraudulent or was an intentional misrepresentation of a material fact;
- Notice that the covered person, or if applicable, the covered person's authorized representative, prior to the date the advance notice of the proposed rescission ends, may immediately file a grievance to request a review of the adverse determination to rescind coverage pursuant to state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72);
- A description of the health carrier's grievance procedures established pursuant to state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72), including any time limits applicable to those procedures; and
- The date when the advance notice ends and the date back to which the coverage will be retroactively rescinded.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

STANDARDS
UTILIZATION REVIEW

Standard 3
The health carrier shall conduct expedited utilization review and benefit determinations, in a timely manner and in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Apply to: Health carriers offering a health benefit plan providing or performing utilization review services

This provision does not apply to grandfathered health plans

Priority: Essential

Documents to be Reviewed

_____ Health carrier utilization review policies and procedures

_____ Form letters

_____ Utilization review files

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Utilization Review and Benefit Determination Model Act (#73)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented written policies and procedures regarding receiving and resolving expedited review of utilization review and benefit determinations, in accordance with final regulations established by HHS, the DOL and the Treasury.

Verify that the health carrier notification of an adverse determination pursuant to an expedited utilization review and benefit determination is set forth in a manner calculated to be understood by the covered person, or, if applicable, the covered person's authorized representative, to include all of the following:

- Information sufficient to identify the benefit request, or claim involved, including the date of service, if applicable, the health care provider and the claim amount, if applicable;

- A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning. Verify that the health carrier:
    - Provides to the covered person, or, if applicable, the covered person's authorized representative, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse determination;
    - Does not consider a request for the diagnosis code and treatment information, in itself, to be a request to file a grievance for review of an adverse determination pursuant to applicable state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72);
    - The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in denying the benefit request or claim; and
    - A statement explaining the availability of and the right of the covered person, or, if applicable, the covered person's authorized representative, as appropriate, to contact the insurance commissioner's office or ombudsman's office at any time for assistance or, upon completion of the health carrier's grievance procedure process as provided under state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72), to file a civil suit in a court of competent jurisdiction. The statement shall include contact information for the insurance commissioner's office or ombudsman's office.

Verify that the health carrier provides the notice in a culturally and linguistically appropriate manner in accordance with federal regulations.

Verify that the health carrier:

- Provides oral language services, such as a telephone assistance hotline, that include answering questions in any applicable non-English language and providing assistance with filing benefit requests and claims and appeals in any applicable non-English language;
- Provides, upon request, a notice in any applicable non-English language; and
- Includes in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the health carrier.

With respect to any United States county to which a notice is sent, a non-English language is an applicable non-English language if 10 percent or more of the population residing in the county is literate only in the same non-English language, as determined in published federal guidance.

If the adverse determination is a rescission, verify that the health carrier provides, in addition to any applicable disclosures required pursuant to applicable state statutes, rules and regulations:

- Clear identification of the alleged fraudulent act, practice or omission or the intentional misrepresentation of material fact;
- An explanation as to why the act, practice or omission was fraudulent or was an intentional misrepresentation of a material fact;
- The date the health carrier made the decision to rescind the coverage; and
- The date when the advance notice of the health carrier's decision to rescind the coverage ends.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

STANDARDS
UTILIZATION REVIEW

Standard 4
The health carrier shall conduct utilization reviews or make benefit determinations for emergency services in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Apply to: Health carriers offering a health benefit plan providing or performing utilization review services

This provision does not apply to grandfathered health plans

Priority: Essential

Documents to be Reviewed

_____ Health carrier utilization review policies and procedures

_____ Member materials

_____ Files of emergency services

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Utilization Review and Benefit Determination Model Act (#73)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented written policies and procedures regarding receiving and resolving utilization reviews or making benefit determinations for emergency services, in accordance with final regulations established by HHS, the DOL and the Treasury.

When conducting utilization review or making a benefit determination for emergency services, verify that a health carrier providing benefits for services in an emergency department of a hospital follows provisions set forth in applicable statutes, rules and regulations.

Verify that a health carrier covers emergency services to screen and stabilize a covered person in the following manner:

- Without the need for prior authorization of such services if a prudent layperson would have reasonably believed that an emergency medical condition existed even if the emergency services are provided on an out-of-network basis;
- Shall cover emergency services whether the health care provider furnishing the services is a participating provider with respect to such services;
- If the emergency services are provided out-of-network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from network providers;
- If the emergency services are provided out-of-network, by complying with the cost-sharing requirements of applicable state statutes, rules and regulations; and
- Without regard to any other term or condition of coverage, other than:
    - The exclusion of or coordination of benefits;
    - An affiliation or waiting period as permitted under PHSA §2704; or
    - Applicable cost-sharing, as provided in applicable state statutes, rules and regulations.

For in-network emergency services, verify that the health carrier provides coverage of emergency services subject to applicable copayments, coinsurance and deductibles.

For out-of-network emergency services, verify that the health carrier's cost-sharing requirement expressed as a copayment amount or coinsurance rate imposed with respect to a covered person does not exceed the cost-sharing requirement imposed with respect to a covered person if the services were provided in-network.

Note: Examiners need to be aware that a health carrier may require a covered person to pay, in addition to the in-network cost-sharing, the excess of the amount the out-of-network provider charges over the amount the health carrier is required to pay.

Verify that the health carrier provides payment of emergency services provided by an out-of-network provider in an amount not less than the greatest of the following:

- The amount negotiated with in-network providers for emergency services excluding any in-network copayment or coinsurance imposed with respect to the covered person (Note: This provision does not apply for capitated or other health benefit plans that do not have a negotiated per-service amount for in-network providers If a health benefit plan has more than one negotiated amount for in-network providers for a particular emergency service, the amount is the median of the negotiated amounts);
- The amount of the emergency service calculated using the same method the plan uses to determine payments for out-of-network services, but using the in-network cost-sharing provisions instead of the out-of-network cost-sharing provisions; or
- The amount that would be paid under Medicare for the emergency services, excluding any in-network copayment or coinsurance requirements.

A health carrier may impose any cost-sharing requirement other than a copayment or coinsurance requirement, such as a deductible or out-of-pocket maximum, with respect to emergency services provided out-of-network if the cost-sharing requirement generally applies to out-of-network benefits.

A health carrier may impose a deductible with respect to out-of-network emergency services only as part of a deductible that generally applies to out-of-network benefits.

If a health carrier's out-of-pocket maximum generally applies to out-of-network benefits, that out-of-network maximum must apply to out-of-network emergency services.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

Chapter 25—Conducting the Medicare Supplement Examination

IMPORTANT NOTE:
The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in Chapter 1—Introduction.

This chapter provides a format for conducting Medicare supplement insurance examinations. Procedures for conducting other types of specialized examinations may be found in separate chapters.

The examination of Medicare supplement insurance operations may involve any review of one or a combination of the following business areas:

A. Operations/Management
B. Complaint Handling
C. Marketing and Sales
D. Producer Licensing
E. Policyholder Service
F. Underwriting and Rating
G. Claims
H. Grievance Procedures
I. Network Adequacy
J. Provider Credentialing
K. Quality Assessment and Improvement
L. Utilization Review

When conducting an exam that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the entity is meeting standards. Some standards may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.

When an examination involves a depository institution or their affiliates, the bank may also be regulated by federal agencies such as the Office of the Comptroller of the Currency (OCC), the Federal Reserve Board, the Office of Thrift Supervision (OTS) or the Federal Deposit Insurance Corporation (FDIC). Many states have executed an agreement to share complaint information with one or more of these federal agencies. If the examination results find adverse trends or a pattern of activities that may be of concern to a federal agency and there is an agreement to share information, it may be appropriate to notify the agency of the examination findings.

Examiners should note that some of the following market conduct standards may apply to all Medicare supplement insurance carriers, while others apply only to Medicare Select (managed care) carriers.

Examiners should also note that states may require by law or regulation, that health plans receive certification by specific private accreditation organizations in order to obtain licensing. Other states may recognize accreditation as meeting specific state requirements. To the extent an examiner may take into account accreditation for specific operational areas (such as quality assessment and improvement, credential verification, utilization review, grievance processes or utilization management), when planning the examination and setting review priorities, the examiner should become familiar with the standards applied by the accrediting entity. Individual jurisdictions may have procedures in place for communicating deviations from such standards to the applicable accrediting entity in addition to administrative procedures.

A. Operations/Management

1. Purpose

The Operations/Management portion of the examination is designed to provide a view of what the entity is and how it operates. Normally, it is not based on sampling techniques; it is more concerned with structure. This review is not intended to duplicate financial examination review, but is important in providing the market conduct examiner with an understanding of the examined entity. Many troubled insurance companies have become so because management has not been structured to recognize and address the problems that can arise in the insurance industry. In addition to the general categories, examiners should also review Section J Provider Credentialing (Medicare Select carriers only) of this chapter.

a. Provider Credentialing

Examiners should determine that a Medicare Select carrier has established written verification programs to ensure that participating health care professionals meet minimum, specific professional qualifications, both initially and on an ongoing basis.

Additional introductory material is located in Chapter 20—General Examination Standards

STANDARDS
OPERATIONS/MANAGEMENT

Standard 1
The Medicare Select carrier's plan of operation complies with applicable statutes, rules and regulations.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Plan of operations

_____ Information to enrollees

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)

Review Procedures and Criteria

Ascertain that the plan of operation has been filed with the insurance commissioner.

Review the plan of operation for compliance with applicable statutes, rules and regulations.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 2
The entity reports to the insurance department on an annual basis, each resident of the state for whom the entity has more than one Medicare supplement policy or certificate in force.

Apply to: All Medicare supplement carriers

Priority: Essential

Documents to be Reviewed

_____ Reporting Medicare supplement policies form

_____ Records of issued Medicare supplement policies/certificates

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)

Review Procedures and Criteria

Ascertain that the reporting Medicare supplement policies form has been filed with the insurance commissioner.

Review policy and certificate records to ascertain whether multiple sales of policies or certificates to individual enrollees have been made.

Review the reporting Medicare supplement policies form and compare with multiple sales findings during the examination to ensure that the entity has accurately reported multiple sales.

Verify plans after Jan. 1, 2020 are in compliance with Section 9.2 of Model # 651.

Verify the Benefit Chart of Medicare Supplement Plans Sold on or after Jan. 1, 2020 is correct pursuant to Model #651.

Verify the information provided by the carrier on Plan F or High Deductible F is correct pursuant to Model #651, for plans issued on or after Jan. 1, 2020.

Verify the information provided by the carrier on Plan G or High Deductible G is correct pursuant to Model #651, for plans issued on or after Jan. 1, 2020.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 3
The entity certifies compliance with standards for claims payments on the Medicare supplement insurance experience reporting form.

Apply to: All Medicare supplement carriers

Priority: Essential

Documents to be Reviewed

_____ Medicare supplement insurance experience reporting form

_____ Claims payment procedures manuals

_____ Claims training manuals

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)

Review Procedures and Criteria

Ascertain that the Medicare supplement insurance experience reporting form has been filed with the insurance commissioner.

Review the procedures and claims training manuals to ascertain whether the entity's standards for claim payments are in compliance with applicable statutes, rules and regulations.

Compare the entity's procedures and claims training manuals with the entity's Medicare supplement insurance experience reporting form. Discuss any discrepancies with the entity.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 4
The entity does not provide producer compensation that encourages replacement sales.

Apply to: All Medicare supplement carriers

Priority: Essential

Documents to be Reviewed

_____ Producer manuals

_____ Producer compensation agreements

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)

Review Procedures and Criteria

Review procedures, producer compensation agreements and producer manuals to ascertain whether the entity's standards for producer compensation are in compliance with applicable statutes, rules and regulations concerning replacement sales.

B. Complaint Handling

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

C. Marketing and Sales

1. Purpose

The marketing and sales portion of the examination is designed to evaluate the representations made by the entity about its product(s). Typically, it is not based on sampling techniques, but sampling may be used as a review tool. The areas to be considered in this kind of review include all written, verbal and electronic advertising and sales materials.

2. Techniques

This area of review should include all advertising and sales material, including Internet advertising, and all producer sales training materials to determine compliance with applicable statutes, rules and regulations. Information from other jurisdictions may be reviewed, if appropriate. The examiner may contact policyholders, producers and others to verify the accuracy of the information provided or to obtain additional information. The examiner should be familiar with outlines of coverage and replacement regulations. Policyholder records are a good source for detection of multiple issues of Medicare supplement policies. Suitability should be considered in reviewing the entity's sales and marketing practices.

The entity must have procedures in place to establish and at all times maintain a system of control over the content, form and method of dissemination of its advertisements. All advertisements maintained by, or for, and authorized by the entity are the responsibility of the entity.

The same statutes, rules and regulations (such as the *Unfair Trade Practices Act* (#880)) that apply to conventional advertising also apply to Internet advertising. When the examiner is reviewing an entity's Internet advertisements, it is important to also review the safeguards implemented by the entity.

All advertisements are required to be truthful and not misleading in fact or by implication. The form and content of an advertisement of a policy shall be sufficiently clear so as to avoid deception. The advertisement must not have the capacity or tendency to mislead or deceive. Whether an advertisement has the capacity or tendency to mislead or deceive must be determined when reviewing the overall impression that the advertisement reasonably may be expected to create upon a person of average education or intelligence with the segment of the public to which the advertisement is directed.

Ensure that the entity actively offers all of its Medicare supplement products to eligible individuals. The company should not engage in marketing practices such as discriminatory commission levels or references to health conditions that discourage individuals with less favorable risk characteristics from seeking or obtaining coverage.

Determine whether producer training materials require the producer to report all sales of Medicare supplement policies and/or certificates.

Ascertain that the entity has procedures for distributing to producers and other company personnel any bulletins issued by state or federal regulators.

Ensure that the entity prohibits the sale of Medicare supplement policies or certificates to people enrolled in a Medicare Choice or private fee-for-service plans.

Ensure that the entity prohibits the sale of a Medicare supplement policy/certificate to an individual already covered under such a policy, unless the new policy/certificate is a replacement policy/certificate.

Ensure that producer commission schedules do not encourage replacement sales or sales of more than one Medicare supplement policy/certificate to an individual, or discourage eligible individuals with unfavorable risk characteristics.

Ensure that the entity offers to all eligible individuals all the Medicare supplement products it sells.

Determine whether individuals in the state have been eligible for guaranteed-issue because of termination of Medicare business by managed care organizations, and review company practices with respect to eligible individuals.

Review entity communications to company personnel, producers and applicants about open enrollment and guaranteed-issue rights.

3. Tests and Standards

The marketing and sales review includes, but is not limited to, the following standards addressing various aspects of the marketing and sales function. The sequence of the standards listed here does not indicate the priority of the standard.

STANDARDS
MARKETING AND SALES

Standard 1
Entity rules concerning replacement are in compliance with applicable statutes, rules and regulations.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ Bulletins, newsletters and memos

_____ Replacement register

_____ Underwriting guidelines and files

_____ Replacement comparison forms (if external replacement)

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)

Review Procedures and Criteria

Review replacement register to see if it is cross-indexed by producer and entity to determine if the entity has been targeted for replacements by a producer (internal or external).

Ensure that the application or other form asks whether the policy or certificate is intended to replace or add to any coverage currently in force.

Ensure that the application or other form asks all the questions required by state law to be asked.

Determine if the entity permits multiple sales of Medicare supplement policies to the same person.

Using a random selection of policyholders, have the entity run a policyholder/certificateholder history to identify the number of policies or certificates sold to those individuals.

Determine if underwriting guidelines place limitations on multiple sales; i.e. limits on coverage, determination of suitability, detection of predatory sales practices, etc.

Ensure that the entity, when determining whether a sale involves replacement, furnishes to the applicant prior to policy/certificate issue, or at the time of issue in the case of a direct response sale, the required notice concerning replacement of Medicare supplement coverage, obtains the signatures required by state law, and maintains one copy of the signed notice on file.

Determine whether marketing materials encourage multiple issues of policies, for example, use of existing policyholder/certificateholder list for additional sales of similar products to those held, birth date solicitations, scare tactics, etc.

Determine if negative enrollment practices are permitted and used.

Determine if the entity has a system to discourage "over-insurance," as defined in the entity's underwriting requirements, of policyholders/certificateholders.

Determine whether individuals in the state have been eligible for guaranteed-issue because of terminations of Medicare business by managed care organizations, and review entity practices with respect to eligible individuals.

Review entity communications to company personnel, producers and applicants about open enrollment and guaranteed-issue rights.

Determine that the regulated entity, upon replacement, does not impose any waiting periods, elimination periods or probationary periods in their replacement policies unless the replaced individual had not satisfied their six month preexisting condition period under their prior coverage.

STANDARDS
MARKETING AND SALES

Standard 2
Outlines of coverage are in compliance with applicable statutes, rules and regulations.

Apply to: All Medicare supplement carriers

Priority: Essential

Documents to be Reviewed

_____ Application files

_____ Outlines of coverage

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 17

Review Procedures and Criteria

Look for verification that outlines of coverage used have been approved by appropriate persons within the entity, and are authorized by the entity.

Ensure that outlines of coverage conform to the requirements of state law for format.

Determine whether mandated benefits, benefit limitations and premiums are completely and accurately described, and can be compared with other Medicare supplement policies or certificates offered by the entity and with other Medicare Select policies and certificates. The outline of coverage includes:

- A description of the principal benefits and coverage provided in the policy;
- A statement of the renewal provisions, including any reservation by the insurer of a right to change premiums and disclosure of the existence of any automatic renewal premium increases based on the policyholder's/certificateholder's age; and
- A statement that the outline of coverage is a summary of the policy issued or applied for, and that the policy should be consulted to determine governing contractual provisions.

STANDARDS
MARKETING AND SALES

Standard 3
The entity obtains receipts from applicants verifying that the outline of coverage has been received and that it is the outline of the policy for which the applicant has applied.

Apply to: All Medicare supplement carriers

Priority: Essential

Documents to be Reviewed

_____ Application files

_____ Outlines of Coverage

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 17C

Review Procedures and Criteria

Verify through signed receipts that outlines of coverage have been provided to applicants prior to the sale of a policy or certificate.

Verify that the outline of coverage provided reflects the benefits of the policy for which the applicant applied, and, if not, that the applicant has been provided with a copy of the correct outline of coverage and the required disclosure concerning the substitution.

STANDARDS
MARKETING AND SALES

Standard 4
The *Guide to Health Insurance for People with Medicare* is provided to the applicant within the time frame required by law and is in compliance with applicable statutes, rules and regulations.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ Application files

_____ Underwriting files

_____ *Guide to Health Insurance for People with Medicare*

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 17A

Review Procedures and Criteria

Verify that the Guide to Health Insurance for People with Medicare was received by the applicant, by ensuring that the receipt for the guide contains the signature of the applicant.

Ensure that the applicant was provided with a copy of the guide prior to policy issuance or at the time of issuance, as required by state law.

Ensure that the guide was provided to the applicant within the time frame specified by state law.

Ensure that the guide is provided in the required format.

STANDARDS
MARKETING AND SALES

Standard 5
The entity maintains a system of control over the content, form and method of dissemination of all of its Medicare supplement advertisements.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ Guide to Health Insurance for People with Medicare

_____ Outlines of coverage

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660)

Review Procedures and Criteria

Ensure that the entity retains responsibility for all advertisements (as the term "advertisement" is defined by state law) regardless of by whom written, created, designed or presented.

STANDARDS
MARKETING AND SALES

Standard 6
Each advertisement of a Medicare supplement product is identified by form number or other means unique to that product and is labeled "insurance policy."

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ Guide to Health Insurance for People with Medicare

_____ Outlines of coverage

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660)

Review Procedures and Criteria

Ensure that all advertisements are identified by form number or other means of identification that distinguishes that advertisement from all others.

Ensure that advertisements clearly state that an advertised Medicare supplement policy is an "insurance policy."

STANDARDS
MARKETING AND SALES

Standard 7
Advertisements that are invitations to join an association, trust or discretionary group—and that are also solicitations of insurance—contain a separate and distinct application for membership of the group and another for the insurance coverage.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660), Section 6

Review Procedures and Criteria

Ensure that advertisements containing applications provide application for membership in an association, trust or other group, separate from the application for the Medicare supplement coverage.

STANDARDS
MARKETING AND SALES

Standard 8
Advertisements truthfully represent the Medicare supplement coverage being marketed.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ Guide to Health Insurance for People with Medicare

_____ Outlines of coverage

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660), Sections 6 and 7
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Ensure that advertisements do not contain words or phrases such as "all," "full," "complete," "comprehensive," "unlimited," "up to," "as high as," "this policy pays all that Medicare doesn't" or similar words or phrases in a manner that exaggerates any benefit beyond the terms of the policy.

Advertisements that are invitations to contract should:

- Disclose exceptions, reductions and limitations affecting the basic provisions of the policy;
- If a preexisting conditions limitation applies, ask a question immediately above the signature line concerning the applicant's understanding of the limitation; and
- Disclose renewability, modification, cancellability, termination, losses covered and premium changes due to age or other reasons in a manner that does not minimize or obscure the qualifying conditions.

Ensure that if the policy is not guaranteed-issue or if a preexisting conditions limitation applies, the advertisement does not state or imply that health history will not affect the issuance of the policy or payment of a claim under the policy.

Ensure that provisions that are negative in nature, such as a preexisting conditions limitation, are presented in a negative light and that if the advertisement is an invitation to contract, the term "preexisting conditions limitation," if used, is defined.

Ensure that advertisements do not state or imply that claim settlements are "liberal" or "generous," or words of similar import, and do not mislead by quoting unusual claims that may have been paid.

STANDARDS
MARKETING AND SALES

Standard 9
Testimonials comply with applicable statutes, rules and regulations.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines, Section 8 (#660)
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Ensure that testimonials used in advertising are genuine, represent the current opinion of the author, are applicable to the policy advertised, are accurately reproduced and otherwise comply with all provisions of state law concerning the use of testimonials.

Ensure that the use of a spokesperson complies with any provisions of state law concerning disclosure of the interests of the spokesperson.

STANDARDS
MARKETING AND SALES

Standard 10
Advertisements that employ statistics accurately represent all relevant facts.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660), Section 9
Model Regulation to Require Reporting of Statistical Data by Property and Casualty Insurance Companies (#751)

Review Procedures and Criteria

Ensure that advertisements containing statistical data accurately represent all relevant facts.

Advertisements should state the source of all statistics used in the advertisement.

STANDARDS
MARKETING AND SALES

Standard 11
Advertisements do not disparage competitors or their policies, services or business methods.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660), Section 10
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Ensure that advertisements do not directly or indirectly disparage competitors.

STANDARDS
MARKETING AND SALES

Standard 12
Advertisements do not imply licensing of the entity beyond the jurisdiction in which the entity is licensed or imply a status with any governmental entity.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ Guide to Health Insurance for People with Medicare

_____ Outlines of coverage

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660), Section 11
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Ensure that advertisements do not imply that the entity is licensed in jurisdictions other than that in which it is licensed.

Ensure that advertisements do not imply that the entity's products are approved, endorsed or accredited, or connected with any governmental entity.

STANDARDS
MARKETING AND SALES

Standard 13
Advertisements state the name of the insurer and all other pertinent information required by applicable statutes, rules and regulations.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ Guide to Health Insurance for People with Medicare

_____ Outlines of coverage

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660), Section 12
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Ensure that the entity's name appears in all advertisements. The entity should not use the name of the parent entity, a group designation or any other designation, without disclosing the name of the actual insurer.

Ensure that advertisements—including stationery, envelopes, etc., do not use any word, symbol, etc., that may confuse or mislead applicants into believing that the solicitation is connected with any government agency. The advertisement must contain a statement that the advertisement is not connected with or endorsed by the U.S. government or the federal Medicare program.

Producers who contact the consumer through a lead-generating device must disclose that fact to the consumer in the initial contact with the consumer.

STANDARDS
MARKETING AND SALES

Standard 14
Advertisements do not state or imply that prospective insureds become group or quasi-group members under a group policy and, as such, will enjoy special rates or underwriting privileges, unless it is a fact.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660), Section 13
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Ensure that advertisements do not state or imply that an applicant will become a member of a group, and therefore, enjoy special rating or underwriting privileges, unless it is a fact.

Ensure that advertisements do not solicit a particular class, such as governmental employees, and imply that their occupational status gives them group privileges, when the policy advertised is sold only on an individual basis at regular rates.

STANDARDS
MARKETING AND SALES

Standard 15
Advertisements should not use incentives to purchase that mislead the prospective insured.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660), Section 14
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Ensure that advertisements for individual policies do not directly or indirectly represent that the policy offering is introductory or special, and that the advantages will not be available at a later date, unless it is a fact.

Ensure that advertisements for individual policies do not describe an enrollment period as special or limited, or use words of similar import, when the insurer uses such enrollment periods as the usual method of advertising.

Ensure that if an enrollment period is used for policies sold on an individual basis, that the lapse between enrollment periods is not less than that provided for by state law, and that the advertisement states the period specified by state law in which the application must be mailed.

Ensure that advertisements do not state that only a specific number of policies will be sold, or that a time is fixed for discontinuance of the sale of a particular policy because of its special advantages, unless it is a fact.

Ensure that advertisements do not advertise a reduced initial premium more frequently or more prominently than the renewal premium, and that the two premiums are stated in juxtaposition.

STANDARDS
MARKETING AND SALES

Standard 16
Advertisements do not contain statements about the entity that are untrue or misleading.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660), Section 15
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Ensure that advertisements do not contain statements that are untrue or misleading about the assets, corporate structure, financial standing, age or relative position of the insurer in the insurance business.

Ensure that advertisements do not contain recommendations by commercial rating systems, unless the advertisements clearly indicate the purpose of the recommendation and the limitations of the scope and extent of the recommendation.

D. Producer Licensing

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

E. Policyholder Service

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

F. Underwriting and Rating

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

G. Claims

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

H. Grievance Procedures

1. Purpose

The grievance procedures portion of the examination is designed to evaluate how well the Medicare Select carrier handles grievances.

A "grievance" means dissatisfaction in writing with the administration, claims practices or provision of services concerning an issuer of a Medicare Select product or network provider.

Note that these definitions may not include all written communications that the company tracks as "complaints" under the definition of complaint.

The examiner should review the company procedures for processing grievances. Specific problem areas may necessitate an overall review of a particular segment of the company's operation.

2. Techniques

A review of grievance procedures should incorporate consumer and provider appeals, consumer direct grievances to the company and those grievances filed with the insurance department. The company should reconcile the company grievance register with a list of grievances from the insurance department. A random sample of grievances and appeals should be selected for review from the company's grievance register.

The company's written grievance procedures should be reviewed. Determine how those procedures are communicated to plan members within membership materials and upon receipt of appeals and grievances.

The examiner should review the frequency of similar grievances and be aware of any pattern of specific types of grievance. Should the type of grievance noted be cause for unusual concern, specific measures should be instituted to investigate other areas of a company's operation. This may include modifying the scope of examination to determine specific company behavior.

3. Tests and Standards

The grievance handling review includes, but is not limited to, the following standards addressing various aspects of a company's operations. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
GRIEVANCE PROCEDURES

Standard 1
The entity defines as a grievance any dissatisfaction expressed in writing with the administration, claims practices or provision of services concerning an issuer of a Medicare Select product or network.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Sample documents and files, including electronic correspondence

_____ Outlines of coverage

_____ Policies and/or certificates of coverage

_____ Contracts

_____ Grievance procedures

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)

Review Procedures and Criteria

Review the contracts, outlines of coverage, grievance procedures, sample grievance files and disclosures to determine if the company is correctly defining "grievance."

STANDARDS
GRIEVANCE PROCEDURES

Standard 2
The entity develops written grievance procedures that comply with applicable statutes, rules and regulations, and provides enrollees with a copy of its grievance procedures.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Procedures manuals

_____ Policies and/or certificates of coverage

_____ Outlines of coverage

_____ All forms used to process a grievance

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)

Review Procedures and Criteria

Determine if the entity provides grievance registration information to the policyholder at the time of the issuance of a policy or certificate.

Determine if the entity has procedures to ensure that a copy of its grievance procedures is provided to any enrollee or prospective enrollee upon request.

Determine if the entity includes a copy of its grievance procedures in its policies, certificates (if applicable) and outlines of coverage.

Review the disclosure form(s) to determine if a description of the entity's grievances procedures is included.

Review the entity's grievance procedures to ensure that the procedures are aimed at mutual agreement for settlement and that, if applicable, any arbitration procedures are disclosed.

STANDARDS
GRIEVANCE PROCEDURES

Standard 3
The entity documents, resolves and records grievances in compliance with applicable statutes, rules and regulations, and their contract language.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Entity's grievance handling policies and procedures

_____ Sample of grievance files

_____ Outlines of coverage

_____ Policies and/or certificates of coverage

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)

Review Procedures and Criteria

The entity maintains a grievance register consisting of written records that document all grievances received during the calendar year.

The entity reports all grievances to the insurance commissioner annually, with the information and in the format required by law.

The entity complies with its written procedures when receiving and resolving grievances.

The entity considers grievances in a timely manner and transmits grievances to appropriate decision-makers.

The entity takes corrective action promptly on valid grievances.

The entity promptly notifies concerned parties of the results of a grievance review.

STANDARDS
GRIEVANCE PROCEDURES

Standard 4
The company provides to any enrollee, who has filed a grievance, detailed information concerning its grievance and appeal procedures, how to use them and how to notify the insurance department, if applicable.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Procedures for processing grievances

_____ Grievance forms and other information provided to an enrollee at the time the enrollee files a grievance

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)

Review Procedures and Criteria

Review the entity's procedures for processing a grievance to determine if the required disclosures are provided.

Review the entity's procedures to determine if, when required by state law, the enrollee is advised of the right to contact the insurance department.

Review the grievance procedures to ensure that a provision is made for grievance registration information to be provided at the time of issue and upon request.

As grievances are detected throughout the entire examination, ensure that they have been handled and recorded properly.

STANDARDS
GRIEVANCE PROCEDURES

Standard 5
The company reports its grievance procedures to the insurance commissioner on an annual basis.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Procedures for processing grievances

_____ Procedures for annually reporting grievances to the insurance commissioner

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)

Review Procedures and Criteria

The examiner should determine whether the entity has procedures in place for recording and reporting grievances to the insurance commissioner.

The examiner should ensure that the entity has reported on an annual basis and in the format prescribed by the insurance commissioner, the number of grievances filed in the previous year and a summary of the subject, nature and resolution of such grievances.

I. Network Adequacy

1. Purpose

The network adequacy portion of the examination is designed to ensure that companies offering Medicare Select plans maintain service networks that are sufficient to ensure that all services are accessible without unreasonable delay. The standards require companies to ensure the adequacy, accessibility and quality of health care services offered through their service networks.

The areas to be considered in this kind of review include the company's plan of operation and measures used by the company to analyze network sufficiency, contracts with participating providers and intermediaries, and ongoing oversight and assessment of access issues.

2. Techniques

To evaluate network adequacy standards, it is necessary for examiners to request from the company a statement or map that reasonably describes the service area. Additional items for review include a list and description by specialty of network providers and facilities. The examiner should determine whether the company has conducted studies to measure waiting times for appointments and other studies to measure the sufficiency and adequacy of the network. The examiner should also determine how the company arranges for covered services that cannot be provided within the network. Examiners should request the carrier's written selection standards for providers and review the plan of operation. Using the list of providers and facilities, examiners should request a sample of specific provider contracts. The review of provider contracts should include an evaluation of compliance with filing requirements and adherence to patient-protection requirements. In addition to direct contracts with providers and facilities, examiners should review the written guidelines and contractual requirements established for intermediary contracts. Availability of emergency care facilities and procedures should be evaluated. Examiners should obtain verification that accurate provider directories are provided upon enrollment, are updated and dispersed periodically, and that the company has filed its updated list of network providers with the insurance commissioner on a quarterly basis. Another area for review includes grievances related to provider access issues.

3. Tests and Standards

The network adequacy review includes, but is not limited to, the following standards related to the adequacy of the health carrier's provider network. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
NETWORK ADEQUACY

Standard 1
The company demonstrates, using reasonable criteria, that it maintains a network that is sufficient in number and types of providers to ensure that all services to enrollees will be accessible without unreasonable delay.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Selection criteria

_____ Documents related to physician recruitment

_____ Provider directory

_____ List of providers by specialty

_____ Reports of out-of-network service denials

_____ Company policy for in-network/out-of-network coverage levels

_____ Provider/enrollee location reports by ZIP code

_____ Any policies or incentives that restrict access to subsets of network specialists

_____ Computer tools used to assess the network's adequacy

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Benefit Plan Network Access and Adequacy Model Act (#74), Section 5

Review Procedures and Criteria

Reasonable criteria include, but are not limited to:

- Ratios of providers (primary care providers and specialty providers) to enrollees;
- Geographic accessibility as measured by the reasonable proximity of participating providers to the business or personal residence of enrollees;
- Waiting times for appointments;
- Hours of operation; and
- Volume of technological and specialty services available to serve the needs of enrollees requiring technologically advanced or specialty care.

The company develops and complies with written policies and procedures specifying when the company will pay for out-of-area and out-of-network services that are covered by the policy, or as are required by state law. In any case where the company is required to cover services and it has an insufficient number or type of participating providers to provide a covered benefit, the company shall ensure that the enrollee obtains the covered benefit at no greater cost than if the benefit were obtained from participating providers, or shall make other arrangements acceptable to the insurance commissioner.

The company establishes and maintains adequate arrangements to ensure reasonable proximity of participating providers to the business or personal residences of enrollees. In determining whether a company has complied with this provision, the insurance commissioner shall give due consideration to the relative availability of health care providers in the enrollees' service area.

The company demonstrates that it monitors, on an ongoing basis, its providers, provider groups and intermediaries with which it contracts to ensure the ability, clinical capacity, financial capability and legal authority, including applicable licensure requirements, to furnish all contracted benefits to enrollees. There are standards pertinent to provider licensing in Section J. Provider Credentialing of this chapter.

The company complies with all applicable provisions of state law not expressly covered by any other of the standards.

STANDARDS
NETWORK ADEQUACY

Standard 2
The company has a plan of operation for each plan offered in the state, and files updates whenever it makes a material change to an existing plan.

Apply to: Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Plan of operation

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)

Review Procedures and Criteria

The plan of operation contains evidence of at least the following:

- Covered services are available and accessible though network providers;
- Either the number of network providers in the service area is sufficient to deliver adequately all services, or that the company makes appropriate referrals for provision of such services outside its network;
- There are written agreements with network providers describing specific responsibilities;
- Emergency care is available 24 hours per day, 7 days per week;
- The provider agreements prohibit the provider from billing or otherwise seeking reimbursement from enrollees, other than for coinsurance, copayments or supplemental charges;
- A description or map of the service area;
- A description of the company's grievance procedures;
- A description of the quality assurance program, including the formal organizational structure, the criteria for selection, retention and removal of network providers and the procedures for evaluating quality of care and taking corrective action when warranted;
- A list and description of network providers, by specialty; and
- Any other information requested by the insurance commissioner.

STANDARDS
NETWORK ADEQUACY

Standard 3
The company ensures that enrollees have access to emergency services 24 hours per day, 7 days per week within its network and provides coverage for urgently needed services and emergency services outside of the service area.

Apply to: Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Provider manuals and contracts

_____ Policy forms

_____ Plan of operation

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)

Review Procedures and Criteria

Within the network, the company operates or contracts with facilities to provide enrollees with access to emergency and urgently needed services on a 24 hours per day, 7 days per week basis.

The company covers in full, emergency services or services that are immediately required for an unforeseen illness, injury or condition, when it is not reasonable to obtain services through network providers.

STANDARDS
NETWORK ADEQUACY

Standard 4
The company files with the insurance commissioner all required contract forms and any material changes to a contract proposed for use with its participating providers and intermediaries.

Apply to: Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Provider manuals

_____ Sample of provider contracts

_____ Credentialing file

_____ Directory of providers

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)

Review Procedures and Criteria

Determine if the provider contracts and endorsements have been filed (if required by state law).

Review provider contracts to determine if the provider is listed in the directory and to determine if credentialing is up-to-date.

STANDARDS
NETWORK ADEQUACY

Standard 5
The company executes with each participating provider written agreements that are in compliance with applicable statutes, rules and regulations.

Apply to: Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Provider manuals, contracts and intermediary subcontracts

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)

Review Procedures and Criteria

Every contract between a Medicare Select carrier and a participating provider or provider group contains a "hold harmless" provision specifying protection for enrollees from being billed by providers for other than coinsurance, copayments or supplemental charges.

The contract provides an extension of benefits beyond the period during which the policy was in force, if the enrollee suffers continuous total disability after contract termination.

STANDARDS
NETWORK ADEQUACY

Standard 6
The company's arrangements with participating providers comply with applicable statutes, rules and regulations.

Apply to: Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Provider manuals and contracts

_____ Credentialing and re-credentialing procedures

_____ Complaints made by providers

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Benefit Plan Network Access and Network Adequacy Model Act (#74) Section 6

Review Procedures and Criteria

When required by state law, the company complies with the following:

- The company establishes a mechanism by which the participating provider will be notified on an ongoing basis of the specific covered health services for which the provider will be responsible, including any limitations or conditions on services;
- The company develops selection standards for primary care professionals and each health care professional specialty. The standards are used in determining the selection of health care professionals by the health carrier, its intermediaries and any provider networks with which it contracts;
- The company makes its selection standards for participating providers available for review by the insurance commissioner;
- The company notifies participating providers of the providers' responsibilities with respect to the carrier's applicable administrative policies and programs, including, but not limited to, payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements and any applicable state insurance law;
- The company does not offer inducements to providers to provide less than medically necessary services to enrollees;
- The company does not prohibit a participating provider from discussing treatment options with enrollees, regardless of the health carrier's position on the treatment options, or from advocating on behalf of enrollees within the utilization review or grievance processes established by the carrier or a person contracting with the carrier;

- The company requires a provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of enrollees, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records;
- The company and the participating provider terminate provider contracts according to contract provisions and as provided by law;
- The company notifies participating providers of their obligations, if any, to collect applicable coinsurance, copayments or deductibles from enrollees pursuant to policy or certificate provisions, or of the providers' obligations, if any, to notify enrollees of their personal financial obligations for non-covered services;
- The company does not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare;
- The company establishes a mechanism by which participating providers may determine in a timely manner whether a person is covered by the carrier; and
- The company establishes procedures for resolution of administrative, payment or other disputes between providers and the health carrier.

STANDARDS
NETWORK ADEQUACY

Standard 7
The company provides at enrollment a directory of providers participating in its network. It also makes available, on a timely and reasonable basis, updates to its directory and files the directory with the insurance commissioner.

Apply to: Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Provider directory and updates

_____ Provider contracts

_____ Credentialing and re-credentialing documentation

_____ Internet directory

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)

Review Procedures and Criteria

Request information regarding the carrier's frequency of updates to the provider directory.

Verify that the company is providing directory updates to enrollees and to the insurance commissioner at the frequency required by state law.

Review how provider data is maintained. If the provider directory is not produced from the same system(s) that handles the administration functions, determine if the data is maintained consistently between systems.

J. Provider Credentialing

1. Purpose

The provider credentialing portion of the examination is designed to ensure that companies offering Medicare Select plans have verification programs to ensure that participating health care professionals meet minimum specific standards of professional qualification.

The areas to be considered in this kind of review include the company's written credentialing and re-credentialing policies and procedures, the scope and timeliness of verifications, the role of health professionals in ensuring accuracy and the oversight of any delegated verification functions.

2. Techniques

Prior to reviewing records for specific providers, examiners should request all written credentialing procedures from the company. Examiners should determine the composition of the carrier's credentialing committee. Examiners should use the company's provider directory to select a sample of specific provider credential files, drawing from a variety of provider types and facilities. For each provider selected, the examiner should request:

a. The provider application;
b. Credentialing verification materials, including materials obtained through primary and secondary sources;
c. Updates to credentialing information; and
d. Copies of correspondence to providers that relates to the credentialing process.

Examiners should determine how the credentialing committee permits providers to correct information and provide additional information for reconsideration. In the event the credentialing process is subcontracted, examiners should determine whether the contracting entity is following applicable standards.

3. Tests and Standards

The provider credentialing review includes, but is not limited to, the following standards related to the adequacy of the health carrier's provider credentialing and contracting processes. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
PROVIDER CREDENTIALING

Standard 1
The company establishes and maintains a program for credentialing and re-credentialing of providers in compliance with applicable statutes, rules and regulations.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Credentialing plan

_____ Credentialing policies and procedures

_____ Minutes of the credentialing committee

_____ Credentialing plan evaluation reports (if any)

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70), Section 5

Review Procedures and Criteria

The company establishes written policies and procedures for credentialing and re-credentialing of all health care professionals with whom the company contracts and applies those standards consistently.

The company ensures that the carrier's medical director or other designated health care professional has the responsibility for, and participates in, the health care professional credentialing verification process.

The company establishes a credentialing verification committee consisting of licensed physicians and other health care professionals to review credentialing verification information and supporting documents in order to make decisions regarding credentialing verification.

The company makes all application and credentialing verification policies and procedures available for review by the applying health care professional upon written request.

The company keeps confidential all information obtained in the credentialing verification process, except as otherwise provided by state law.

The company retains all records and documents relating to a health care professional's credentialing verification process for at least the number of years required by state law.

The company's policies and procedures for credentialing and re-credentialing of providers are in compliance with state law.

STANDARDS
PROVIDER CREDENTIALING

Standard 2
The company verifies the credentials of a health care provider before entering into a contract with that health care provider.

Apply to: All Medicare Select plans

Priority: Essential

Documents to be Reviewed

_____ Provider credentialing files

_____ Provider contracts

_____ Provider credentialing policies and procedures

_____ Provider directory

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70), Section 5

Review Procedures and Criteria

Ensure that the company verifies that providers are properly credentialed, prior to entering into a contract with the provider and placing the provider name in the provider directory. This can be achieved by comparing the effective date of the provider's contract with the date of credentialing and the date the provider's name is entered in the provider directory.

STANDARDS
PROVIDER CREDENTIALING

Standard 3
The company obtains primary verification of the information required by state law relating to provider credentialing.

Apply to: All Medicare Select plans

Priority: Essential

Documents to be Reviewed

_____ Checklist for credentialing

_____ Checklists and forms for site visits (if any)

_____ Reports made from site visits (if any)

_____ Sample of credentialing files

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70), Section 6

Review Procedures and Criteria

If required by state law, the company verifies the following:

- Current license, certificate of authority or registration to practice his or her particular profession in the state and history of licensure;
- Current level of professional liability coverage (if applicable);
- Status of hospital privileges (if applicable);
- Specialty board certification status (if applicable);
- Current Drug Enforcement Agency (DEA) registration certificate (if applicable);
- Graduation in his or her specialty from an accredited school;
- Completion of post-graduate training (if applicable);
- The provider's license history in other states;
- The provider's malpractice history (if applicable); and
- The provider's practice history.

STANDARDS
PROVIDER CREDENTIALING

Standard 4
The company obtains, at the interval provided for by state law, primary verification of the information required by state law relating to provider credentialing.

Apply to: All Medicare Select plans

Priority: Essential

Documents to be Reviewed

_____ Checklist for credentialing

_____ Checklists and forms for site visits (if any)

_____ Reports made from site visits (if any)

_____ Sample of credentialing files

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70), Section 6

Review Procedures and Criteria

The company verifies the following:

- Current license, certificate of authority or registration to practice his or her particular profession in the state and history of licensure;
- Current level of professional liability coverage (if applicable);
- Status of hospital privileges (if applicable);
- Specialty board certification status (if applicable); and
- Current Drug Enforcement Agency (DEA) registration certificate (if applicable).

STANDARDS
PROVIDER CREDENTIALING

Standard 5
The company requires all participating providers to notify the individual designated by the company of changes in the status of any provider information that is required to be verified by the company.

Apply to: All Medicare Select plans

Priority: Essential

Documents to be Reviewed

_____ Credentialing policies and procedures

_____ Provider contracts

_____ Credentialing files

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70), Section 6

Review Procedures and Criteria

The company identifies for participating providers the individual to whom they should report changes in the status of provider information required to be verified by the company.

STANDARDS
PROVIDER CREDENTIALING

Standard 6
The company provides the provider with the opportunity to review and correct information submitted in support of the provider's credentialing verification.

Apply to: All Medicare Select plans

Priority: Essential

Documents to be Reviewed

_____ Credentialing policies and procedures

_____ Provider manual

_____ Listing of active and terminated providers

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70), Section 7

Review Procedures and Criteria

The company makes available to each provider who is subject to the credentialing verification process, the information and the source of the information obtained by the company to satisfy the company's credentialing process.

The company notifies the provider of any information obtained during the company's credentialing verification process that does not meet the company's credentialing verification standards or that varies substantially from the information provided to the company by the provider, if the information is required to be verified by state law, unless such disclosure is prohibited by law.

The company permits the provider to correct any incorrect information and request a reconsideration of the provider's credentialing verification application through a formal process by which the provider may submit supplemental or corrected information to the company's credentialing verification committee or the entity delegated to perform credentialing.

STANDARDS
PROVIDER CREDENTIALING

Standard 7
The company monitors the activities of the providers and provider entities with which it contracts and ensures that the requirements of state law are met.

Apply to: All Medicare Select plans

Priority: Essential

Documents to be Reviewed

_____ Provider credentialing and re-credentialing policies and procedures

_____ Intermediary contracts

_____ Periodic reports from intermediaries

_____ Reports of entity reviews and audits (if any) of credentialing activities by the company

_____ Minutes of the credentialing committee

_____ Minutes of the board of directors

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#74)

Review Procedures and Criteria

The company ensures that providers and provider entities with which it contracts meet the requirements of state law applicable to such providers and provider entities.

K. Quality Assessment and Improvement

1. Purpose

The quality assessment portion of the examination is designed to ensure that companies offering Medicare Select plans have quality assessment programs in place that enable the company to evaluate, maintain and, when required by state law, improve the quality of health care services provided to enrollees. For Medicare Select plans that limit access to health care services to a closed network, the standards also require a quality improvement program with specific goals and strategies for measuring progress toward those goals.

The areas to be considered in this kind of review include the company's written quality assessment and improvement policies and procedures, annual certifications, reporting of disciplined providers, communications with members about the program and oversight of delegated quality-related functions.

2. Techniques

In some jurisdictions, the quality assessment and improvement function may be monitored jointly by the Department of Insurance and Department of Health (or similar agency). To evaluate quality assessment and improvement activities, examiners should request information relative to the composition of the quality assessment and improvement committee. Examiners should also determine frequency of quality assessment and improvement meetings. To obtain an accurate assessment of a company's quality assessment and improvement program, it is advisable to review quality assessment and improvement committee meeting minutes for all meetings conducted during the examination period. Ascertain whether the quality assessment program reasonably encompasses all aspects of the covered health care services. Determine whether the carrier has obtained certification from a nationally recognized accreditation entity. Determine which standards will be met by virtue of the certification process. Examiners should evaluate the process by which quality assessment and improvement information and directives are communicated to network providers. Review procedures such as peer review, for including network providers in the quality assessment and improvement process. Ascertain whether outcome-based goals and objectives are being monitored and met.

3. Tests and Standards

The quality assessment and improvement review includes, but is not limited to, the following standards related to the assessment and improvement activities conducted by the health carrier. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 1
The company develops and maintains a quality assessment program that is in compliance with state law to evaluate, maintain and improve the quality of health services provided to enrollees.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Quality assessment policies and procedures

_____ Quality assessment plan (if any)

_____ Minutes of the quality assessment committee

_____ Minutes of the board of directors

_____ Evaluations of the quality assessment program

_____ Job descriptions of the chief medical officer or clinical director

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Quality Assessment and Improvement Model Act (#71)

Review Procedures and Criteria

The company develops a quality assessment program and procedures to ensure effective corporate oversight of the program.

The company develops and maintains the infrastructure and disclosure systems necessary to measure the quality of health care services provided to enrollees on a regular basis and appropriate to the types of plans offered by the company.

The company establishes a system designed to assess the quality of health care provided to enrollees. The system includes systematic collection, analysis and reporting of relevant data in accordance with statutory and regulatory requirements.

The company communicates findings in a timely manner to applicable regulatory agencies, providers and consumers as provided for by state law.

The company appoints a chief medical officer or clinical director to have primary responsibility for the quality assessment activities carried out by, or on behalf of, the company (*Quality Assessment and Improvement Model Act* (#71), Section 7).

The chief medical officer or clinical director approves the written quality assessment program, periodically reviews and revises the program documents and acts to ensure ongoing appropriateness. Not less than semi-annually, the chief medical officer or clinical director reviews reports of quality assessment activities (*Quality Assessment and Improvement Model Act* (#71), Section 7).

The company has an appropriate written policy to ensure the confidentiality of an enrollee's health information used in the company's quality assessment programs (*Quality Assessment and Improvement Model Act* (#71), Section 9).

The company complies with all applicable provisions of state law not expressly covered by any other of these standards.

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 2
The company develops and maintains a quality improvement program that is in compliance with applicable statutes, rules and regulations to evaluate, maintain and improve the quality of health services provided to enrollees.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Quality improvement policies and procedures

_____ Quality improvement plan

_____ Minutes of the quality improvement committee

_____ Minutes of the board of directors

_____ Evaluations of the quality improvement program

_____ Job descriptions of the chief medical officer or clinical director

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Quality Assessment and Improvement Model Act (#71)

Review Procedures and Criteria

The company develops a quality improvement program and procedures to ensure effective corporate oversight of the program (*Quality Assessment and Improvement Model Act* (#71), Section 7).

The company develops and maintains the infrastructure and disclosure systems necessary to measure, on a regular basis, the quality of health care services provided to covered persons and appropriate to the types of plans offered by the company.

The company establishes a system designed to improve the quality and outcomes of health care provided to enrollees. The system includes systematic collection, analysis and reporting of relevant data in accordance with statutory and regulatory requirements (*Quality Assessment and Improvement Model Act* (#71), Section 6C).

The company has a written quality improvement plan that includes:

- A statement of the objectives, lines of authority and accountability, evaluation tools, data collection responsibilities, performance improvement activities and annual effectiveness review of the program;
- Intent to analyze processes and outcomes of care to discern the causes of variation;
- Identification of the targeted diagnoses and treatments to be reviewed each year;
- Methods to analyze quality, including collection and analysis of information on:
    - Over- or under-utilization of services;
    - Evaluation of courses of treatment and outcome of care; and
    - Collection and analysis of information specific to an enrollee or provider gathered from multiple sources and documentation of both the satisfaction and grievances of the enrollee(s);
- A method to compare program findings with past performance and internal goals and external standards;
- Methods for:
    - Measuring the performance of participating providers;
    - Conducting peer review activities to identify practices that do not meet the company's standards;
    - Taking action to correct deficiencies;
    - Monitoring participating providers to determine whether they have implemented corrective action; and
    - Taking appropriate action when they have not;
- A plan to utilize treatment protocols and practice parameters developed with clinical input and using evaluations described above or acquired treatment protocols and providing participating providers with sufficient information about the protocols to meet the standards; and
- Evaluating access to care for covered persons according to the state's standards, and a strategy for integrating public health goals with services offered under the plan, including a description of good faith efforts to communicate with public health agencies.

The company establishes an internal system to identify practices that result in improved health care outcomes, identify problematic utilization patterns, identify those providers that may be responsible for either exemplary or problematic patterns and foster an environment of continuous quality improvement (*Quality Assessment and Improvement Model Act* (#71), Section 6A).

The company ensures that participating providers have the opportunity to participate in developing, implementing and evaluating the quality improvement system (*Quality Assessment and Improvement Model Act* (#71), Section 6D).

The company provides enrollees with the opportunity to comment on the quality improvement process (*Quality Assessment and Improvement Model Act* (#71), Section 6E).

The company uses the findings generated by the system to work on a continuing basis with participating providers and other staff to improve the health care delivered to enrollees (*Quality Assessment and Improvement Model Act* (#71), Section 6B).

The company appoints a chief medical officer or clinical director to have primary responsibility for the quality improvement activities carried out by, or on behalf of, the health carrier (*Quality Assessment and Improvement Model Act* (#71), Section 7).

The chief medical officer or clinical director approves the written quality improvement program, periodically reviews and revises the program document and acts to ensure ongoing appropriateness. Not less than semi-annually, the chief medical officer or clinical director reviews reports of quality assessment activities (*Quality Assessment and Improvement Model Act* (#71), Section 7).

The company has an appropriate written policy to ensure the confidentiality of an enrollee's health information used in the company's quality improvement programs (*Quality Assessment and Improvement Model Act* (#71), Section 9).

The company complies with all applicable provisions of state law not expressly covered by any other of these standards.

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 3
The company files with the insurance commissioner a written description, in the prescribed format, of the quality assessment program, which includes a signed certification by a corporate officer of the company that the filing meets the requirements of applicable statutes, rules and regulations.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Written description of the quality assessment program

_____ Signed certification by a corporate officer

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Quality Assessment and Improvement Model Act (#71), Section 5D

Review Procedures and Criteria

Determine if the forms have been filed.

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 4
The company monitors the activities of the entity with which it contracts to perform quality assessment or quality improvement functions and ensures that the requirements of applicable statutes, rules and regulations are met.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Quality assessment and improvement policies and procedures

_____ Contracts with entities

_____ Minutes of the quality assessment and improvement committees

_____ Minutes of the board of directors

_____ Evaluations of the quality improvement program

_____ Reports of entity reviews and audits (if any) by the company

_____ Periodic reports from the entity

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Quality Assessment and Improvement Model Act (#71)

Review Procedures and Criteria

The company establishes, implements and enforces a policy to address effective methods of accomplishing oversight of each delegated activity.

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 5
The company reports to the appropriate licensing authority any persistent pattern of problematic care provided by a provider that is sufficient to cause the company to terminate or suspend contractual arrangements with the provider.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Quality assessment and improvement policies and procedures

_____ Reports made to the licensing authority

_____ Files of terminated and suspended provider contracts

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Quality Assessment and Improvement Model Act (#71), Section 5C

Review Procedures and Criteria

Determine that policies and procedures address reporting requirements.

Ascertain whether applicable terminated and suspended contract files reflect compliance with reporting requirements. Examiners should note that some terminated and suspended contracts will involve issues that are not necessary to report.

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 6
The company documents and communicates information about its quality assessment program and its quality improvement program to enrollees and providers.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Quality assessment and improvement policies and procedures

_____ Enrollee materials (e.g., enrollee newsletters and advertisements, etc.)

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Quality Assessment and Improvement Model Act (#71), Section 8

Review Procedures and Criteria

The company includes a summary of its quality assessment and quality improvement programs in marketing materials.

The company includes a description of its quality assessment and quality improvement programs, in addition to a statement of patient rights and responsibilities with respect to those programs, in the certificate of coverage or handbook provided to new enrollees.

The company makes available annually to providers and covered persons, findings from its quality assessment and quality improvement programs, as well as information about its progress in meeting internal goals and external standards, where available. The reports shall include a description of the methods used to assess each specific area and an explanation of how any assumptions may have affected the findings.

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 7
The company annually certifies to the insurance commissioner that its quality assessment and quality improvement program, along with the materials provided to providers and consumers, meets applicable statutes, rules and regulations.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Certification filings

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Quality Assessment and Improvement Model Act (#71), Section 8

Review Procedures and Criteria

The company makes the certified materials available for review by the public upon request, subject to a reasonable fee (except for those materials subject to confidentiality requirements and materials that are proprietary to the health plan).

The company retains all certified materials for at least 3 years from the date the material has been used or until the material has been examined as part of a market conduct examination, whichever is longer.

L. Utilization Review

Check state-specific laws to determine if utilization review is applicable to Medicare supplement insurance within a state.

Chapter 26—Conducting the Long-Term Care Examination

IMPORTANT NOTE:
The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in Chapter 1—Introduction.

This chapter applies to all long-term care insurance policies, including qualified long-term care insurance contracts, group and individual annuities and life insurance policies or riders that provide directly or supplement long-term care insurance. This chapter does not apply to life insurance contracts that accelerate benefits in the form of a lump sum payment, in anticipation of death or some other specified occurrence.

This chapter provides a format for conducting long-term care insurance examinations. Procedures for conducting other types of specialized examinations may be found in separate chapters.

The examination of long-term care insurance operations may involve any review of one or a combination of the following business areas:

A. Operations/Management
B. Complaint Handling
C. Marketing and Sales
D. Producer Licensing
E. Policyholder Service
F. Appeal of Benefit Trigger Adverse Determination
G. Underwriting and Rating
H. Claims

When conducting an exam that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the entity is meeting standards. Some standards may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.

When an examination involves a depository institution or their affiliates, the bank may also be regulated by federal agencies such as the Office of the Comptroller of the Currency (OCC), the Federal Reserve Board, the Office of Thrift Supervision (OTS) or the Federal Deposit Insurance Corporation (FDIC). Many states have executed an agreement to share complaint information with one or more of these federal agencies. If the examination results find adverse trends or a pattern of activities that may be of concern to a federal agency and there is an agreement to share information, it may be appropriate to notify the agency of the examination findings.

HIPAA—Federal Minimum Requirements
Examiners should be aware that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Section 7702B of the Internal Revenue Code impose minimum requirements for health insurance coverage in certain areas and prohibits the application of any state law to the extent that it prevents the application of a HIPAA requirement. However, states that have laws in these areas that extend beyond HIPAA's minimum requirements may enforce those laws.

Group and individual long-term care insurance issues affected by HIPAA include minimum standards for tax-qualified long-term care policies.

Long-Term Care Insurance
Two sections of HIPAA (7702B and 4980C) establish requirements for qualified long-term care insurance contracts and companies issuing those contracts. For the purposes of HIPAA requirements, the following definitions apply: "Qualified long-term care services" are necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services; and "maintenance or personal care services" are services required by a chronically ill individual that are provided pursuant to a plan of care prescribed by a licensed health care practitioner. Under HIPAA, qualified long-term care insurance contracts and issuers of those contracts are required to satisfy certain requirements of the *Long-Term Care Insurance Model Act* (#640) and *Long-Term Care Insurance Model Regulation* (#641).

Many states have requirements that impose more consumer protection requirements on carriers than HIPAA, in which case the state's requirements should be enforced. (For example, a state may include a group of 1 in its definition of "group" or "small group.")

IIPRC-Approved Products
When conducting an exam that includes long-term care insurance products, rates, advertisements and associated forms approved by the Interstate Insurance Product Regulation Commission (IIPRC) on behalf of a compacting state, it is important to keep in mind the uniform standards, and not state-specific statutes, rules and regulations, are applicable to the content and approval of the product. The IIPRC website is www.insurancecompact.org and the uniform standards are located on its rulemaking record. Compacting states have access through the NAIC System for Electronic Rate and Form Filing (SERFF) to product filings submitted to the IIPRC for approval and use in their respective state or jurisdiction and can also use the export tool in SERFF to extract relevant information. Each IIPRC-approved product filing has a completed reviewer checklist(s) to document the applicable uniform standards compliance review. The IIPRC office should be included when a compacting state(s) is concerned that an IIPRC-approved product constitutes a violation of the provisions, standards or requirements of the IIPRC (including the uniform standards). Under the uniform standards, a long-term care insurance product approved by the IIPRC can be used in a compacting state's partnership program provided the company has obtained the necessary approval from the compacting state or made the necessary certification to the compacting state, as applicable. Please note that the company must still comply with a compacting state's laws for minimum daily benefit amounts, minimum benefit periods and maximum elimination periods when selling a long-term care insurance product approved by the IIPRC.

A. Operations/Management

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 1
The entity files all reports and certifications with the insurance department as required by applicable statutes, rules and regulations.

Apply to: All long-term care companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Insurance department records of reports and certifications made by the entity

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Long-Term Care Insurance Model Act (#640)
Long-Term Care Insurance Model Regulation (#641)

Review Procedures and Criteria

Each insurer should file with the insurance commissioner, prior to offering group long-term care insurance to a resident of the state, evidence that the group policy or certificate has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in the state of issue. (Note: Section 21 of the *Long-Term Care Model Regulation* (#641)) requires an evidentiary filing only from discretionary groups. Review individual state statutes, rules and regulations to determine the extent of the state's jurisdiction over coverage sold to state residents under an out-of-state group policy.)

Each insurer should file with the insurance commissioner a copy of any long-term care insurance advertising intended for use in the state—whether through written, radio or television medium—for review or approval to the extent required by state law. All advertisements should be retained for at least three years from the date of first use.

Determine if replacement/lapse reporting is submitted by the entity as required. Items to be reported are:

- Top 10 percent of producers with the highest percentage of replacements and lapses; and
- Number of lapsed policies as a percentage of annual sales and policies in force at the end of the previous calendar year.

Determine that the entity complies with filing and certification requirements set forth by statutes, rules and regulations for associations endorsing or selling long-term care insurance. Generally, these requirements are imposed on an association group meeting the definition of a professional/trade/occupational association found in Section 4E(2) of the *Long-Term Care Insurance Model Act* (#640).

Ensure that the insurer has filed all requested advertising with the insurance department regarding association sold or endorsed long-term care insurance, as may be requested by the insurance department. Any such advertising must disclose:

- The specific nature and amount of compensation that the association receives from the endorsement or sale of the policy or certificate to its members; and
- A brief description of the process under which the policies and the issuing insurer were selected.

Determine that the entity submits suitability and rescission information as required by applicable statutes, rules and regulations.

Determine the regulated entity has proper procedures in place to ensure its producers are properly trained and that the training meets the minimum standards established by the applicable laws and regulations.

Insurers subject to the *Long-Term Care Insurance Model Act* (#640) shall maintain records with respect to the training of its producers concerning the distribution of its partnership policies that will allow the state insurance department to provide assurance to the state Medicaid agency that producers have received the training contained in Subsection B(2)(a) as required by Subsection A of the *Long-Term Care Insurance Model Act* (#640) and that producers have demonstrated an understanding of the partnership policies and their relationship to public and private coverage of long-term care, including Medicaid, in a state. These records shall be maintained in accordance with state record retention requirements and shall be made available to the commissioner upon request.

Most states have a long-term care partnership policy forms certification process in order for long-term care partnership forms to be sold in their state.

B. Complaint Handling

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

C. Marketing and Sales

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.

STANDARDS
MARKETING AND SALES

Standard 1
The entity has suitability standards for its products, when required by applicable statutes, rules and regulations.

Apply to: All long-term care products

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Producer records

_____ Training materials

_____ Procedure manuals

_____ Underwriting/Policy files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Long-Term Care Insurance Model Act (#640)
Long-Term Care Insurance Model Regulation (#641)

Review Procedures and Criteria

Determine whether the entity makes multiple sales to individuals of the same product. Use random selection of policyholders and have the entity run a policyholder history to identify the number of policies sold to those individuals.

Determine if entity guidelines place limitations on multiple sales; i.e., limits on coverage, determination of suitability, detection of predatory sales practices, etc.

Ensure that the entity has developed and uses suitability standards for the purchase or replacement of long-term care insurance, including, but not limited to:

- Presentation to the applicant, at or prior to application, of the "Long-Term Care Insurance Personal Worksheet" and any other suitability related information requested by the insurer;
- Presentation, at the same time as the personal worksheet, of the disclosure form titled "Things You Should Know Before You Buy Long-Term Care Insurance";
- Confirm that a completed personal worksheet was returned to the issuer prior to the consideration of the applicant for coverage, except that the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses; and

- If the issuer has determined that the applicant did not meet its financial suitability standards, confirmation that the insurer informed the applicant that the policy may not be suitable and obtained the applicant's written verification to proceed with the transaction prior to issuance of coverage (using a letter similar to Appendix D of the *Long-Term Care Insurance Model Regulation* #641). If the applicant has declined to provide financial information, confirm that the insurer verified the applicant's intent to purchase the coverage by either written verification (using a letter similar to Appendix D of Model #641) or alternative means. If an alternative method of verification was used for those who declined to provide financial information, confirm that the insurer has a record of the alternative method used.

Note: Pursuant to Section 24A of the *Long-Term Care Insurance Model Regulation* (#641), suitability standards do not apply to life insurance policies or riders that accelerate benefits for long-term care as defined in the *Long-Term Care Model Act* (#640), Section 4A.

Determine whether the personal worksheet and disclosure form are in the form, content and text prescribed by applicable statutes, rules and regulations.

Determine whether the required personal worksheet and disclosure forms are retained as required by applicable statutes, rules and regulations.

Determine if the insurer is reporting suitability information to the insurance commissioner as required by applicable statutes, rules and regulations.

Determine whether marketing materials encourage multiple issues of policies; for example, use of existing policyholder list for additional sales of similar products to those held, birth date solicitations, care tactics, etc.

Determine if negative enrollment practices are permitted and used by the entity.

Ensure the entity maintains a written statement specifying the standards of suitability used by the insurer and provides the standards to its producers, and that both follow the standards. The standards should specify that no recommendation should be made and/or no policy issued in the absence of reasonable grounds to believe that the purchase of the policy is not unsuitable for the applicant (based on information known to the insurer or producer making the recommendation).

STANDARDS
MARKETING AND SALES

Standard 2
Policy forms provide required disclosure material regarding standards for benefit triggers.

Apply to: All long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ Claim procedure/Underwriting manuals

_____ Claim files

_____ Policy forms

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Long-Term Care Insurance Model Act (#640)
Long-Term Care Insurance Model Regulation (#641)

Review Procedures and Criteria

Ensure the policy conditions the payment of benefits on a determination of the insured's ability to perform activities of daily living (ADLs) and cognitive impairment.

Ensure that the policy contains the definition of ADLs, cognitive impairment and other key terms as required by statutes, rules and regulations.

Determine that the eligibility for payment of benefits is not more restrictive than requiring either a deficiency in the ability to perform not more than 3 of the ADLs or the presence of cognitive impairment. Ensure that payment of benefits is not more restrictive than those allowed by statutes, rules and regulations.

Ensure that the policy contains a clear description of the process for appealing and resolving benefit determinations.

STANDARDS
MARKETING AND SALES

Standard 3
Marketing for long-term care products complies with applicable statutes, rules and regulations.

Apply to: Long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, telemarketing scripts and pictorial materials

_____ Required reports filed with the insurance department

_____ Marketing materials filed with the insurance department

_____ Underwriting files or other files containing proof of issuance of outline of coverage

_____ Review state statutes, rules and regulations to determine if state long-term care requirements apply to annuity products with a long-term care element. If so, then the applicable *Annuity Disclosure Model Regulation* (#245) would apply

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Long-Term Care Insurance Model Act (#640)
Long-Term Care Insurance Model Regulation (#641)
Life Insurance Disclosure Model Regulation (#580)
Life Insurance Illustrations Model Regulation (#582)
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Verify that the entity uses applications for long-term care insurance policies or certificates containing clear and unambiguous questions designed to ascertain the health condition of the applicant. (In most cases, application forms should have been reviewed by the insurance department's rates and forms division.)

Verify that the entity complies with right to return/"free look" requirements.

Verify that the outline of coverage is delivered to the applicant at time of initial solicitation through means that prominently directs the attention of the recipient to the document and its purpose.

Verify that at the time of policy delivery the insurer has delivered a policy summary for an individual life insurance policy that provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, verify that the insurer has delivered the policy summary upon the applicant's request, but regardless of request has made delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, ensure that the summary also includes:

- An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;
- An illustration of the amount of benefits, the length of benefits, and the guaranteed lifetime benefits, if any, for each covered person;
- Any exclusions, reductions and limitations on benefits of long-term care; and
- A statement that any long-term care inflation protection option required by the applicable state's statutes, rules and regulations regarding inflation protection option requirements comparable to Section 13 of the *Long-Term Care Insurance Model Regulation* (#641) is not available under this policy.

In addition to the above, if applicable to the policy type, ensure that the summary includes the following:

- A disclosure of the effects of exercising other rights under the policy;
- A disclosure of guarantees related to long-term care costs of insurance charges; and
- Current and projected maximum lifetime benefits.

The required provisions of the policy summary may be incorporated into a basic illustration required to be delivered in accordance with the applicable state's basic illustration requirements comparable to Sections 7 and 8 of the *Life Insurance Illustrations Model Regulation* (#582) or into the life insurance policy summary, which is required to be delivered in accordance with the applicable state's life insurance policy summary requirements comparable to Section 5 of the *Life Insurance Disclosure Model Regulation* (#580).

Verify that the entity complies with records maintenance and reporting requirements:

- Entity must maintain records for each producer of that producer's amount of replacement sales as a percentage of the producer's total annual sales and the amount of lapses of long-term care insurance policies sold by the producer as a percentage of the producer's total annual sales;
- Every insurer shall report annually by June 30 the 10 percent of its producers with the greatest percentages of lapses and replacements;
- Every insurer shall report annually by June 30 the number of lapsed policies as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the end of the preceding calendar year;
- Every insurer shall report annually by June 30 the number of replacement policies sold as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the preceding calendar year; and
- Every insurer shall report annually by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied.

STANDARDS
MARKETING AND SALES

Standard 4
All advertising and sales materials are in compliance with applicable statutes, rules and regulations.

Apply to: All long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for advertisements approved by the IIPRC)

_____ All company advertising and sales materials, including radio and audiovisual items, such as TV commercials, telemarketing scripts and pictorial materials

_____ Policy forms, including any required buyer's guides, outline of coverage, long-term care insurance personal worksheets and disclosure forms as they coincide with advertising and sales materials

_____ Producer's own advertising and sales materials

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Long-Term Care Insurance Model Act (#640)
Long-Term Care Insurance Model Regulation (#641)
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Evaluate the company's system for controlling advertisements. Every insurer should have and maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All advertisements, regardless of by whom written, created, designed or presented, are the responsibility of the insurer.

Ensure the company maintains, at its home or principal office, a complete file containing a specimen copy of every printed, published or prepared advertisement of its individual policies and specimen copies of typical printed, published or prepared advertisements of its blanket, franchise and group policies. There should be a notation indicating the manner and extent of distribution and the form number of every policy advertised. All advertisements should be maintained in the file for a period of either at least three years from the date the advertisement was first used or later if required by state statutes, rules and regulations.

Review advertising materials in conjunction with the appropriate policy form. Materials should not:

- Misrepresent policy benefits, advantages or conditions by failing to disclose limitations, exclusions or reductions, or use terms or expressions that are misleading or ambiguous;
- Make unfair or incomplete comparisons with other policies;
- Make false, deceptive or misleading statements or representations with respect to any person, company or organization in the conduct of insurance business;
- Offer unlawful rebates;
- Use terminology that would lead prospective buyers to believe that they are purchasing an investment or savings plan. Problematic terminology may include the following terms: investment, investment plan, founder's plan, charter plan, deposit, expansion plan, profit, profits, profit sharing, interest plan, savings or savings plan;
- Omit material information or use words, phrases, statements, references or illustrations, if such omission or such use has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, premium payable or state or federal tax consequences;
- Use terms such as "non-medical" or "no medical examination required," if the issue is not guaranteed, unless the terms are accompanied by a further disclosure of equal prominence and juxtaposition that issuance of the policy may depend on the answers to the health questions set forth in the application;
- State that a purchaser of a policy will share in or receive a stated percentage or portion of the earnings on the general account assets of the company;
- State or imply that the policy or combination of policies is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless that is a fact. Enrollment periods may not be described in terms such as "special" or "limited" when the insurer uses successive enrollment periods as its usual method of marketing its policies;
- State or imply that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy;
- Offer a policy that utilizes a reduced initial premium rate in a manner that overemphasizes the availability and the amount of the reduced initial premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, all references to the reduced initial premium should be followed by an asterisk or other appropriate symbol that refers the reader to that specific portion of the advertisement that contains the full rate schedule for the policy being advertised;
- Imply licensing beyond limits, if an advertisement is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed;
- Exaggerate, suggest or imply that competing insurers or insurance producers may not be licensed, if the advertisement states that an insurer or insurance producer is licensed in the state where the advertisement appears;
- Create the impression that the insurer, its financial condition or status, the payment of its claims or the merits, desirability or advisability of its policy forms or kinds of plans of insurance are recommended or endorsed by any governmental entity. However, where a governmental entity has recommended or endorsed a policy form or plan, that fact may be stated, if the entity authorizes its recommendation or endorsement to be used in the advertisement;
- State or imply that prospective insureds are or become members of a special class, group or quasi-group and enjoy special rates, dividends or underwriting privileges, unless that is a fact; and
- Misrepresent any policy as being shares of stock.

Materials should:

- Clearly disclose the name and address of the insurer;
- If using a trade name, disclose the name of the insurer, insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device or reference, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the insurer or create the impression that a company other than the insurer would have any responsibility for the financial obligation under a policy;
- Prominently describe the type of policy being advertised;
- Indicate that the product being marketed is insurance;
- Comply with applicable statutes, rules and regulations;
- Cite the source of statistics used;
- Identify the policy form that is being advertised, where appropriate;
- Clearly define the scope and extent of a recommendation by any commercial rating system;
- Only include testimonials, appraisals or analysis if they are genuine, represent the current opinion of the author, are applicable to the policy advertised and accurately reproduced to avoid misleading or deceiving prospective insureds. Any financial interest by the person making the testimonial in the insurer or related entity must be prominently disclosed; and
- Only state or imply endorsement by a group of individuals, society, association, etc., if it is a fact. Any proprietary relationship or payment for the testimonial must be disclosed.

Determine if the company approves producer sales materials and advertising. Ensure that copies of sales material other than company-approved materials, if permitted, are maintained in a central file. Determine if advertisements or lead-generating calls falsely project the image that they were sent by a government agency.

Determine if the advertising and solicitation materials mislead consumers relative to the producer's capacity as an insurance producer. Improper terms may include "financial planner," "investment advisor," "financial consultant" or "financial counseling," if they imply the producer is primarily engaged in an advisory business in which compensation is unrelated to sales, if such is not the case.

Review the use of the words "free," "no cost," "without cost," "no additional cost," "at no extra cost" or words of similar import. Those words should not be used with respect to any benefit or service being made available with a policy, unless it is a fact. If there is no charge to the insured, then the identity of the payor must be prominently disclosed. An advertisement may specify the charge for a benefit or a service or may state that a charge is included in the premium or use other appropriate language.

Ensure the advertisement does not contain a statement or representation that premiums paid for a long-term care insurance policy can be withdrawn under the terms of the policy. Reference may be made to amounts paid into an advance premium fund, which are intended to pay premiums at a future time, to the effect that they may be withdrawn under the conditions of the prepayment agreement. Reference may also be made to withdrawal rights under any unconditional premium refund offer.

Determine that company procedures and materials relative to long-term care products comply with right to return/"free look" requirements.

Review the company and producer's Internet sites with the following questions in mind:

- Does the website disclose who is selling/advertising/servicing for the website?
- Does the website disclose what is being sold or advertised?
- If required by statutes, rules or regulations, does the website reveal the physical location of the company/entity?
- Does the website reveal the jurisdictions where the advertised products are (or are not) approved, or use some other mechanism (including, but not limited to, identifying persons by geographic location) to accomplish an appropriate result?
- For the review of Internet advertisements:

- Run an inquiry with the company's name;
- Review the company's home page;
- Identify all lines of business referenced on the company's home page;
- Research the ability to request more information about a particular product and verify that the information provided is accurate; and
- Review the company's procedures related to producers' advertising on the Internet and ensure that the company requires prior approval of the producers' web pages, if the company name is used.

STANDARDS
MARKETING AND SALES

Standard 5
Company rules pertaining to producer requirements in connection with replacements are in compliance with applicable statutes, rules and regulations.

Apply to: All long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Replacement register

_____ Policy/Underwriting file

_____ Loan and surrender files, if applicable

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Life Insurance and Annuities Replacement Model Regulation (#613), if applicable
Long-Term Care Insurance Model Regulation (#641)

Review Procedures and Criteria

Review policy/underwriting files to determine if producers have identified replacement transactions on applications.

Review replacement register and policy/underwriting files to determine if required disclosure forms have been submitted on replacement transactions.

Review policy/underwriting files to confirm applicant's receipt of replacement notice.

Review replacement disclosure forms for completeness and signatures as required.

STANDARDS
MARKETING AND SALES

Standard 6
Company rules pertaining to company requirements in connection with replacements are in compliance with applicable statutes, rules and regulations.

Apply to: All long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Replacement register

_____ Policy/Underwriting file

_____ Agency correspondence file/Agency bulletins

_____ Agency procedural manual

_____ Claim files

_____ Agency sales/Lapse records

_____ Company systems manual

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Life Insurance and Annuities Replacement Model Regulation (#613), if applicable
Long-Term Care Insurance Model Regulation (#641)

Review Procedures and Criteria

Determine if the company has advised its producers of its replacement policy.

Determine if the company has separate commission schedules for replacement business, pursuant to applicable state statutes, rules and regulations. Note some states limit the compensation payable on replacement business to no more than that payable on renewal policies.

Determine if the company has provided timely notice to the existing insurers of the replacement.

Examine the company systems for identifying undisclosed replacements for effectiveness.

Determine if the company has the capacity to produce the data required by replacement regulation to assess producer replacement activity.

Determine if the company has issued letters in a timely manner to policyholders advising of the effects of preexisting conditions on covered benefits.

Review policy/underwriting files to determine if the company is retaining required records for required time frames.

Examine company procedures for verifying producer compliance with requirements on replacement transactions.

Review claim files to determine if the company provides required credit for preexisting conditions or probationary periods on replacements.

D. Producer Licensing

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

E. Policyholder Service

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.

STANDARDS
POLICYHOLDER SERVICE

Standard 1
Policy renewals are applied consistently and in accordance with policy provisions.

Apply to: All long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ Underwriting/Policy file

_____ Underwriting/Administrative procedure manuals

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review renewal business to determine if the entity's procedures for handling renewals are in accordance with applicable statutes, rules and regulations.

Ensure that individual policies or certificates do not contain renewal provisions other than "guaranteed renewable" or "noncancellable," and that these terms are adequately defined in the policy or certificate.

Review the underwriting/policy file to determine if premium notices were sent in a timely and accurate manner.

Review mailroom records for billings sent by the entity to ensure they were sent in a timely manner.

STANDARDS
POLICYHOLDER SERVICE

Standard 2
Nonforfeiture upon lapse and reinstatement provisions is applied consistently and in accordance with policy provisions.

Apply to: All long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ Underwriting/Administrative files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Long-Term Care Insurance Model Act (#640)
Long-Term Care Insurance Model Regulation (#641)

Review Procedures and Criteria

Determine if the required notification of lapse or termination is sent to the proper addressee(s), within the required time frames and that the required information is provided, per applicable statutes, rules and regulations.

Ensure that the entity receives designation of a person(s), other than the insured, to receive notice of lapse or termination of the policy or certificate for nonpayment of premiums or a written waiver by the insured not to designate an additional person(s) to receive notice.

Ensure that the insurer notifies existing insureds of their right to change their written designation at least once every two years, or as specified by state statutes, rules and regulations.

Verify that nonforfeiture and reinstatement provisions were applied consistently and in a non-discriminatory manner. Nonforfeiture provisions upon lapse and reinstatements should be applied per policy provisions and in accordance with applicable statutes, rules and regulations.

Ensure that the policy includes a provision that provides for reinstatement of coverage in the event of lapse, if the entity has provided evidence that the policyholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option should be made available to the insured for a period of 5 months after the date of termination.

STANDARDS
POLICYHOLDER SERVICE

Standard 3
Nonforfeiture options are communicated to the policyholder and correctly applied in accordance with the policy contract.

Apply to: All long-term care products, except life insurance policies or riders containing accelerated benefits as defined in Section 4A of the *Long-Term Care Insurance Model Act* (#640)

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ Underwriting/Administrative file

_____ Entity procedures manual

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Long-Term Care Insurance Model Act (#640)
Long-Term Care Insurance Model Regulation (#641)

Review Procedures and Criteria

Determine if the entity offers applicants the opportunity to purchase a long-term care policy that includes a nonforfeiture benefit, as required by applicable statutes, rules and regulations.

If the applicant declines the nonforfeiture benefit, ensure that the entity provides a contingent benefit upon lapse of the policy for a specified period following a substantial increase in premium rates, as required and defined by applicable statutes, rules and regulations.

Ensure that a policy offered with nonforfeiture benefits contains the same coverage elements, eligibility, benefit triggers and benefit length as a policy without the nonforfeiture benefit.

Determine if the entity provides notice as required by applicable statutes, rules and regulations prior to the due date of the premium reflecting a substantial premium increase.

Ensure that the entity offers the proper nonforfeiture benefit, nonforfeiture credit and attained age rating, as required by applicable statutes, rules and regulations.

Determine if the policy contains the proper time frames for nonforfeiture benefit and the contingent benefit upon lapse, as required by applicable statutes, rules and regulations.

Determine if the correct nonforfeiture option is provided in case of policy lapse.

Review correspondence with policyholders to determine if options were explained adequately.

If there are questions related to nonforfeiture values, refer to applicable statutes, rules and regulations regarding the calculation of nonforfeiture values.

Review the entity's procedures and policies regarding the handling of each type of nonforfeiture transaction (including whether the request may be made verbally).

Ensure that the entity notifies policyowners of material changes to any nonforfeiture benefits in accordance with applicable statutes, rules and regulations.

STANDARDS
POLICYHOLDER SERVICE

Standard 4
Policyholder service for long-term care products complies with applicable statutes, rules and regulations.

Apply to: Long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ Underwriting/Policy file

_____ Underwriting/Administrative procedures manuals

_____ Procedure manuals

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Long-Term Care Insurance Model Act (#640)
Long-Term Care Insurance Model Regulation (#641)
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Verify that the entity issues monthly reports to policyholders when the long-term care benefit is funded through a life insurance vehicle by the acceleration of the death benefit and is in benefit payment status.

Verify that the entity offers nonforfeiture benefits.

F. Appeal of Benefit Trigger Adverse Determination

Use the standard set forth below.

STANDARDS
APPEAL OF BENEFIT TRIGGER ADVERSE DETERMINATION

Standard 1
Insurers shall be in compliance with applicable state statutes, rules and regulations regarding appeal of adverse benefit trigger determination.

Apply to: All long-term care insurers

Priority: Essential

Documents to be Reviewed

_____ Company's written procedures explaining administration of appeals process and template denial letters

_____ Internal company procedures which describe the appeals process

_____ Applicable statutes, rules and regulations

_____ Request copies of correspondence on actual claimants who have appealed benefit trigger decisions (e.g., request for appeal, acknowledgement of appeal, appeal outcome communicated) after state statutes, rules and regulations became effective

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Long-Term Care Insurance Model Regulation (#641)

Review Procedures and Criteria

Ask insurer how it describes its appeal procedures to the insured.

Ask for copies of correspondence on actual claimants who have appealed benefit trigger decisions (e.g., request for appeal, acknowledgement of appeal, appeal outcome communicated) after state statutes, rules and regulations became effective.

In the event the insurer has determined that the benefit trigger of a long-term care insurance policy has not been met, verify that the insurer has provided a clear written notice to the insured and the insured's authorized representative, if applicable, of all of the following:

- The reason that the insurer determined that the insured's benefit trigger had not been met;
- The insured's right to internal appeal and the right to submit new or additional information relating to the benefit trigger denial with the appeal request within 120 calendar days of receipt of the notice; and
- The insured's right, after exhaustion of the insurer's internal appeal process, to have the benefit trigger determination reviewed under the independent review process.

Ensure that the individual or individuals making the internal appeal decision are not the same individual or individuals who made the initial benefit determination.

Verify that the insurer, within 30 calendar days of the insurer's receipt of all necessary information upon which a final determination can be made, has completed and sent written notice of the internal appeal decision to the insured and the insured's authorized representative, if applicable.

If the insurer's original determination is upheld upon internal appeal, ensure that the notice of the internal appeal decision describes any additional internal appeal rights offered by the insurer.

If the insurer's original determination is upheld after the internal appeal process has been exhausted, and new or additional information has not been provided to the insurer, verify that the insurer has provided a written description of the insured's right to request an independent review of the benefit determination to the insured and the insured's authorized representative, if applicable.

As part of the written description of the insured's right to request an independent review, verify that the insurer has included in the written description of the insured's right to request an independent review of benefit determination the following, or substantially equivalent, language:

> "We have determined that the benefit eligibility criteria ("benefit trigger") of your [policy] [certificate] has not been met. You may have the right to an independent review of our decision conducted by long-term care professionals who are not associated with us. Please send a written request for independent review to us at [address]. You must inform us, in writing, of your election to have this decision reviewed within 120 days of receipt of this letter. Listed below are the names and contact information of the independent review organizations approved or certified by your state insurance commissioner's office to conduct long-term care insurance benefit eligibility reviews. If you wish to request an independent review, please choose one of the listed organizations and include its name with your request for independent review. If you elect independent review, but do not choose an independent review organization with your request, we will choose one of the independent review organizations for you and refer the request for independent review to it."

Examiners should be aware that not all jurisdictions maintain a list of independent review organizations qualified to review long-term care benefit trigger decisions, and the language of the above paragraph may have been modified in accordance with state statutes, rules and regulations.

In the event that the insurer has not considered a benefit trigger decision eligible for independent review, verify that the insurer has informed the insured and the insured's authorized representative, if applicable, and the commissioner in writing and has included in the notice the reasons for its determination of independent review ineligibility.

Verify that the cost of independent review is borne solely by the insurer.

Verify that the insurer refers requests to the independent review organization that the insured or the insured's authorized representative has chosen within five business days of receiving a written request for independent review. If the insured or the insured's authorized representative has not chosen an approved independent review organization to perform the review, verify that the insurer has chosen an independent review organization approved or certified by the state. Verify that the insurer varies its selection of authorized independent review organizations on a rotating basis.

Verify that the insurer refers requests for independent review of a benefit trigger determination to an independent review organization, which may include, but not be limited to the following provisions, subject to applicable state statutes, rules and regulations:

- An independent review organization shall be on a list of certified or approved independent review organizations that satisfy the requirements of a qualified long-term care insurance independent review organization; and
- Independent review shall be limited to the information or documentation provided to and considered by the insurer in making its determination, including any information or documentation considered as part of the internal appeal process.

If the insured or the insured's authorized representative has new or additional information not previously provided to the insurer, whether submitted to the insurer or the independent review organization, ensure that such information is considered first in the internal review process:

- Verify that the insurer completes its review of the information and provides written notice of the results of the review to the insured and the insured's authorized representative, if applicable, and the independent review organization within five business days of the insurer's receipt of such new or additional information; and
- If the insurer maintains its denial after such review, the independent review organization shall continue its review. If the insurer overturns its decision following its review, the independent review request shall be considered withdrawn.

Verify that the insurer acknowledges in writing to the insured and the insured's authorized representative, if applicable, and the commissioner that a request for independent review was received, accepted and forwarded to an independent review organization for review. Ensure that the notice includes the name and address of the independent review organization.

Verify that if any new or additional information not previously provided to the insurer is submitted by the insured or the insured's authorized representative, the insurer either (1) considers and affirms or (2) overturns its benefit trigger determination. In the event that the insurer affirms its benefit trigger determination, verify that the insurer promptly provides such new or additional information to the independent review organization for its review, along with the insurer's analysis of such information.

If the insurer overturns its benefit trigger determination, verify that the insurer has provided notice to the independent review organization and the insured and the insured's authorized representative, if applicable, and the commissioner of its decision. Verify that the independent review process ceased immediately upon receipt of such notice.

Verify that the insurer abides by the decision of the independent review organization with respect to whether the insured met the benefit trigger.

Ensure that the insurer has not in any way restricted the insured's right to submit a new request for benefit trigger determination after the independent review decision, should the independent review organization uphold the insurer's decision.

G. Underwriting and Rating

1. Purpose

The underwriting portion of the examination is designed to provide a view of how the entity treats the public and whether that treatment is in compliance with applicable statutes, rules and regulations. It is typically determined by testing a random sampling of files and applying various tests to the sampled files. It is concerned with compliance issues. The areas to be considered in this kind of review include:

- Rating practices;
- Underwriting practices;
- Use of correct and properly filed and approved forms and endorsements;
- Termination practices;
- Unfair discrimination;
- Use of proper disclosures, outlines of coverage and delivery receipts;
- Reinsurance; and
- Marketing and sales materials.

2. Techniques

During an examination, it is necessary for examiners to review a number of information sources, including:

- Rating manuals and rate cards;
- Underwriting manuals, guidelines and classification manuals;
- Medical underwriting manuals;
- Individual and group issued and renewed policy files;
- Policy summaries;
- Replacement and conservation materials;
- Documentation of required disclosures and delivery receipts;
- Individual and group canceled policy files and certificates;
- Documentation of premium refund upon election of "free look" period;
- Recessions occurring prior to a claim;
- Policy forms, endorsements and applications, along with appropriate filings;
- Producer licensing information;
- Producer compensation agreements, where applicable;
- Premium statements and billing statements;
- Group trust arrangements, where applicable;
- Declined applications and notices;
- Individual and group lapsed policy files and notices;
- Individual and group nonforfeiture files and notices;
- Reinsurer policies/treaties; and
- Reinsurer guidelines and manuals.

For the purposes of this chapter, "underwriting file" means the file or files containing the new business application, renewal application, certificates or evidences of coverage, including binders, rate calculation sheets, billings, medical information, credit information, inspection or interview reports, all underwriting information obtained or developed, policy summary page, endorsements, cancellation or reinstatement notices, correspondence and any other documentation supporting selection, classification, rating or termination of the policy.

In selecting samples for testing, individual policies should generally not be combined with group policies. Because these two areas are generally not homogeneous, any conclusions or inferences made from the results of sampling may not be valid if combined. The examiner should be familiar with the process for gathering and processing underwriting information and the quality controls for the issuance of policies, endorsements and premium statements. The list of files from which a sample is to be drawn may be generated through a computer run or, in some cases, through a policy register covering the period of time selected in the notice of the examination.

Next, determine the entity's policy population (policy count) by line of business. Review a random selection of business for application of a particular test or apply specific tests to a census population using automated tools. (In the event specific files are chosen for a target review, the examiner must be certain that the examination results are clearly identified as representative of the target selection.) The examiner should maintain a list of the various tests to be applied to each file in the sample. This will aid in consistency by ensuring that each test is considered for each file in the sample.

If exceptions are noted, the examiner must determine if the exception is caused by such practices as the use of faulty automated rating systems, or the development and use of improperly or vaguely worded manuals or guidelines. When exceptions are noted, it is advisable to determine the scope and extent of the problem. The examiner's responses should maximize objectivity; the examiner should avoid replacing examiner judgment for entity judgment.

a. Rating Practices

It is necessary to determine if the entity is in compliance with rating systems that have been filed with and, in some cases, approved by the insurance department. When rates are not required to be filed with an applicable regulatory agency, it is prudent to determine if rates are being applied consistently and in accordance with the entity's own rating methods. Segmented rates should not be unfairly discriminatory. Wide-scale application of incorrect rates by an entity might raise financial solvency questions or be indicative of inadequate management oversight. Deviation from established rating plans might also indicate that an entity is engaged in unfair competitive practices. Inconsistent application of rates or classifications can result in unfair discrimination.

If rating exceptions are noted, the examiner must determine if the exception is caused by such practices as the use of faulty automated rating systems or the use of improperly worded, vague or obsolete rating manuals. When exceptions are noted, it is advisable to determine the scope and extent of the problem.

Occasionally, the examiner may need to review loss statistics to determine if premiums are fair and reasonable in relation to the associated claims experience. When possible, the examination team should make use of audit software to verify the correct application of specific rating components and the consistent use of rates. This allows for a more thorough review and can save time during the examination process. All new automated audit applications that are developed should be submitted to the NAIC FAST Repository, in order to assist in building a comprehensive set of audit programs.

The rating practices for renewal policies and newly issued policies should be reviewed. The examination team should also review premium notices and billing statements. The examiner should ensure the proper application of rate increases or rate decreases.

The examiner should also ensure that the underwriting files contain sufficient information to support the rates that have been developed.

b. Underwriting Practices

The examiner should review relevant underwriting information; e.g., the entity's underwriting manuals, underwriting guidelines, underwriting bulletins, declination procedures, agency agreements and correspondence with producers. Interoffice memoranda and entity minutes that may furnish evidence of anti-competitive behavior may also be requested. In addition to reviewing the content of the above information for indications of unfairly discriminatory practices, the examination team also should use the above information to determine the entity's compliance with its own manuals and guidelines. The examiner should confirm that the entity's underwriters and producers consistently apply the entity guidelines for all business selected or rejected. The examination team should verify that the entity has correctly classified insured individuals.

File documentation should be sufficient to support the underwriting decisions made. Underwriting decisions that are adequately documented generally afford the entity's management team with the opportunity to know what business it has selected through its underwriters and producers. The examiner should verify that properly licensed and appointed (where applicable) producers have been used in the production of the business. Underwriting guidelines may vary by geographic areas in the jurisdiction and, therefore, such guidelines should be reviewed for each applicable field office.

Any practice suggesting anti-competitive behavior may involve legal considerations that should be referred to the insurance department's counsel. Ultimately, the information obtained may be useful in drafting legislation or regulations.

c. Use of Correct and Properly Filed Forms and Endorsements

The examination team should verify that all policy forms and endorsements used have been filed with the appropriate regulatory authority, if applicable. In addition, the examination team should verify the consistent and correct use of policy forms and endorsements. The examiner should be mindful of possible outdated forms or endorsements. If coverage and riders requested by the applicant are not issued, proper notification should be provided to the applicant. In some cases, supplemental applications are appropriate.

d. Termination Practices

The examination team should review the entity's policy cancellation and reinstatement practices to determine compliance with applicable statutes, rules and regulations, as well as to determine compliance with the entity's own rules, guidelines and policy provisions.

Cancellation and lapsed policy processing should include a formal notice to the insured, including secondary addressees, where elected by the insured. Adherence to policy provisions for renewal language and for applicable grace periods should be reviewed.

The examination team should verify that premium refunds upon election of "free look" provisions are handled correctly, uniformly and in a timely manner.

The examination team should review reinstatement offers and determine what the entity's practice is for offering reinstatement. In addition, the examination team should be mindful of billing practices that may encourage policy lapses.

e. Unfair Discrimination

The examination team should be mindful of entity underwriting practices that may be unfairly discriminatory. The classification of insureds into rating or underwriting groups must be based on sound business or actuarial principles. Failure to follow established rating and underwriting guidelines may result in unintentional, yet unfair discrimination. Unfair trade practice acts and related regulatory rules adopted by the applicable jurisdiction also may prohibit specific underwriting practices.

f. Use of Proper Disclosures, Buyer's Guides and Outlines of Coverage

The examination team should review the entity's use of required disclosure forms, buyer's guides, policy summaries, replacement notices, "free look" periods and outlines of coverage. In addition to the use of such required items, the examiner may wish to verify that the above items contain the correct content and are in the correct format.

g. Reinsurance

Most state statutes include a feature that for many lines of business the entity is not permitted to place more than 10 percent of its surplus to policyholders at risk on any one placement of insurance. While this is primarily a solvency issue, it is one that market conduct examiners are in an ideal position to test in view of the sampling of underwriting files.

Adherence to the requirement is easy to test, but requires familiarity with the structure and content of the reinsurance treaties covering the business written by the entity. This item is particularly important for companies that hold minimal policyholder surplus accounts (i.e., surplus of less than $10 million). It also may reflect on the care that the entity's management places on its selection of business, and represent a danger to the financial health of the entity. Errors in this area should be forwarded to the appropriate state financial examiners. Any tests of this type must be coordinated with the state's financial examiners.

h. Marketing and Sales Materials

It is recommended that a review of all forms and materials be conducted by reviewing the marketing and sales standards simultaneously during the underwriting and rating review.

3. Tests and Standards

The underwriting and rating review includes, but is not limited to, the following standards addressing various aspects of the entity's underwriting activities. The sequence of the standards listed here does not indicate priority of the various standards.

STANDARDS
UNDERWRITING AND RATING

Standard 1
All mandated definitions and requirements for group long-term care insurance are followed in accordance with applicable statutes, rules and regulations.

Apply to: All group long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files

_____ Rating/Quote information provided electronically

____ Marketing materials

____ Correspondence to producers

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Long-Term Care Insurance Model Act (#640)
Long-Term Care Insurance Model Regulation (#641)

Review Procedures and Criteria

If a group policy is issued to an employer or labor organization or association, determine if the group meets the required criteria to qualify the association or organization as a bona fide organization established for the benefits of its members.

Determine if all group long-term care policies offered in one state and issued in another state comply with applicable extraterritorial jurisdiction statutes, rules and regulations.

Ensure that any group long-term care policy standard provisions that are applicable in the examining jurisdiction are incorporated into the group policy. These provisions include, but are not limited to, grace periods, periods of incontestability, required copies of applications, deemers of representations and not warranties, medical or other evidence of insurability, provision for a certificate of insurance and conversion to an individual policy in the event of termination or total disability.

Ensure that when a group long-term disability policy is replaced by another policy, the succeeding carrier offers coverage to all persons covered under the previous group policy on its date of termination and that the coverage and premium amounts meet the requirements of applicable statutes, rules and regulations.

STANDARDS
UNDERWRITING AND RATING

Standard 2
Pertinent information on applications that form a part of the policy is complete and accurate, and applications conform to applicable statutes, rules and regulations.

Apply to: All long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ All applications

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine if the requested coverage is issued.

Determine if the entity has a verification process in place to determine the accuracy of application information.

Verify that applicable nonforfeiture options and inflation protection options are indicated on the application.

Verify that changes to the application and supplements to the application are initialed by the applicant.

Verify that supplemental applications are used, where appropriate.

Determine if the application complies with applicable statutes, rules and regulations regarding form and content.

STANDARDS
UNDERWRITING AND RATING

Standard 3
The entity complies with specific requirements for AIDS-related concerns in accordance with applicable statutes, rules and regulations.

Apply to: All long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Applications and related disclosure and consent forms

_____ Health questionnaires for applicants

_____ Medical underwriting guidelines

_____ Entity guidelines regarding the handling of AIDS-related test results, if such tests are allowed

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Ensure the entity does not use medical records indicating AIDS-related concerns to discriminate against applicants without medical evidence of disease. Companies shall establish reasonable procedures related to the administration of an AIDS-related test.

Medical underwriting guidelines may consider factual matters that reveal the existence of a medical condition. For example, no adverse underwriting decision shall be based on medical records that only indicate the applicant demonstrated AIDS-related concerns by seeking counseling from a health care professional.

Disclosure forms signed by the applicant must clearly disclose the requirement, if any, for applicants to take an AIDS-related test, and should be a part of the underwriting file. Applications must contain a consent form for such testing.

Review any application forms and health questionnaires used by the entity or its producers for questions that would require the applicant to provide information regarding sexual orientation.

Questions may ask if the applicant has been diagnosed with AIDS or ARC, if they are designed to establish the existence of the condition, but are not to be used as a proxy to establish sexual orientation of the applicant.

Ensure the entity or insurance support organization does not use the sexual orientation of an applicant in the underwriting process or in the determination of insurability.

Underwriting guidelines must not consider an applicant's sexual orientation a factor in the determination of insurability.

Review a sample of underwriting files for denied applications in order to verify that denials were non-discriminatory.

Review inspection reports to determine if they are being used in a discriminatory manner, or ordered on the basis of the entity guidelines (e.g., based on the amount of insurance).

Neither the marital status, the living arrangements, the occupation, gender, medical history, beneficiary designation, nor the ZIP code or other territorial classification may be used to establish the applicant's sexual orientation.

STANDARDS
UNDERWRITING AND RATING

Standard 4
Policies, riders, amendments, endorsements, applications and certificates of coverage contain required provisions, definitions and disclosures.

Apply to: All long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ Underwriting/Administration file

_____ Policies, riders, amendments, endorsements, applications and certificates of coverage

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Long-Term Care Insurance Model Act (#640)
Long-Term Care Insurance Model Regulation (#641)

Review Procedures and Criteria

Determine if the policy contains the required terms and definitions of such terms per applicable statutes, rules and regulations, including, but not limited to:

- Guaranteed renewable and noncancellable;
- Activities of daily living, acute condition, adult day care, bathing, cognitive impairment, continence, dressing, eating, hands-on assistance, home health care services, Medicare, mental or nervous disorder, personal care, skilled nursing care, toileting and transferring; and
- Reasonable and customary/usual and customary.

Determine if riders and endorsements added after the original date of issue, at reinstatement or renewal that reduce or eliminate benefits or coverage (except as requested by the insured) require signed acceptance by the insured.

Ensure that the entity has not established a new waiting period in the event existing coverage is converted or replaced by a new or other form within the same entity, except with respect to an increase in benefits voluntarily selected by the individual or group policyholder.

Ensure that the entity does not apply preexisting condition provisions more restrictive than "…a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services within 6 months preceding the effective date of coverage of an insured person," unless the insurance commissioner has extended limitation periods.

A long-term care insurance policy or certificate, other than a policy or certificate issued to a defined group, may not exclude coverage for a loss or confinement that is the result of a preexisting condition, unless such loss or confinement begins within 6 months following the effective date of coverage of an insured person.

A long-term care insurance policy or certificate may not exclude or use riders or waivers to exclude, limit or reduce benefits for specifically named or described preexisting conditions or physical conditions beyond the defined waiting period.

Determine if the policy meets the requirements under applicable statutes, rules and regulations with regard to prior hospitalization/institutionalization. The policy may not:

- Condition eligibility of any benefits on a prior hospitalization requirement, or, in the case of benefits provided in an institutional care setting, on the receipt of a higher level of institutional care;
- Condition eligibility for benefits (other than waiver of premium, post-confinement, post-acute care or recuperative benefits) on a prior institutionalization requirement;
- Condition eligibility of non-institutional benefits based on the prior receipt of institutional care on a prior institutional stay of more than 30 days; and
- Condition the receipt of benefits following institutionalization upon admission to a facility for the same or related conditions within a period of less than 30 days after discharge.

A policy or rider containing post-confinement, post-acute care or recuperative benefit shall contain in a separate paragraph titled "Limitations or Conditions on Eligibility for Benefits" such limitations or conditions, including any required number of days of confinement.

Determine if the policy contains any limitations regarding preexisting conditions, and, if so, ensure that they are outlined in a separate paragraph titled "Preexisting Condition Limitations."

Ensure that the policy measures the need for long-term care on the activities of daily living (ADLs) and cognitive impairment, and that they are described—along with any additional benefit triggers, benefits and entity-required certification of functional dependency—in a separate paragraph titled "Eligibility for the Payment of Benefits."

If a long-term care policy provides benefits for home health care or community care services, ensure that it meets the required minimum standards required by applicable statutes, rules and regulations.

STANDARDS
UNDERWRITING AND RATING

Standard 5
Underwriting and rating for long-term care products complies with applicable statutes, rules and regulations.

Apply to: Long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ Policy contract

_____ Notice of cancellation/nonrenewal

_____ Insurance department approval of forms

_____ Underwriter's file or notes on a system log

_____ Insured's request (if applicable)

_____ Entity cancellation/nonrenewal guidelines

_____ Certificate of mailing

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Long-Term Care Insurance Model Act (#640)
Long-Term Care Insurance Model Regulation (#641)

Review Procedures and Criteria

Determine if the notice of cancellation/nonrenewal was valid according to policy provisions and applicable statutes, rules and regulations.

Review entity procedures for cancellation/nonrenewal to determine if the entity is following its own guidelines.

Review cancellation and billing notices, grace period descriptions, reinstatement offers, lapse notices, etc., to ensure the forms, if necessary, were approved by the insurance department.

In addition to other applicable review procedures, verify the following:

- The entity has not cancelled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificateholder;
- The entity has not established a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same entity, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder;
- The entity does not provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care; and
- The entity does not apply preexisting condition provisions more restrictive than "…a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services within 6 months preceding the effective date of coverage of an insured person," unless limitation periods have been extended by the insurance commissioner.

Verify that standards for incontestability periods are no more restrictive than as follows:

- Within 6 months, misrepresentations must be material;
- Within 2 years and more than 6 months, misrepresentation must be material and pertain to the condition for which benefits are sought; and
- After 2 years, benefits are contestable only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

Verify that the entity's underwriting practices reflect minimum requirements related to guaranteed renewability, noncancellability and continuation or conversion.

Replacement of a group long-term care policy with another group long-term care policy shall offer coverage to all persons covered under the previous group policy on its date of termination, without preexisting condition exclusions that would have been covered on the prior policy and shall not vary or otherwise depend on the individual's health or disability status, claim experience or use of long-term care services.

Verify that the entity provides notice to the designated person, in addition to the applicant, for termination of a policy or certificate for nonpayment of premium.

Verify that the entity allows for reinstatement of coverage in the event of lapse if provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired.

Verify that prior to issuance of a long-term care policy or certificate to an applicant age 80 or older, the insurer obtains one of the following:

- A report of a physical examination;
- An assessment of functional capacity;
- An attending physician's statement; or
- Copies of medical records.

Verify that the entity delivers a copy of the completed application or enrollment form (whichever is applicable) to the insured no later than at the time of delivery of the policy or certificate, unless it was retained by the applicant at the time of application.

Verify that the entity maintains a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily effectuated. The entity shall annually furnish this information to the insurance commissioner in the format prescribed by applicable statutes, rules and regulations.

Verify that the premium charged does not increase due to increase of age beyond 65 or the duration the insured has been covered under the policy.

STANDARDS
UNDERWRITING AND RATING

Standard 6
The company's underwriting practices are not unfairly discriminatory. The company adheres to applicable statutes, rules and regulations and company guidelines in the selection of risks.

Apply to: All long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ New business application

_____ All underwriting information obtained

_____ Company underwriting guidelines and bulletins

_____ Declination procedures

_____ Agency agreements and correspondence with producers

_____ Riders or extensions of coverage

_____ Interoffice memoranda and company minutes

_____ Policy specifications page

_____ Underwriter's file or notes on a system log

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Insurance Fraud Prevention Model Act (#680)
Long-Term Care Insurance Model Act (#641)
Model Regulation on Unfair Discrimination in Life and Health Insurance on the Basis of Physical or Mental Impairment (#887)
Model Regulation on Unfair Discrimination on the Basis of Blindness or Partial Blindness (#888)
Unfair Discrimination Against Subjects of Abuse in Life Insurance Model Act (#896)
Unfair Trade Practices Act (#880)
Credit Reports and Insurance Underwriting White Paper

Review Procedures and Criteria

Ensure the file documentation adequately supports the decisions made:

- The application should be complete and signed;
- Determine when, and under what conditions the company requires motor vehicle reports, inspection reports, credit reports, Medical Information Bureau (MIB) or other medical physician reports or other underwriting information to confirm exposure or premium basis;
- Determine if the file contains the necessary information to support the classification, rating and selection decision made; and
- Verify that when a policy is issued on a basis other than applied for, that notice of an adverse underwriting decision is provided in accordance with applicable statutes, rules and regulations.

Review relevant underwriting information to ensure that no unfair discrimination is occurring, according to the state's definition of unfair discrimination.

Determine if the company is following its underwriting guidelines, and that the guidelines conform to applicable statutes, rules and regulations, including, but not limited to:

- The insurer shall obtain one of the following prior to issuance of a policy or certificate to an applicant aged 80 or older:
    - A report of physical examination;
    - An assessment of functional capacity;
    - An attending physician's statement; or
    - Copies of medical records.
- All applications for long-term care, except policies issued on a guaranteed-issue basis, shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant; and
- If an application for long-term care coverage contains a question regarding whether the applicant has had medication prescribed by a physician, the company shall also ask the applicant to list the medication.

Determine if the company underwriting guidelines have been filed, where applicable.

Review interoffice memoranda for evidence of anti-competitive behavior, coercive practices or improper replacement tactics.

Underwriting guidelines may vary by geographic areas in the jurisdiction and, therefore, such guidelines should be reviewed for each office being examined.

Inconsistent handling of rating or underwriting practices, even if not intentional, can result in unfair discrimination. Companies may not permit discrimination between individuals of the same class and equal health status.

Ensure that underwriting requirements are not applied in an unfairly discriminatory manner.

Review guaranteed-issue criteria to ensure correct handling.

Review policy provisions for skilled nursing care to ensure that no restrictions are placed on the proper level of care; i.e., the company does not provide only skilled nursing care or does not provide more coverage for skilled care in a facility than coverage for lower levels of care.

Verify that the questions on applications are sufficiently clear and applicable to the coverage being requested.

Verify that Medical Information Bureau (MIB) information is not used as the sole basis for an underwriting decision.

Companies may not refuse to insure, continue to insure or limit coverage based on:

- Sex;
- Marital status;
- Race;
- Religion;
- National origin;
- Physical or mental impairment (except where based on sound actuarial principles or actual or reasonably anticipated experience);
- Blindness or partial blindness only* (however, all other conditions, including the underlying cause of the blindness or partial blindness, are subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as a sighted person); and
- Abuse status.

*Note: Review individual state statutes, rules and regulations that may provide that an insurer may not refuse to insure, refuse to continue to insure or limit the amount, extent or kind of coverage available to an individual solely because of blindness or partial blindness.

Many jurisdictions have enacted legislation regarding subjects of abuse. Examiners should be familiar with their statutes, rules and regulations in this area.

Examine new business applications for the required fraud statement.

H. Claims

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.

STANDARDS
CLAIMS

Standard 1
Claim files are handled in accordance with policy provisions and applicable statutes, rules and regulations.

Apply to: All long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ Company claim procedure manuals

_____ Claim training manuals

_____ Internal company claim audit reports

_____ Claim bulletins and procedure manuals

_____ Company claim forms manual

_____ Claim files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Insurance Fraud Prevention Model Act (#680)
Long-Term Care Insurance Model Act (#640)
Unfair Claims Settlement Practices Act (#880)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)

Review Procedures and Criteria

Review company procedures, training manuals and claim bulletins to determine if company standards exist and whether standards comply with state statutes. Determine if company procedures provide for the detection and reporting of fraudulent or potentially fraudulent insurance acts to the insurance commissioner.

Determine if claim handling meets applicable statutes, rules and regulations, including:

- Correct payees and addresses; and
- Correct benefit amounts.

Ascertain whether the company has misrepresented relevant facts or policy provisions relating to coverages at issue.

Determine if claim files are handled according to policy provisions.

If a claim under a long-term care insurance contract is denied, the issuer shall, within 60 days of the date of a written request by the policyholder or certificateholder, or a representative thereof:

- Provide a written explanation of the reasons for the denial; and
- Make available all information directly related to the denial.

Determine if the insurer is in compliance with proper payment of "clean claims," as defined in applicable state statutes, rules and regulations. Verify that the insurer pays clean claims within 30 business days after receipt of a clean claim. For claims that do not fall within the category of a clean claim, verify that the insurer has sent a written notice acknowledging the date of receipt of the claim and containing one of the following provisions within 30 business days:

- The insurer has declined to pay all or part of the claim and the specific reason(s) for denial; or
- That additional information is necessary to determine if all or any part of the claim is payable and the specific additional information that is necessary.

Verify that the insurer has paid clean claims within 30 business days after receipt of all requested additional information, or has sent a written notice that the insurer has declined to pay all or part of the claim within 30 days. The notice should specify the specific reason(s) for denial.

If, upon review of insurer clean claim payment practices, an examiner determines that an insurer has failed to comply with clean claim requirements, verify that the insurer has paid interest at the rate of one percent per month on the amount of the claim that should have been paid but that remains unpaid 45 business days after the receipt of the claim or, in the event the insurer has requested additional information, upon receipt of all requested additional information.

Verify that the insurer has included interest payable in any late reimbursement without requiring the individual who filed the original claim to make any additional claim for such interest.

It is an unfair practice to settle, or attempt to settle, a claim on the basis of an application that was materially altered without the consent of the insured.

Confirm that a monthly report is issued to the policyholder whenever long-term care benefits are issued through acceleration of death benefit provisions of a life insurance product.

Confirm that mandatory nonforfeiture benefits are offered.

Determine that eligibility for the payment of benefits is based on a deficiency in the ability to perform not more than 3 of the activities of daily living (ADLs) or the presence of cognitive impairment.

Ensure that determination of deficiency is not more restrictive than:

- Requiring the hands-on assistance of another person to perform the prescribed ADLs; and
- For a cognitive impairment, supervision or verbal cueing by another person is needed to protect the insured or others.

Ensure that licensed or certified professionals, such as physicians, nurses or social workers, perform assessments of ADLs and cognitive impairment.

Chapter 27—Conducting the Consumer Credit Examination

IMPORTANT NOTE:
The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in Chapter 1—Introduction.

This chapter provides a suggested format for conducting examinations of companies that offer one or more consumer credit products. The fundamental purpose of the examination is to determine compliance with applicable statutes, rules and regulations governing companies that write credit insurance.

The examination of credit insurance operations may involve any review of one or a combination of the following business areas:

A. Operations/Management
B. Complaint Handling
C. Marketing and Sales
D. Producer Licensing
E. Policyholder Service
F. Underwriting and Rating
G. Claims

When conducting an exam that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the company is meeting standards. Some standards may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.

Many states have executed an agreement to share complaint information with one or more federal agencies. If the examination results find adverse trends or a pattern of activities that may be of concern to a federal agency and there is an agreement to share information, it may be appropriate to notify the agency of the examination findings.

A. Operations/Management

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 1
The company conducts a thorough periodic review of creditors with respect to their credit insurance business to ensure compliance with applicable statutes, rules and regulations.

Apply to: Credit life insurance
Credit accident and health insurance
Credit involuntary unemployment insurance
Credit personal property insurance

Priority: Essential

Documents to be Reviewed

_____ Certificates and policies

_____ Company procedures

_____ Applicable statutes, rules and regulations

_____ State-specific periodic review requirements

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Consumer Credit Insurance Model Regulation (#370)
Credit Personal Property Insurance Model Act (#365)

Review Procedures and Criteria

In some states, a credit insurer is responsible for conducting a thorough periodic review of creditors with respect to their credit insurance business. The review should ensure compliance with applicable statutes, rules and regulations. There may be a requirement that written records of the reviews be maintained by the insurer. If applicable, review company procedures and, if required, written records of reviews.

Note: The examiner should be mindful of the proprietary nature of internal audit reports. Administrative action should not be recommended by the examiner based on results of internal audit findings for which the company has taken appropriate corrective action.

B. Complaint Handling

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

C. Marketing and Sales

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.

STANDARDS
MARKETING AND SALES

Standard 1
All mandated disclosures and advertisements are documented and in compliance with applicable statutes, rules and regulations.

Apply to: Credit life insurance
Credit accident and health insurance
Credit involuntary unemployment insurance
Credit personal property insurance

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Bulletins, newsletters and memos

_____ Underwriting files

_____ Rating/Quote information provided electronically

_____ Marketing materials

_____ Organizational chart of marketing division

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Consumer Credit Insurance Model Act (#360)
Credit Personal Property Insurance Model Act (#365)
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Note: The NAIC model acts related to the marketing and sale of credit insurance are listed above and are the source for the following review procedures and criteria. In some cases, a state may have one or more of these measures, or a combination thereof, in force. The examiner will need to determine which models or sections of the models have been adopted by the state to conform the examination.

Review written and electronic communication related to mandated disclosures in advertisements between company and producers/debtors/insureds in accordance with applicable statutes, rules and regulations.
Determine if communication conforms to Standard 1 when referencing advertising and sales.

The company may use email to communicate with producers. The examiners should ask for saved, stored or archived email that was broadcast to the sales force.

Ensure the debtor is provided a disclosure in writing with the following information prior to the election to purchase insurance (*Consumer Credit Insurance Model Act* (#360), Section 6). This may be produced by the company or as part of the loan document:

- That the purchase of consumer credit insurance is optional;
- If more than one kind of consumer credit insurance is being made available to the debtor, whether the debtor can purchase each kind separately, or the multiple coverages are available for purchase only as a package;
- The conditions of eligibility;
- That, if the consumer has other insurance that covers the risk, he or she may not want or need credit insurance;
- That, within the first 30 days after receiving the individual policy or group certificate, the debtor may cancel the coverage and have all premiums paid by the debtor refunded or credited. Thereafter, the debtor may cancel the policy at any time and receive a refund of any of the unearned premium;
- A brief description of the coverage, including a description of the amount, the term, any exceptions, limitations and exclusions, the insured event, any waiting or elimination period, any deductible, any applicable waiver of premium provision, to whom the benefits would be paid and the premium rate for each coverage or for all coverages in a package; and
- That, if the premium or insurance charge is financed, it will be subject to finance charges.

Personal Property—Pre-Purchase Disclosure

The following is to be disclosed to the debtor in writing, and may be combined with other disclosures required by state or federal laws and regulations (*Credit Personal Property Insurance Model Act* (#365), Section 5):

- That the purchase of credit personal property insurance through the creditor is optional, and not a condition of obtaining credit approval;
- If more than one kind of credit insurance is being made available to the debtor, that the debtor can purchase credit personal property insurance separately;
- That, if the consumer has other insurance that covers the risk, he or she may not want or need credit personal property insurance;
- That, within the first 30 days after receiving the individual policy or certificate of insurance, the debtor may cancel the coverage and have all premiums paid by the debtor refunded or credited. Thereafter, the debtor may cancel the policy at any time during the term of the loan and receive a refund or any of the unearned premium. However, only in those instances where the creditor requires evidence of insurance for the extension of credit, the debtor may be required to offer evidence of alternative insurance acceptable to the creditor at the time of cancellation;
- A brief description of the coverage, including a description of the major perils and exclusions, any deductible, to whom the benefits would be paid and the premium or premium rate for the credit personal property coverage; and
- If the premium or insurance charge is financed, it will be subject to finance charges at the rate applicable to the credit transaction.

STANDARDS
MARKETING AND SALES

Standard 2
The amount of credit insurance sold is in compliance with the requirements of applicable statutes, rules and regulations.

Apply to: Credit life insurance
Credit accident and health insurance
Credit involuntary unemployment insurance
Credit personal property insurance

Priority: Essential

Documents to be Reviewed

_____ Certificates, policies and company procedures

_____ Consumer disclosures

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Consumer Credit Insurance Model Act (#360)
Credit Personal Property Insurance Model Act (#365)

Review Procedures and Criteria

Note: The NAIC model acts related to the marketing and sale of credit insurance are listed above and are the source for the following review procedures and criteria. In some cases, a state may have one or more of these measures, or a combination thereof, in force. The examiners will need to determine which models or sections of the models have been adopted by the state to conduct the examination.

Credit Life Insurance

- Verify the amount of insurance at no time exceeds the greater of the actual net debt, scheduled net debt, level, gross and/or monthly outstanding balance (*Consumer Credit Insurance Model Act* (#360), Section 4A(1));
- If the coverage is written on the actual net debt, verify the amount payable at the time of loss is not less than the actual net debt less any payments more than 2 months overdue (*Consumer Credit Insurance Model Act* (#360), Section 4A(2)); and
- If the coverage is written on the scheduled net debt, verify the amount payable at the time of loss is:
    - If the actual net debt is less than or equal to the scheduled net debt, then the scheduled net debt;
    - If the actual net debt is greater than the scheduled net debt, but less than or equal to the scheduled net debt plus 2 months of payments, then the actual net debt; or
    - If the actual net debt is greater than the scheduled net debt plus two months of payments, then the scheduled net debt plus two months of payments (*Consumer Credit Insurance Model Act* (#360), Section 4A(3)).

Credit Accident and Health insurance and Credit Unemployment Insurance

- Verify the total amount of periodic indemnity does not exceed the aggregate of the periodic scheduled unpaid installments of the gross debt[33] (*Consumer Credit Insurance Model Act* (#360), Section 4B(1));
- Verify the amount of each periodic indemnity payment does not exceed the original gross debt divided by the number of periodic installments (*Consumer Credit Insurance Model Act* (#360), Section 4B(1)); and
- If coverage is written in connection with an open-ended credit agreement, verify the amount of insurance does not exceed the gross debt that would accrue on that amount using the periodic indemnity. Subject to any policy maximums, the periodic indemnity must not be less than the creditor's minimum repayment schedule (*Consumer Credit Insurance Model Act* (#360), Section 4B(2)). Periodic indemnity can be less than the creditor's minimum payment, if the policy has a maximum monthly indemnity.

Credit Personal Property Insurance

- Verify coverage is, at a minimum, included in the coverages in the standard fire policy (*Credit Personal Property Insurance Model A*ct (#365), Section 4D); and covers a substantial risk of loss of or damage to the property related to the credit transaction (*Consumer Credit Insurance Model Act* (#360), Section 4E).
- Verify that an insurer does not require the bundling of other credit insurance coverages with the purchase of credit personal property insurance coverage and that a debtor has the choice to purchase credit personal property insurance separate from other credit insurance coverage (*Consumer Credit Insurance Model Act* (#360), Section 4F);
- Verify that the insurer is not using gross debt as an exposure base in determining credit personal property insurance premiums (*Consumer Credit Insurance Model Act* (#360), Section 4G);
- Verify that when insurance is sold in conjunction with a closed-ended transaction, the insurer:
    - Is not issuing credit personal property insurance coverage unless the amount financed exceeds the dollar amount established in state statute (*Consumer Credit Insurance Model Act* (#360), Section 4A);
    - Is not issuing credit personal property insurance in an amount that exceeds the amount of the underlying credit transaction, unless otherwise required by state law (*Consumer Credit Insurance Model Act* (#360), Section 4B); and
    - Is not selling credit personal property insurance with a term that exceeds in duration the scheduled term of the underlying credit transaction (*Consumer Credit Insurance Model Act* (#360), Section 4C).

[33] Gross debt is defined as the sum of the remaining payments owed to the creditor by the debtor.

D. Producer Licensing

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

E. Policyholder Service

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

F. Underwriting and Rating

1. Purpose

The underwriting portion of the examination is designed to provide a view of how the company treats the public and whether that treatment is in compliance with applicable statutes, rules and regulations. It is typically determined by testing a random sampling of files and applying various tests to the sampled files. It is concerned with compliance issues. The areas to be considered in this kind of review include:

a. Rating practices;
b. Underwriting or enrollment practices;
c. Use of correct and properly filed and approved forms and endorsements;
d. Termination practices;
e. Declination practices;
f. Unfair discrimination; and
g. Use of proper disclosures.

2. Techniques

During an examination, it is necessary for the examiner to review a number of information sources, including:

- Rating manuals and rate cards;
- Rate classifications;
- Rating systems filed with regulators;
- Payment plans;
- Minimum premiums;
- Company-automated rating systems;
- Rating materials provided to producers;
- Underwriting guidelines;
- Applicable policy or certificate forms and endorsements;
- Producer compensation agreements, where applicable; and
- Underwriting files' content and structure.

For the purposes of this chapter, "underwriting file" means the file or files containing the new business application or enrollment, rate calculation sheets, billings, audits, all underwriting information obtained or developed, schedule page, enrollment forms, medical records, policy or certificate endorsements, cancellation or refinancing transactions, correspondence and any other documentation supporting selection, classification, rating or termination of the risk.

The list of files from which a sample is to be drawn may be generated through a computer run or listing of certificates or policies covering the period of time selected in the notice or call of examination.

Next, determine the company's policy or certificate population (policy or certificate count) by line of business. Review a random selection of business for application of a particular test or apply specific tests to a census population using automated tools. (In the event specific files are chosen for a target review,

the examiner must be certain that the examination results are clearly identified as being from the target selection.) The examiner should maintain a list of the various tests to be applied to each file in the sample. This will aid in consistency by ensuring that each test is considered for each file in the sample.

If exceptions are noted, the examiner must determine if the exception is caused by such practices as the use of faulty automated rating systems, or the development and use of improperly or vaguely worded manuals or guidelines. When exceptions are noted, it is advisable to determine the scope and extent of the problem. The examiner's responses should maximize objectivity; the examiner should avoid replacing examiner judgment for company judgment.

a. Rating Practices

It is necessary to determine if the company is in compliance with rating systems that have been filed with and, in some cases, approved by, the state insurance departments. Where rates are not required to be filed with an applicable regulatory agency, it is prudent to determine if rates or formulas are being applied consistently and in accordance with the company's own rating methods. Many states have established prima facie rates. In general, rates should not be unfairly discriminatory. Wide-scale application of incorrect rates by a company might raise financial solvency questions or be indicative of inadequate management oversight. Deviation from established rating plans might also indicate that a company is engaged in unfair competitive practices. Inconsistent application of rates, individual risk premium modifications, modification factors and deviations can result in unfair discrimination.

The examiner should become familiar with the company's policy or certificate form numbers or other identification procedures, inasmuch as references may be made to such numbers or procedures in lieu of having the particular form attached. If certificates or policies are issued by an automated system, the examiner should manually rate a random selection of policies or certificates to verify that the computer has been programmed correctly. If rating exceptions are noted, the examiner must determine if the exception is caused by such practices as the use of faulty rating systems. When exceptions are noted, it is advisable to determine the scope and extent of the problem. Rating errors will generally involve use of incorrect rates, interest rates, loan amounts or loan terms.

When possible, the examination team should make use of audit software to verify the correct application of rates. This allows for a more thorough review, and can save time during the examination process. All new automated audit applications that are developed should be submitted to the NAIC File Repository, in order to assist in building a comprehensive set of audit programs.

b. Underwriting or Enrollment Practices

The examiner should review relevant underwriting information; e.g., the company's underwriting guidelines, underwriting bulletins, declination procedures, agency agreements and correspondence with producers, interoffice memoranda or other relevant information which may furnish evidence of inappropriate behavior may also be requested, if deemed necessary. In addition to reviewing the content of the above information for indications of unfairly discriminatory practices, the examination team also should use the above information to determine the company's compliance with its own manuals and guidelines. The examiner should confirm that the company's underwriters and producers consistently apply the company guidelines for the business selected or rejected.

File documentation should be sufficient to support the underwriting decisions made. Underwriting decisions that are adequately documented generally afford the company's management team with the opportunity to know what business it has selected through its underwriters and producers. The examiner should verify that properly licensed and appointed (where applicable) producers have been used in the production of business.

c. Use of Correct and Properly Filed Forms and Endorsements

The examination team should verify that all policy or certificate forms and endorsements used have been filed with the appropriate regulatory authority, if applicable. In addition, the examination team should verify the consistent and correct use of policy or certificate forms and endorsements. The examiner should be mindful of possible outdated forms or endorsements. If coverage requested by the applicant is not issued, proper notification (if required) should be provided to the applicant. In some cases, supplemental applications are appropriate. The examination team should be aware of state-specific requirements relating to policy or certificate disclosure requirements for preexisting conditions limitations.

d. Termination Practices

The examiner should review the company's declination, cancellation and rescission practices to determine compliance with applicable statutes, rules and regulations, as well as to determine compliance with the company's own rules, guidelines and policy or certificate provisions.

The review of these practices should involve a request for the enrollment or underwriting file for each policy or certificate selected from the random sample of canceled policies or certificates. The examiners should review material submitted to determine that these practices comply with the statutory provisions and policy or certificate provisions. Refund calculations are usually based on filed pro rata, the Rule of 78, the Rule of Anticipation[34] or the actuarial method depending on the state or coverage. The accuracy of return premiums on canceled policies or certificates refunded should be verified.

The examination team should review the company's practices relating to credit insurance issued in conjunction with refinanced loans. Special state provisions may apply.

Review policy or certificate provisions to determine if cancellation notices are applicable. Adherence to policy provisions for renewal language and for applicable grace periods for monthly outstanding balance policies should be reviewed.

e. Declination Practices

The examiner should review the company's declination of policy or certificate practices to determine compliance with applicable statutes, rules and regulations and to determine conformance with the company's own rules and guidelines. "Declination" includes only refusal by an insurer to issue an underwritten policy or certificate upon receipt of a written nonbinding application or written request for coverage or enrollment form from a producer or an applicant.

Insurers should maintain declination files, and the applicant must be provided with a written, specific reason for declination.

The review of declination practices should involve a request for the underwriting or enrollment file for each policy or certificate selected from the random sample.

[34] The Rule of Anticipation establishes unearned premium as the gross single premium for the remaining term and remaining benefits.

3. Tests and Standards

The underwriting and rating review includes, but is not limited to, the following standards addressing various aspects of the company's underwriting activities. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
UNDERWRITING AND RATING

Standard 1
The effective dates and termination dates of coverage are in accordance with applicable statutes, rules and regulations.

Apply to: Credit life insurance
Credit accident and health insurance
Credit involuntary unemployment insurance
Credit personal property insurance

Priority: Essential

Documents to be Reviewed

_____ Certificates and policies

_____ Company procedures

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Consumer Credit Insurance Model Act (#360)
Consumer Credit Insurance Model Regulation (#370), Section 3G
Credit Personal Property Insurance Model Act (#365)

Review Procedures and Criteria

All Credit Insurance
Review polices and/or certificates chosen for review to determine:

- The coverage commences on the date when the debtor becomes obligated to the creditor, if the coverage was selected before or in conjunction with the credit transaction. Note: Special rules apply if evidence of insurability is required before the company affects coverage;
- The date of coverage is the date the election to obtain coverage is made, or within 30 days of the date the company accepts the risk, according to an objective method such as a date in accordance with a billing or repayment cycle or calendar month, if the coverage is selected after the date of the credit transaction; and
- Under a group policy, coverage does not commence before the effective date of the group policy and no charge for the insurance is retained by the creditor or insurer for any time prior to the effective date of the insurance to which the charge is related.

Credit Life, Credit Accident and Health Insurance, and Credit Involuntary Unemployment Insurance

Review polices and/or certificates chosen for review to determine:

- The coverage does not extend beyond the termination date specified in the policy or certificate;
- The term of coverage does not extend more than 15 days beyond the scheduled maturity date of the debt, unless extended without cost to the insured or unless there is a written agreement in connection with the loan; and
- The coverage is terminated if the debt is discharged in full and before any new coverage is written, if the debt is refinanced.

Note: Terminations may be requested at any time by the debtor. There may be written requirements for the termination request, and it may be subject to terms of the policy or certificate.

STANDARDS
UNDERWRITING AND RATING

Standard 2
Group consumer credit insurance policies and certificates are terminated in accordance with applicable statutes, rules and regulations.

Apply to: Credit life insurance
Credit accident and health insurance
Credit involuntary unemployment insurance
Credit personal property insurance

Priority: Essential

Documents to be Reviewed

_____ Group master policies

_____ Certificates

_____ Company procedures

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Consumer Credit Insurance Model Regulation (#370), Section 3C
Credit Personal Property Insurance Model Act (#365)

Review Procedures and Criteria

Insurance coverage under a group consumer credit insurance policy or certificate is continued for the entire period for which premium has been paid upon termination of the policy or certificate for any reason.

If a debtor is covered under a policy or certificate providing for the payment of premiums on a monthly basis, the policy or certificate provides for at least 30 days' prior notice of termination, except where replacement with the same or another insurer in the same or greater amount takes place without lapse of coverage. The insurer shall provide or cause to be provided this required information to the debtor.

STANDARDS
UNDERWRITING AND RATING

Standard 3
The creditor submits premium to the insurer in accordance with applicable statutes, rules and regulations.

Apply to: Credit life
Credit accident and health insurance
Credit involuntary unemployment insurance
Credit personal property insurance

Priority: Essential

Documents to be Reviewed

_____ Group master policies

_____ Certificates and individual policies

_____ Company procedures

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Consumer Credit Insurance Model Regulation (#370)
Credit Personal Property Insurance Model Act (#365)

Review Procedures and Criteria

Verify the creditor is remitting and the insurer is collecting the premium within the amount of time required by applicable statutes, rules and regulations.

Note: For credit insurance, the premium is often remitted monthly "in bulk" on a net basis (with commissions and refunds for the reporting period netted out).

STANDARDS
UNDERWRITING AND RATING

Standard 4
The insurer and creditor comply with requirements for the payment of compensation in accordance with applicable statutes, rules and regulations.

Apply to: Credit life insurance
Credit accident and health insurance
Credit involuntary unemployment insurance
Credit personal property insurance

Priority: Essential

Documents to be Reviewed

_____ Certificates and policies

_____ Company procedures

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Consumer Credit Insurance Model Regulation (#370), Section 5A
Credit Personal Property Insurance Model Act (#365)
Producer Licensing Model Act (#218)
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

If the applicable statutes, rules or regulations limit the amount of compensation that may be paid to a producer for credit insurance, ascertain if compensation is in accordance with the allowable percentage.

Determine that producer commissions are aligned with the amounts stated in the agreement between the company and the producer and, if not, ascertain the reason for the variance.

Determine that producer commissions adhere to the company commission schedule(s) and, if not, ascertain the reason for the variance.

In reviewing company advertising, watch for indications of illegal commission-cutting or inducements.

STANDARDS
UNDERWRITING AND RATING

Standard 5
The insurer does not engage in activities that constitute unfair methods of competition.

Apply to: Credit life insurance
Credit accident and health insurance
Credit involuntary unemployment insurance
Credit personal property insurance

Priority: Essential

Documents to be Reviewed

_____ Certificates, policies and company procedures

_____ Applicable statutes, rules and regulations

_____ Complaint files

_____ Underwriting or enrollment files

_____ Marketing materials

_____ Correspondence to producers from files chosen for review

_____ Producer contracts chosen for review

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Consumer Credit Insurance Model Regulation (#370)
Unfair Trade Practices Act (#880), Section 4H

Review Procedures and Criteria

Review documents to determine:

- No offers of any special advantage or service to creditors not set out in the contract, other than the payment of producer's commissions, have been made;
- There are no agreements to deposit with a bank or financial institution money or securities with the design or intent that the same shall affect or take the place of a deposit of money or securities that otherwise would be required of the creditor by the bank or financial institutions as a compensating balance or offsetting deposit for a loan or other advancement; and
- The insurer has not deposited money or securities without interest or at a lesser rate of interest than is currently being paid by the creditor, bank or financial institution to other depositors of like amounts for similar durations. This requirement does not prohibit demand deposits or premium deposit accounts necessary for the in the ordinary course of the insurer's business.

Review company correspondence to producers, as well as advertising and marketing materials, for indications of illegal rebating, commission-cutting or inducements.

G. Claims

1. Purpose

The claims portion of the examination is designed to provide a view of how the company treats claimants and whether that treatment is in compliance with applicable statutes, rules and regulations. It is determined by testing a random sampling of files and applying various tests to open and closed claims. For purposes of this chapter, "claim file" means the documentation that allows the examiner to recreate the claim, which may include some or all of the following documents that may be electronic, paper or in some other format:

- The notice of claim;
- Claim forms;
- Proof of loss;
- Settlement demands;
- Accident reports;
- Police reports;
- Adjusters' logs;
- Claim investigation documentation;
- Inspection reports;
- Supporting bills;
- Correspondence to and from insureds and claimants or their representatives;
- Complaint correspondence;
- Proof of payment;
- All applicable notices and correspondence used for determining and including claim payments or denials;
- Salvage documentation; and
- Any other documentation necessary to support claim handling activity.

The review is concerned with the company's claims practices by line of business for compliance with applicable statutes, rules and regulations, as well as policy or certificate provisions. The areas to be considered in this kind of review include:

a. Time studies to measure acknowledgment, investigation and settlement times;
b. General handling study;
c. Closed without payment survey;
d. Unfair claims practices survey;
e. Claims forms review;
f. Company procedures, training manuals and claim bulletin review; and
g. Review of other procedures, as deemed necessary.

2. Techniques

Each area of claims review involves selecting a sample of claims (open, closed without payment, closed with payment, denied). However, it is not necessary to use different samples to review timeliness of payment, conformity to policy, certificate language or adequacy of proof. A general approach to examination would be to:

- Define the scope of the examination in terms of the lines of business and type of claims covered. Lines of business should be defined as specifically as possible;

- Become familiar with the company's claim handling procedures for the line of business identified. Review corresponding policy or certificate forms for coverage, exclusions and nonstandard provisions. Review the methods for processing claims from notification to conclusion. Review with the claim manager, or other appropriate personnel, the maintenance of claim records and draft and settlement authority. Any claim procedure manuals, adjuster training manuals and claim bulletins should be reviewed. Company procedures for total loss settlement and salvage disposition efforts should be determined; and
- Select a representative sample of files to be reviewed. Chapter 17—Sampling should be reviewed. If field sizes are relatively small and company records appear complete, representative samples or a census should be selected. In the case of large field sizes and incomplete or complicated records, the use of audit software should be considered. Care should be taken that no adverse selection occurs.

a. Time Studies to Measure Acknowledgment, Investigation and Settlement Times

Record the date of loss, the date reported to the producer or company, the date sufficient information was available to determine the company's liability and the date the company accepted or rejected the claim. Record identifying data such as the claim/policy number and the claimant's name.

Determine for each claim the number of days the company took to accomplish each task. Compare the days required by the company to the appropriate state standards, and document in the report those claims that exceed standards for inclusion in the report. Delays beyond the control of the company should be excluded; e.g., delay caused by an uncooperative insured. Establish a mean and median time to acknowledge, investigate and accept/deny claims, if necessary, to determine business practice.

Note: If a file has a violation of a standard with multiple tests, and the standard is the item measured, the file can only fail one time. If the individual test is the item measured, the file can fail each test. If failure of a standard or of a test assures failure of another standard or test under another standard, then no substitution of the file need occur. The relationship, however, should be explained.

b. General Handling Study

Record identifying data such as claim/policy or certificate number, date of loss and claimant name. Files should be reviewed for adequate and accurate documentation. The correct application of deductibles and limits of coverage should be established. Mathematical accuracy should be determined. Reductions should be reviewed for fairness and accuracy.

Proof of payment should be reviewed for correct payees. Files should be reviewed for specific state requirements. Compliance with company standards should be established.

c. Closed without Payment Survey

This includes denied, rejected and incomplete claims, and claims not paid for any reason including deductibles/waiting periods not met. Conduct tests similar to the "General Handling Study" above. Record identifying data such as claim/policy or certificate number, date of loss and claimant name. Review specific state requirements for content and method of denial notification to the claimant. Note general handling by the company to determine validity of its action in the final disposition of these types of claims.

d. Unfair Claims Practices Survey

Record identifying data such as claim/policy or certificate number, date and claimant name. Review selected files for violations of specific state unfair claims practices such as misrepresentation of policy or certificate provisions or concealment of coverage.

Calculate error ratios for the sample and field sizes. This is especially important in this study, because most unfair claims practices statutes make reference to "business practices."

e. Claim Forms Review

Request copies of all claim forms in use for the lines of business being examined. Forms should be reviewed for content and appropriate usage. Inappropriate forms should be documented and included in the report. Claim forms also may be reviewed as they are encountered in the file reviews.

f. Company Procedures, Training Manuals and Claim Bulletin Review

Review company procedures, training manuals and claim bulletins to determine if company standards exist and whether such standards comply with applicable statutes, rules and regulations, including:

- If company procedures provide for the detection and reporting of fraudulent or potentially fraudulent insurance acts to the insurance commissioner;
- Whether all claims are paid by draft drawn upon the insurer, by electronic funds transfer or by check of the insurer to the order of the claimant to whom payment of the claim is due or upon direction of such claimant; and
- That no plan or arrangement is used whereby any person, firm or corporation other than the insurer or its designated claim representative is authorized to settle or adjust claims. The creditor has not been designated as claim representative for the insurer adjusting claims, provided that a group of policyholders may, by arrangement, draw drafts, checks or electric transfers subject to audit and review by the insurer.

g. Review of Other Procedures

Other review, as deemed necessary, should follow the same format for objectivity and sampling techniques as those already described. These reviews may be investigated by consumer complaints regarding specific claims practices and should be analyzed to resolve specific issues.

3. Tests and Standards

The claim review includes, but is not limited to, the following standards addressing various aspects of the company's claim handling. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
CLAIMS

Standard 1
Proof of payments reflect appropriate claim handling practices.

Apply to: Credit life insurance
Credit accident and health insurance
Credit involuntary unemployment insurance
Credit personal property insurance

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Cashed benefit checks and drafts

_____ Company claim procedure manuals

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Consumer Credit Insurance Model Act (#360)
Credit Personal Property Insurance Model Act (#365)
Unfair Claims Settlement Practices Act (#900)

Review Procedures and Criteria

Perform a time study on proof of payment documentation—which may include canceled claim checks, drafts, electronic funds transfer documentation or accounting reports for accounts doing batch reporting on a net basis—to ascertain whether claim proceeds are being promptly mailed or delivered.

Determine if proof of payment includes the correct payee and is for the correct amount.

Ascertain whether the proof of payment indicates the payment is "final," when such is not the case.

Ascertain whether checks or drafts purport to release the insurer from total liability, when such is not the case.

Review endorsements to see if they are consistent with the payee name listed on the check or draft.

If drafts are used, ascertain whether there is prompt clearance by the insurer.

STANDARDS
CLAIMS

Standard 2
Claim files clearly establish pertinent events and the dates of such events.

Apply to: Credit life insurance
Credit accident and health insurance
Credit involuntary unemployment insurance
Credit personal property insurance

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Closed claim files

_____ Company claim procedures manuals

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Consumer Credit Insurance Model Act (#360)
Credit Personal Property Insurance Model Act (#365)
Unfair Claims Settlement Practices Act (#900)

Review Procedures and Criteria

Ensure documents provide chronological order of events in claim file.

Chapter 28—Conducting the Surplus Lines Broker Examination

IMPORTANT NOTE:
The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in Chapter 1—Introduction.

This chapter provides a suggested format for conducting surplus lines broker examinations. Procedures for conducting other types of specialized examinations may be found in separate chapters.

The examination of surplus lines brokers may involve any review of one or a combination of the following business areas:

A. Broker Operations/Management
B. Complaint Handling
C. Marketing and Sales
D. Producer Licensing
E. Policyholder Service
F. Underwriting and Rating
G. Claims
H. Procedural Considerations
I. Placement, Cancellation and Nonrenewal

When conducting an exam that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the broker is meeting standards. Some standards may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.

Surplus lines carriers, by definition, are nonadmitted carriers that are not subject to many requirements (e.g., rate and form filing). Since U.S.-domiciled surplus lines carriers will be licensed in at least one state, it is recognized that they will be subject to the same examination process in their domiciliary state that applies to other types of carriers. Alien insurers are not subject to a state's examination process, but may nonetheless be reviewed by the NAIC International Insurers Department (IID), if the insurer is listed on the *Quarterly Listing of Alien Insurers*.

A. Broker Operations/Management

1. Special Considerations for the Surplus Lines Examination

a. Resident or Non-Resident

Appropriate licensing of persons who, by their function, should be licensed is more of a challenge with the non-resident.

b. Wholesale vs. Retail Production

There are distinct differences in wholesale vs. retail production. Standards that require direct contact with an insured/applicant may not apply to a wholesale surplus lines broker. For the purposes of this chapter, the definitions of wholesale vs. retail business are as follows:

- Retail: Retail surplus lines business is insurance that is obtained or placed for the client directly with the nonadmitted insurer by the client's agent/broker (retail agent/broker). The producer/broker must have a surplus lines license to place business with the nonadmitted carrier and the carrier must be eligible, or "white listed," in order for the licensed surplus lines broker to use the company.
- Wholesale: Wholesale surplus lines business is insurance that is obtained or placed for an insured or prospective insured by an intermediary broker, licensed as a surplus lines broker, with a nonadmitted insurer, at the request of an agent or broker working for the insured or prospective insured. The agent or broker requesting the insurance does not need to have a surplus lines license, as long as the placing intermediary broker is properly licensed for surplus lines and complies with applicable statutes, rules and regulations concerning surplus lines. The agent/broker requesting the coverage can be known as the retail, initiating or producing agent/broker.

c. Relationship with Insurer (MGA, Producer, Intermediary, Subsidiary, Controlling Producer, etc.)

Of concern is the oversight utilized by the controlling party and the conflicts of interest or with statute that arise due to the nature of the relationship.

d. Policy Not Produced in Examining State

This can pose a significant taxation concern. Is the examining state getting the appropriate level of tax for risk placed in another state, but which is resident, located or to be performed in that state?

e. Staff Training

Are copies of the laws and regulations available to persons operating under a surplus lines broker license? Does the licensee provide training to staff concerning state developments, including case law, laws, regulations, orders and bulletins?

f. Stamping Office vs. No Stamping Office

In some jurisdictions, a stamping office performs many functions that would otherwise be done by the state. They may be able to provide the examiner with valuable information and reports.

g. Placement File

For purposes of this chapter, "placement file" means the file or files containing:

- The application;
- Rate calculation sheets;
- Billings;
- Audits, including binders;
- Engineering reports;
- Inspection reports;
- Risk or hazard investigative or evaluation reports;
- Motor vehicle reports (MVRs);
- Credit reports;
- All placement information obtained or developed;

- Policy declaration page;
- Endorsements;
- Premium finance agreements, with accompanying activities;
- Cancellation or reinstatement notices; and
- Correspondence and any other documentation supporting selection, classification, rating or termination of the risk.

STANDARDS
BROKER OPERATIONS/MANAGEMENT

Standard 1 **All statutorily required bonds are in force.**

Apply to: All surplus lines brokers

Priority: Essential

Documents to be Reviewed

_____ Statutory bonds

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Ensure all required bonds are procured and in force.

STANDARDS
BROKER OPERATIONS/MANAGEMENT

Standard 2
All required reports have been filed with the insurance department or the appropriate authority.

Apply to: All surplus lines brokers

Priority: Essential

Documents to be Reviewed

_____ Reports

_____ Individual placement files

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Verify reports were filed with the appropriate authority in a timely manner.

Verify the accuracy of the reports.

Track individual placements to ensure they are accurately reflected in the required reports.

STANDARDS
BROKER OPERATIONS/MANAGEMENT

Standard 3
The applicable taxes are reported and are credited to the state.

Apply to: All surplus lines brokers

Priority: Essential, if a function of the insurance department

Documents to be Reviewed

_____ Tax worksheets in the files

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Allocation of Surplus Lines and Independently Procured Insurance Premium Tax on Multistate Risks Model Regulation (#872)

Review Procedures and Criteria

There are no consistent state-by-state requirements regarding the payment of taxes related to multistate placements. Certain states regard 100 percent of the surplus lines premium tax as due in the state if the placement is made in their state, even if some of the coverage and premium derives from another state. Other states regard that tax as payable on a pro rata basis based on the share of the premium derived from their state. These two philosophies can, and do, conflict, such that the same premium might be taxed twice by two different states.

If the placement is a multistate placement and the state recognizes the sharing of premium tax, check the calculation and reasonableness of the methodology to allocate the premium tax. The *Allocation of Surplus Lines and Independently Procured Insurance Premium Tax on Multistate Risks Model Regulation* (#872) provides examples of criteria for tax allocation of multistate risks.

Ensure the premium is properly allocated and the applicable taxes are reported to the examining state.

STANDARDS
BROKER OPERATIONS/MANAGEMENT

Standard 4
If the surplus lines broker is responsible for such calculations, then unearned premiums are correctly calculated and returned to the appropriate party in a timely manner and in accordance with applicable statutes, rules and regulations.

Apply to: All surplus lines brokers

Priority: Essential

Documents to be Reviewed

_____ Policy contract

_____ Notice of cancellation/nonrenewal

_____ Refund check or complete documentation of refund, if canceled check information is maintained in the computer system

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Calculate the unearned premium (short rate or pro rata method) in accordance with policy provisions or state law.

Determine if the broker, in accordance with the carrier's requirements, advances its audit date on auditable policies when the cancellation occurs.

Verify that any unearned premium was returned to the appropriate party in a timely manner.

Make note of any delays caused by the broker, producer or premium financier.

B. Complaint Handling

Not applicable.

C. Marketing and Sales

Not applicable.

D. Producer Licensing

Not applicable.

E. Policyholder Service

Not applicable.

F. Underwriting and Rating

Not applicable.

G. Claims

Not applicable.

H. Procedural Considerations

Although the focus of the surplus lines broker examination differs from that of the insurer examination, much of the material in Chapter 20—General Examination Standards also applies to the surplus lines examination.

I. Placement, Cancellation and Nonrenewal

1. Special Considerations for the Surplus Lines Examination

Surplus lines brokers have the burden of determining that the insurer with whom their business is placed is in sound financial condition and can be expected to pay claims when due. The examiner should ensure that a process is in place to make these determinations. If permitted by specific state statute, the function of ascertaining financial soundness by the broker may be supplemented by financial analysis performed by a stamping office.

The policy forms and rates used by a surplus lines broker are generally not required to be filed. The concern with the marketing, advertising and producer files is that most state laws require that there be a diligent effort to place the business in an admitted market before export to a nonadmitted insurer is allowed. Ensure that the marketing files, advertising files and producer correspondence do not conflict with this requirement. In addition, ensure that the export list is referenced as required. The export list is a list of coverages generally regarded as unavailable in the admitted market in the relevant state and for which the diligent search requirements under the surplus lines laws are generally waived.

2. Tests and Standards

The placement, cancellation and nonrenewal review includes, but is not limited to, the following standards addressing various aspects of the surplus lines broker's underwriting activities. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
PLACEMENT, CANCELLATION AND NONRENEWAL

Standard 1
All required disclosures are made in accordance with applicable statutes, rules and regulations.

Apply to: All surplus lines brokers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

A copy of the insured's permission and acknowledgement of the use of a nonadmitted carrier is in the file.

The name and address of the nonadmitted carrier is listed on the policy and is in the file.

The policy reflects the exact amounts of exposure and the policy limits.

The policy reflects gross premiums charged for the contract.

The policy contains a description of the risk and exposure location.

The surplus lines broker's records indicate the exact amount of premium that was charged to and collected from the insured.

The policy includes the binder or other evidence of coverage if issued in lieu of the policy.

The broker's firm name and license number are disclosed as required.

STANDARDS
PLACEMENT, CANCELLATION AND NONRENEWAL

Standard 2
When issued by the surplus lines broker, all forms and endorsements forming a part of the contract are listed on the declarations page.

Apply to: All surplus lines brokers

Priority: Essential

Documents to be Reviewed

_____ New business application

_____ Policy declaration page

_____ Broker files

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

When the surplus lines broker is issuing the contract, determine if the broker lists all forms and endorsements that form part of the contract on the declarations page.

STANDARDS
PLACEMENT, CANCELLATION AND NONRENEWAL

Standard 3
The selected carrier was evaluated to ensure it complies with applicable statutes, rules and regulations regarding financial condition.

Apply to: All surplus lines brokers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Some states have a list of eligible insurers; others may refer to the *Quarterly Listing of Alien Insurers* published by the NAIC IID.

The broker will need to validate that the coverage is placed with an eligible company and is "stamped" in those states that require review by a stamping office.

STANDARDS
PLACEMENT, CANCELLATION AND NONRENEWAL

Standard 4
The authorization to bind was provided before the binder was extended to the insured.

Apply to: All surplus lines brokers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Applicable producer contracts between the insurer and surplus lines producer.

STANDARDS
PLACEMENT, CANCELLATION AND NONRENEWAL

Standard 5
All advertising and sales materials are in compliance with applicable statutes, rules and regulations.

Apply to: All surplus lines brokers

Priority: Recommended

Documents to be Reviewed

_____ Producers' advertising and sales materials related to surplus lines activities

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review advertising materials to ensure they are in compliance with applicable statutes, rules and regulations.

Materials should not:

- Make unfair or incomplete comparisons; and
- Make false, deceptive or misleading statements or representations with respect to any person or broker in the conduct of insurance business.

Materials should:

- Disclose the name and address of the surplus lines broker; and
- Comply with applicable statutes, rules and regulations.

STANDARDS
PLACEMENT, CANCELLATION AND NONRENEWAL

Standard 6
Diligent effort was made to place the risk with an admitted carrier in compliance with applicable statutes, rules and regulations.

Apply to: All surplus lines brokers

Priority: Essential

Documents to be Reviewed

_____ Underwriting/Placement files

_____ Export lists

_____ Producer affidavits

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Include due consideration to export list and industrial insured exemptions.

In those states with a stamping office, the examiner may want to review the affidavits on file with the stamping office.

If the surplus lines broker is the producing broker, ensure that there is documentation to show a diligent effort to place the risk with an admitted insurer. If the surplus lines broker is not the producing broker, the presence of a producer affidavit in the file is sufficient to pass this test. If the surplus lines broker is the producing broker, a review of the information on the producer affidavit is appropriate.

To the extent permitted by applicable statutes, rules and regulations, the broker may rely on financial analysis and approval of an insurer by the state insurance department or the stamping office.

Chapter 29—Conducting the Advisory Organization Examination

IMPORTANT NOTE:
The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in Chapter 1—Introduction.

This chapter provides a suggested format for conducting advisory organization examinations and reviews. In addition to this chapter, the examiner should be familiar with the *Statistical Handbook of Data Available to Insurance Regulators* (*Statistical Handbook)* if reviewing an advisory organization that conducts statistical agent functions.

Background and Definitions
"Advisory organizations" are currently authorized by statute and are defined in the *Property and Casualty Model Rating Law (Prior Approval Version)* (#1780), which was amended in 2009 to a guideline, as:

> "Advisory organization" means any entity, including it affiliates or subsidiaries, which either has two or more member insurers or is controlled either directly or indirectly by two or more insurers, and which assists insurers in ratemaking-related activities such as enumerated in Sections 10 and 11. Two or more insurers having a common ownership or operating in this State under common management or control constitute a single insurer for purposes of this definition.

State statutes based on an older version of this NAIC model may use the term "rating organization" or "rate service organization" to mean the same thing.

The *Property and Casualty Model Rating Law (Prior Approval Version)* specifically permits advisory organizations to:

a. Develop statistical plans including territorial and class definitions;
b. Collect statistical data from members, subscribers or any other source;
c. Prepare, file and distribute prospective loss costs which may include provisions for special assessments;
d. Prepare and distribute factors, calculations or formulas pertaining to classification, territory, increased limits and other variables;
e. Prepare and distribute manuals of rating rules and rating schedules that do not include final rates, expense provisions, profit provisions or minimum premium;
f. Distribute information that is required or directed to be filed with the commissioner;
g. Conduct research and on-site inspections in order to prepare classifications of public fire defenses;
h. Consult with public officials regarding public fire protection as it would affect members, subscribers and others;
i. Conduct research in order to discover, identify and classify information relating to causes or prevention of losses;
j. Conduct research relating to the impact of statutory changes upon prospective loss costs and special assessments;
k. Prepare policy forms and endorsements and consult with members, subscribers and others relative to their use and application;
l. Conduct research and on-site inspections for the purpose of providing risk information relating to individual structures;
m. Conduct on-site inspections to determine rating classifications for individual insureds;
n. For workers' compensation insurance, establish a committee which may include insurance company representatives to review the determination of the rating classification for individual insureds and suggest modifications to the classification system;

o. Collect, compile and distribute past and current prices of individual insurers and publish such information;
p. Collect and compile exposure and loss experience for the purpose of individual risk experience ratings;
q. File final rates, at the direction of the commissioner, for residual market mechanisms; and
r. Furnish any other services, as approved or directed by the commissioner, related to those enumerated in this section.

The term "statistical agent" is commonly used to describe an advisory organization when it is performing functions a. and b. above. Some advisory organizations limit the activities of the advisory organization to just the statistical agent functions. In general, statistical agents collect data in accordance with the requirements established in the *Statistical Handbook of Data Available to Insurance Regulators* (*Statistical Handbook*) or as otherwise specified by the regulator. Statistical agents typically compile that data into aggregate reports to regulators as specified in the *Statistical Handbook* or as otherwise specified by the regulator. Statistical agents' services are used for the purpose of fulfilling the statistical reporting obligations of insurers under the various state rating laws.

It is unlikely that any single advisory organization will be engaged in all of the permitted activities. Additionally, some entities may provide services that are listed above or that were not contemplated by the various state rate and form acts. Whether or not advisory organization services are regulated and permitted will depend on the various states' laws. Likewise, certain services may not be deemed a priority for examination purposes. Those services that have the greatest potential impact on insurance consumers should be given priority for review.

For purposes of this chapter, the term "advisory organization" will be used to encompass rating organizations, rate service organizations and statistical agents, as appropriate. It should be noted that advisory organizations that develop and file insurance programs and loss costs frequently collect data beyond the minimum standards required of all insurers under the *Statistical Handbook*. This additional detail or additional data is used to support insurance programs and for research.

For purposes of this chapter, the terms "subscriber" and "member company" are used interchangeably to refer to insurers that rely on the advisory organization's services and products. Some advisory organizations provide multiple levels of member company services. For example, with the appropriate advisory organization agreement in place, insurers may designate an advisory organization to file on its behalf. Or, an insurer may file with the department to adopt filed advisory organization materials. Alternatively, an insurer may purchase the right to use advisory organization materials, with or without modifications.

In addition to providing guidance for performing an advisory organization examination, this chapter emphasizes the desirability to coordinate advisory organization examinations between states to prevent duplication. Acceptance of other states' reports of examinations for advisory organizations is permissible in most or all states. It is generally considered acceptable for one state to utilize the report of another state for purposes of fulfilling the state's statutory obligations related to examination of advisory organizations. Generally speaking, processes and procedures established and used by advisory organizations are not unique to single states.

Nature, Scope and Type of the Examination

The advisory organization examination is a review of the organization's systems, operations and management for the collection and reporting of statistical data, preparation of loss cost filings, and rule and form filings. Other regulated permitted activities may also be examined. Its purpose should include a check of the validity of the systems in place. It is neither a traditional market conduct nor financial examination. It is rather a hybrid of a market conduct examination and a data/systems audit. The advisory organization examination is not an examination of the accuracy of the underlying company data reported to the organization. The main purpose of the examination is to determine that the advisory organization is performing its permitted regulated functions in a manner consistent with state rating laws and in a manner that results in accurate and compliant products or services for its subscribing or member companies. When reviewing statistical agent functions, it is important to review how the advisory organization processes, edits and manages the data it collects, compiles and reports so that state regulators know that the statistical filings made with them are accurate and reliable.

The *Property and Casualty Model Rating Law (Prior Approval Version)* has several sections regarding advisory organizations that form the bulk of the statutory requirements that apply specifically to advisory organizations in most states and, therefore, form the basis of an examination:

- Licensing advisory organizations;
- Insurers and advisory organizations: Prohibited activity;
- Advisory organizations: Prohibited activity;
- Advisory organizations: Permitted activity;
- Advisory organizations: Filing requirements;
- Examinations; and
- Statistical and rate administration.

The regulated functions of an advisory organization that are subject to examination may include one or more of the following:

- Filings of insurance programs, including coverage forms, rating rules, policy writing rules and rating manuals;
- Filings of insurance program pricing (i.e., loss costs and related relativity factors);
- Submission of required annual statistical compilations to the states (statistical agent);
- Inspections; and
- Classification administration.

Examinations of advisory organizations can be either comprehensive or targeted. Targeted examinations may be conducted on one of the listed functions, and, for advisory organizations that service more than one line of business, on one function and one line. This has occurred rarely, but most frequently for the statistical agent function, where examinations have focused on that one function across all statistical agents for the line in question.

An advisory organization examination can be conducted by one jurisdiction or as a multi-state cooperative examination. To the extent that the advisory organization's systems and procedures are similar, if not identical, for every state or line of business, the examination and resulting report should be acceptable in all states, regardless of which jurisdiction conducts the examination.

Unlike insurance company examinations, there generally is little, if any, "market analysis" for advisory organization examinations. Similarly, advisory organizations are not regulated for solvency. Rather, advisory organization examinations review the processes and procedures used to collect, compile and ensure quality of the data, calculate loss costs and develop insurance programs on behalf of insurers and perform other regulated activities.

Preparation Phase—Pre-Examination for Use in Evaluating, Scheduling, Coordination and Planning Scope
The procedures discussed in this section are to assist the regulator in determining if an examination or other type of regulatory action needs to be scheduled. It will also assist in developing a plan for conducting examinations, investigations, desk audits, interrogatories, letters or interviews when deemed necessary.

1. Determine the jurisdiction's requirements for licensing and examining advisory organizations and statistical agents to ascertain whether examinations are required, optional or permitted. Determine if the jurisdiction is permitted to accept the examination report of another state;
2. Survey appropriate divisions within the insurance department to identify potential areas of concern or interest relating to statistical agents and/or advisory/rating organizations. Identify all advisory organizations and statistical agents operating in the jurisdiction;

3. For those advisory organizations that have provided a current examination report and no unaddressed regulatory concerns exist, no additional analysis should be necessary. If analysis indicates that a market regulation action—such as a desk audit, letter, interrogatory, interview, investigation or examination—is appropriate, consider the possibility of coordinating with other jurisdictions with similar requirements or market regulation issues. Consider use of NAIC tools such as the Market Action Tracking System (MATS) for recording continuum types of regulatory responses and the Advisory Organization Examination Oversight (C) Working Group for multistate coordination of regulatory responses;
4. Survey the NAIC Research Division for relevant information to identify potential areas of concern in the evaluation process; and
5. Determine what specialists may be necessary to assist with the examination, such as an actuary (ideally one with experience with the functions of an advisory organization and the lines of business) and an information systems examiner.

For very narrow or specific regulatory issues, or for situations in which an examination is not required by statute, consider use of regulatory options other than an examination. For example, certain issues can be handled by a telephone call, letter or email; a data request; policy and procedure review; interrogatories; or desk audits. The remainder of this chapter is primarily written to facilitate examinations; however, certain information may be adaptable for the above-mentioned "continuum" type responses. Additional discussion of continuum of market actions is located in Chapter 2 of this handbook.

The examination of advisory organizations may require an examination of one or more of the following areas:

A. Procedural Considerations;
B. Advisory Organization Operations/Management/Governance;
C. Statistical Plans;
D. Data Collection and Handling;
E. Correspondence with Insurers and States;
F. Reports, Report Systems and Other Data Requests;
G. Ratemaking Functions;
H. Classification and Appeal Handling;
I. Form Development;
J. Inspection Services;
K. Residual Market Functions—Plan Administration;
L. Residual Market Functions—Reinsurance Administration;
M. Acceptance of Examination Report by Participating States; and
N. Future Examinations of Regulated Entity.

When conducting an examination that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the advisory organization is meeting standards. Some standards may not be applicable to all jurisdictions or entities. The standards may suggest other areas of review that may be appropriate in a particular examination. If additional standards will be reviewed, it is best to define those standards prior to the start of the examination. The insurance department Examiner-In-Charge (EIC) should approve additional review standards found to be necessary during the course of the examination. Revision of the examination plan should also be made and communicated to the advisory organization if additional standards are added.

A. Procedural Considerations

Although not an insurance company examination, the basic procedures for a market conduct examination in Chapter 20 of this handbook should be followed in an advisory organization examination:

- Scheduling an examination;
- Determining the scope of the examination;
- Estimating time requirements;
- Calling the examination;

- Notification of the examination;
- Pre-examination procedures;
- On-site coordination;
- Communication with advisory organization management;
- Post-examination procedures; and
- The examination report.

Where possible, each state's defined examination protocols applicable to the examination of insurers—such as time frames and report submissions—should be applied to advisory organization examinations, as well.

Pre-Examination Conference
A pre-examination conference call or a pre-examination visit should be conducted at the offices of the advisory organization with state examiners or contract examination companies so they can obtain specific detail from the advisory organization about its processes and procedures.

Scope of the Examination
The scope of the examination should clearly identify which regulated activities are being examined. Activities to be examined are limited to those identified under the Background and Definitions section of this chapter. If there are ad hoc review standards for a particular examination, they should be discussed by the lead state and the examined entity before they are administered by the state examiner or an examination contractor. The scope of the examination should be transparent to the examined entity.

Qualifications of Examiners
In addition to the examiner qualifications addressed in previous chapters of this handbook, specific qualifications and experience are recommended for advisory organization examinations. These operations differ substantially from insurers in terms of operations and regulatory requirements. The unique nature of advisory organization functions requires a sound knowledge of insurance rating, underwriting and classification systems. For purposes of examining statistical organization functions, knowledge is desirable of statistical and ratemaking data and databases, actuarial calculations and procedures, processing controls, and other elements of large mainframe database processing. When necessary, the examiners, together with qualified persons or actuaries, should be able to assess the effectiveness of advisory organization data processing controls, implementation policies and procedures. If these skills are not available within an insurance department, consideration should be given to engaging other qualified entities to coordinate and oversee, and perhaps conduct, the technical portions of the advisory organization examination. This would include actuarial expertise in ratemaking and technical expertise in information systems.

The plan developed for conducting the examination or other regulatory action should assist in evaluating the appropriate experience and qualifications needed.

Understanding the nature, services and regulation of advisory organizations is necessary. Confidentiality and nondisclosure agreements are appropriate when engaging contract examiners. Detailed billing must be reviewed by both the state and the examined entity. To avoid conflict of interest, determination of the scope of the examination should be performed by the state, rather than the contracted entities.

Types of Examinations

When planning the examination, it is helpful to first identify which services and products are regulated and the impact on regulated entities. An advisory organization examination can take the form of a comprehensive examination, a targeted examination, a risk-focused examination, a re-examination, a multistate cooperative examination or a desk examination. Most of the elements found in Chapter 13—Types of Examinations will apply to the advisory organization examination. Because most operations for these entities remain consistent in all states, it is recommended to coordinate examinations or communicate with the NAIC Advisory Organization Examination Oversight (C) Working Group, especially when conducting comprehensive reviews. The following special considerations apply:

a. A comprehensive examination of a single statistical agent will encompass a review of all or most of the following areas: operations/management; statistical plans; licensing or authorization (where needed); data receipt and controls; processing; editing and compilation procedures; error handling and correspondence with reporting insurers; and report submissions to regulators;

b. A comprehensive examination of a single advisory organization will encompass all of the above, plus processes for loss costs, rules, forms and other regulated activities;

c. Limited or targeted examinations of a single advisory organization may be used to address specific concerns. To address specific concerns, additional types of responses should also be considered, such as investigations, letters, desk audits, interrogatories or interviews;

d. A line of business examination for statistical data. This type of examination gathers information from all advisory organizations that provide statistical agent functions for a particular line of business, rather than reviewing a single advisory organization. At times, the regulator will be interested in examining all the data or services for a particular line of insurance. Care must be taken in apportioning expenses among all the examined entities in a manner acknowledging that the time spent at any one entity is likely to be somewhat related to the sequence in which the entities are reviewed. Consideration should be given to apportioning total examination expenses in a reasonable manner. One example is to apportion expenses by the relative premium volume of each statistical agent's reporting insurers for the line examined. When multiple entities are included in the line of business examination, seeking input or advice about apportioning expenses from the entities being examined is recommended;

e. Regardless of whether the activity being undertaken is comprehensive in nature or limited in scope, states are encouraged to coordinate with other states to prevent duplication and to obtain a better overall picture of the entities' operations. Such coordination may simply take the form of communication with other interested states. In some cases, a multistate examination may be desirable. In multistate examinations, the examination of operations/management, statistical plans, data processing and reporting systems will likely have countrywide application. However, data and data elements reviewed by an examiner will be either multistate or that of the participating jurisdictions. The lead state or lead states should seek the assistance of the state's Collaborative Action Designee (CAD) and applicable NAIC committees and working groups for the coordination and communication involved with a multistate endeavor. Confidentiality agreements, if not already in place, may be necessary in order to access or share information or data among jurisdictions; and

f. It is recommended that all billings from outside firms engaged be reviewed by the insurance department for reasonableness prior to submitting to examinees for payment. To the extent that the examination is a multi-statistical agent examination, the allocation of such examination costs should be discussed and agreed upon up front with the participating regulators and the examined entities.

Scheduling, Coordinating and Communications

Most of the chapter elements—including documenting the basis for the examination, review of previous examinations, estimating time requirements, content and timing of notification to the advisory organization, pre-examination procedures, on-site coordination, communicating with company management, and post-examination procedures—will apply to the examination. However, the following special considerations also apply:

a. Obtaining copies of other states' examination reports, either directly from the other states or from the advisory organization, will help to determine the scope of the examination. Many state laws may specifically permit consideration of another state's examination report to meet statutory examination requirements;

b. In determining priorities, the examiner should be aware that many of the listed elements have no application to advisory organizations, including:
   - Complaint ratios and analysis;
   - Producer licensing;
   - NAIC information systems, including the Regulatory Information Retrieval System (RIRS), Complaints Database System (CDS), and Financial Analysis and Solvency Tracking System (FAST);
   - Financial analysis workpapers;
   - Pre-admission; and
   - Annual statements;

c. Some functions—such as the promulgation of rates/loss costs and rules and policy forms and endorsements—may primarily be regulated through existing regulatory processes, such as filing and/or approval mechanisms. When planning an examination, such processes should be considered to prevent duplication of work and potentially conflicting insurance department conclusions;

d. The scope of the examination will be somewhat limited, in that complaint handling, marketing and sales, policyholder services, underwriting and claims do not apply. The scope should be clearly defined and communicated to the examinee prior to the start of the examination;

e. Regulator-only communication with members of the Advisory Organization Examination Oversight (C) Working Group is also encouraged for purposes of avoiding duplicative examinations. Communication can also be sent to each state's Collaborative Action Designee, so that information can be directed to the correct person within each insurance department, such as the state's chief property/casualty actuary and property/casualty division administrator. The contact list of Collaborative Action Designees is located on the NAIC website at *https://www.naic.org/cmte_d_mawg.htm*;

f. Consider analysis of existing internal and external audit or consulting reports that may be available from the licensee; and

g. The relevant materials to be required of advisory organizations will not include advertising materials, producer records, renewal material, methods used to solicit business or the consumer complaint register, as these activities do not apply to these entities.

When developing the examination plan, the examination supervisor should be mindful that the examination should not be used as a tool for testing insurers' proper reporting of data. Testing the accuracy of individual insurers' data submissions is best handled during examinations of each specific insurer. That being said, it is appropriate for advisory organizations to communicate unresolved insurer reporting problems to regulators. It may also be appropriate to consider a targeted examination of non-compliant insurers if persistent data reporting problems are known to exist.

Conducting the Examination—Review General Organizational and Entity-Specific Information

Obtain the applicable information, listed below, from the entity being examined:

- Applicable organization contact name, address, telephone number and email address for this review;
- List of licenses, appointments and/or registrations in each jurisdiction that is participating in the examination;
- The previous examination of the organization conducted by the state, along with the organization's response to the report and a description of the organization's implementation of the recommendations from the previous report;
- A brief description and history of the company and its subsidiaries; highlight any major changes since the last examination;
- The certificate of incorporation and bylaws, including amendments made during the examination period.
- The table of organization and overview of management structure;
- Copy of the organization's policies and business practices relative to prohibited activities and adherence to such policies/practices;
- Organizational chart of all departments and divisions, including field offices performing advisory organization activities and officers and management staff of those areas;
- Description of regulated functions and services for each unit listed above. Obtain a list of services and products, along with states where offered and number of insurers using each service or product;
- A brief explanation of how each service or product is used by insurers, and how the product or service impacts ratemaking, actuarial, development or issuance of policy forms and endorsements, loss control purposes or information purposes, as applicable. It is important to keep in mind that some advisory organizations provide additional services and products that are not regulated by the insurance department. There should not be a need to include unregulated activities in the examination work plan or review;
- An explanation of the source of information gathered to produce each product or service;
- Copies of policies or business practices relating to the availability of services to authorized insurers;
- Committee appointments, agendas and minutes of meetings relating to any licensed activity. Examiners should be mindful of the proprietary nature of such documents. No copy of these documents should be retained. Confidentiality agreements, if not already in place, may be necessary in order to view such information;
- A list or statement of the states and lines of business in which the organization is permitted to operate;
- A list of participating insurers or member companies, by line of business;
- A description of the method and basis for the assessment of fees and charges;
- A review of the advisory organization's policy or business practice relating to the availability of regulated services to authorized insurers;
- A description of the organization's methodology of offering new products in the marketplace;
- A list and general description of internal audits performed during the examination period related to any regulated advisory organization activity; and
- A list of complaints received by the department and advisory organization relating to any regulated advisory organization activity during the examination period should be obtained from the insurance department and advisory organization.

Note: The examiner should be mindful of the proprietary nature of internal audit reports. Administrative action should not be recommended by the examiner based on results of internal audit findings for which the advisory organization has taken appropriate action. No copy of the report should be retained. States should review confidentiality and trade secret laws when deciding what notes to keep.

Writing the Examination Report

The report preparation elements are generally applicable to advisory organization examinations. However, the following special considerations also apply:

- In addition to safeguarding the confidentiality of individual policyholder information, care should be taken to not disclose trade secret information of the examinees or insurers that are customers of the examinees (e.g., individual insurer information in class or territory detail, or the processes and procedures of the examinee). Advisory organizations should be given the opportunity to mark exhibits and/or portions of the report as "confidential and proprietary," if such is allowed under state law and these are not subject to otherwise applicable public release laws outside the regulatory community; and
- The advisory organization should be given the opportunity to review the examination findings prior to issuing a final report, if such practice is consistent with the state's insurers' examination act or other applicable statute.

Insurance Service and Support Programs

In most regulatory environments, the actual content of the advisory organization's loss cost, manual rules, forms and rating plan filings and the related actuarial formulas are front-end regulated and are not reviewed again during an examination. During an examination, the implementation of those filings in manuals or other distributions to insurers may be reviewed to the extent that these distributions have not been previously reviewed. Typically, examiners also review systems and data quality activities that are used in the loss cost production (i.e., "ratemaking"). These are typically additions to and extensions of systems and data quality activities that the organization performs as a statistical agent. As such, it is recommended that the "statistical agent" functions be reviewed prior to the review of ratemaking systems and additional ratemaking data quality reviews.

Some or all of the following list of items are functions of insurance service and support programs that should be considered for review:

- A description of the significant insurance program revisions (i.e., coverage revisions) made during the examination period;
- A description of significant changes in ratemaking methodology made during the examination period;
- A description of the data handling, systems, control and quality reviews conducted for the ratemaking reviews. Note that this may begin in the "statistical agent" part of the examination, but that additional data quality reviews may be incorporated into the ratemaking/loss cost making function. If the complete statistical agent function is not being examined at this time, this part of the review will be more extensive;
- A list of filings (loss costs, rules and forms) made in the state for the time period under examination;
- A description of the organization's procedures for notifying participating insurers about filings that have been submitted to the insurance department;
- From the list of filings obtained above, review the filing and related documentation for a set of sample filings, including the organization's communications and distribution to its participating insurers on the selected filings; and
- The organization's manuals and all revisions made thereto for the examination period. A list of current forms in effect in the state.

Note: For efficiency, when conducting an examination of a large organization that is licensed for many lines of business, examinations are usually conducted in detail for four or five of the larger significant lines, and by analogy or exception for the other lines.

If the examining state does not review the advisory organization's loss cost filings at the time of filing, a ratemaking review may be conducted. The review should include an overall description of the ratemaking procedures for each line of business discussing:

- Significant ratemaking changes implemented since the previous examination;
- The data used and its source, its limitations and adjustments;
- Quality procedures applied to the data;
- Data compilation basis and historical experience period selected;
- Classification methodology;

- Trend methodology;
- Loss development methodology;
- Credibility methodology;
- Catastrophe treatment methodology;
- Increased limits analyses;
- Other ratemaking methods used; and
- Rating plans.

Inspection Services
If applicable to the entity being reviewed and to the planned scope of review, obtain a description of the procedures for initial inspections and re-inspections of risks and/or communities, including a description of the training of such inspectors, and the inspector's oversight, in order to ensure compliance with established procedures. A random review of specific inspection reports will provide insight into the organization's adherence to its relevant internal procedures. The examiner may find it useful to check the examined entity's website to see what services the entity says it provides and verify this with the examined entity's examination contact person.

Classification Administration
The use of classifications should be done in a manner that results in consistent and fair application of the resulting rating plans. Classifications that are ambiguous or unclear for the ultimate users should be clarified. Classifications that may overlap with other classification codes should also be redefined or eliminated to prevent inconsistent or inappropriate use. Classification definitions are generally filed and approved in an organization's loss costs or rules filings. It is not contemplated that definitions be re-examined for compliance in an examination, unless known concerns or complaint patterns indicate the need for review.

The review of classification administration is primarily appropriate for advisory organizations, such as workers' compensation advisory organizations, that develop and maintain the classification system. The examiner should keep in mind that classifications are filed with and approved by the regulator. It is best to limit the review to how the advisory organization addresses known problems or questions that have been communicated by insurance department staff or insurance companies.

Advisory organizations that do not have control over the administration of classification codes may wish to bring known problems (if any) to the attention of the insurance department.

Some advisory organizations, particularly those that handle workers' compensation, may be responsible for processing classification appeals. Handling of such appeals should be done in a timely, fair and consistent manner. Reviewing classification appeals and related complaints may be useful when evaluating the effectiveness of classification administration.

Evaluation of Data Functions
Use of a generalized Information Systems Questionnaire (ISQ) developed for evaluation of insurers should not be used for advisory organizations; but a specialized questionnaire relating to data functions may be appropriate for advisory organizations that are engaged in data-dependent services. For example, it would not be necessary to use the specialized questionnaire during an examination of an advisory organization that only develops and files policy forms and endorsements.

Please reference Appendix F (a specialized questionnaire) and Appendix G (an interactive PDF), which are used to evaluate advisory organization data functions. Regulators with an active myNAIC login ID and password may access Appendices F and G electronically:

- Choose StateNet from the myNAIC login categories;
- Click on Market Regulation Handbook, Handbook Updates and Reference Documents (located in the Market Regulation section of the StateNet home page); and
- Click on Market Regulation Handbook Reference Documents. Appendices F and G are found at the top of the Market Regulation Handbook Reference Documents web page.

Non-regulators may access Appendices F and G on the NAIC Account Manager web page at https://www.naic.org/account_manager.htm.

Comprehensive Annual Analysis (CAA) Form for Advisory Organizations and Statistical Reporting Agents
At the 2015 Fall National Meeting, the Property and Casualty (C) Committee and the Market Regulation and Consumer Affairs (D) Committee adopted the Comprehensive Annual Analysis (CAA) form,* which is a form designed to be completed each year by an advisory organization or statistical agent. The form includes questions taken directly from existing examination standards in this chapter. The only difference is the form takes a snapshot of the last 12 months of activity at the advisory or statistical organization, instead of the last five years that an examiner would ask for when performing an examination.

The Advisory Organization Examination Oversight (C) Working Group that adopted the form believes that by identifying operational or staffing level changes in an advisory or statistical organization earlier, the Working Group will be able to speed up the examination process and ultimately reduce examination costs for the state insurance departments or for a contractor hired by a state insurance department.

*An updated Comprehensive Annual Analysis Form for Advisory Organizations and Statistical Reporting Agents (which replaced the CAA form adopted in 2015) was adopted in 2017 by the NAIC Executive (EX) Committee and Plenary. Regulators may access the 2017 updated Comprehensive Annual Analysis Form for Advisory Organizations and Statistical Reporting Agents form via myNAIC at the Market Regulation Handbook, Handbook Updates and Reference Documents link on the StateNet home page. The updated CAA form is located in the Market Regulation Handbook Reference Documents section of the web page together with Appendices F and G referenced above. Non-regulators may access the 2017 updated Comprehensive Annual Analysis Form for Advisory Organizations and Statistical Reporting Agents form on the NAIC Account Manager web page at https://www.naic.org/account_manager.htm

Use of Examination Standards
Each of the following examination standards may be applicable to specific functions performed by advisory organizations. The examination plan should indicate which standards for review will be used for each specific examination. Section B of this chapter lists standards specific to advisory organization functions. Section C of this chapter lists standards specific to statistical agent functions. These standards, along with the preceding text of the chapter, used in accordance with the *Statistical Handbook of Data Available to Regulators* (applicable to statistical agent functions) should form the basis of the examination. Each standard includes an "Applicable to" notation. Those notations may assist in developing an examination plan.

B. Advisory Organizations Operations/Management/Governance

1. Purpose

The advisory organization examination is designed to verify that the advisory organization maintains procedures for providing regulated services that are in accordance with applicable statutes, rules and regulations.

2. Techniques

The examiner should review the services provided by the advisory organization to the extent required by applicable statutes, rules and regulations.

Section C of this chapter deals with standards that are specific to statistical agent duties.

3. Tests and Standards

The advisory organization operations/management/governance review includes, but is not limited to, the following standards related to the use of advisory organization services. The sequence of the standards listed here does not indicate priority of the standard.

4. Voluntary Self-Reporting

The advisory organization may elect to submit a detailed report on how it complies with the examination standards before the detailed examination work plan is developed. The lead state may take information contained in this self-report into consideration when developing the scope of the examination work plan. However, a self-report should not be considered a substitute for a scheduled examination.

STANDARDS
ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE

Standard 1
The advisory organization has implemented written policies and procedures to prevent anti-competitive practices in the insurance marketplace, as related to the advisory organization's services and communications to insurers.

Apply to: All advisory organizations

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Service agreements with insurance companies

_____ Board of director and other committee minutes, along with applicable policies and procedures that are applicable to anti-competitive practices

_____ Regulatory actions and lawsuit register (if any)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review policies and procedures to determine if the advisory organization provides guidance to its staff and adopts practices to prevent anti-competitive activity. Although adoption of written policies and procedures are likely not required by law, it is permissible to comment on the lack of, or weaknesses in, such policies or procedures.

Examples of anti-competitive practices in the insurance market include:

- Attempting to monopolize, combine or conspire with any other person to monopolize an insurance market;
- Engaging in boycott on a concerted basis of an insurance market;
- Agreeing with an insurer to mandate adherence to or mandate use of any rate, prospective loss cost, rating plan, rating schedule, rating rule, policy bond form, rate classification, rate territory, underwriting rule, survey, inspection or similar material except as needed to facilitate the reporting of statistics. The fact that two or more insurers use consistently or intermittently the same rate, prospective loss cost, rating plan, rating schedule, rating rule, policy bond form, rate classification, rate territory, underwriting rule, survey, inspection or similar material is not sufficient in itself to support a finding that an agreement exists;
- Entering into arrangements which have the purpose or effect of unreasonably restraining trade or unreasonably lessening competition in the business of insurance; and

- Except as otherwise permitted by statute, compiling or distributing recommendations relating to rates that include expenses (other than loss adjustment expenses) or profits. Examples of permitted exceptions include information required or directed by the insurance commissioner, research related to impact of statutory changes, compilations of current insurer prices which are also made available to the public, and filing of final rates for residual market mechanisms.

Examples of sound practices include, but may not be limited to:

- Implementation of policies that require reading anti-trust statements and monitoring of meetings or forums with multiple insurers to prevent anti-competitive practices;
- Use of written guidelines that promote the advisory organization's making its products and services available to entitled affiliates, subscribers or purchasers in an appropriate and consistent manner. Written policies should protect the advisory organization, yet not promote anti-competitive results; and
- Implementation of training materials or employee codes of conduct that address prohibition of anti-competitive activities.

STANDARDS
ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE

Standard 2
The advisory organization uses sound actuarial principles for the development of prospective loss costs.

Apply to: Advisory organizations that develop prospective loss costs

Priority: Essential

Note: If the examining state does not review the advisory organization's loss costs filings at the time of filing, a ratemaking review may be conducted. The review should include an overall description of the ratemaking procedures for each line of business.

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Actuarial guidelines

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review processes and procedures for development of loss costs, along with a random sample of specific prospective loss costs.

- Prospective loss costs developed by the advisory organization do not contribute to premiums that are inadequate, excessive or unfairly discriminatory;
- Data used to develop prospective loss costs is applicable, complete (as appropriate) and actuarially sound;
- The advisory organization has procedures in place to test the soundness of data prior to use for development of prospective loss costs; and
- Assumptions, trending factors and other factors used during the development of prospective loss costs are actuarially sound and reasonable.

STANDARDS
ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE

Standard 3
The advisory organization prepares, submits filings as necessary, adheres to applicable state filing and/or approval requirements and written procedures prior to distribution of prospective loss costs, policy forms, endorsements, factors, classifications or rating rule manuals.

Apply to: Advisory organizations that develop and file prospective loss costs, policy forms, endorsements, factors, classifications or rating rule manuals

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Procedural information from the advisory organization

_____ Filings made to applicable states

_____ Communications and manuals provided by the advisory organization to its members and subscribers

_____ Distributed prospective loss costs, policy forms, endorsements, factors, classifications or rating rules

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review a sample of actual filings and materials distributed to members or subscribing companies.

- The advisory organization makes filings on the System for Electronic Rate and Form Filing (SERFF) or other state-approved filing systems;
- The advisory organization follows mandated time requirements (if applicable) following filing or approval before permitting use of materials;
- The advisory organization is responsive to state filing analyst questions regarding filings;
- Distributed materials are the same as those filed with applicable state insurance departments;
- Prospective loss costs, policy forms, endorsements, factors, classifications or rating rules are filed and approved (as applicable) in accordance with state filing laws;
- Instructions are included in the advisory organization's manuals for all prospective loss costs, policy forms, endorsements, factors, classifications or rating rules; and
- The advisory organization provides accurate information to its members and subscribers relating to the states' approval status and approved usage date of prospective loss costs, policy forms, endorsements, factors, classifications or rating rules in a timely manner.

STANDARDS
ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE

Standard 4
Experience rating factors are developed in a correct and timely manner.

Apply to: Advisory organizations that provide individual risk experience rating modification factors

Priority: Essential

Note: If the examining state does not review the advisory organization's experience rating plan at the time of filing, a review of the plan may be conducted.

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Advisory organization policies and procedures for the development of experience rating modification factors

_____ Random samples of developed individual experience rating modification factors

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

The advisory organization adheres to consistent and actuarially sound processes and formulas for developing individual experience rating modification factors.

The advisory organization has data integrity checks in place to evaluate data used during calculation of individual experience rating modification factors.

Experience rating modification factors are developed and made available to applicable insurers in a timely manner.

The advisory organization maintains adequate documentation to support individual experience rating modification factors that it developed.

The advisory organization is responsive to questions and grievances relating to individual experience rating modification factors that it developed.

STANDARDS
ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE

Standard 5
The advisory organization performs thorough and meaningful inspections and research when required for individual insured rating classification.

Apply to: Advisory organizations that provide individual insured rating classifications

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Inspection reports

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review a sample of inspection reports used for individual rating classifications.

- Inspection and research reports are well documented, including dates of inspection and notes of relevant inspection results;
- Resulting individual rating classifications are provided to applicable entities in a timely manner; and
- Individual rating classifications are consistent with the filed classification system. Examiners should be mindful that such individual classification information may be proprietary.

STANDARDS
ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE

Standard 6
The advisory organization develops sound, understandable and appropriate risk classifications.

Apply to: Advisory organizations that administer risk classification manuals

Priority: Essential

Note: If the examining state does not review the advisory organization's classification rules at the time of filing, a review of these rules may be conducted.

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Advisory organization classification manuals

_____ Appeals and grievances related to classifications

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Classifications and accompanying manuals provide clear guidance.

Wherever possible, classifications are developed in a manner that leads to consistent handling of risk classification.

Risk classifications include only risks with similar expected loss exposures within each rating class.

STANDARDS
ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE

Standard 7
Loss control services are effective and based on valid risk management, engineering and scientific evidence.

Apply to: Advisory organizations that provide loss control services

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Advisory organization policies and procedures for loss control services

_____ Random samples of loss control and inspection reports

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

The advisory organization uses appropriate expertise in analysis and development of loss control reports.

The advisory organization uses up to date technical and scientific evidence in its development of loss control reports.

The advisory organization employs sound and meaningful inspection practices, where required, for loss control purposes.

STANDARDS
ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE

Standard 8
The advisory organization conducts ongoing research and review of state insurance laws and insurance-related case law in order to be responsive to necessary changes in prospective loss costs, policy forms, endorsements, factors, classifications or manuals, as applicable.

Apply to: Advisory organizations that develop and file prospective loss costs, policy forms, endorsements, factors, classifications or manuals

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Filings made to applicable states

_____ Advisory organization processes and procedures for researching insurance laws and case law

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

From the applicable state or states, obtain specimen copies of recent insurance law changes or case law that directly and significantly impact the content of materials filed by the advisory organization. Review the advisory organization's procedures for responding to those changes or, in the absence of implementing changes, notifying member or subscribing companies when deemed appropriate.

- The advisory organization conducts research into law changes during regular and reasonable intervals;
- The advisory organization identifies applicable materials impacted by law or case law changes; and
- The advisory organization makes appropriate modifications, additions, deletions or withdrawals as necessitated by law changes or case law and performs applicable filings and notifications to member or subscriber companies.

STANDARDS
ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE

Standard 9
The advisory organization uses objective and established procedures when administering assigned risks.

Apply to: Advisory organizations that administer residual market assigned risk mechanisms

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Advisory organization policies and procedures

_____ Contracts or agreements with applicable states for which the assigned risk mechanisms are administered

_____ Random sample of assignments

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

The advisory organization adheres to an objective and established selection process for assigning risks.

The advisory organization handles assignments in a timely manner.

STANDARDS
ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE

Standard 10
When performing analysis and impact studies of proposed legislation, the advisory organization presents thorough and objective information.

Apply to: Advisory organizations that provide legislative impact studies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Reports submitted to insurance departments and legislatures in response to requests from those entities for legislative impact studies

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

- Impact studies present information in an objective manner; and
- Best estimates of impact are presented, using reasonable assumptions, research and data.

STANDARDS
ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE

Standard 11
The advisory organization has an up-to-date, valid internal or external audit program.

Apply to: Advisory organizations

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Audit plan and advisory organization's procedural manuals

_____ Audit reports and results

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review audit reports to determine if the function is providing meaningful information to management. If external, obtain an explanation.

Determine how management is using the reports.

Determine if the advisory organization responds to internal audit recommendations to correct, modify and implement procedures.

Determine if the accuracy of internal statistical data and information systems is periodically tested by the advisory organization's audit program.

Note: The examiner should be mindful of the proprietary nature of internal audit reports. Administrative action should not be recommended by the examiner based on results of internal audit findings for which the advisory organization has taken appropriate corrective action. No copy of the report should be retained. States should review confidentiality and trade secret laws when deciding what notes to keep.

STANDARDS
ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE

Standard 12
The advisory organization has appropriate controls, safeguards and procedures for protecting the integrity of computer information.

Apply to: Advisory organizations

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Electronic records control, and advisory organization's procedural manuals

_____ Negotiated contracts

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Insurance Information and Privacy Protection Model Act (#670)
Health Information Privacy Model Act (#55)

Note: When evaluating use of standards relating to privacy, keep in mind that most advisory organizations do not gather protected personal information.

Review Procedures and Criteria

Review physical security procedures related to the computer processing facilities and the network:

- Confirm that the computer/communication facilities (computer room, network operations center, wiring closets, etc.) are secure and protected from hazards;
- Confirm that access to the computer/communication facilities is restricted to only authorized personnel at all times;
- Confirm that the advisory organization uses firewall technology to protect its internal network from unauthorized external access;
- Confirm that the advisory organization scans inbound messages and files for malicious content; and
- Confirm that the advisory organization encrypts sensitive data files when transmitting data outside the physical premises.

Review logical security and computer system control procedures:

- Confirm that access to the advisory organization's network and computer systems is protected minimally with user IDs and passwords, based upon the sensitivity of the information and the requirements of the individuals; and
- Confirm that computer programs/databases/files impacted by user change requests are properly monitored, modified, tested and migrated to the secure production libraries.

Review the segregation of duties between the application development, operations and user departments to confirm that information systems projects are authorized, controlled and documented.

- Confirm that changes to the application portfolio are authorized, controlled and documented;
- Confirm that the user departments review, approve and sign-off on the implemented changes and the test results prior to the migration to the production environment; and
- Confirm that there are sufficient controls in the migration of the new application components to the production environment which guarantee accuracy and completeness.

STANDARDS
ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE

Standard 13
The advisory organization has a valid disaster recovery plan.

Apply to: Advisory organizations

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Description of the advisory organization's disaster recovery plan, procedural manuals and controls

_____ Negotiated contracts

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Ensure that critical business applications, databases and files are regularly backed up and stored off-site.

Review the disaster recovery plan and procedures:

- Confirm that the recovery procedures are current, detailed and reputable;
- Confirm that the inventory of critical business applications, databases and files is current and is defined and prioritized in the recovery process; and
- Confirm that critical business areas developed manual recovery testing (off-site retrieval through restoration of a fully operational computing environment) on a regular basis.

STANDARDS
ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE

Standard 14
The advisory organization is adequately monitoring the activities of any entity that contractually assumes a business function or is acting on behalf of the advisory organization.

Apply to: Advisory organizations

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Contracts

_____ Audit reports

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review audit reports to determine whether the advisory organization is adequately monitoring the activities of the contracted entity.

STANDARDS
ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE

Standard 15
Records are adequate, accessible, consistent and orderly and comply with state record retention requirements.

Apply to: Advisory organizations

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ All records, files and documents

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Market Conduct Record Retention and Production Model Regulation (#910)
Model Law on Examinations (#390), Section 4

Review Procedures and Criteria

Evaluate the orderly organization, legibility and structure of files.

Review state record retention requirements to determine advisory organization compliance.

STANDARDS
ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE

Standard 16
The advisory organization is appropriately licensed.

Apply to: Advisory organizations

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Certificate of authority or other similar documents

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review authority to act as an advisory organization.

STANDARDS
ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE

Standard 17
The advisory organization cooperates on a timely basis with examiners performing the examinations.

Apply to: Advisory organizations

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations, especially insurance examination law

_____ All records, files and documents

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Law on Examinations (#390)

Review Procedures and Criteria

Monitor the advisory organization's cooperation during the course of the examination; this may be noted in the examination report.

Automation Tip:
Requests for information or "crits" can be monitored using either a database or spreadsheet. The information that should be captured includes: area of review, type of request, contact person, date given, date due and date received. Databases and spreadsheets contain functions that will calculate the number of days between two dates. The information can be easily sorted and reviewed to see what is still outstanding and if the advisory organization is responding in a timely fashion.

STANDARDS
ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE

Standard 18
The advisory organization has developed and implemented written policies, standards and procedures for the management of insurance information.

Note: This standard applies only to those organizations that maintain data files containing personally identifiable information such as birth dates, social security numbers or other personal information. If the organization does not collect and report information on an individual level, examination of policies and procedures for this standard should not be included in the examination.

Apply to: Advisory organizations

Priority: Essential

Documents to be Reviewed (where applicable)

_____ Applicable statutes, rules and regulations

_____ Advisory organization procedure manual

_____ Advisory organization training manual

_____ Internal advisory organization claim audit procedures

_____ Advisory organization bulletins regarding insurance information

_____ Contractual arrangements between the carrier and a person other than the covered person

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Information Privacy Model Act (#55), Section 5
Insurance Information and Privacy Protection Model Act (#670), Sections 4–9

Review Procedures and Criteria (where applicable)

Review advisory organization procedures, training manuals and claim bulletins to determine if advisory organization standards exist and whether standards comply with state law.

Review contractual arrangements between the advisory organization and other persons to determine if the contracts address privacy procedures and standards for the person with whom the advisory organization is contracting.

Review the advisory organization's methods for handling, disclosing, storing and disposing of insurance information. The examiners should determine whether there are procedures in place to ensure proper authorization is obtained prior to disclosure of insurance information.

Review the advisory organization's training manual to determine whether the advisory organization's employees are properly trained on the handling of insurance information.

Verify that the advisory organization provides a "Notice of Information Practices" to all applicants or policyholders or has procedures in place for the producer to deliver the notice. The examiner should determine whether the notice contains all provisions required by applicable state law.

Verify that the advisory organization specifies those questions designed to obtain information solely for marketing or research purposes.

Verify that the advisory organization has implemented reasonable procedures to address investigative consumer reports and personal interviews.

Verify that the advisory organization has established procedures to address access to, correction, amendment or deletion of recorded personal information.

C. Statistical Plans

1. Purpose

The statistical plans portion of the examination is designed to verify that the statistical agent maintains adequate statistical plans in accordance with applicable statutes, rules and regulations, and that the data are reported in accordance with the statistical plans. This test is also intended to measure a statistical agent's compliance regarding the filing and approval of statistical plans, if any.

2. Techniques

The examiner should review the statistical plans in use by the statistical agent and verify that the statistical plans have been filed with the state insurance departments, to the extent required by applicable statutes, rules and regulations. The examiner should also verify that the appropriate statistical plans are being used by the companies that are reporting data to the statistical agent. The examiner should review the statistical plans for consistency with the output specified in the *Statistical Handbook of Data Available to Insurance Regulators*, in addition to other state specifications.

3. Tests and Standards

The statistical plan review includes, but is not limited to, the following standards related to the use of statistical plans by the statistical agent. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
STATISTICAL PLANS

Standard 1
The statistical agent has filed its statistical plans in accordance with applicable statutes, rules and regulations.

Apply to: All statistical agents

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Letters or other documentation verifying that statistical plans have been filed, where necessary

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review letters or other documents to determine if the statistical agent is in compliance with applicable statutes, rules and regulations.

STANDARDS
STATISTICAL PLANS

Standard 2
The statistical plans are reviewed and updated in accordance with applicable statutes, rules and regulations.

Apply to: All statistical agents

Priority: Essential

Documents to be Reviewed

_____ Statistical plans

_____ Statistical plan updates

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review documentation to determine if statistical plans are periodically updated and in compliance with applicable statutes, rules and regulations.

STANDARDS
STATISTICAL PLANS

Standard 3
The statistical agent verifies that companies submit data in accordance with the appropriate statistical plan.

Apply to: All statistical agents

Priority: Essential

Documents to be Reviewed

_____ Edit documentation

_____ Annual calls for statistical submissions

_____ Technical requirements for reporting

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review statistical agent's procedures to ascertain that its member companies are submitting complete and accurate data in compliance with applicable statutes, rules and regulations.

Review edits that the statistical agent applies to data it receives from insurers.

Review incentives applied by statistical agents to encourage member companies to report timely and error-free data.

Review annual calls for statistical submissions and periodic special calls to determine how effective the statistical agent's procedures are in collecting complete and accurate statistical information.

D. Data Collection and Handling

1. Purpose

The data collection and handling portion of the examination is extremely important and is designed to verify that the statistical agent adequately tests reported data for validity, completeness and reasonableness. The areas to be considered in this kind of review include:

- Statistical agent standards regarding data quality; and
- Data checking procedures and edit programs.

2. Techniques

During an examination, it is necessary for examiners to review a number of information sources, including the statistical agent's written policies and procedures regarding data quality (i.e., validity, reasonableness and completeness); the edit programs run by the statistical agent on the data when it is first received; the system of edits that the statistical agent applies to the data; and the steps used by the statistical agent in processing the data.

a. Statistical Agent Standards Regarding Data Quality

The examiner should verify that the statistical agent has formal written policies regarding the quality of the data to be submitted and what level of quality is required of the companies. The statistical agent should also have policies regarding what level of error tolerance is considered to be acceptable.

b. Data Checking Procedures and Edit Programs

The examiner should review the programs and procedures used to verify the validity, reasonableness and completeness of the data. The examiner should verify that the edit systems function as intended and check a sample of data both before and after it has run through the checking programs, to verify that all detectable errors have been caught.

c. Sequence of Examination

Data related to protocols need to be examined in their proper sequence as they exist at the advisory organization. The examiner should review the systems and procedures as they exist and identify gaps that could result in compliance issues for data that is used in loss cost filings, other pricing filings and statistical agent reports.

3. Tests and Standards

The data collection and handling review includes, but is not limited to, the following standards related to the statistical agent's handling of data. The sequence of the standards listed here does not indicate priority of the standard. The *Statistical Handbook of Data Available to Insurance Regulators* includes a comprehensive set of data quality tests to be performed by statistical agents. The *Statistical Handbook* should be used as an additional reference and guide for evaluating data collection and handling functions.

STANDARDS
DATA COLLECTION AND HANDLING

Standard 1
The statistical agent's series of edits are sufficient to catch material errors in data submitted by a company.

Apply to: All statistical agents

Priority: Essential

Documents to be Reviewed

_____ Edit definitions

_____ Distributional edit procedures

_____ Statistical agent edit reports

_____ *Statistical Handbook of Data Available to Insurance Regulators*

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review edit definitions and distributional edit procedures to determine that all required data elements are tested.

Review a sample of edit/distributional edit reports to verify that material errors are adequately identified.

STANDARDS
DATA COLLECTION AND HANDLING

Standard 2
All data that is collected pursuant to the statistical plan is run through the editing process.

Apply to: All statistical agents

Priority: Essential

Documents to be Reviewed

_____ Submission control and balance procedures

_____ *Statistical Handbook of Data Available to Insurance Regulators*

_____ Submission control file

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review procedures and submission control file, and a sample of edit and distribution reports to verify that all submissions are subject to the editing process.

STANDARDS
DATA COLLECTION AND HANDLING

Standard 3
Determine that all databases are updated as needed with all accepted company data.

Apply to: All statistical agents

Priority: Essential

Documents to be Reviewed

_____ Database update balancing reports

_____ *Statistical Handbook of Data Available to Insurance Regulators*

_____ Database control logs

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review logs and a sample of reports to confirm that appropriate data is moved to databases.

A predetermined sample size should be established and included in the examination scope document.

STANDARDS
DATA COLLECTION AND HANDLING

Standard 4
Determine that financial data is reconciled to the State Page—Exhibit of Premiums and Losses, Statutory Page 14, of the NAIC annual statement on an annual basis.

Apply to: All statistical agents[35]

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ *Statistical Handbook of Data Available to Insurance Regulators*

_____ Financial reconciliation procedures

_____ Financial reconciliation reports

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine compliance with applicable statutes, rules and regulations and any standards prescribed in the *Statistical Handbook of Data Available to Insurance Regulators*.

Review procedures and a sample of reconciliation reports to confirm that reconciliations are performed.

Review financial reconciliation criteria (e.g., rules for reconciliation, acceptance tolerance levels).

[35] Statistical agents handling workers' compensation data are expected to undertake substantial data quality checking activities, but the necessary standards and activities relevant to workers' compensation are different than those required for other lines of ins

STANDARDS
DATA COLLECTION AND HANDLING

Standard 5
Determine that all calculations associated with the database have been accurately applied.

Apply to: All statistical agents

Priority: Essential

Documents to be Reviewed

_____ Statistical agent documentation of database specifications

_____ *Statistical Handbook of Data Available to Insurance Regulators*

_____ Statistical agent database control reports

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review documentation and a sample of control reports to confirm that specifications have been accurately applied.

Note: The examiner should be mindful of the proprietary nature of database specifications and control reports. Administrative action should not be recommended by the examiner based on results of control reports for which the advisory organization has taken appropriate action. No copies of the specifications or reports should be retained. States should review confidentiality and trade secret laws when deciding what notes to keep. Confidentiality agreements, if not already in place, may be necessary in order to view such information.

STANDARDS
DATA COLLECTION AND HANDLING

Standard 6
Where applicable, determine that the statistical agent employs use of data completeness tests as outlined in the *Statistical Handbook of Data Available to Insurance Regulators.*

Apply to: All statistical agents

Priority: Essential

Documents to be Reviewed

_____ Statistical agent documentation of database specifications

_____ *Statistical Handbook of Data Available to Insurance Regulators* (Section 2.3.1)

_____ Statistical agent database control reports

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review documentation and a sample of control reports to confirm that data completeness tests have been performed.

E. Correspondence with Insurers and States

1. Purpose

Statistical agents frequently need to contact or correspond with companies regarding the quality and timeliness of the company's data. The purpose of this section of the examination is to verify that the statistical agent promptly notifies the company (and regulators, as requested or required) when a problem with or question about the data is found, and then follows up, if the company does not respond within the appropriate time frame.

2. Techniques

The examiner should review the statistical agent's records of or contact with companies (and regulators, as requested or required) to note the timeliness of the statistical agent's notification to the companies (and regulators, as requested or required) of data errors or questions, as well as any necessary follow-up communications.

3. Tests and Standards

The review of communications includes, but is not limited to, the following standards addressing various aspects of the statistical agent's contact and/or correspondence with companies and regulators. The sequence of the standards listed here does not indicate priority of the standard. The *Statistical Handbook of Data Available to Insurance Regulators* describes reports to be made by statistical agents. The *Statistical Handbook* should be used as an additional reference and guide for evaluating reporting functions and other data requests.

STANDARDS
CORRESPONDENCE WITH INSURERS AND STATES

Standard 1
The statistical agent keeps track of companies that fail to meet deadlines.

Apply to: All statistical agents

Priority: Essential

Documents to be Reviewed

_____ Submission control files

_____ Financial incentive program or penalty structure, if one exists

_____ Late company monitoring and reporting procedures

_____ Communications to insurers that fail to meet deadlines

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review statistical agent controls and procedures for determining insurer reporting status.

Review a sample of the statistical agent's communications with each delinquent insurer and other documentation to determine if insurers that fail to meet deadlines are identified and notified.

Review the statistical agent's financial incentive program or penalty structure, if one exists.

STANDARDS
CORRESPONDENCE WITH INSURERS AND STATES

Standard 2
The statistical agent has established procedures for notifying companies (and regulators, as requested or required) of material errors and for correcting those errors.

Apply to: All statistical agents

Priority: Essential

Documents to be Reviewed

_____ Data validation reports

_____ Submission control files

_____ Communications to insurers (and regulators, as requested or required)

_____ Financial incentive or penalty structure, if one exists

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review documentation to confirm that appropriate procedures exist for notifying companies (and regulators, as requested or required) of material errors and for correcting those errors.

Review a sample of communications to confirm that material errors are brought to the attention of insurers (and regulators, as requested or required).

STANDARDS
CORRESPONDENCE WITH INSURERS AND STATES

Standard 3
The statistical agent maintains a follow-up procedure with companies that have reporting errors or questions.

Apply to: All statistical agents

Priority: Recommended

Documents to be Reviewed

_____ Outline of communications procedures

_____ Financial incentive programs or penalty structure, if one exists

_____ Correspondence and/or other contact between statistical agent and companies (and regulators, as requested or required)

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review statistical agent procedures and controls to determine that appropriate procedures exist.

Review a sample of correspondence/contact documentation to demonstrate follow up performance.

Review the statistical agent's financial incentive programs or penalty structure, if one exists.

STANDARDS
CORRESPONDENCE WITH INSURERS AND STATES

Standard 4
Review any additional data quality programs maintained by the statistical agent pertaining to data collected pursuant to the statistical plan.

Apply to: All statistical agents

Priority: Optional

Documents to be Reviewed

_____ Educational programs or materials

_____ Support procedures

_____ Financial incentive programs or penalty structure, if one exists

_____ Executive evaluations

_____ Individual company assistance the statistical agent uses to promote data quality

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine the extent that other data quality programs are in use by the statistical agent.

STANDARDS
CORRESPONDENCE WITH INSURERS AND STATES

Standard 5
With each standard premium and loss report to the states, the statistical agent provides a listing of companies whose data is included in the compilations and a historical report listing insurers whose data for the state was excluded, as set forth in Section 2.4 of the *Statistical Handbook of Data Available to Insurance Regulators.*

Apply to: All statistical agents

Priority: Optional

Documents to be Reviewed

_____ Standard premium and loss reports to states

_____ Support procedures

_____ *Statistical Handbook of Data Available to Insurance Regulators* (Section 2.4)

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine the applicable lists are included with state reports.

F. Reports, Report Systems and Other Data Requests

1. Purpose

The purpose of this portion of the examination is to review the statistical agent's reports and other statistical compilations prepared for the states, as well as the statistical agent's internal procedures for preparing reports and responding to data requests, including the timeliness and quality of the response.

2. Techniques

The examiner should review recent reports and other statistical compilations prepared for the insurance departments. The examiner should note whether the data submission required that the statistical agent collect additional information from insurers and the procedure the statistical agent used in fulfilling the data request. The examiner should also determine that the statistical agent met the deadline set by the insurance department and that any data collected for the purpose of submitting the aforementioned reports to the insurance department, in addition to that collected under the statistical plan, was adequately reviewed for quality and correctly compiled.

3. Tests and Standards

The report, report systems and other data requests review includes, but is not limited to, the following standards. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
REPORTS, REPORT SYSTEMS AND OTHER DATA REQUESTS

Standard 1
All calculations used to develop the database have been performed accurately.

Apply to: All statistical agents

Priority: Recommended

Documents to be Reviewed

_____ Statistical agent documentation of report specifications

_____ Statistical agent database control reports

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review documentation and a sample of control reports to confirm that specifications have been accurately applied.

STANDARDS
REPORTS, REPORT SYSTEMS AND OTHER DATA REQUESTS

Standard 2
The statistical agent has accurately extracted the appropriate information from the statistical database.

Apply to: All statistical agents

Priority: Recommended

Documents to be Reviewed

_____ Data extraction control reports

_____ Report system specification documentation

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review documentation and a sample of reports to determine if the appropriate data has been included.

Note: The examiner should be mindful of the proprietary nature of database specifications. No copy of the specifications should be retained by the examiner. States should review confidentiality and trade secret laws when deciding what notes to keep. Confidentiality agreements, if not already in place, may be necessary in order to view such information.

STANDARDS
REPORTS, REPORT SYSTEMS AND OTHER DATA REQUESTS

Standard 3
Any data extracted from the statistical database has been accurately reviewed with any additional data obtained directly from a company in preparing a response to a data request.

Apply to: All statistical agents

Priority: Recommended

Documents to be Reviewed

_____ Report system specifications and documentation

_____ Data extraction control reports

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review documentation and a sample of reports to determine if the appropriate data has been included.

STANDARDS
REPORTS, REPORT SYSTEMS AND OTHER DATA REQUESTS

Standard 4
Data collected, in addition to the data collected under the statistical plan, was adequately reviewed for quality and compiled according to applicable statutes, rules and regulations.

Apply to: All statistical agents

Priority: Recommended

Documents to be Reviewed

_____ Data quality procedures

_____ Data validation reports

_____ Report system control reports

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review data quality procedures and a sample of data validation and control reports to determine if the data was adequately reviewed for quality and correctly compiled.

G. Ratemaking Functions

1. Purpose

The purpose of this portion of the examination is to review the advisory organization's ratemaking, reports and reporting systems, if any, as well as the advisory organization's internal procedures for preparing related reports and responding to data requests, including the timeliness and quality of the response. There should be no need for review of the advisory organization's pricing formulae as they have already been subjected to front-end regulation when rates are approved by the state insurance department.

2. Techniques

The examiner should review recent ratemaking results and related reports, if any, and other statistical compilations prepared for the insurance departments.

3. Tests and Standards

The ratemaking functions review includes, but is not limited to, the following standards. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
RATEMAKING FUNCTIONS

Standard 1
The advisory organization submits filings and/or submissions to the state within the established time frame.

Apply to: All advisory organizations

Priority: Essential

Documents to be Reviewed

_____ Filings or submissions to individual state insurance departments providing rate/loss cost information

_____ Filings or submissions to individual state insurance departments seeking approval of loss costs and accompanying rules

_____ Other correspondence with individual state insurance departments related to rates or loss costs

_____ Communications and manuals provided by the advisory organization to its subscribers

_____ Applicable statutes, rules and regulations

_____ *Statistical Handbook of Data Available to Insurance Regulators*

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Identify which filings and submissions are required by the state (if any), along with any required time frames. For filings that are optional, but require prior approval by the state, identify the required waiting periods, if any, between approval and usage.

Determine compliance with state statutes, rules and regulations.

The examiner should review regulators' requests for additional information and check for timeliness of the response to such requests.

Determine that the organization prepares and disseminates information impacting the rating of individual policies, such as experience rating modification factors, on a timely basis.

Determine that the organization provides accurate information to its subscribers relating to the states' approval status and approved usage date of regulated materials and services, such as loss costs.

H. Classification and Appeal Handling

1. Purpose

The purpose of this portion of the examination is to review the advisory organization's classification and appeal processes, where applicable. The examiner should note that this section will not be applicable to all advisory organizations.

2. Techniques

The examiner should review recent classification appeals or requests for clarification, if any.

3. Tests and Standards

The classification and appeal handling review includes, but is not limited to, the following standards. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
CLASSIFICATION AND APPEAL HANDLING

Standard 1
The advisory organization takes adequate steps to finalize and dispose of the classification appeal in accordance with applicable statutes, rules and regulations, and written manuals and procedures.

Apply to: Advisory organizations that process classification appeals

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Advisory organization's listing of appeals

_____ Supporting documentation (e.g., manuals, etc.)

_____ Advisory organization correspondence

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review appeal documentation to determine if the advisory organization response fully addresses the issues raised. If the advisory organization did not properly address/resolve the appeal, the examiner should ask the advisory organization what corrective action it intends to take.

Review manuals to verify appeal procedures exist.

Procedures in place should be sufficient to require satisfactory handling of appeals received, as well as internal procedures for analysis of classification codes that commonly cause appeals.

Criteria for reviewing appeal responses:

- The response is timely;
- The response is complete and responsive to all issues raised;
- The response includes adequate documentation to support the respondent's position;
- The respondent's actions are appropriate from a business practice standpoint;
- The respondent's actions comply with all applicable statutes, rules and policy or contract provisions, and
- The appropriate remedies for the consumer are identified.

I. Form Development

1. Purpose

The purpose of this portion of the examination is to review the advisory organization's processes for development, maintenance and filing of forms for insurance programs. The examiner should note that this section will not be applicable to all advisory organizations.

2. Techniques

The examiner should review communications with insurers and states relating to forms developed and determine that the communications to insurers are consistent with existing filings. Quality assurance programs should be in place to ensure that the forms remain up-to-date and that filings to states are checked for the appropriate level of quality.

3. Tests and Standards

The insurance program development and maintenance review includes, but is not limited to, the following standards. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
FORM DEVELOPMENT

Standard 1
The advisory organization has processes in place to identify and provide subscribers with necessary changes (by virtue of changes in state laws or case law) to advisory forms.

Apply to: All advisory organizations

Priority: Recommended

Documents to be Reviewed

_____ Communication with companies regarding changes to applicable forms

_____ Procedural information from the advisory organization

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

If the examiner knows law changes or case law necessitating changes to applicable forms, verify that the advisory organization responded accordingly.

Alternatively, provide the advisory organization with a brief questionnaire, asking about procedures for handling such changes.

STANDARDS
FORM DEVELOPMENT

Standard 2
The advisory organization has quality assurance processes in place to review submissions of forms prior to filing or submitting to the applicable state.

Apply to: All advisory organizations

Priority: Optional—best practice only

Documents to be Reviewed

_____ Procedural information from the advisory organization

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine whether the advisory organization uses applicable readability tools, such as Flesch tests, if required by law.

Provide the advisory organization with a brief questionnaire, asking about procedures for quality control and readability.

J. Inspection Services

1. Purpose

The purpose of this portion of the examination is to review the advisory organization's processes for ensuring proper classification of risks that are subject to inspection, and to report the results of this review to carriers and insureds.

2. Techniques

The examiner should review the procedural information from the advisory organization, as well as completed reports. Communications and manuals provided by the advisory organization to its members and subscribers—as well as applicable statutes, rules and regulations—should be reviewed to determine that the communications to insurers and insureds are consistent with existing classifications of risk.

3. Tests and Standards

The inspection services review includes, but is not limited to, the following standards. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
INSPECTION SERVICES

Standard 1
The advisory organization conducts inspection services in accordance with applicable statutes, rules and regulations, and written procedures.

Apply to: All advisory organizations maintaining a workers' compensation classification system

Priority: Essential

Documents to be Reviewed

_____ Procedural information from the advisory organization

_____ Reports to individual state insurance departments providing inspection services information

_____ Communications and manuals provided by the advisory organization to its subscribers

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

The advisory organization has an inspection program in place to ensure proper classifications of risks.

The advisory organization communicates inspection results to carriers and insureds.

K. Residual Market Functions—Plan Administration

1. Purpose

The purpose of this portion of the examination is to review all advisory organizations acting as a residual plan administrator in regard to the implementation of rules, procedures, manuals, policy forms, endorsements, pricing programs, application processing procedures, carrier selection, compensation and oversight. The examiner should note that this section will not be applicable to all advisory organizations.

2. Techniques

The examiner should review contracts, designations or agreements with applicable states for which the assigned risk mechanisms are administered as available and/or required. The examiner should also check to be sure that applicable statutes, rules and regulations are addressed in national and/or state rules and/or procedures where appropriate. A sample of actual filings and materials should be submitted for review.

3. Tests and Standards

The residual market functions—plan administration review includes, but is not limited to, the following standards. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
RESIDUAL MARKET FUNCTIONS—PLAN ADMINISTRATION

Standard 1
The advisory organization uses objective and established procedures when administering assigned risk plans.

Apply to: All advisory organizations, acting as a residual market plan administrator, that develop file and implement prospective rules, procedures, manuals, policy forms and endorsements, pricing programs, application processing procedures, carrier selection, compensation and oversight

Priority: Essential—market of last resort

Documents to be Reviewed

_____ Administration of the rules and procedures

_____ Standards of performance for assigned carriers

_____ Servicing carrier selection, compensation and oversight

_____ Application processing procedures

_____ Dispute resolution process

_____ Contractual agreements with state, if applicable

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Contracts, designations or agreements with applicable states for which the assigned risk mechanisms are administered as available and/or required.

Applicable statutes, rules and regulations are addressed in national and/or state-approved filing systems and inquiries are responded to in a timely manner.

Review a sample of actual filings and materials submitted for approvals.

The plan administrator makes filings on the System for Electronic Rate and Form Filing (SERFF) or other state-approved filing systems and responds to inquiries.

The plan administrator is responsive to inquiries relating to individual assigned risk policy issues.

The plan administrator develops standards of performance for assigned carriers.

The plan administrator adheres to an established selection process for choosing and compensating service carriers.

The plan administrator handles applications for assigned risk coverage in a timely manner.

The plan administrator adheres to an established process for making assignments to assigned carriers.

The plan administrator adheres to established audit practices and procedures for auditing an assigned carrier.

The plan administrator develops and/or implements a dispute resolution process for resolution of assigned risk policyholder disputes.

STANDARDS
RESIDUAL MARKET FUNCTIONS—PLAN ADMINISTRATION

Standard 2
The advisory organization uses objective and established procedures when administering residual market or pool assessments.

Apply to: Advisory organizations that administer residual market mechanisms or pools with assessment provisions

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Advisory organization policies and procedures

_____ Contracts or agreements with applicable states for which the residual market mechanisms are administered

_____ Random sample of assessments

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

The advisory organization uses data integrity checks to test the quality of the data upon which calculation of assessments is based.

The advisory organization provides accurate and timely information to applicable state insurance departments relating to assessments made, and reporting or payment problems.

L. Residual Market Functions—Reinsurance Administration

1. Purpose

The purpose of this portion of the examination is to review the advisory organization's processes for preparing and publishing manuals, procedures and/or information for such reinsurance administration. The examiner should note that this section will not be applicable to all advisory organizations.

2. Techniques

The examiner should review communications with insurers and states relating to contracts, designations or agreements with applicable states for which the assigned risk reinsurance pooling mechanisms are administered as available and/or required. Actuarial practices and procedures for developing reserves should also be reviewed, and the examiner should verify that accurate information is being reported to member participants relating to the state's assigned risk deficit or surplus on a timely basis.

3. Tests and Standards

The residual market functions—reinsurance administration review includes, but is not limited to, the following standards. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
RESIDUAL MARKET FUNCTIONS—REINSURANCE ADMINISTRATION

Standard 1
The advisory organization uses established procedures when administering residual market pool assessments or reinsurance pooling mechanisms.

Apply to: All advisory organizations, acting as a residual market reinsurance administrator, that manage a reinsurance pooling mechanism required by statute on behalf of member participants

Priority: Essential—market of last resort

Documents and Procedures to be Reviewed

_____ Manuals, procedures and information prepared or published by the advisory organization that relate to residual market pool assessments or reinsurance

_____ Reporting of financial information

_____ Financial and accounting responsibilities

_____ Reserving practices

_____ Deficit/surplus administration

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Contracts, designations or agreements with applicable states for which the assigned risk reinsurance pooling mechanisms are administered as available and/or required.

The reinsurance administrator adheres to established actuarial practices and procedures for developing reserves.

The reinsurance administrator provides accurate information to its member participants relating to the state's assigned risk deficit or surplus on a timely basis.

The reinsurance administrator provides accurate and timely information to applicable state insurance departments relating to state deficit or surplus results on a timely basis.

M. Acceptance of Examination Report by Participating States

1. Purpose

Once the examination is complete and the examination report has been reviewed by the advisory organization and the lead states, the lead states will certify the examination. Copies of the certified examination will be distributed to the participating states; the participating states will be asked to review the report and sign off on the examination.

2. Techniques

The staff support person of the NAIC Advisory Organization Examination Oversight (C) Working Group will distribute copies of the certified examination report to the Collaborative Action Designees (CADs) for review and approval by each CAD's state insurance commissioner. An examination certification form developed by the NAIC Legal Division will accompany a copy of the examination report. States may elect to use the supplied form, or if state statutes require modification of the form, states may modify the form to satisfy state requirements. If a state has issues with any of the findings in a report that has been certified, a state should bring these to the attention of the NAIC staff support person and the chairperson of the Advisory Organization Examination Oversight (C) Working Group.

3. Standards for State Responses

- States should return the certification form to the NAIC staff support person responsible for the Advisory Organization Examination Oversight (C) Working Group no later than **30 days** from the date that the state receives the examination report;
- If a state disagrees with the finding in a multistate examination, the state should advise NAIC staff and the chairperson of the Advisory Organization Examination Oversight (C) Working Group no later than **30 days** after the examination report is published; and
- All discussions of Advisory Organization Examination Oversight (C) Working Group findings should be kept confidential until all states have accepted the examination report.

N. Future Examinations of Examined Entity

1. Purpose

Future examinations will occur no later than five years from the start date of the most recent completed exam. If states identify particular issues at any point before the normal examination date, the Advisory Organization Examination Oversight (C) Working Group may elect to schedule an immediate examination.

2. Techniques

The examination calendar will be reviewed by the Advisory Organization Examination Oversight (C) Working Group during each conference call and at each NAIC national meeting. States may suggest that additional examinations be added to the examination schedule. As new advisory organizations are formed and licensed, those advisory organizations' names should be added to the examination calendar.

Chapter 30—Conducting the Third-Party Administrator Examination

IMPORTANT NOTE:
The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in Chapter 1—Introduction.

This chapter provides a format for conducting third-party administrator examinations. The standards found within this chapter may not be applicable for other licensed entities—such as property and casualty and life and health companies—whose examination standards may be found elsewhere within this handbook.

The examination of a third-party administrator's operations may involve any review of one or a combination of the following business areas:

A. TPA Operations/Management
B. Complaint Handling
C. Marketing and Sales
D. Producer Licensing
E. Policyholder Service
F. Underwriting and Rating
G. Claims
H. Special Considerations for the Third-Party Administrator Examination
I. Contracts and Written Agreements

When conducting an exam that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the TPA is meeting standards. Some standards may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.

When an examination involves a depository institution or their affiliates, the bank may also be regulated by federal agencies such as the Office of the Comptroller of the Currency (OCC), the Federal Reserve Board, the Office of Thrift Supervision (OTS) or the Federal Deposit Insurance Corporation (FDIC). Many states have executed an agreement to share complaint information with one or more of these federal agencies. If the examination results find adverse trends or a pattern of activities that may be of concern to a federal agency and there is an agreement to share information, it may be appropriate to notify the agency of the examination findings.

A. TPA Operations/Management

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.

STANDARDS
TPA OPERATIONS/MANAGEMENT

Standard 1
The TPA is in compliance with applicable statutes, rules and regulations regarding financial security.

Apply to: All TPAs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Evidence of bonding (fidelity or surety)

_____ Evidence of errors and omissions coverage

_____ Letters of credit

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Registration and Regulation of Third-Party Administrators, An NAIC Guideline (#1090)
Third-Party Administrator Statute (#90)

Review Procedures and Criteria

Review evidence of financial security to ensure compliance with applicable statutes, rules and regulations.

B. Complaint Handling

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

C. Marketing and Sales

Not applicable.

D. Producer Licensing

Not applicable.

E. Policyholder Service

Not applicable.

F. Underwriting and Rating

Not applicable.

G. Claims

Not applicable.

H. Special Considerations for the Third-Party Administrator Examination

1. Definition of Third-Party Administrator

While the NAIC definition of TPA specifically identifies life, health and annuity products, there has been a recent increase in the number of property and casualty TPAs. In addition, some of the physician and hospital organizations, health insurance purchasing cooperatives (HIPCS), associations for member employers, administrative services only (ASO) and consulting firms providing continuing benefit administrative services, etc., are also performing administrative functions that would meet the definition of a TPA.

A TPA is someone who contracts with an entity on a third-party basis to provide employee benefit administrative services, distribute benefits for a benefit plan, and/or adjudicate claims. Parties are defined as follows: (first-party) employer; (second-party) plan; and (third-party) entity providing administrative services. Examiners should refer to individual state statutes to determine what is and is not considered a TPA in their respective state.

The NAIC *Third-Party Administrator Statute* (#90) defines a third-party administrator (TPA) as follows:

A. "Administrator" or "third-party administrator" or "TPA" means a person who directly or indirectly underwrites, collects charges or premiums from, or adjusts or settles claims on residents of this state, in connection with life, annuity or health coverage offered or provided by an insurer, except any of the following:
   (1) An employer or a wholly-owned direct or indirect subsidiary of an employer, on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of such employer;
   (2) A union on behalf of its members;

(3) An insurer that is authorized to transact insurance in this state pursuant to [insert appropriate state statutory citation];
(4) An insurance producer licensed to sell life, annuities or health coverage in this state, whose activities are limited exclusively to the sale of insurance;
(5) A creditor on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors;
(6) A trust and its trustees, agents and employees acting pursuant to such trust established in conformity with 29 USC Section 186;
(7) A trust exempt from taxation under Section 501(a) of the Internal Revenue Code, its trustees and employees acting pursuant to such trust, or a custodian and the custodian's agents or employees acting pursuant to a custodian account which meets the requirements of Section 401(f) of the Internal Revenue Code;
(8) A credit union or a financial institution that is subject to supervision or examination by federal or state banking authorities, or a mortgage lender, to the extent they collect and remit premiums to licensed insurance producers or to limited lines producers or authorized insurers in connection with loan payments;
(9) A credit card issuing company that advances for and collects insurance premiums or charges from its credit card holders who have authorized collection;
(10) A person who adjusts or settles claims in the normal course of that person's practice or employment as an attorney at law and who does not collect charges or premiums in connection with life, annuity or health;
(11) [Optional] An adjuster licensed by this state whose activities are limited to adjustment of claims;
(12) A person licensed as a managing general agent in this state, whose activities are limited exclusively to the scope of activities conveyed under such license; or

Drafting Note: This exception to the definition of "administrator" should be included if the state has enacted the NAIC Managing General Agents Model Act.

(13) An administrator who is affiliated with an insurer and who only performs the contractual duties (between the administrator and the insurer) of an administrator for the direct and assumed insurance business of the affiliated insurer. The insurer is responsible for the acts of the administrator and is responsible for providing all of the administrator's books and records to the insurance commissioner, upon a request from the insurance commissioner. For purposes of this paragraph, "insurer" means a licensed insurance company, prepaid hospital or medical care plan or a health maintenance organization.

Note: Many trade associations and professional organizations at the national, regional and state level offer members group benefits. Traditionally, these programs are direct member-only benefits. Typically, the sponsoring trade or professional group is the owner of the program. These programs typically are not items states should examine, due to their relationship and legal obligations to their paying members.

2. Duties of the Third-Party Administrator

There are a significant number of variations in the duties that a TPA performs. Some TPAs only collect and bill for premiums, while others may issue policies, handle claims and provide client service duties. The written agreement between a TPA and the client, applicable insurer or other related entity should provide details of the relationship between the two organizations. Some contracts may grant authority to the TPA to accept risks, assess eligibility for benefits and make management decisions on behalf of a client, applicable insurer or other related entity. If the examination team finds a violation of standards, they should determine if the TPA or the client, applicable insurer or other related entity had contractual control of the practice in question.

I. Contracts and Written Agreements

1. Purpose

The written contract between the TPA and the client, applicable insurer or other related entity is an essential document that ensures proper treatment of covered persons. Accordingly, there are standards required to ensure the agreement is adequately defining the relationship between the TPA and client, applicable insurer or other related entity.

2. Techniques

The examiner should review all written agreements between the TPA and the client, applicable insurer or other related entity to ensure they meet the standards outlined in this chapter. Many jurisdictions have statutes defining specific provisions and requirements for these written agreements.

3. Tests and Standards

The review of contracts and agreements includes, but is not limited to, the following standards addressing various aspects of a TPA's contracts. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
CONTRACTS AND WRITTEN AGREEMENTS

Standard 1
Verify written agreement(s) are executed between the TPA and client, applicable insurer or other related entity.

Apply to: All TPAs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Written agreement(s)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Registration and Regulation of Third-Party Administrators, An NAIC Guideline (#1090)
Third-Party Administrator Statute (#90)

Review Procedures and Criteria

Verify the contract includes the following:

- The insurer or TPA may, with written notice, terminate the written agreement for cause as provided in the agreement;
- The insurer may suspend the underwriting authority of the TPA pending any dispute regarding the cause for termination of the written agreement;
- The insurer shall fulfill any lawful obligations with respect to policies affected by the written agreement, regardless of any dispute between the insurer and the TPA; and
- Ensure an agreement is executed for each client, applicable insurer or other related entity in accordance with applicable statutes, rules and regulations.

STANDARDS
CONTRACTS AND WRITTEN AGREEMENTS

Standard 2
The written agreement includes a statement of duties the TPA is expected to perform on behalf of the insurer or regulated, risk-bearing entity subject to the jurisdiction of the insurance department and the lines, classes or types of insurance for which the TPA is authorized to administer.

Apply to: All TPAs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ TPA correspondence files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Registration and Regulation of Third-Party Administrators, An NAIC Guideline (#1090)
Third-Party Administrator Statute (#90)

Review Procedures and Criteria

The agreement shall make provision with respect to underwriting or other standards pertaining to the business underwritten by the insurer.

To the extent the agreement requires a TPA to perform duties on behalf of an insurer or a regulated, risk-bearing entity subject to the jurisdiction of the insurance department, the examiner should ensure those functions are in compliance with applicable statutes, rules and regulations (e.g., underwriting, producer licensing, claims).

STANDARDS
CONTRACTS AND WRITTEN AGREEMENTS

Standard 3
The written agreement between the TPA and the insurer provides for the TPA to periodically render an accounting to the client, applicable insurer or other related entity detailing all transactions performed by the TPA pertaining to the business underwritten by the client, applicable insurer or other related entity.

Apply to: All TPAs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Written agreements

_____ Detailed accounting of transactions

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Registration and Regulation of Third-Party Administrators, An NAIC Guideline (#1090)
Third-Party Administrator Statute (#90)

Review Procedures and Criteria

Ensure the TPA provides an accounting of transactions to the client, applicable insurer or other related entity as required by the written agreement, in addition to applicable statutes, rules and regulations.

STANDARDS
CONTRACTS AND WRITTEN AGREEMENTS

Standard 4
The written agreement defines specifics of the TPA's authority to make withdrawals from financial institution accounts.

Apply to: All TPAs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Registration and Regulation of Third-Party Administrators, An NAIC Guideline (#1090)
Third-Party Administrator Statute (#90)

Review Procedures and Criteria

The written agreement should include details for handling the following:

- Remittance to an insurer entitled to remittance;
- Deposit in an account maintained in the name of the insurer;
- Transfer to and deposit in a claims-paying account, with claims to be paid as provided for in applicable statutes, rules and regulations;
- Payment to a group policyholder for remittance to the insurer entitled to such remittance;
- Payment to the TPA of its commissions, fees or charges paid;
- Remittance of return premium to the person or persons entitled to such return premium.

STANDARDS
CONTRACTS AND WRITTEN AGREEMENTS

Standard 5
If prohibited by applicable statutes, rules or regulations, the TPA does not enter into an agreement or understanding with the client, applicable insurer or other related entity to make the TPA's commissions, fees or charges contingent upon savings effective in the adjustment, settlement or payment of losses on behalf of the client, applicable insurer or other related entity.

Apply to: All TPAs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Agreement(s)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Registration and Regulation of Third-Party Administrators, An NAIC Guideline (#1090)
Third-Party Administrator Statute (#90)

Review Procedures and Criteria

Compensation for performance for providing hospital or other auditing services is allowed.

Compensation may be based on premiums or charges collected or the number of claims paid or processed.

STANDARDS
CONTRACTS AND WRITTEN AGREEMENTS

Standard 6
The TPA holds all insurance charges or premiums collected on behalf of the client, applicable insurer or other related entity in a fiduciary capacity.

Apply to: All TPAs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Accounting records

_____ Financial institution account records

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Registration and Regulation of Third-Party Administrators, An NAIC Guideline (#1090)
Third-Party Administrator Statute (#90)

Review Procedures and Criteria

The following applies, per Section 7 of the NAIC *Third-Party Administrator Statute*:

Section 7. Premium Collection and Payment of Claims

A. All insurance charges or premiums collected by an administrator on behalf of or for an insurer, and the return of premiums received from that insurer, shall be held by the administrator in a fiduciary capacity. The funds shall be immediately remitted to the person entitled to them or shall be deposited promptly in a fiduciary account established and maintained by the administrator in a federally or state insured financial institution. The written agreement between the administrator and the insurer shall provide for the administrator to periodically render an accounting to the insurer detailing all transactions performed by the administrator pertaining to the business underwritten by the insurer.

B. If charges or premiums deposited in a fiduciary account have been collected on behalf of or for one or more insurers, the administrator shall keep records clearly recording the deposits in and withdrawals from the account on behalf of each insurer. The administrator shall keep copies of all the records and, upon request of an insurer, shall furnish the insurer with copies of the records pertaining to the deposits and withdrawals.

C. The administrator shall not pay any claim by withdrawals from a fiduciary account in which premiums or charges are deposited. Withdrawals from the account shall be made as provided in the written agreement between the administrator and the insurer. The written agreement shall address, but not be limited to, the following:
   (1) Remittance to an insurer entitled to remittance;
   (2) Deposit in an account maintained in the name of the insurer;
   (3) Transfer to and deposit in a claims-paying account, with claims to be paid as provided for in Subsection D;
   (4) Payment to a group policyholder for remittance to the insurer entitled to such remittance;
   (5) Payment to the administrator of its commissions, fees or charges; and
   (6) Remittance of return premium to the person or persons entitled to such return premium.

D. All claims paid by the administrator from funds collected on behalf of or for an insurer shall be paid only on drafts or checks of and as authorized by the insurer.

STANDARDS
CONTRACTS AND WRITTEN AGREEMENTS

Standard 7
The TPA provides required written notices (approved by the client, applicable insurer or other related entity) to covered individuals in accordance with applicable statutes, rules and regulations.

Apply to: All TPAs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Written notices

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Registration and Regulation of Third-Party Administrators, An NAIC Guideline (#1090)
Third-Party Administrator Statute (#90)

Review Procedures and Criteria

Notice may be required to covered individuals advising them of the identity of and the relationship between the TPA, the policyholder and the client, applicable insurer or other related entity.

Notice may also be required for fees collected by the TPA. The reason for collection must be identified and the fee must be shown separately from any premium.

STANDARDS
CONTRACTS AND WRITTEN AGREEMENTS

Standard 8
The TPA delivers materials and written communications in a timely manner.

Apply to: All TPAs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ TPA correspondence files

_____ Policy files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Registration and Regulation of Third-Party Administrators, An NAIC Guideline (#1090)
Third-Party Administrator Statute (#90)

Review Procedures and Criteria

All policies, certificates, booklets, termination notices or other written communications delivered by the client, applicable insurer or other related entity to the TPA shall be delivered promptly after receipt of instructions from the client, applicable insurer or other related entity to deliver them.

STANDARDS
CONTRACTS AND WRITTEN AGREEMENTS

Standard 9
Transactions are processed accurately and completely.

Apply to: All TPAs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ TPA correspondence files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Registration and Regulation of Third-Party Administrators, An NAIC Guideline (#1090)
Third-Party Administrator Statute (#90)

Review Procedures and Criteria

Ensure proper documentation is maintained.

Ensure that requests from the client, applicable insurer or other related entity, agent and policyholder are processed accurately, completely and as soon as reasonably possible.

STANDARDS
CONTRACTS AND WRITTEN AGREEMENTS

Standard 10
The TPA maintains and makes available to the client, applicable insurer or other related entity complete books and records of all transactions performed on behalf of the client, applicable insurer or other related entity.

Apply to: All TPAs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ TPA correspondence files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Registration and Regulation of Third-Party Administrators, An NAIC Guideline (#1090)
Third-Party Administrator Statute (#90)

Review Procedures and Criteria

Ensure proper documentation is maintained.

Books and records should be maintained in accordance with prudent standards of insurance recordkeeping and should be maintained in accordance with applicable statutes, rules and regulations regarding record retention (or a period of not less than 5 years from the date of their creation).

In the event the TPA and the client, applicable insurer or other related entity cancel their agreement, the TPA may, by written agreement with the client, applicable insurer or other related entity, transfer all records to a new TPA rather than retain them for 5 years. In such cases, the new TPA shall acknowledge, in writing, that it is responsible for retaining the records of the prior TPA.

STANDARDS
CONTRACTS AND WRITTEN AGREEMENTS

Standard 11
The TPA uses only advertising pertaining to the business underwritten by the client, applicable insurer or other related entity that has been approved by the client, applicable insurer or other related entity in advance of its use.

Apply to: All TPAs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Written agreements

_____ Advertising

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Registration and Regulation of Third-Party Administrators, An NAIC Guideline (#1090)
Third-Party Administrator Statute (#90)

Review Procedures and Criteria

Ensure applicable advertisements are approved in accordance with the written agreements.

Chapter 31—Conducting the Examination of a Viatical Settlement Provider

IMPORTANT NOTE:
The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in Chapter 1—Introduction.

This chapter provides a suggested format for conducting examinations of viatical settlement providers, for state insurance departments that regulate them. The fundamental purpose of the examination is the determination of compliance with state statutes, rules and regulations governing viatical settlement providers and contracts.

Viatical settlements are state-regulated insurance activities that involve the following:

1. A life insurance contract owner enters into a contractual sale, exchange, assignment or other transfer of a life insurance policy or named beneficiary for compensation or value, thereby becoming a "viator";
2. The compensation or value is less than the expected death benefit of the insurance policy or certificate; and
3. A viator shall not be limited to mean the owner of a life insurance contract under which the insured has been diagnosed with a catastrophic or life-threatening illness or condition.

The typical transaction occurs after a life insurance policy has been in force beyond the contestable period. The policyowner and insured may be different persons. The viatical settlement may involve the transfer of all, or a portion, of the ownership of the life insurance policy, as long as ownership may be transferred. This is true for almost any type of policy, be it term, whole or universal life, or even an employer group policy.

The scope of a viatical settlement provider examination differs from that of an insurer. Viatical settlement providers arrange for the transfer of a life insurance policy in exchange for consideration. The scope of examination, therefore, should be modified to reflect this difference. There are various market conduct areas that may be covered in an examination. These include, but are not limited to:

- Provider operations/management, including licensure;
- Viatical settlement contracts and disclosure forms;
- Advertising;
- Complaint handling;
- Customer service;
- Reporting requirements; and
- Reasonableness of payments.

For the purposes of categorizing these market conduct areas in relation to the viatical settlements examination, the following viatical business areas should be reviewed:

A. Provider Operations/Management
B. Complaint Handling
C. Marketing and Sales
D. Producer Licensing
E. Policyholder Service
F. Underwriting and Rating
G. Claims
H. Viatical Settlement Contracts and Disclosures (also refer to the supplemental checklist in Section K.)
I. Viatical Settlement Transactions (also refer to the supplemental checklist in Section L.)

J. Viatical Settlement Provider Marketing and Sales (also refer to the supplemental checklist in Section M.)
K. Supplemental Checklist for Viatical Settlement Contracts and Disclosures, Standard #2
L. Supplemental Checklist for Viatical Settlement Transactions, Standard #5
M. Supplemental Checklist for Viatical Settlement Provider Marketing and Sales, Standard #5

When conducting an examination that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the provider is meeting standards established by applicable statutes, rules and regulations. Some standards listed in this chapter may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.

The content of the notice of examination is discussed in Chapter 16—Scheduling, Coordinating and Communicating. In most instances, an examination notification and some form of pre-examination information request (coordinator's handbook, pre-examination packet or memorandum) will have been sent to the provider prior to the start of the examination. The request is a listing of those items and information essential for the conduct and completion of the examination. The request should note that any exceptions to the items requested will be specified by the Examiner-in-Charge during the examination.

The pre-examination information request listing may include the following:

1. Computer access to or listing of all viaticated policies from a state or, if a multistate examination, from all of the participating states during the time frame of the examination;
2. Computer access to or listing of all applications from a state or, if a multistate examination, from all of the participating states that were received by the provider, but were not viaticated during the time frame of the examination;
3. Insurance department complaint records and provider complaint files, as required by applicable statutes, rules or regulations;
4. Business operation forms used by the provider during the time frame of the examination. These will include disclosure forms, financing agreements, purchase agreements, notices to insureds and any other forms or form letters used to communicate with insurers, viators or any other parties to the settlement contract;
5. Advertising materials present in the state or, if a multistate examination, of all of the participating states and as required by applicable statutes, rules or regulations;
6. Any viator payment calculation formulae or forms, as required by applicable statutes, rules or regulations;
7. Annual statements or reports, as required by applicable statutes, rules or regulations;
8. Listing of agreements or contracts with other entities relating to the assignment, servicing, sale or purchase of viatical settlement contracts; and
9. Copies of filings and antifraud plans, as required by applicable statutes, rules or regulations.

When an examination involves a depository institution or their affiliates, the bank may also be regulated by federal agencies such as the Office of the Comptroller of the Currency (OCC), the Federal Reserve Board, the Office of Thrift Supervision (OTS) or the Federal Deposit Insurance Corporation (FDIC). Many states have executed an agreement to share complaint information with one or more of these federal agencies. If the examination results find adverse trends or a pattern of activities that may be of concern to a federal agency and there is an agreement to share information, it may be appropriate to notify the agency of the examination findings.

A. Provider Operations/Management

1. Antifraud Initiatives

The viatical settlement provider should have antifraud initiatives reasonably calculated to detect, prevent and report fraudulent insurance acts. Written procedural manuals or guides and antifraud plans should provide sufficient detail to enable employees to perform their functions in accordance with the goals and direction of management.

Examples of possible fraudulent activity related to viaticals may include:

- "Cleansheeting" scams, whereby the viator, life insurance producer or broker obtains or sells a life insurance policy that was obtained by means of a false, deceptive or misleading application;
- "Fence posting," whereby the underlying insurance policy is issued on the life of a fictitious person or on an actual person without their knowledge;
- "Wet ink" or "wet paper" scams, whereby there is a transfer of the policy interest to a viator immediately after a policy is issued; and
- "Dirtysheeting," whereby the policy is procured by a healthy person that is transferred to a viatical provider with the insured claiming to be critically ill. The insured may submit a forged medical report from another person to the viatical settlement provider.

If the examiner notes or suspects any suspicious activity, it should be reported to the appropriate individual or agency.

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.

STANDARDS
PROVIDER OPERATIONS/MANAGEMENT

Standard 1
The viatical settlement provider has procedures for the collection and reporting of information regarding the provider's viatical settlement transactions, as required by applicable statutes, rules and regulations.

Apply to: All viatical settlement providers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Written procedures of viatical settlement provider for the collection and reporting of information

_____ Viatical settlement provider files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Insurance Information and Privacy Protection Model Act (#670)
Unfair Discrimination Against Subjects of Abuse in Life Insurance Model Act (#89
Viatical Settlements Model Act (#697), Section 6
Viatical Settlements Model Regulation (#698), Section 6

Review Procedures and Criteria

Determine if the viatical settlement provider, broker or investment agent has established and implemented procedures for the collection and reporting of information regarding the provider's viatical settlement transactions where the viator is a resident of the state and for all states in the aggregate. The examiner may have to seek this information from other sources.

Determine if the viatical settlement provider, broker or investment agent has established procedures to safeguard the privacy of the insured's financial and medical information.

B. Complaint Handling

Not applicable.

C. Marketing and Sales

Not applicable.

D. Producer Licensing

Not applicable.

E. Policyholder Service

Not applicable.

F. Underwriting and Rating

Not applicable.

G. Claims

Not applicable.

H. Viatical Settlement Contracts and Disclosures

1. Purpose

The review of viatical settlement contracts and disclosure forms is designed to verify that contracts entered into with a viator have been filed with and approved by the insurance department and that the forms are reasonable and not contrary to the interests of the public.

2. Tests and Standards

The contract and disclosure review includes, but is not limited to, the following standards addressing various aspects of a viatical settlement provider's use of the viatical settlement contracts. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
VIATICAL SETTLEMENT CONTRACTS AND DISCLOSURES

Standard 1
The viatical settlement provider uses viatical settlement contracts that have been filed with and approved by the insurance department.

Apply to: All viatical settlement providers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of viatical contracts and related account records

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Viatical Settlements Model Act (#697), Sections 5 and 9

Review Procedures and Criteria

Verify that the provider maintains contracts as required by applicable statutes, rules and regulations.

Verify that the provider maintains completed copies of each contract.

Verify that contract forms have been filed with and approved by the insurance department and comply with the requirements of applicable statutes, rules and regulations.

Verify that all rescissions comply with applicable statutes, rules and regulations.

STANDARDS
VIATICAL SETTLEMENT CONTRACTS AND DISCLOSURES

Standard 2
The viatical settlement provider complies with applicable disclosure and notice requirements.

Apply to: All viatical settlement providers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of viatical disclosure forms and related account records

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Viatical Settlements Model Act (#697), Section 8
Viatical Settlements Model Regulation (#698), Sections 7H and 8

Review Procedures and Criteria

Ensure that all notice and disclosure forms and documents are complete, timely presented to the proper individuals or entities and that the signatures are obtained as required by applicable statutes, rules and regulations.

Refer to the supplemental checklist in Section K of this chapter for a list of disclosure requirements.

I. Viatical Settlement Transactions

1. Purpose

The review of viatical settlement practices is designed to verify that viatical settlement providers conduct transactions in a manner that complies with applicable laws, rules and regulations.

2. Tests and Standards

The transaction review includes, but is not limited to, the following standards addressing various aspects of a provider's viatical settlement practices. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
VIATICAL SETTLEMENT TRANSACTIONS

Standard 1
The viatical settlement provider obtains and/or provides required documents relating to each viatical settlement transaction.

Apply to: All viatical settlement providers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of viatical settlement contract files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Viatical Settlements Model Act (#697)

Review Procedures and Criteria

Verify that the following items have been obtained:

- If the viator is the insured, a written statement from an attending physician that the viator is of sound mind and under no constraint or undue influence to enter into a viatical settlement contract;
- A witnessed document, in which the viator 1) consents to the contract; 2) represents that he or she has a full and complete understanding of the contract; 3) signifies that he or she has full and complete understanding of the benefits of the life insurance policy; and 4) acknowledges that he or she is entering into the contract freely and voluntarily;
- For persons with a terminal or chronic illness or condition, acknowledgement that the insured has a terminal or chronic illness that was diagnosed after the life insurance policy was issued;
- A document in which the insured consents to the release of his or her medical records to the viatical settlement provider, viatical settlement broker and the insurance company that issued the life insurance policy covering the life of the insured; and
- Notice to the insurer after a viator executes the documents necessary for the transfer, along with a copy of the viator's application for the viatical settlement contract and a request for verification of coverage. The notice should be provided in the time frame required by applicable statutes, rules and regulations.

STANDARDS
VIATICAL SETTLEMENT TRANSACTIONS

Standard 2
The viatical settlement provider complies with applicable statutes, rules and regulations relating to the confidentiality of medical records.

Apply to: All viatical settlement providers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of viatical settlement contract files

_____ Signed contracts relative to the release of confidential medical information

_____ Transactions involving the release of medical information

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Insurance Information and Privacy Protection Model Act (#670)
Viatical Settlements Model Act (#697), Section 9B
Viatical Settlements Model Regulation (#698), Sections 8B, 8C, 9A and 9B

Review Procedures and Criteria

Verify that the release of medical information is made in accordance with applicable statutes, rules and regulations.

Except as otherwise allowed or required by law, a viatical settlement provider, broker, insurance company, insurance producer, information bureau, rating agency or company or any other person with actual knowledge of an insured's identity, shall not disclose that identity to any other person unless the disclosure:

- Is necessary to effect a viatical settlement contract between the viator and viatical settlement provider, and the insured has provided prior written consent to the disclosure;
- Is necessary to effect a viatical settlement purchase agreement between the viatical settlement purchaser and a viatical settlement provider, and the insured has provided prior written consent to the disclosure;
- Is necessary to permit a financing entity to finance the purchase of policies by a viatical provider or a viatical settlement purchaser, and the insured has provided prior written consent to the disclosure;
- Is provided in response to an examination or investigation by the insurance department or any other governmental officer or agency; and
- Is a term of or condition to the transfer of a viaticated policy by one viatical settlement provider to another viatical settlement provider, and the insured has provided prior written consent to disclosure.

Verify the following with respect to the release of patient identifying information:

- That the patient identifying information is released in accordance with applicable statutes, rules and regulations;
- That the insured and viator have provided written consent to the release of the information at or before the time of the viatical settlement transaction;
- That the person obtaining the patient identifying information has provided a signed affirmation that the person will not further divulge the information without procuring the express written consent of the insured for the disclosure; and
- That the viatical settlement provider has established procedures to adequately inform the viator and the insured in writing, if the patient identifying information has been subpoenaed.

STANDARDS
VIATICAL SETTLEMENT TRANSACTIONS

Standard 3
The viatical settlement provider tenders consideration in the form required by law and within 3 business days of receipt of documents necessary to effect the transaction (unless otherwise indicated in state statutes, rules or regulations).

Apply to: All viatical settlement providers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of viatical settlement contract files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Viatical Settlements Model Act (#697), Section 9
Viatical Settlements Model Regulation (#698), Sections 7B and 7C

Review Procedures and Criteria

The viatical settlement provider shall instruct the viator to send the executed documents required to effect the change in ownership, assignment or change in beneficiary directly to the independent escrow agent. Within 3 business days after the date the escrow agent receives the documents, the provider shall pay or transfer the proceeds into an escrow or trust account maintained in a state or federally chartered financial institution whose deposits are insured by the Federal Deposit Insurance Corporation (FDIC). Upon payment of the settlement proceeds into the escrow account, the escrow agent shall deliver the original change in ownership, assignment or change in beneficiary forms to the viatical settlement provider or related provider trust. Upon the escrow agent's receipt of the acknowledgement, the escrow agent shall pay the settlement proceeds to the viator.

Failure to tender consideration to the viator for the contract within the time disclosed renders the contract voidable by the viator for lack of consideration until the time consideration is tendered and accepted by the viator.

STANDARDS
VIATICAL SETTLEMENT TRANSACTIONS

Standard 4
Post-settlement contacts with the insured made by the viatical settlement provider are in compliance with applicable statutes, rules and regulations.

Apply to: All viatical settlement providers and viatical settlement brokers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of viatical settlement contract files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Viatical Settlements Model Act (#697), Section 9G

Review Procedures and Criteria

Verify that contacts with the insured for the purpose of determining health status are

- Limited to no more than once every 3 months for insureds with a life expectancy of more than one 1 year; and
- Limited to no more than once per month for insureds with a life expectancy of 1 year or less.

Verify that the provider or broker has explained the procedure for making these contacts at the time the viatical settlement contract is entered into.

Verify that such contacts are logged for the purpose of documenting compliance with this provision.

Note: This information may not be available for some types of settlements.

STANDARDS
VIATICAL SETTLEMENT TRANSACTIONS

Standard 5
The viatical settlement provider does not engage in prohibited practices relating to the viatication of policies within the first 2-year period after issuance.

Apply to: All viatical settlement providers and viatical settlement brokers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of viatical settlement contract files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Viatical Settlements Model Act (#697), Section 4A

Review Procedures and Criteria

Verify that viatical settlement contracts were entered into within the guidelines of applicable statutes, rules and regulations.

Verify that proper documentation, submission of documentation that may be required and proper notification to individuals or entities has been provided as required by applicable statutes, rules and regulations for the effectuation of a viatical settlement transaction.

Verify that any assigning, transferring or pledging of any viaticated policies complies with applicable statutes, rules and regulations.

Refer to the supplemental checklist in Section L of this chapter for a list of transaction requirements.

Note: The examiner should review applicable statutes, rules and regulations to determine their state's prohibited practices.

STANDARDS
VIATICAL SETTLEMENT TRANSACTIONS

Standard 6
The viatical settlement provider demonstrates a pattern of reasonable payments to viators.

Apply to: All viatical settlement providers and viatical settlement brokers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of viatical settlement contract files

_____ Other materials relative to viatical settlement reimbursement guidelines

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Viatical Settlements Model Act (#697), Section 4
Viatical Settlements Model Regulation (#698), Sections 5 and 9

Review Procedures and Criteria

Review payments made to viators to determine whether payments are reasonable and fair.

Review documents to ensure that life expectancies are consistent with the requirements of applicable statutes, rules and regulations.

STANDARDS
VIATICAL SETTLEMENT TRANSACTIONS

Standard 7
Verify rescission period refund procedures and timeliness of refunds issued.

Apply to: All viatical settlement providers and viatical settlement brokers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ All requests for rescission by viators

_____ Rescission procedures and all completed rescission transactions

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Viatical Settlements Model Act (#697)
Viatical Settlements Model Regulation (#698)

Review Procedures and Criteria

Verify that rescission requests are handled in accordance with applicable statutes, rules and regulations.

STANDARDS
VIATICAL SETTLEMENT TRANSACTIONS

Standard 8
The viatical settlement provider obtains required documents prior to entering into a viatical settlement purchase agreement.

Apply to: All viatical settlement providers that do not hold 100% of the ownership and beneficiary interest in the policies it has viaticated or otherwise purchased

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of viatical settlement contract files (and viatical settlement purchase agreements related to the sample)

_____ Representative sample of viatical settlement purchase agreements (and viatical settlement contracts related to the sample)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Viatical Settlements Model Act (#697)
Viatical Settlements Model Regulation (#698)

Review Procedures and Criteria

Verify the following items:

- Investment agent licensure, if applicable, as required by respective state statutes;
- A policy exists for the viatical settlement purchase transaction;
- Beneficiaries and their status are included on policies in the sample;
- Proper and timely verification of coverage was received and documented; and
- Viatical settlement purchase agreements were properly documented and executed, including what ownership or beneficiary rights, if any, the viatical settlement purchaser has in the policies in the sample.

STANDARDS
VIATICAL SETTLEMENT TRANSACTIONS

Standard 9
The viatical settlement provider, or its representative, has procedures in place to document and resolve complaints from viators and viatical settlement purchasers.

Apply to: All viatical settlement providers and/or their representatives

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Insurance department complaint records

_____ Provider complaint files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation for Complaint Records to be Maintained Pursuant to the NAIC Unfair Trade Practices Act (#884)
Consumer Complaints White Paper

Review Procedures and Criteria

Ensure that the provider has procedures in place to document and resolve complaints from viators and viatical settlement purchasers.

STANDARDS
VIATICAL SETTLEMENT TRANSACTIONS

Standard 10
The viatical settlement provider has antifraud initiatives in place that are reasonably calculated to detect, prevent and report fraudulent insurance acts.

Apply to: All viatical settlement providers and/or their representatives

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Procedures and antifraud plans, where required, to be submitted to the insurance department for detection and reporting of suspected fraudulent activities

_____ Representative sample of viatical settlement contract files (and viatical settlement purchase agreements related to the sample)

_____ Representative sample of viatical settlement purchase agreements (and viatical settlement contracts related to the sample)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Insurance Fraud Prevention Model Act (#680)
Viatical Settlements Model Act (#697), Section 12

Review Procedures and Criteria

Review the provider's procedures to ensure that the licensee avoids transactions where the insurance policy was obtained by means of a false, deceptive or misleading application.

Review the provider's procedures to ensure compliance with fraud reporting, education and training requirements in the state where the viatical settlement occurred or where business is conducted. Antifraud initiatives shall include fraud investigators, who may be viatical settlement provider or broker employees or independent contractors.

Determine that antifraud plans are submitted to the insurance department, where required by applicable statutes, rules and regulations. Such plans shall include procedures for reporting possible fraudulent viatical settlement acts to the insurance department, a description of the plan for antifraud education and training, and a description or chart outlining organization arrangement of antifraud personnel responsible for investigation and reporting fraud. Antifraud plans shall be privileged and confidential.

A person in the business of viatical settlement shall not knowingly or intentionally permit any person convicted of a felony involving dishonesty or breach of trust to participate in the business of viatical settlements.

Viatical settlement contracts and purchase agreement forms shall include the following or substantially similar fraud warning statement:

> "Any person who knowingly presents false information in an application for insurance or viatical settlement contract or viatical settlement purchase agreement is guilty of a crime and may be subject to fines and confinement in prison."

Any person engaged in the business of viatical settlements having knowledge or reasonable belief that a fraudulent viatical settlement act is or will be committed must notify the insurance department.

J. Viatical Settlement Provider Marketing and Sales

1. Purpose

The marketing and sales portion of the examination is designed to evaluate the representations made by the company about its product(s). Examiners should review representations to ensure that viatical settlement providers and viatical settlement brokers provide prospective viators and purchasers with clear and unambiguous statements in advertisements. Guidelines for advertising viatical settlement contracts or purchase agreements include Internet and media advertising viewed by persons located in the examining department's state. The advertising review is not typically based on sampling techniques, but it can be. The areas to be considered in this kind of review include all written, visual and verbal advertising and sales materials.

2. Tests and Standards

The marketing and sales review includes, but is not limited to, the following standards addressing various aspects of the marketing and sales function. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
VIATICAL SETTLEMENT PROVIDER MARKETING AND SALES

Standard 1
The viatical settlement provider does not discriminate in the making or solicitation of viatical settlements.

Apply to: All viatical settlement providers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of viatical settlement contract files

_____ Representative sample of viatical settlement contracts declined

_____ Marketing and sales material

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Unfair Trade Practices Act (#880)
Viatical Settlements Model Regulation (#698), Section 7D

Review Procedures and Criteria

Determine whether the viatical settlement provider exhibits a pattern of discrimination in the making or solicitation of viatical settlement contracts on the basis of race, age, sex, national origin, creed, religion, occupation, marital or family status or sexual orientation.

Determine whether the viatical settlement provider exhibits a pattern of discrimination in the making or solicitation of viatical settlement contracts between viators with and without dependents.

STANDARDS
VIATICAL SETTLEMENT PROVIDER MARKETING AND SALES

Standard 2
The viatical settlement provider pays finder's fees, commission or other compensation in accordance with applicable statutes, rules and regulations.

Apply to: All viatical settlement providers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Commission or compensation records or reports

_____ Representative sample of viatical settlement contract files

_____ Other materials relative to the payment of commissions or other compensation paid to entities related to the viatical settlement transaction

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Viatical Settlements Model Regulation (#698), Section 7E

Review Procedures and Criteria

Determine if the viatical settlement provider pays any finder's fees, commission or other compensation to any insured's physician, or to an attorney, accountant or other person providing medical, legal or financial planning services to the viator, or to any other person acting as an agent of the viator with respect to the viatical settlement.

Note: This language as written, "any other person acting as an agent of the viator," includes the viatical settlement broker, because they are technically an agent of the viator and receive compensation.

STANDARDS
VIATICAL SETTLEMENT PROVIDER MARKETING AND SALES

Standard 3
The viatical settlement provider solicits viatical settlement purchasers in accordance with applicable statutes, rules and regulations.

Apply to: All viatical settlement providers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Marketing and solicitation materials

_____ Representative sample of viatical settlement contract files

_____ Other materials relative to the solicitation of viatical settlement purchasers

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Viatical Settlements Model Regulation (#698), Section F

Review Procedures and Criteria

Determine if the viatical settlement provider knowingly solicits viatical settlement purchasers who have treated, or have been asked to treat, the illness of the insured whose coverage would be the subject of the viatical settlement purchase.

STANDARDS
VIATICAL SETTLEMENT PROVIDER MARKETING AND SALES

Standard 4
The viatical settlement provider has an established system of control over the content, form and dissemination of all advertisements of its contracts, products and services.

Apply to: All viatical settlement providers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Advertising and solicitation materials

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Viatical Settlements Model Regulation (#698), Section 11B

Review Procedures and Criteria

Review advertisements to ensure that proper notification requirements and procedures for approval are provided to any person disseminating any advertisements on behalf of the licensee.

STANDARDS
VIATICAL SETTLEMENT PROVIDER MARKETING AND SALES

Standard 5
The viatical settlement provider advertises in accordance with applicable statutes, rules and regulations.

Apply to: All viatical settlement providers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Advertising and solicitation materials

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Unfair Trade Practices Act (#880)
Viatical Settlements Model Regulation (#698)

Review Procedures and Criteria

Determine if all advertising materials have been filed with the insurance department, if required by applicable statutes, rules and regulations.

Review all advertising and solicitation materials to determine if the material is truthful and not misleading by fact or implication.

Refer to the supplemental checklist in Section M for a list of marketing and sales requirements.

K. Supplemental Checklist for Viatical Settlement Contracts and Disclosures, Standard #2

Yes	No	Requirement
No later than at the time of application, the viatical settlement provider or the provider's representative shall disclose the following to the viator:		
		If the provider transfers ownership or changes the beneficiary of the insurance policy, the provider shall communicate the change of ownership or beneficiary to the insured within 20 days after the change.
		The viatical settlement purchase agreement is voidable by the purchaser at any time within 3 days after the disclosures mandated are received by the purchaser.
		Possible alternatives to viatical settlement contracts for individuals with catastrophic, life threatening or chronic illnesses, including any accelerated death benefits or policy loans offered under the viator's life insurance policy.
		Some or all of the proceeds may be taxable under federal income tax and state franchise and income taxes, and assistance should be sought from professional tax advisor.
		Proceeds of the viatical settlement could be subject to the claims of creditors.
		Receipt of the proceeds may adversely affect the viator's eligibility for Medicaid or other government benefits or entitlements, and advice should be obtained from the appropriate government agencies.
		The viator has the right to rescind a viatical settlement contract within 15 calendar days after receipt of the viatical settlement proceeds. If the insured dies during the rescission period, the settlement contract shall be deemed to have been rescinded, subject to repayment of all viatical settlement proceeds and any premiums, loans and loan interest to the viatical settlement provider or purchaser.
		Funds will be transferred to the viator within 3 business days after the viatical settlement provider has received the insurer or group administrator's acknowledgement that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated.
		Entering into a contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy or certificate, to be forfeited by the viator. Assistance should be sought from a financial advisor.
		Disclosure to a viator shall include distribution of a brochure describing the process of viatical settlements. The NAIC's form for the brochure shall be used, unless one has been developed by the insurance department.

Supplemental Checklist for Viatical Settlement Contracts and Disclosures, Standard #2 (cont'd)

Yes	No	Requirement
		The disclosure document shall contain the following language: "All medical, financial or personal information solicited or obtained by a viatical settlement provider or viatical settlement broker about an insured, including the insured's identity or the identity of family members, a spouse or a significant other may be disclosed as necessary to effect the viatical settlement between the viator and the viatical settlement provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years."
		The insured may be contacted by the viatical settlement provider or broker or its authorized representative for the purpose of determining the insured's health status. This contact is limited to once every 3 months if the insured has a life expectancy of more than 1 year, and no more than once per month if the insured has a life expectancy of 1 year or less.
Prior to the date the contract is signed by all parties, the viatical settlement provider or the provider representative shall disclose the following to the viator:		
		State the affiliation, if any, between the viatical settlement provider and the issuer of the insurance policy to be viaticated.
		The document shall include the name, address and telephone number of the viatical settlement provider.
		A viatical settlement broker shall disclose to a prospective viator the amount and method of calculating the broker's compensation. The term "compensation" includes anything of value paid or given to the viatical settlement broker for the placement of a policy.
		If an insurance policy to be viaticated has been issued as a joint policy or involves family riders or any coverage of a life other than the insured under the policy to be viaticated, the viator shall be informed of the possible loss of coverage on the other lives under the policy and shall be advised to consult with his or her insurance producer or the insurer issuing the policy for advice on the proposed viatical settlement.
		The dollar amount of the current death benefit payable to the viatical settlement provider under the policy or certificate. If known, the viatical settlement provider shall also disclose the availability of any additional guaranteed insurance benefits, the dollar amount of any accidental death and dismemberment benefits under the policy or certificate and the viatical settlement provider's interest in those benefits.

Supplemental Checklist for Viatical Settlement Contracts and Disclosures, Standard #2 (cont'd)

Yes	No	Requirement
		State the name, business address and telephone number of the independent third-party escrow agent, and the fact that the viator or owner may inspect or receive copies of the relevant escrow or trust agreements or documents.
A viatical settlement provider or its viatical settlement investment agent shall provide the viatical settlement purchaser with at least the following information prior to the date the agreement is signed by all parties:		
		The purchaser will receive no returns (i.e., dividends and interest) until the insured dies.
		The actual annual rate of return on a viatical settlement contract is dependent upon an accurate projection of the insured's life expectancy, and the actual date of the insured's death. An annual "guaranteed" rate of return is not determinable.
		The viaticated life insurance contract should not be considered a liquid purchase, because it is impossible to predict the exact timing of its maturity and the funds probably are not available until the death of the insured. There is no established secondary market for resale of these products by the purchaser.
		The purchaser may lose all benefits or may receive substantially reduced benefits if the insurer goes out of business during the term of the viatical investment.
		The purchaser is responsible for payment of the insurance premiums or other costs related to the policy, if required by the terms of the viatical purchase agreement. These payments may reduce the purchaser's return. If a party other than the purchaser is responsible for the payment, the name and address of that party shall also be disclosed.
		The purchaser is responsible for payment of the insurance premiums or other costs related to the policy if the insured returns to health. Disclose the amount of such premiums, if applicable.
		State the name and address of any person providing escrow services and the relationship to the broker.
		Disclose the amount of any trust fees or other expenses to be charged to the viatical settlement purchaser.
		State whether the purchaser is entitled to a refund of all or part of his or her investment under the settlement contract, if the policy is later determined to be null and void.

Supplemental Checklist for Viatical Settlement Contracts and Disclosures, Standard #2 (cont'd)

Yes	No	Requirement
		Disclose that group policies may contain limitations or caps in the conversion rights, additional premiums may have to be paid if the policy is converted, name the party responsible for the payment of the additional premiums and, if a group policy is terminated and replaced by another group policy, state that there may be no right to convert the original coverage.
		Disclose the risks associated with policy contestability, including, but not limited to, the risk that the purchaser will have no claim or only a partial claim to death benefits should the insurer rescind the policy within the contestability period.
		Disclose whether the purchaser will be the owner of the policy in addition to being the beneficiary, and if the purchaser is the beneficiary only and not also the owner, the special risks associated with that status, including, but not limited to, the risk that the beneficiary may be changed or the premium may not be paid.
		Describe the experience and qualifications of the person who determines the life expectancy of the insured (i.e., in-house staff, independent physicians and specialty firms that weigh medical and actuarial data), the information this projection is based on and the relationship of the projection-maker to the viatical settlement provider, if any.
		Distribute to investors a brochure describing the process of investment in viatical settlements. The NAIC's form for the brochure shall be used unless one has been developed by the insurance department.
A viatical settlement provider or its viatical settlement investment agent shall provide the viatical settlement purchaser with at least the following no later than at the time of the assignment, transfer or sale:		
		Disclose all the life expectancy certifications obtained by the provider in the process of determining the price paid to the seller.
		State whether premium payments or other costs related to the policy have been escrowed. If escrowed, state the date upon which the escrowed funds will be depleted and whether the purchaser will be responsible for payment of premiums thereafter and, if so, the amount of the premiums.
		State whether premium payments or other costs related to the policy have been waived. If waived, disclose whether the investor will be responsible for payment of the premiums if the insurer that wrote the policy terminates the waiver after purchase and the amount of those premiums.

Supplemental Checklist for Viatical Settlement Contracts and Disclosures Standard #2 (cont'd)

Yes	No	Requirement
		Disclose the type of policy offered or sold (i.e., whole life, term life, universal life or a group policy certificate), any additional benefits contained in the policy and the current status of the policy.
		If the policy is term insurance, disclose the special risks associated with term insurance, including, but not limited to, the purchaser's responsibility for additional premiums, if the viator continues the term policy at the end of the current term.
		State whether the policy is contestable.
		State whether the insurer that wrote the policy has any additional rights that could negatively affect or extinguish the purchaser's rights under the viatical settlement contract, what these rights are and under what conditions these rights are activated.
		State the name and address of the person responsible for monitoring the insured's condition. Describe how often the insured's condition is monitored, how the date of death is determined and how and when this information will be transmitted to the purchaser.

L. Supplemental Checklist for Viatical Settlement Transactions, Standard #5

Yes	No	Requirement
The viatical settlement provider or viatical settlement broker shall not enter into a viatical settlement contract within a 2 year period after issuance of a life insurance policy or certificate, unless the viator certifies that one or more of the following conditions have been met:		
		The policy was issued upon the viator's exercise of conversion rights arising out of a group or individual policy, provided the total of the time covered under the conversion policy plus the time covered under the prior policy is at least 24 months. The time covered under a group policy shall be calculated without regard to any change in insurance carriers, provided the coverage has been continuous and under the same group sponsorship.
		The viator is a charitable organization exempt from taxation under 26 USC §501(c)(3).
		The viator is not a natural person (e.g., the owner is a corporation, limited liability company, partnership, etc.).
		(1) The viator submits independent evidence to the viatical settlement provider that one or more of the following conditions have been met within the 2 year period:
		• The viator or insured is terminally or chronically ill;
		• The viator's spouse dies;
		• The viator divorces his or her spouse;
		• The viator retires from full-time employment;
		• The viator becomes physically or mentally disabled and a physician determines that the disability prevents the viator from maintaining full-time employment;
		• The viator was the insured's employer at the time the policy or certificate was issued and the employment relationship terminated;
		• A final order, judgment or decree is entered by a court of competent jurisdiction, on the application of a creditor of the viator, adjudicating the viator bankrupt or insolvent, or approving a receiver, trustee or liquidator for all or a substantial part of the viator's assets;
		• The viator experiences a significant decrease in income that is unexpected and that impairs the viator's reasonable ability to pay the policy premium; or
		• The viator or insured disposes of his or her ownership interests in a closely held corporation.

Supplemental Checklist for Viatical Settlement Transactions, Standard #5 (cont'd)

Yes	No	Requirement
		(2) Copies of the independent evidence described in (1) above and documents required by Section 9A of the model act shall be submitted to the insurer when the viatical settlement provider submits a request to the insurer for verification of coverage. The copies shall be accompanied by a letter of attestation from the viatical settlement provider that the copies are true and correct copies of the documents received by the viatical settlement provider.
		The viatical settlement provider shall submit to the insurer a copy of the owner or insured's certification described in (1) and (2) above when the provider submits a request to the insurer to effect the transfer of the policy or certificate to the viatical settlement provider, the copy shall be deemed to conclusively establish that the viatical settlement contract satisfied the requirements of this section, and the insurer shall timely respond to the request.

M. Supplemental Checklist for Viatical Settlement Provider Marketing and Sales, Standard #5

Yes	No	Requirement
Advertisements shall not make the following representations:		
		That viatical settlement contracts are "guaranteed," "fully secured," "100 percent secured," "fully insured," "secure," "safe," "backed by rated insurance companies," "backed by federal law," "backed by state law," "backed by state guaranty funds" or similar representations.
		That viatical settlement contracts are "no risk," "minimal risk," "no speculation," "no fluctuation" or similar representations.
		That viatical settlement contracts are "qualified or approved for individual retirement accounts" or otherwise qualified for other tax-deferred retirement-type accounts.
		That viatical settlement contract returns, principal, earnings, profit or investments are "guaranteed."
		That there are no sales charges or fees, or similar representations.
		That viatical settlement contracts provide "high yield," "superior return," "excellent return," "high return," "quick profit" or similar representations.
		Purport favorable representations or testimonials about the benefits of viatical settlement contracts or viatical settlement purchase agreements as an investment, taken out of context from newspapers, trade papers, journals, radio and TV programs, and all other forms of print and electronic media.

Supplemental Checklist for Viatical Settlement Provider Marketing and Sales, Standard #5 (cont'd)

Yes	No	Requirement
Verify that all advertising and solicitation material contains the disclosures required by applicable statutes, rules and regulations in a manner that is not minimized, obscure, ambiguous or misleading. An advertisement shall not:		
		Omit material information or use words, phrases, statements, references or illustrations if the omission or use has the capacity, tendency or effect of misleading or deceiving viators, purchasers or prospective purchasers as to the nature or extent of any benefit, loss covered, premium payable or state or federal tax consequence. "Free look" periods shall not remedy misleading statements.
		Use the name or title of a life insurance company or policy, unless the advertisement has been approved by the insurer.
		Represent that premium payments will not be required to be paid on the life insurance policy that is the subject of a viatical settlement contract or viatical settlement purchase agreement in order to maintain that policy, unless that is a fact.
		State or imply that interest charged on an accelerated death benefit or policy loan is unfair, inequitable or in any manner an incorrect or improper practice.
		Falsely use the words "free," "no cost," "without cost," "no additional cost," "at no extra cost" or words of similar import regarding any benefit or service. An advertisement may specify the charge for a benefit or service or may state that a charge is included in the payment or use other appropriate language.
		Contain statistical information, unless it accurately reflects recent and relevant facts. The source of all statistics used in an advertisement shall be identified.
		Disparage insurers, viatical settlement providers, viatical settlement brokers, viatical settlement investment agents, insurance producers, policies, services or methods of marketing.
		Fail to identify the name of the viatical settlement licensee, the contract form number and application and, if the application is part of the advertisement, identify the viatical settlement provider.
		Use a trade name, group designation, name or the parent company name of a viatical settlement licensee, service mark, slogan, symbol or other device or reference without disclosing the name of the viatical settlement licensee, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the viatical settlement licensee, or create the impression that a company other than the viatical settlement licensee would have any responsibility for the financial obligation under a viatical settlement contract or purchase agreement.
		Use any combination of words, symbols or physical materials that would mislead prospective viators or purchasers into believing that the solicitation is in some manner connected with a government program or agency.

Supplemental Checklist for Viatical Settlement Provider Marketing and Sales, Standard #5 (cont'd)

Yes	No	Requirement
		Imply that competing viatical settlement licensees may not be licensed. An advertisement may state that a viatical settlement licensee is licensed in the state where the advertisement appears or may ask the audience to consult its website or contact the state insurance department to check on licensing status.
		Create the impression that the viatical settlement provider, its financial condition or status, the payment of its claims or the merits, desirability or advisability of its contracts or purchase agreement forms are recommended or endorsed by any government entity.
		Directly or indirectly create the impression that any division or agency of the state or U.S. government endorses, approves or favors 1) any viatical settlement licensee or its practices or methods of operation; 2) the merits, desirability or advisability of any contract or purchase agreement; 3) any viatical settlement contract or purchase agreement; or 4) any life insurance policy or life insurance company.
		Emphasize the speed that the viatication will occur, unless the average time from completed application to the date of offer and from acceptance of the offer to receipt of the funds by the viator are disclosed.
		Emphasize the dollar amounts available to viators, unless the average purchase price as a percent of face value obtained by viators contracting with the licensee during the past 6 months is disclosed.

Chapter 32—Conducting the Premium Finance Company Examination

IMPORTANT NOTE:
The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in Chapter 1—Introduction.

This chapter provides a suggested format for conducting examinations of premium finance companies for state insurance departments that regulate such companies. The fundamental purpose of the examination of an insurance premium finance company is the determination of compliance with state statutes, rules and regulations governing premium financing transactions.

The scope of a premium finance company examination differs from that of an insurer. Premium finance companies finance insurance premiums, they do not provide insurance. The scope of examination, therefore, should be modified to reflect this difference. There are various market conduct areas that may be covered in an examination. These include, but are not limited to:

A. Operations/Management, including licensure
B. Complaint Handling
C. Marketing and Sales
D. Producer Licensing
E. Policyholder Service
F. Underwriting and Rating
G. Claims
H. Premium Finance Agreements
I. Borrower Complaints
J. Customer Service

When conducting an examination that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the company is meeting standards established by applicable statutes, rules and regulations. Some standards listed in this chapter may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.

When an examination involves a depository institution or their affiliates, the bank may also be regulated by federal agencies such as the Office of the Comptroller of the Currency (OCC), the Federal Reserve Board, the Office of Thrift Supervision (OTS) or the Federal Deposit Insurance Corporation (FDIC). Many states have executed an agreement to share complaint information with one or more of these federal agencies. If the examination results find adverse trends or a pattern of activities that may be of concern to a federal agency and there is an agreement to share information, it may be appropriate to notify the agency of the examination findings.

The content of the notice of examination is discussed in Chapter 16—Scheduling, Coordinating and Communication. In most instances, an examination notification and some form of pre-examination information request (coordinator's handbook, pre-examination packet or memorandum) will have been sent to the company prior to the start of the examination. The request is a listing of those items and information essential for the conduct and completion of the examination. The request should note that any exceptions to the items requested will be specified by the Examiner-in-Charge during the examination. The memorandum listing may include the following:

1. Computer access or listing of all active and paid out agreements during the time frame of the examination;
2. Computer access or listing of all agreements canceled during the time frame of the examination;
3. Insurance department complaint records;
4. Business operation forms used by the company during the time frame of the examination. These include:
    - Premium finance agreement with power-of-attorney;
    - Notice of premium finance agreement;
    - Notice of intent to cancel;
    - Notice of cancellation;
    - Reinstatement request; and
    - Any other forms or form letters used to communicate with insurers, borrowers or producers, as required by applicable statutes, rules and regulations.
5. Rate and adjustment schedules, as required by applicable statutes, rules and regulations;
6. Annual operations report, as required by applicable statutes, rules and regulations; and
7. Listing of agreements or contracts with other entities relating to the assignment, servicing, sale or purchase of premium finance agreements.

A. Operations/Management

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 1
Company does not pay any compensation to producers if such payment is prohibited by applicable statutes, rules and regulations.

Apply to: All premium finance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Company financial statement

_____ Producer files

_____ Disbursements to producer for non-premium items

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review insurance department complaint files.

B. Complaint Handling

Not applicable.

C. Marketing and Sales

Not applicable.

D. Producer Licensing

Not applicable.

E. Policyholder Service

Not applicable.

F. Underwriting and Rating

Not applicable.

G. Claims

Not applicable.

H. Premium Finance Agreements

1. Purpose

The premium finance agreements portion of the examination is designed to review the documentation of the principal product of the premium finance company. It is based on sampling techniques. It is concerned with individual application of the rules applying to its product rather than overall structure.

The review of premium finance agreements and account information enables determination of the company's compliance in several areas, including the following:

a. Acceptance of completed agreements;
b. Notification and funding;
c. Correct calculation of finance charges;
d. Financing of insurance products;
e. Proper cancellation procedures;
f. Correct calculation of unearned finance charges; and
g. Collection practices in regard to unearned premiums and commissions.

2. Techniques

Special attention should be directed toward the company's cancellation procedures. The use of correct forms, correct calculation of unearned interest, collection practices and prompt returns of any moneys due borrowers is essential for compliance.

3. Tests and Standards

The premium finance agreements review includes, but is not limited to, the following standards addressing various aspects of a company's use of the agreements. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
PREMIUM FINANCE AGREEMENTS

Standard 1
Company maintains individual account records in compliance with applicable statutes, rules and regulations.

Apply to: All premium finance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of premium finance agreements and related account records

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Ensure that the company maintains agreements as required by applicable statutes, rules and regulations.

Ensure that the company maintains completed agreements, which must contain power-of-attorney language and be signed by or on behalf of the borrower, or by the borrower, if required by applicable statutes, rules and regulations.

Ensure that the company maintains a copy of the power-of-attorney.

STANDARDS
PREMIUM FINANCE AGREEMENTS

Standard 2
Notification and funding procedures are in compliance with applicable statutes, rules and regulations.

Apply to: All premium finance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of premium finance agreements

_____ Notifications required by applicable statutes, rules and regulations

_____ Disbursement records

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine if wording used in notifications provides adequate notification.

Ensure the disbursement is in accordance with applicable statutes, rules and regulations.

STANDARDS
PREMIUM FINANCE AGREEMENTS

Standard 3
Products that the company is financing comply with applicable statutes, rules and regulations.

Apply to: All premium finance companies

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of premium finance agreements

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine whether the agreement distinguishes between primary coverage and add-on products.

Ensure that add-on products meet state-specific limitations and disclosures. Add-on products may include motor/travel clubs, auto medical supplementary plans, etc.

STANDARDS
PREMIUM FINANCE AGREEMENTS

Standard 4
Agency fees are not financed, if prohibited; or, if permitted to be financed, agency fees are properly disclosed, if required by applicable statutes, rules and regulations.

Apply to: All premium finance companies

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of all premium finance agreements

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine if premium finance agreements distinguish between premium for insurance coverage and producer fees or charges.

STANDARDS
PREMIUM FINANCE AGREEMENTS

Standard 5
The company uses the appropriate forms for premium finance agreements.

Apply to: All premium finance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of all premium finance agreements

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

If forms are subject to approval, ensure that the approved forms are used.

Ensure that the forms contain a clearly worded power-of-attorney.

Verify that the required disclosures are made on appropriate forms.

Verify that the forms include the premium finance company's address and telephone number, if required, and the producer's name.

If the forms are not subject to approval, ensure that the premium finance agreement complies with applicable statutes, rules and regulations.

STANDARDS
PREMIUM FINANCE AGREEMENTS

Standard 6
The company makes a diligent effort to obtain completed agreements.

Apply to: All premium finance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Sample of all premium finance agreements

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Ensure that the premium finance agreements contain no material blank spaces.

Verify that there is evidence the premium finance company sought correct information for any incomplete agreement.

STANDARDS
PREMIUM FINANCE AGREEMENTS

Standard 7
The company charges the correct finance charge. The interest rate charged complies with applicable statutes, rules and regulations.

Apply to: All premium finance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of all premium finance agreements

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine if the rate of interest charged is in compliance with applicable statutes, rules and regulations.

Confirm the finance charge calculation is correct.

STANDARDS
PREMIUM FINANCE AGREEMENTS

Standard 8
Notice of intent to cancel procedures is handled correctly, including the use of the proper forms.

Apply to: All premium finance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of premium finance agreements canceled during the time frame of the examination

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine if borrowers are provided the required period of notice of company intent to cancel for nonpayment of the loan.

STANDARDS
PREMIUM FINANCE AGREEMENTS

Standard 9
Notice of cancellation procedures are handled correctly, including the use of the proper forms.

Apply to: All premium finance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of premium finance agreements canceled during the time frame of the examination

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Notice of cancellation procedures can only be used if a premium finance company has been assigned the right to cancel by the borrower. Ensure that the premium finance company received such authorization in the premium finance agreement or otherwise.

Verify that the approved forms are used. If approval is not required, verify that appropriate forms are used.

STANDARDS
PREMIUM FINANCE AGREEMENTS

Standard 10
Insurer and producer returns of unearned premiums and commissions comply with applicable statutes, rules and regulations.

Apply to: All premium finance companies

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Sample of premium finance agreements canceled during the time frame of the examination

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine if insurer and producer returns are made in a timely manner to the premium finance company following cancellation for nonpayment of the loan.

Note: If it is determined that insurer and producer returns are not made in a timely manner to the premium finance company, it is not a violation by the premium finance company. The noncomplying insurers and producers should be reported to the Examiner-in-Charge for further investigation and examination into their refund practices.

STANDARDS
PREMIUM FINANCE AGREEMENTS

Standard 11
Unearned interest is calculated correctly.

Apply to: All premium finance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of premium finance agreements prepaid during the time frame of the examination

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine if the premium finance company's unearned interest calculations are in accordance with applicable statutes, rules and regulations.

STANDARDS
PREMIUM FINANCE AGREEMENTS

Standard 12
Refunds due borrowers are calculated accurately and paid in a timely manner.

Apply to: All premium finance companies

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of premium finance agreements prepaid during the time frame of the examination

_____ Disbursement logs or register or other evidence of payment of refund

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine the average time for disbursement of refunds.

Ensure that the reasons for delay are documented, and determine if the company has a standard for timeliness on refunds.

I. Borrower Complaints

1. Purpose

The borrower complaints portion of the examination is designed to evaluate company responsiveness to borrower complaints arising from its product. It is typically based on sampling techniques. The NAIC definition of "complaint" is "any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the state's insurance laws. An oral communication, which is subsequently converted to a written form, would meet the definition of a complaint for this purpose."

2. Techniques

The examiner should review the company's procedures for processing borrower or other related complaints. Specific problem areas may necessitate an overall review of a particular segment of the company's operation.

A review of complaint handling may incorporate both borrower direct complaints to the company and complaints filed with the insurance department. A random sample of complaints should be selected for review from the company's complaint register. If such a register is not maintained, alternative methods of isolating complaints may be implemented.

The examiner should review the frequency of similar complaints and be aware of any pattern of specific type of complaints. The examiner should take into consideration the increase of complaints that typically follows a catastrophe. Should the type of complaints generated be cause for unusual concern, specific measures should be instituted to investigate other areas of the company's operations. This may include modifying the scope of examination to examine specific company behavior.

The examiner should review the NAIC Complaints Database System (CDS) to determine the company's complaint index, along with any adverse trends in complaint volume. The examiner may wish to review complaint trends and the complaint index for the preceding 3 years.

The examiner should review the final disposition of the complaints and determine if the company has taken adequate steps to finalize the complaint. The examiner should determine if the actions taken are in compliance with applicable statutes, rules and regulations.

In states that have established a statutory or regulatory standard of promptness, a study should be conducted to determine how promptly the company responds to complaints, the adequacy of the responses and what, if any, actions were taken to resolve the problems.

If the examination involves a depository institution or their affiliates, it may also be regulated by a federal agency such as the Office of the Comptroller of the Currency (OCC), the Federal Reserve Board, the Office of Thrift Supervision (OTS) or the Federal Deposit Insurance Corporation (FDIC). If the state has signed an agreement to share complaint information with these agencies, any adverse trends or pattern of concern to the examiners may be identified and relayed to the agency.

3. Tests and Standards

The complaints review includes, but is not limited to, the following standards addressing various aspects of a company's handling of complaints. The sequence of the standards listed here does not indicate priority of the standards.

STANDARDS
BORROWER COMPLAINTS

Standard 1
The company responds to inquiries from the insurance department appropriately and in a timely manner.

Apply to: All premium finance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Borrower complaint registers, files and logs or other complaint records

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine if the company responds to the insurance department within the time frame required by applicable statutes, rules and regulations.

Determine if any directives from the insurance department have been followed and completed as required.

Reconcile the company complaint register with a list of complaints from the insurance department.

STANDARDS
BORROWER COMPLAINTS

Standard 2
The company complaint files demonstrate fair treatment of borrowers.

Apply to: All premium finance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Borrower complaint files and complaint logs

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Ensure that the company is maintaining adequate documentation. Review borrower complaint files and complaint logs to make sure the company is:

- Recording all complaints (both borrower-direct and insurance department); and
- Recording required information in the company complaint register.

Review manuals to verify complaint procedures exist. Ensure that the procedures in place are sufficient to require satisfactory handling of complaints received, as well as internal procedures for analysis by the areas of the company that handle complaints.

Determine if there is a method for the distribution of and the obtaining and recording of responses to complaints. This method should be sufficient to allow a response within the time frame required by applicable statues, rules and regulations.

Determine if the company responds in the time frame required by applicable statutes, rules and regulations.

Ensure that the company provides a telephone number and address for borrower inquiries.

Review complaint documentation to determine if the company's response fully addresses the issues raised. If the company did not properly address/resolve the complaint, the examiner should ask the company what corrective action it intends to take.

J. Customer Service

1. Purpose

The customer service portion of the examination is designed to test a company's compliance with applicable statutes, rules and regulations regarding notice/billing, delays/no response, cancellation and refunds.

2. Techniques

Customer service departments vary from company to company. It is important to check with the examination coordinator to determine where the borrower service function lies and then apply the following tests to determine the effectiveness of the unit.

3. Tests and Standards

The customer service review includes, but is not limited to, the following standards related to the adequacy and level of customer service provided by the company. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
CUSTOMER SERVICE

Standard 1
Reinstatement request is applied consistently and in accordance with premium finance agreement provisions.

Apply to: All premium finance companies

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Premium finance agreement files

_____ Notice of reinstatement

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Verify that the notice was sent out in a timely manner, if required by applicable statutes, rules and regulations.

Reinstatement should be applied per the premium finance agreement provisions, if any.

STANDARDS
CUSTOMER SERVICE

Standard 2
Procedures for handling unclaimed property are proper.

Apply to: All premium finance companies

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Premium finance agreement files

_____ Unpaid payees of returned refund checks

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine if the company has a proper procedure that handles unclaimed property.