MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

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Draft: 9/30/09

Market Regulation and Consumer Affairs (D) Committee
Washington, DC
September 24, 2009

The Market Regulation and Consumer Affairs (D) Committee met in a joint session with the Health Insurance and Managed Care (B) Committee in Washington, DC, Sept. 24, 2009.

The following D Committee members participated: Kim Holland, Chair (OK); Ralph S. Tyler, III, Vice Chair (MD); Jay Bradford represented by Joe Musgrove (AR); Sharon P. Clark (KY); Adam Hamm (ND); Wayne Goodwin represented by Ernest Nickerson and Lois Belo (NC); Neil N. Jasey represented by Anne Marie Narcini (NJ); Scott J. Kipper (NV); Mary Jo Hudson represented by Lynette Baker, Jo LeDuc, Anne Jewel and Guenther Ruch (OH); Mike Kreidler (WA); Sean Dilweg, Sue Ezalarab and Eileen Mallow (WI); and Ken Vines represented by Linda Johnson (WY). Also participating were: Rosanne Mead (IA); Ted Clark (KS); John Huff (MO); Bruce Ramge (NE); and Leslie Krier (WA).

The following B Committee members participated: Sandy Praeger, Chair (KS); Joel Ario, Vice Chair (PA); Marcy Morrison represented by Peg Brown (CO); Kevin McCarty represented by Mary Beth Senkewicz (FL); Michael T. McRaith represented by Bill McAndrew (IL); Morris J. Chavez (NM); Kent Michie represented by Suzette Green-Wright and Tanji Northrup (UT); Paulette Thabault (VT); and Jane L. Cline represented by Bill Kenny (WV). Also participating were: Linda Hall (AK); Steve Ostlund (AL); Linda Nemes (DE); Teresa Miller (OR); Chris Koller (RI); and Don Beatty (VA).

1. Public Hearing on Usual Customary and Reasonable Rates

Commissioner Holland explained that the B Committee and D Committee joint public hearing would focus on how usual, customary and reasonable (UCR) rates, including the issue of balance billing, are determined and disclosed to consumers.

- Testimony of America's Health Insurance Plans

Marty Mitchell (America's Health Insurance Plans—AHIP) said protecting consumers from runaway charges billed by some providers who decline to participate in provider networks is an important responsibility. A new report released by AHIP shows that some physicians who do not participate in networks are charging fees that are several hundred percent—and in some cases, several thousand percent—of the Medicare reimbursement rate for the same service in the same geographic area. For example, in one state, a physician billed a patient $6,791 for "cataract surgery with insertion of artificial lens"—more than 1,100% of the Medicare fee of $581. Mr. Mitchell said that despite glaring examples of excessive charges by out-of-network providers, recent public discussions regarding out-of-network services and UCR determinations have focused only on how much insurers pay, without addressing the critical issue of how much patients are charged by out-of-network providers.

Mr. Mitchell said research by the Dartmouth Institute for Health Policy and Clinical Practice has shown that spending more on health care does not necessarily equate to better quality; rather, the opposite is true. He said one tool that health insurance plans use to improve quality and control costs is the establishment of provider networks. Through contracting with credentialed providers, health plans and payers create networks that provide consumers with lower-cost, high-quality care. Nevertheless, Mr. Mitchell said, the majority of private health insurance plans offer consumers the choice of obtaining care from a network of contracted physicians, hospitals and other health care professionals or receiving care from out-of-network physicians, hospitals, and other providers.

Mr. Mitchell said consumers see measureable savings if they see a contracted provider. The in-network provider is prohibited, by contract with the health plan and often by law, from charging the patient the difference between the billed charge and the payment negotiated under the contract with the health plan (in other words, prohibited from what is commonly referred to as balance billing). He said if the consumer receives services from an in-network provider, the deductible, coinsurance and co-payment obligations are typically lower than if the services are received from an out-of-network provider. He said that by providing access to high-quality provider networks at substantially discounted rates, health insurance plans save consumers billions of dollars each year in out-of-pocket costs and premiums.

Mr. Mitchell said the establishment of networks also offers tangible benefits to participating providers, with the overwhelming majority of physicians and hospitals in the United States participating in provider networks. Specifically, by participating in networks and agreeing to provide services at negotiated rates, providers and facilities obtain direct claims payment from the health plan or payer, plus an increase in patient volume.

Mr. Mitchell said the issue of what constitutes a UCR payment arises when out-of-network providers seek reimbursement for covered services under a network-based health insurance plan. Mr. Mitchell said out-of-network providers and facilities are free to charge whatever fee they choose and, without a contract or law that establishes the amount to be paid, an approach or system is needed to determine how out-of-network providers will be compensated for covered services.

Mr. Mitchell said a common approach for calculating the payment to out-of-network providers involves a determination of the "usual, customary and reasonable" amount, or UCR amount. Most approaches use a compilation and statistical analysis of provider charge data for identical or similar services in a certain geographic area to determine a UCR amount. The health plan or payer then selects the amount, usually expressed as a percentile (e.g., 75th percentile), that it will consider as the covered charge from out-of-network providers. In other words, if the 75th percentile is used, the amount deemed eligible for payment will be equal to or greater than the amount billed for that procedure by 75% of the providers in the area.

Mr. Mitchell said there are several databases available for health plans to use to determine their UCR reimbursement rates. In addition, several states—such as Massachusetts, New Jersey and Vermont—set a minimum UCR rate by reference to a specific database that must be paid to out-of-network providers for covered services by a health plan, the state employee plan, and/or a state guaranty fund. Some health plans and payers engage in a similar analysis, but compile information using charge data from their own claims.

Mr. Mitchell said another methodology uses a reimbursement schedule that may be fixed, such as no more than $500 per hospital bed day or $100 for an office visit. Mr. Mitchell said another approach reimburses out-of-network providers based on a percentage of the Medicare published rate for the same or similar service in a specific geographic area, such as 150% of the Medicare published rate.

Mr. Mitchell said that when a health plan or payer offers coverage for services received out-of-network, consumers may choose to receive covered services from out-of-network providers and facilities. To encourage utilization of in-network providers, consumers who go outside the network to receive covered services will likely be subject to higher deductible, coinsurance, and/or co-payment obligations. In addition, when services are provided out-of-network, the consumer is responsible and can be billed by the provider or facility for any amounts not paid by the health insurance plan, payer or public program.

Mr. Mitchell said there are many reasons a consumer may choose to receive services outside their network. He said AHIP believes that disclosure is a critical part of any solution to afford consumers the opportunity to determine what their out-of-pocket costs will be prior to services being rendered by an out-of-network provider.

Mr. Mitchell said it is also important that policy solutions on this issue encourage the development of networks. In addition, he urged the study of the amounts charged by providers and facilities for services before any policy solutions are adopted, particularly since high charges are not proxies for high-quality care.

- Testimony of American Medical Association

Dr. Robert Wah (American Medical Assocation—AMA) said patients do not receive the value of the out-of-network access that they pay for when they purchase health insurance. He said the AMA believes there must be greater transparency relating to out-of-network health benefit coverage. He said the AMA has developed a 2010 state legislative campaign focused on this issue.

Dr. Wah said the most significant problems are the following: (1) consumers not receiving the benefit of higher premiums they are charged for insurance products offering out-of-network coverage; (2) insufficient payments by health insurers for out-of-network services unfairly burdening patients; (3) a lack of clear and comprehensive information regarding contracted networks and out-of-network policies; and (4) inadequate provider networks to meet the needs of enrollees.

Dr. Wah said the AMA is working proactively on these issues, and their solution would require that health insurers comply with the following: (1) pay out-of-network benefits at the level they have promised; (2) clearly disclose the scope and limitations of any out-of-network benefit they provide in language that is meaningful to the average patient; (3) charge premiums that reasonably reflect the actuarial value of the out-of-network benefit provided; (4) maintain a network of contracted physicians and other health care providers that is sufficiently robust and transparent, so patients go out-of-network only when they choose to do so; (5) provide accurate, comprehensive information about contracted physicians in provider directories; and (6) require that health insurers recognize valid assignment of benefits.

Dr. Wah said the AMA's approach to addressing the problems in this area of the health care market are guided by the following principles: (1) transparency of information is critical to improving patients' situations; (2) insurance products with out-of-network options must not provide an illusory benefit; (3) fair and transparent out-of-network claims payment and adjudication will help address the problem; (4) underpayment for out-of-network charges unfairly shifts costs to patients; (5) patients must have access to information about providers' contractual status and charges; (6) provider network adequacy must be certified in order to avoid undue reliance on out-of-network providers by patients in need of care; and (7) provider directories must be accurate and comprehensive.

Commissioner Ario asked what the AMA's solution is for those situations in which a person obtains service through an in-network facility but is seen by an out-of-network physician. Dr. Wah explained that the insurer needs a better network of physicians. In addition, Dr. Wah said insurance regulators need to understand why physicians may choose not to join a particular network.

Commissioner Praeger asked about the incentive of physicians to provide more care as opposed to quality care. Dr. Wah said the AMA is focused on ensuring quality care and has worked to establish best practices for the delivery of care.

- Testimony of Ellen Kuhn, Maryland Assistant Attorney General

Ms. Kuhn said consumers do not complain about UCR issues because they do not know what UCR is. She said consumers complain about balance billing. The Maryland Attorney General's office received 138 complaints involving inappropriate billing in 2008. She said balance billing is when the consumer is liable to the provider for the difference between the amount charged by the provider for a service and the portion of the allowed amount paid by the carrier for that service. She explained that the average consumer believes that when they are balance billed, they are liable to a provider for the difference between what the carrier lists on the explanation of benefits as the allowed amount and the amount the carrier actually paid.

Ms. Kuhn explained that consumers are further confused by the language of insurance plan summaries. For example, one plan summary stated on page 26 that "for PPO out-of-network services, the plan pays 80% of allowed benefit after deductible." The definition of "allowed benefit" was found on page 76 as "the maximum fee a health plan will pay for a covered service or treatment."

Ms. Kuhn said most consumers try to stay within their network; however, consumers lack control or information in certain in-patient situations. For example, if a consumer is admitted to a hospital from an emergency room, the consumer generally is not able to control whether the hospital and/or providers are participating. She said even when consumers are scheduled to go into a hospital setting, many assume that all of the providers work for the hospital. She said even when a consumer knows that not all of the providers are participating, the consumer often does not get to choose a participating provider in the hospital. And, even when consumers try to check, they may not be able to get the information.

Ms. Kuhn said the feeling of most consumers that she hears from is that they are paying what they consider to be ever-increasing premiums along with greater co-payments, coinsurance and deductibles. So, to then receive a balance bill, particularly in the emergency room and hospital setting, is very upsetting to them. She said this is the case because consumers do not understand balance billing, and because they have little or no control to avoid such a situation.

Ms. Kuhn said balance billing prohibitions stop providers from billing consumers. She said Maryland passed these provisions but apply them only to HMO members. PPO members are not covered by the law and are still liable for balances owed to providers. She said a balance billing prohibition is not popular among providers. Maryland law also provides a protection for HMO members who must receive service from an out-of-network provider, either because the HMO does not have a provider in the consumer's area or the only specialist available is out-of-network. Under such circumstances, the law provides that the out-of-network provider shall be treated as a participating provider to the consumer. This means the consumer pays only the applicable co-payment/coinsurance/deductible and cannot be balance billed. At the same time, the provider is paid an enhanced fee, which is more than the carrier's participating fee but less than billed charges.

Ms. Kuhn said the NAIC should consider the following issues: (1) how to calculate appropriate reimbursement of providers who treat out-of-network HMO patients; (2) should balance billing prohibitions extend to PPO consumers in emergency room and hospital settings; and (3) should balance billing prohibitions extend to PPO consumers in all settings?

- Testimony of Bonita Kallestad (Mid-Minnesota Legal Assistance)

Ms. Kallestad provided an example of how a family with health insurance found out that their newborn child had a rare heart defect and needed surgery shortly after his birth. Even though treatment was provided at an in-network facility, the surgeon

was an out-of-network physician. Today, the family owes more than $40,000 to the service provider, on top of the $900 per month they pay for insurance premiums. Ms. Kallestad said consumers who have health insurance and are paying premiums can find themselves subject to additional expenses and are not aware this could occur.

- Testimony of Kevin Lucia (Georgetown University)

Mr. Lucia provided an overview of how balance billing practices occur, how often it occurs and state restrictions on it. He said few states have passed laws protecting patients from balance billing by out-of-network providers. He said the fundamental conflict is how to protect consumers while establishing a clear means of determining a payment level appropriate for both the insurer and the provider.

Commissioner Kreidler said consumers need to know what charge they will incur at the time a procedure is ordered and not after the procedure or when the consumer is checking into a facility for a procedure.

Ms. Jewel asked about those situations where a provider does not contact an insurer. Dr. Wah said this occurs when an insurer's reimbursement rates are too low, there is a history of late payments from the insurer to the provider, or the insurer has a very complicated contract structure. Dr. Wah said consumers do expect an insurer's network to be adequate. Ms. Jewel said the lack of providers within a network is a particular problem when a specific specialist is exclusive to a certain geographic area.

Commissioner Praeger recognized the most recent AHIP study, "The Value of Provider Networks and the Role of Out-Of-Network Charges in Rising Health Care Costs: A Survey of Charges Billed by Out-Of-Network Physicians" and suggested AHIP should study and compare the in-network charges for care and the out-of-network charges for care.

Commissioner Holland concluded the hearing by obtaining AHIP's and AMA's commitment to work with state insurance regulators to help resolve the issues discussed.

2. Market Regulation and Consumer Affairs Committee's Strategic Planning

Commissioner Holland said the Committee met in Kansas City in July to review its strategic plan. She said the purpose of the session was to ensure progress and continuity. She said Committee members were passionate about market regulation and wanted it to have significant meaning to consumers, but some of the current processes and regulatory structure were not adequately supporting efforts to protect consumers.

Commissioner Holland said the NAIC had established a vision for market regulation reform in 2003, which called for state insurance regulators to focus on the areas of (1) Market Analysis, (2) Uniformity, and (3) Interstate Collaboration. She said several of the goals tied to the three areas needed to be changed, as they were functionally impractical. She said it has become clear that because market regulation and financial regulation are not the same, some of the processes that work for financial regulation do not work for market regulation. She said the evolution of market regulation is not a single-year endeavor.

Commissioner Holland said the Committee had agreed to retain the Market Analysis goal that "Each state will have a formal and rigorous market analysis program that provides consistent and routine reports on general market problems and companies that may be operating outside general industry norms." However, the Committee had agreed to delete the goal that "Each state will produce a standardized market regulatory profile for each nationally significant domestic company." She said the Committee had changed the goal that "Each state will adopt uniform market analysis standards and procedures and integrate market analysis with other key market regulatory functions," to read "Each state will adopt minimum market analysis standards and procedures and integrate market analysis with other key regulatory functions within each department."

Commissioner Holland said the scope of market analysis was inadequate. She said states need to shift their focus from company-specific to general market conditions and from specific state issues to regional and national. She said it was clear that the current market analysis tools need evaluation and upgrades, and that standards and accountabilities must be established to ensure that states have a "formal and rigorous market analysis program."

Commissioner Holland said the next steps regarding the Market Analysis goals were for the Committee to (1) clarify the definition of a "formal and rigorous market analysis program"; and (2) develop standards, processes, procedures and best practices to ensure that (a) states expand their focus on company-specific issues to general market problems, (b) market analysis is completed at both the company and group level, and (c) market analysis is completed on a state, regional and national basis.

Commissioner Holland said the Committee had agreed to retain the Market Conduct goal that "Each state will implement uniform market conduct examination procedures that leverage the use of automated examination techniques and uniform data calls." However, the Committee had agreed to change the goal that "States will implement uniform training and certification standards for all market regulatory personnel, especially market analysts and market conduct examiners," to read "States will implement minimum training and certification standards for all market regulatory personnel, especially market analysts and market conduct examiners." She said the Committee had agreed to delete the goal that "The Market Actions (D) Working Group (MAWG) will provide the expertise and guidance to ensure the viability of uniform market regulatory oversight while preserving local control over matters that directly affect consumers within each state," as it was functionally impractical. She said Market Conduct's uniform standards, processes and applications need development and improvement to be reliable; intrastate communication needs improvement; and enhanced training and certification is necessary.

Commissioner Holland said the next steps regarding the Market Conduct goals were for the Committee to (1) develop minimum standards for market regulation that all states should follow; (2) explore the possibility of including the review of producer activity in market analysis; (3) develop a certification program for state regulation staff; and (4) coordinate with Financial Condition (E) Committee to ensure effective assessment and monitoring of the internal controls of companies.

Commissioner Holland said the Committee had agreed to delete the last sentence in the Interstate Collaboration goal that says, "The implementation of uniform standards and enhanced training will create a regulatory system in which states have the confidence to rely on each other's regulatory efforts. This reliance will create a market regulatory system of greater domestic deference." She said the Committee agreed to delete the goals that "Each state will monitor its nationally significant domestic companies on an ongoing basis, including market analysis and appropriate follow-up to address any identified problems"; and "Market conduct examinations of nationally significant companies performed by a non-domestic state will be eliminated unless there is a specific reason that requires a targeted market conduct examination," as they were both found to be impractical. Commissioner Holland said the Committee agreed to change the goal that "The MAWG will assist states to identify market activities that have a national impact and provide guidance to ensure that appropriate regulatory action is being taken. This peer review process will become a fundamental and essential part of the NAIC market regulatory system," to "The MAWG will assist states to identify market activities that have a multi-jurisdictional impact and provide guidance to ensure that appropriate regulatory action is being taken," as the last sentence of the original goal had proven to be functionally impractical.

Commissioner Holland said the next steps regarding the Interstate Collaboration goals were for the Committee to (1) revamp MAWG to address concerns that MAWG is not proactive, does not receive an adequate number of referrals, and takes too long to resolve issues; (2) emphasize market analysis over examinations; (3) implement improved intrastate communication processes and tools to enhance awareness of regulatory activities; and (4) determine the scope of domestic state responsibility versus the assumption of domestic deference.

Commissioner Holland said the Committee's goals were to promote greater emphasis on market analysis instead of examinations; facilitate additional and better data collection; fully implement the Market Conduct Annual Statement; develop and implement an Accreditation Program; and create a system of continual improvement for tools and processes.

Commissioner Holland said the Committee's Strategic Planning Session indicated that there is a general need to re-evaluate the current market systems, and that development and modifications need to be based on broad regulator support. She said there were also concerns over sufficient NAIC resources to respond adequately to regulators' requests for system updates and modifications.

3. Current Activities Regarding the Market Conduct Annual Statement (MCAS)

Commissioner Holland said a survey had been conducted of the states who were currently participating in the Market Conduct Annual Statement. She said a survey also had been developed by Deidre Manna (Property Casualty Insurers Association of America—PCI) and Lee Wood (Prudential), which they would distribute to insurance companies regarding the difficulties in obtaining the information required for the Market Conduct Annual Statement.

Ms. LeDuc said surveys had been received from the majority of states that participated in the Market Conduct Annual Statement project for more than one year. She said that, given the large amount of data received and the lack of time to perform a detailed review, she and Ms. Baker would give only a high-level overview of the findings.

Ms. LeDuc said the Property and Casualty MCAS is composed of two lines of business—private passenger automobile and homeowners. She said that for each of the lines, seven standard ratios are calculated. For each of the standard ratios, states were asked if they used the ratio in their market analysis. She said the survey results clearly show that an overwhelming

number of states are using the ratios in their market analysis programs. She said a majority of states reported that the ratios were either useful or essential, and an overwhelming majority of states using the ratios also indicated that they had no concerns with how they were calculated. She said most states also felt the level of detail provided with each ratio was the appropriate amount. She said states were also asked if any of the ratios helped them identify a market-based or company-specific problem that required action; most states had not identified a problem, though several states did. She said more than half of the states indicated that they would not have been able to identify at least one problem from sources if they had not been utilizing MCAS. She said states also indicated that they use the information for their prioritization of examinations and market analysis efforts.

Ms. Baker said the Life and Annuity MCAS survey had been organized by the five schedules and included the same questions for each of the seven ratios. She said the majority of the states said they used the ratios in their analysis. She said the only ratio that had a lower percentage of states using it was Ratio 4, which is the number of policy loans with loan balances greater than 25% compared to the number of policies in force. She said the majority of states indicated that the ratios were either useful or essential, and very few indicated any problems with either the calculation of the ratios or the amount of detail. She said the survey indicated that a number of states have used the ratios to confirm that there was not a problem, in particular with the replacements, surrenders, and claims-paid ratios. She said that except for Ratio 4, the survey indicated that the ratios were being used extensively by the states.

Commissioner Holland said she observed from the survey that the MCAS data elements and ratios may not be indicative of a problem in and of themselves, but do help market regulators to use their resources more efficiently by pointing them in a direction of potential concern. She said the results show that some of the ratios need to be enhanced to be more useful, additional ratios need to be added, and new ratios can be developed based on the data elements already being collected.

Birny Birnbaum (Center for Economic Justice—CEJ) said that when the MCAS data elements were selected, they were only supposed to indicate that a problem already existed. He said the data elements should be expanded so that regulators might better target and identify issues that had not previously been identified.

Ms. Narcini said she encouraged a detailed review of the survey responses, as she believed they would indicate additional areas where training should occur for regulators.

Mr. Birnbaum asked why more states had not participated in the MCAS Project. Ms. LeDuc said she believed it was due to lack of resources instead of lack of interest. Commissioner Holland said all states would be required to participate in future years.

Ms. Wood said industry representatives were eager to see if other data elements, which might be easier for companies to collect, may be used in lieu of some of the data elements currently being collected.

Commissioner Holland said the Market Analysis Procedures Working Group would continue to look at the possible collection of new data elements.

Kelly Ireland (American Counsel of Life Insurers—ACLI) asked about the status of the project to centralize the collection and analysis of the MCAS data at the NAIC.

Tim Mullen (NAIC) said all of the states that had collected the 2008 data had submitted the data to NAIC staff for collection and analysis. He said the NAIC had entered into confidentiality agreements with each of the states; the data had been transmitted in an encrypted manner; and only limited NAIC staff had access to the data. He said they were in the process of reviewing the data for inconsistencies.

Mr. Mullen said a Business Fiscal Impact Statement had been prepared for inclusion in the proposed 2010 budget. He said it allowed for the hiring of an additional individual to work with the data, plus the development of an automated system for collecting the data. He said the new states needed to notify the companies writing in their state that they may need to hire additional resources to analyze the data, but that states should not be required to do any additional programming.

Ms. Ireland said she was concerned about the proposed May 1 collection deadline for all statement types, as it would present a burden for many carriers. Ms. Baker said it was important for analysts to get the information as soon as possible. Mr. Birnbaum said states should get the data sooner rather than later. Mr. Mullen said the collection date was flexible for the automated system. Commissioner Holland said she would be willing to discuss the matter as the system was developed.

4. Appointment of Market Information System Task Force

Commissioner Holland said she was appointing a Market Information Systems Task Force to prioritize and provide oversight for all market systems modifications and enhancements. She said the Task Force would be responsible for the oversight of the automation of MCAS and evaluating the current market analysis tools for effectiveness. She said Director Huff had agreed to chair the Task Force.

5. Discussion of the Public Hearing Regarding the Use of "Usual, Customary and Reasonable" in the Reimbursement of Medical Expenses

Commissioner Holland said the Committee, in conjunction with the Health Insurance and Managed Care (B) Committee, had conducted a public hearing regarding the use of "Usual, Customary and Reasonable" in the reimbursement of medical expenses. She said the hearing was both balanced and informative, and highlighted the need for additional work to be accomplished.

6. Discussion of the Public Hearing Regarding the Use of Credit-Based Insurance Scores

Commissioner Holland said the Committee, in conjunction with the Property and Casualty Insurance (C) Committee, had conducted a public hearing regarding the use of credit-based insurance scores in the underwriting and rating of property and casualty insurance. She said it was clear additional work needed to be done regarding the use of credit-based insurance scores.

7. Adoption of the 2010 Working Group Charges

Commissioner Holland said she wanted to defer the adoption of the 2010 charges until a later date.

Mr. Birnbaum suggested that the charges include one for a working group to develop a best practices document for the consumer disclosures, since many of the disclosures being developed are inadequate. Bonita Kallestad (Mid-Minnesota Legal Assistance) also requested the addition of a charge regarding the development of best practices for consumer disclosures.

Mr. Belo said the Consumer Connections Working Group had decided to look at the readability of consumer disclosures. Ms. LeDuc said Wisconsin had a focus group reviewing consumer disclosures. Commissioner Holland said it would be a good charge to add. Commissioner Tyler suggested the charge include a review of when consumer disclosures should be used.

8. Consider Adoption of Working Group Reports

Commissioner Tyler stated that the Special Accreditation Standards Working Group met Sept. 22 (Attachment One) and discussed the draft accreditation proposal. He said the discussion focused on how the draft could be enhanced to ensure that the outputs required for effective market regulation could be properly measured, and the Working Group agreed to extend the comment deadline so additional feedback could be collected. He said a revised draft, based on the discussion and comments received, would then be distributed for comment.

Ms. Krier stated that the Market Analysis Procedures Working Group had met several times since the Summer National Meeting. She said the Working Group had adopted changes to the Minimum Level 1 Analysis requirements for the states (Attachment Two). She said the number of analyses is now going to be measured on a calendar-year basis, and the analyses must use the most current market and financial data available at the time of the analysis.

Mr. Belo said the Consumer Connections Working Group had discussed the autism coverage and mandates survey and decided that future versions of the survey be made public, after the states had an opportunity to revise their responses. He said the Working Group suggested they refer the Insurance Consumer Affairs Exchange (ICAE) Complaint Data Analysis Position Paper to the Special Accreditation Standards Working Group and the Committee for consideration. He said the Working Group had discussed next steps based on the results of the complaint reconciliation survey (Attachment Three).

Mr. Ramge said the Market Conduct Examination Standards Working Group had adopted many new standards and was on track to do more by the end of the year. He said discussions regarding risk-based examinations will likely carry over to the 2010 charges (Attachment Four).

Ms. Mead said the Market Actions Working Group had conducted a survey of Collaborative Action Designees (CADs). She said the results were being reviewed, and changes would likely occur based on the results of the survey. She said the

Working Group had also been conducting its own strategic planning to ensure that it had a vision for where it wanted to be in five years.

Commissioner Tyler made a motion to adopt the reports. Commissioner Hamm seconded the motion. There was no additional discussion, and the reports were unanimously adopted.

9. Any Other Matters

Commissioner Holland said that in line with her strategic direction, two new education programs would be conducted in 2010 by NAIC staff. She said the courses will focus on the Cost of Compliance and Market Conduct Examination Standards.

Having no further business, the Market Regulation and Consumer Affairs (D) Committee adjourned.

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Draft: 9/24/09

Special Accreditation Standards (D) Working Group
Washington, DC
September 22, 2009

The Special Accreditation Standards (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met in Washington, DC, Sept. 22, 2009. The following Working Group members participated: Ralph S. Tyler, Chair (MD); Jim Hattaway (AL); Joel Laucher (CA); Luther Ellis (DC); Sharron Burton (KY); Ron Musser (LA); Matthew Regan, III (MA); Paul Hanson (MN); Ernest Nickerson (NC); Bruce Ramge (NE); Anne Marie Narcini (NJ); Lynette Baker (OH); Joel Ario (PA); Suzette Green-Wright (UT); Leslie Krier (WA); Sue Ezalarab (WI); and Andrew Pauley (WV). Also participating were: Mike Woolbright and Jim Mealer (MO); and Jo LeDuc (WI).

1. Adoption of the Aug. 17 Conference Call Minutes

Mr. Musser made a motion to adopt the Aug. 17 conference call minutes. Ms. Narcini seconded the motion. There was no additional discussion and the minutes were unanimously adopted (Attachment One-A).

2. Discussion of the Sept. 1 Draft Proposal for Accreditation Standards

Mr. Musser said he is concerned about the requirement in the current draft that the NAIC Market Conduct Surveillance Model Law (#693) or substantially similar provisions should be part of state law. He said that the requirement in the model to develop a penalty matrix would mean that multi-state settlements would be become almost impossible to resolve. He said the model has not been adopted by most states due to objectionable items, such as the penalty matrix.

Ms. LeDuc said she is also concerned with the requirement that states have the model in place and suggested the Working Group identify the items in the model that would be needed for a proper accreditation program. Ms. Baker said the model is mentioned in the accreditation proposal to ensure that the states could perform proper market analysis.

Mr. Mealer said the language in the draft proposal includes the option of having substantially similar provisions as part of state law. He said this language allows the states to have provisions that are equivalent to the model. He said the draft is designed to be similar to the Financial Regulation and Accreditation Standards Program, in that the proposal includes standards that are at a level to stand the test of time, and then guidelines to allow for the measurement of the states' compliance with the standards. He said the adopted core competencies were used to develop the specific guidelines; however, the guidelines would likely need to be updated as the states' market regulation processes change. He suggested that the Working Group develop a timeline for the development of additional guidelines.

Ms. Narcini asked whether the Market Conduct Surveillance Model Law is the appropriate standard for proper market regulation. Mr. Hanson said it is not the appropriate standard, because most of the states have not adopted it. Mr. Laucher suggested that the Working Group identify specific requirements in the Market Conduct Surveillance Model Law that should be included in an accreditation proposal.

Mr. Laucher said the proposal should lay out the overall process should be conducted by the states, instead of prescribing how each of the processes should be done. He said that if a state is doing the appropriate number of Level 1 Analysis Reviews, it should not matter who was doing them. He said the standards that are nice to have, such as requiring department of insurance staff to have professional designations, should not be included in an accreditation program. He said the Working Group should focus its discussion on the items that are absolutely required for proper market regulation. Mr. Hanson said that just because a state is performing a process does not mean they are doing it correctly — noting that many market-regulation issues are identified by the media.

Ms. Ezalarab said the proposal, like the Financial Regulation Standards and Accreditation Program, is only designed to provide standards.

Commissioner Tyler said the proposal says little about what a state would be required to do to be accredited and fails to include specific performance measures, like those found in the Financial Regulation Standards and Accreditation Program. He said the Financial Regulation Standards and Accreditation Program includes specific outputs and suggested the Working Group focus its discussion on defining the required outputs.

Mr. Laucher said the proposal needs to be enhanced to ensure that the states would know whether they are meeting each of the guidelines. He stated that several guidelines are vague and would be confusing for a state that is attempting to verify its own compliance. He asked how a state would know whether it is conducting "necessary analysis" — adding that vague standards would lead to the states not being able to rely on each other. Ms. Narcini agreed that the current draft includes several standards that could not be objectively measured. She also suggested that references in the draft to "market conduct" be changed to "market regulation."

Ms. Narcini said that — while there would likely be several problems in attempting to measure the activities required for proper market analysis and continuum options — if the states consistently follow the same processes, they should accomplish the desired results.

Ms. Baker asked whether the Working Group could agree to base any further discussion on the current draft. She said if that is not the case, the Working Group should at least agree on the main areas that would be required for an accreditation program. Ms. Krier said the Working Group should develop specific guidelines after it has agreed on the standards. She said the current draft is a good starting point for future discussions.

Commissioner Tyler asked whether any state would not be accredited under the current proposal.

Mr. Laucher said the Working Group should develop standards that are achievable by most states. He said that the market analysis process had not been successful for several states. He said he feared that many states would give up on striving for accreditation if the standards were not easily obtainable.

Commissioner Ario said he agreed that the Working Group should draft requirements that are measurable. He said insurance companies often criticize state insurance departments for focusing their regulatory efforts on technical issues that fail to demonstrate any consumer harm. In addition, he said consumer groups often criticize the states for not being proactive and for not focusing on emerging issues.

Mr. Hattaway said the draft provides a good framework, but needs to be enhanced. He suggested that language, such as "the department of insurance should have adequate resources to (accomplish a specific task)," should be changed to require the state to do a specific task.

Mr. Laucher said processes need to be developed to allow the states to use consumer-complaint data and other market analysis to identify companies with market-regulation issues.

Commissioner Tyler said that because one consumer complaint often means that other consumers are also harmed by a particular practice, he would like to know the relationship between consumer complaints and proper market regulation. He said market regulators should leverage consumer-complaint data to ensure that what happens to one consumer is not happening to others.

Mr. Mealer said complaints are included in the adopted market analysis process. Ms. Baker said the *Market Regulation Handbook* includes the use of consumer-complaint data in the market analysis process.

Commissioner Ario said there are two methods of analyzing consumer complaints. He said the first method is to perform statistical analysis of the complaint data and the second method is to have ongoing discussions with a state's complaint analysts. He said the consumer complaint analysts in a state are a "focus group" that each state should rely on.

Mr. Narcini said that because the adopted processes included the use of consumer complaints, they are not specifically mentioned in the proposal.

Commissioner Tyler said the requirement in the proposal that a state hold certain items confidential should be eliminated. He said the requirement to hold items such as Market Conduct Annual Statement data confidential because of the manner in which it is collected is inappropriate for a government agency. He said that taking something that is not confidential and making it confidential because of the way it is collected makes no sense and has no legal standing. Commissioner Ario agreed, but said that a state might want to hold an item that a company self-reports as confidential, in order to encourage the practice.

Mr. Laucher said that some market regulators have been willing to compromise their authority, because they believe it is the only way to accomplish anything. He said the fact that the Market Conduct Annual Statement is still using the same data elements that were included in the pilot project is a good example of market regulators not making changes because they did not want to offend insurance companies. Commissioner Ario said the development of a good accreditation program is an opportunity for market regulators to feel better about their work.

Commissioner Ario said the Consumer Connections Working Group had requested that this Working Group let them know which working group they recommend should be developing the process for the reconciliation of consumer complaints. Ms. LeDuc said she thought the Consumer Connections Working Group should develop the process and that this Working Group should incorporate the process into the standards. Commissioner Ario said he would let the Consumer Connections Working Group know of the recommendation.

Commissioner Tyler said the deadline for comments on the draft accreditation proposal would be extended to Oct. 9 to allow Working Group members, interested regulators and interested parties the opportunity to submit comments, based on the Working Group's expressed desire to develop objective, measurable outputs.

Commissioner Tyler said that if the proposal allows for the states to be easily accredited, it would not be "raising the bar" for market regulation — and the Market Regulation and Consumer Affairs Committee has charged this Working Group with developing a formal accreditation process that has high standards.

Commissioner Ario said the comments should focus on what is needed for proper market regulation and that the individual making the comments should not "self-censor" them for fear of not being able to get what they want.

Having no further business, the Special Accreditation Standards (D) Working Group adjourned.

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Draft: 8/19/09

Special Accreditation Standards (D) Working Group
Conference Call
August 17, 2009

The Special Accreditation Standards (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Aug. 17, 2009. The following Working Group members participated: Ralph S. Tyler, Chair (MD); Jim Hattaway (AL); Luther Ellis (DC); Laura Moore (KY); Ron Musser (LA); Matthew Regan, III (MA); Manny Munson-Regala (MN); Anne Marie Narcini (NJ); Ernest Nickerson (NC); Lynette Baker (OH); Peter Camacci (PA); Suzette Green-Wright (UT); Joanne Scott (VA); and Sue Ezalarab (WI). Also participating were: Maria Chavira (AZ); Mike Woolbright and Jim Mealer (MO); and Guenther Ruch and Jo LeDuc (WI).

1. Discussion of New Accreditation Proposal

Commissioner Tyler said that based on the Working Group's discussion at the Summer National Meeting, a new proposal had been developed that would allow for flexibility in how state insurance departments regulate their marketplace. He said the proposal calls for each state to develop an accreditation plan, have the plan evaluated for adequacy, and then be evaluated against that plan. He said the proposal was distributed for comments prior to the call.

Craig Leonard (NAIC) said the themes that ran though many of the written comments received on the proposal were 1) the need for minimum standards to be developed for all states; 2) concerns over the amount of detail required in each state's plan; 3) concerns over the need to change state statutes and/or regulations based on this proposal; and 4) the desire to use a proposal previously submitted by Mr. Woolbright.

Mr. Woolbright said he used the NAIC Policy Statement on Financial Regulation Standards as a template for the proposed market regulation accreditation standards he submitted previously. He said his proposal included the states having the authority to analyze, investigate and examine companies and the authority to take corrective action, as necessary, as well as oversee producer licensing and consumer complaint handling. He said his proposal also required the states to have sufficiently qualified staff and resources to properly communicate, conduct priority-based and in-depth analysis, and conduct continuum actions and market conduct examinations. He said his proposal also included the need for professional development of staff, including a requirement for them to meet minimum education and experience requirements.

Commissioner Tyler said that for financial accreditation, the states are required to conduct examinations of domestic insurers every five years. He said that because the Working Group had determined it was not appropriate for the states to be required to conduct examinations of domestic insurers for market regulation at a pre-determined interval, he was not sure what states would actually be required to do. Mr. Woolbright said the states would be required to conduct analysis, continuum actions and examinations on an ongoing basis.

Ms. Baker said that the Mr. Woolbright's proposal could be combined with the other proposal. Ms. Moore echoed the comment.

Commissioner Tyler asked if there needed to be an objective measure for an accreditation program. Ms. Narcini said objective measures were needed so that each jurisdiction would not develop a different plan. Mr. Ruch agreed that objective measures should be developed.

Mr. Regan said he thought that Mr. Woolbright's proposal might be where the Working Group would end up in five years, but he liked the concept of the current proposal, because it allowed for those states with limited resources to manage them properly. He said the Working Group needs to remember that several states have limited resources. Mr. Ruch said that financial regulators were able to use the momentum of financial accreditation to get the additional resources they needed.

Mr. Ellis asked if standards would be lower for smaller states. Commissioner Tyler said he did not believe that would be the case. Mr. Mealer said he believed the standards should be raised over time. Commissioner Tyler agreed.

Ms. Scott suggested that all states could certify that they were using the adopted Core Competencies found in the *Market Regulation Handbook*. She said this would give smaller states the flexibility they need. Mr. Leonard said the Uniformity Working Group conducted a survey in 2006 in which the states were asked to self-certify whether they were in compliance with the Core Competencies. He said that, at that time, the majority of states certified that they were meeting most of the Core Competencies.

Commissioner Tyler asked what would be accomplished by having the states self-certify to the standards. Ms. Scott said it would help the states ensure that they were all using the same standards.

Mr. Nickerson questioned whether the program should be looking at traditional market regulation areas, such as market analysis and market conduct examinations. He suggested the program be broad enough to ensure all areas impacting market regulation are included in the proposal. Ms. Chavira stated that some states might need to restructure based on the proposal.

Mr. Ramge stated that, because market regulation often involves several areas at an insurance department, the accreditation program should include all areas required for effective market regulation.

Ms. Narcini stated that the proposal should be an overarching market regulation program — and not narrowly focused on just analysis or examinations. She stated that the program would help ensure proper resources and processes are in place.

Mr. Ruch suggested that a subgroup be formed for the purposes of merging the two proposals. Commissioner Tyler agreed and said the subgroup should use the two proposals, the discussion from the call and written comments to merge all items into one document for distribution to the Working Group and interested parties prior to the Fall National Meeting.

Mr. Ruch, Ms. Scott and Mr. Woolbright agreed to work on the subgroup.

Having no further business, the Special Accreditation Standards (D) Working Group adjourned.

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Draft: 9/9/09

Market Analysis Procedures (D) Working Group
Conference Call
September 3, 2009

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Sept. 3, 2009. The following Working Group members participated: Leslie Krier, Chair (WA); Maria Chavira, Vice Chair (AZ); Kathy Talley (AL); Joe Musgrove (AR); Damian Hughes and Carol O'Bryan (CO); Stephen Deangelis (CT); Pamela Lovell (FL); Robert Rapp (IL); Debra Webb (IN); Laura Moore (KY); Ron Musser (LA); Matthew Regan (MA); Tom Marshall (MD); Lynella Cauther (MI); Paul Hanson (MN); Dave Drynan (MT); Tracy Biehn (NC); Reva Vandevoorde (NE); Deb Stone (NH); Gail Keren (NY); Lynette Baker (OH); Mike Lydon (OR); Peter Camacci (PA); Robert Herrera (UT); Karen Gerber (VA); Jo LeDuc (WI); and Mark Hooker (WV). Also participating was: Angela Dingus (OH).

1. Minutes of the July 22 Meeting

Mr. Hooker moved to approve the minutes of the July 22 meeting and Ms. Biehn seconded the motion. The minutes of the July 22 meeting were approved (Attachment Two-A).

2. *Market Regulation Handbook*

Ms. Baker said a subgroup was formed to incorporate the risk-focused approach into the Examinations section of the *Market Regulation Handbook*. The subgroup would like to add some explanation of the risk-focused approach into the analysis chapter of the handbook. The subgroup is asking for comments and direction on how to add information on the risk-focused approach to the market analysis chapter and submit it for approval.

Ms. Krier said that the charge given to the Market Analysis Procedures (MAP) Working Group was broad enough to allow a recommendation to revise the market analysis chapter of the handbook. Ms. Krier said the risk-focused approach to market analysis is a tool that is available to analysts. When analysts complete Level 1 and Level 2 Analysis reviews, they can review the work of others that has already been done. The risk-focused approach is already being used in financial examinations.

Mr. Musgrove moved that Ms. Baker's subgroup draft a risk-focus approach section to the market analysis chapter of the handbook. Ms. LeDuc seconded the motion and the motion passed.

Ms. Lovell asked for a definition of "risk-focused." Ms. Baker said that the risk-focused approach examines how a company monitors its own compliance. She added that it is useful in market analysis, because it gives the analyst insight into what the company is doing and it gives an overview of the company.

Mr. Musser asked if the Working Group intended to incorporate this approach into the Level 1 and Level 2 Analysis questions, or whether it was only meant to be another tool for an analyst to use. Ms. Baker said it was just another area of the company to review. Ms. O'Bryan said a Level 1 Analysis review is only meant to look at the company, using information already available about the company without asking for additional information. The risk-focused approach could be incorporated into an analyst's Level 2 analysis as an additional area of review.

Ms. Krier said that Ms. Baker has already done some work on this approach and it has been exposed for comment on the Market Conduct Examination Working Group (MCES) page on the NAIC Web site. Those comments are being sent to Petra Wallace (NAIC). Ms. Krier said a combined meeting of MCES and MAP Working Groups might be needed.

Mr. Musser said that one of Ms. Baker's documents mentioned risk-focused market conduct examination standards. He asked if Ms. Baker was expecting to include market conduct examination standards in the handbook. Ms. Baker said that one of her documents is an outline of what could be put in each chapter about the risk-focused approach. Because some states already use this approach, she said she thought it should be mentioned in the handbook.

Birney Birnbaum (Center for Economic Justice—CEJ) said the terminology "risk-focused exams" is confusing. He said what is being discussed is reviewing a company's procedures for compliance. It is examining the company procedures and how those procedures are implemented. He said it is useful, but it is not market analysis. It is either an initial approach to examining a company or it can be used to examine a company after market analysis has determined there may be concerns.

Mr. Birnbaum said the document suggests this approach is a framework for market regulation and that the approach identifies risk. He said it is not a framework and it does not identify risk. He said it should be renamed a "compliance system review." As such, it would fit better into the current procedures rather than when it is referred to as an entire framework and a new approach to market conduct exams. Ms. Moore agreed and said that Kentucky already does this type of review in their exams and she believes others states do as well.

Ms. LeDuc said it would be helpful for the next call to have a presentation about the concept to help those who are unfamiliar with it. Ms. Krier said that Ms. Baker would contact regulators from New York and Washington, DC, to help with this presentation because those two jurisdictions already use this approach.

Ms. Dingus said that the "Market Analysis Focus Standards" document posted on the MAP Working Group Web page was drafted in the same format as the Market Conduct Standards already in the handbook. It provides a start for how to proceed when conducting market analysis. Ms. Krier asked the group whether the document should be separated into three different best practices documents for Baseline, Level 1 and Level 2, or if it should remain one document. Ms. Krier said comments will be received on the document and posted on the MAP Working Group Web page until Oct. 9.

Mr. Musser asked whether these standards would be in the accreditation standards. Ms. Krier said that was a question that depended on what was decided for accreditation. The intent of the current document was to provide a reference tool for market analysts.

3. Complaint Database System

Ms. Brown said there is an interactive PDF file that is used by the Operational Efficiencies (EX) Working Group for tracking suggested changes to SERFF. She recommended a similar process be used for tracking suggested coding changes to the Complaint Database System (CDS). The suggestions would be collected throughout the year, reviewed by a subgroup and then brought to MAP for approval and implementation the next year.

A subgroup consisting of Ms. Brown, Mr. Musgrove, Mr. Hooker and Susan Ezalarab (WI) was formed to develop an interactive PDF file to collect the suggested changes.

4. Level 1 and Level 2 Analysis — "Referral to MAWG" Recommendations

Ms. Krier said the discussion of the Level 1 and Level 2 Analysis Reviews — "Referral to MAWG" Recommendations would be moved to the next MAP meeting.

5. New Data Elements and Lines of Business

Ms. O'Bryan said that a priority list was almost complete and would be available within the next two weeks. Mr. Birnbaum asked what the procedure was for completing this task, and why the interested parties have had no opportunity to contribute to the process. Mr. Birnbaum said he was concerned that the process was not very transparent. Ms. Krier said that discussions about this task have occurred at each MAP Working Group meeting this year, but that no document had yet been exposed for comment. She indicated that comments could be sent to Randy Helder (NAIC) prior to the production of a draft document.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.

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Draft: 7/28/09

Market Analysis Procedures (D) Working Group
Conference Call
July 22, 2009

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call July 22, 2009. The following Working Group members participated: Leslie Krier, Chair (WA); Maria Chavira, Vice Chair (AZ); Kathy Talley (AL); Joe Musgrove (AR); Don McKinley (CA); Damian Hughes (CO); Kurt Swan (CT); Luther Ellis (DC); Pamela Lovell (FL); Robert Rapp (IL); Stacy Rinehart (KS); Lori Cunningham (KY); Larry Hawkins (LA); Tom Marshall (MD); Kendra Godbout (ME); Regan Johnson (MI); Mike Woolbright (MO); Kerry Banks (MN); Tracy Biehn (NC); Bruce Ramge (NE); Chuck Vanasdalan (NH); Anne Marie Narcini (NJ); Gail Keren (NY); Lynette Baker (OH); June DuBard (SC); Robert Herrera (UT); Rusty Shropshire (VA); Jo LeDuc (WI); and Mark Hooker (WV). Other participants included Sue Ezalarab (WI), and Doug Pennington (WA)

1. Minutes of the June 17, 2009 Meeting

Mr. Vanasdalan moved to approve the minutes of the June 17 meeting and Ms. Chavira seconded the motion. The minutes of the June 17 meeting were approved (Attachment Two-A1).

2. Complaint Database System (CDS) Manual

Ms. Ezalarab presented a format used by the Operational Efficiencies (EX) Working Group to track suggested changes to the rate and form tools. The use of this on-line template allows users to make suggestions at one centralized location. There is a deadline for the submissions and once a year, prior to the Spring National Meeting, the Operational Efficiencies Working Group reviews the suggestions and forwards them to the Speed to Market Task Force for action. Ms Ezalarab said a process like this would work well to track suggested changes to the CDS Manual and coding.

Ms. Ezalarab requested that NAIC staff collect additional information about the details of the process and report to the Ms. Ezalarab, Peg Brown (CO) and Bob Lisson (NC).

3. Level 1 Analysis Minimum Requirements

Mr. Hooker said that many states believed moving the requirement date to March 1 did not give them enough time to complete the Level 1 analyses. The June 30 date had been chosen to allow time to include Market Conduct Annual Statement (MCAS) data in the analyses. Because many states wait for the MCAS data to be received before conducting the Level 1 analyses, moving the requirement due date to March 1 does not provide enough time to complete the required number of analyses. Mr. Hooker said that May 1 is a better date to use for this year, and it ties into the expected due date for future MCAS submissions. Ms. LeDuc said that using May 1 does not encourage states to begin conducting Level 1 analyses as soon as the financial data is received in March. Ms. Krier said that the MCAS questions could be eliminated from the Level 1 review questions and moved to the Level 2 analyses. Doug Pennington (WA) said that 90% of the information needed to complete a Level 1 analysis is available in March. It should not be allowed to get old. Ms. DuBard, Ms. Rinehart and Mr. Vanasdalan said that their states use the most current data available at the time of the analysis. Mr. Vanasdalan said that New Hampshire may even have not met the requirements for a prior data year by using the newer data between March and June. Ms. Narcini said that the "data year" requirement should be eliminated and the analysts should be required to use the freshest data available at the time of the analysis. Ms. LeDuc said that no date to begin reviews was necessary. All that is needed is a date by which to have the reviews completed.

Mr. Musgrove moved that the number of analyses be measured on a calendar year basis with the analyses using the most current market and financial data available at the time of the analysis. Mr. Musgrove also moved that report cards be issued each January, beginning in 2011, measuring the number of analyses completed in the jurisdiction and approved by the Market Analysis Chief of the jurisdiction in the previous year between January 1 and December 31. Mr. Herrera seconded the motion. The motion carried unanimously.

Ms. Krier said a report card will be generated in January, 2010 as a sample of how the new minimum requirements will be measured.

4. Level 1 and 2 Analysis "Referral to MAWG" Recommendations

Ms. Krier said comments have been received on the Level 1 and Level 2 "referral to MAWG" issue and posted to the committee web page. NAIC staff will put together a synopsis of the comments and distribute them to the group. They will be discussed at the next meeting.

5. New Data Elements and Lines of Business

Ms. Chavira said recommendations and prioritizations by market analysis tool for lines of business and data elements will be made prior to the Market Regulation and Consumer Affairs (D) Committee meeting at the Fall National Meeting.

6. *Market Regulation Handbook*

Ms. Baker said best practices for complaint analysis are being developed by a small group of regulators. Ms Baker said that once they are finalized, they will be presented to the Working Group for review.

7. Market Analysis Research and Development (MARD) Focus Group Update

Randy Helder (NAIC) said the Market Analysis Research and Development (MARD) focus group met on July 9. The enhancements worksheet used by the group will be revised to provide more detail that will be useful for prioritizing requests.

The following changes were approved by MARD:
CDS – Summary Index Report – removing companies that have no market share in the initial state;
MAPR – replacing the Modified IRIS – 1 year report with the 5 years of IRIS information form the Complete Profile Report;
Market Share Report – provide a clarification of the title "US Market Share" for instances when jurisdictional market share is being reported;
MARS – add Title LOB, provide a warning box after 25 minutes of inactivity, modify the "view" option to provide a more detailed view of the analysis, and change the error notification from a banner to a pop-up;
MITS – increase field size from 50 to 100 characters.

Mr. Helder said the group will be discussing adding a field in MARS to identify the trigger for a Level 1 or Level 2 analysis, allowing edits to be made to "approved" Level 1 and Level 2 analyses, and the need to limit access to MITS information available in MARS to only those users that have MITS authority roles.

Ms. LeDuc asked if the suggestion tracking form discussed for the CDS Manual may be used for MARD. Ms. Krier agreed that it could be.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.

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Draft: 7/14/09

Market Analysis Procedures (D) Working Group
Conference Call
June 17, 2009

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call June 17, 2009. The following Working Group members participated: Leslie Krier, Chair (WA); Maria Chavira, Vice Chair (AZ); Kathy Talley (AL); Joel Laucher (CA); Peg Brown (CO); Jennifer Miner (CT); Luther Ellis (DC); Barbara Szumowski (FL); Robert Rapp (IL); Stacy Rinehart (KS); Bob Rutledge (KY); Ron Musser (LA); Dudley Ewen (MD); Kendra Godbout (ME); Regan Johnson (MI); Jim Mealer (MO); Carol Roy and Dave Drynan (MT); Tracy Biehn (NC); Bruce Ramge (NE); Deb Stone (NH); Anne Marie Narcini (NJ); Gail Keren (NY); Lynette Baker (OH); Gary Holliday (OR); Chris Monahan (PA); June DuBard (SC); Robert Herrera (UT); Rusty Shropshire (VA); Jo LeDuc (WI); and Mark Hooker (WV).

1. New Data Elements and Lines of Business

Ms. Chavira said the group has reviewed the lines of business in the market and financial tools of I-SITE to determine which lines of business were not available. The group also asked NAIC staff to identify which lines of business were scheduled to be available in the market tools. The long-term-care and credit insurance lines of business are scheduled to be available in the Market Analysis Prioritization Tool (MAPT). The title insurance line of business will be available in the Market Analysis Review System (MARS) tool. The individual annuity and group annuity lines of business will be available in MAPT and MARS. John Haworth (WA) is researching the usage of the tools and reports available in the systems. The group will begin considering new lines of business to add to the market analysis tools.

2. *Market Regulation Handbook*

Ms. Baker said this group has had one meeting and is scheduled to meet again June 18. They will be developing entry-level, intermediate-level and advanced-level market analysis methods to be included in the *Market Regulation Handbook*. Ms. Baker asked the Working Group to send suggestions regarding market analysis methods to be considered for inclusion in the handbook.

3. Level 1 Analysis Minimum Requirements

Ms. LeDuc said a recommendation on the minimum required number of Level 1 Analysis reviews per state has been posted on the Working Group's Web page. Ms. LeDuc encouraged everyone to review the recommendation and to submit comments by June 26.

4. Complaint Database System (CDS) Manual

Ms. Krier said the CDS Manual revisions were adopted by the Market Regulation and Consumer Affairs (D) Committee at the Summer National Meeting. The Committee discussed having the revision date placed on the manual. Currently, the NAIC is considering a Business Fiscal Impact Statement (BFIS) for the implementation of the coding changes. The BFIS will need to be approved before there is any commitment of resources to the implementation of the coding changes. The date the coding changes can be completed will be the revision date of the manual.

Ms. Brown said the Working Group should establish a formal process for regular revisions to the manual. Ms. Brown suggested an annual review of revisions. Ms. Ezalarab said the group should look at the System for Electronic Rate and Form Filing (SERFF) coding process, whereby a form must be completed for any suggested changes. Periodically, a committee considers whether to implement the suggestions. She suggested that this group consider a similar process for suggested changed to the CDS Manual.

Ms. Krier asked Ms. Brown and Ms. Ezalarab to develop a suggestion for the Working Group to consider.

5. Market Analysis Research and Development (MARD) Focus Group Update

Randy Helder (NAIC) said the MARD Focus Group met May 7 to review upcoming enhancements to the Market Analysis Review System (MARS) and Market Initiative Tracking System (MITS) reports. The Focus Group also considered a suggestion regarding one of the available recommendations after Level 1 and Level 2 Analyses are completed. This recommendation is: "We will contact the Collaborative Action Designee (CAD) of other states with similar concerns regarding possible collaborative activity." The recommendation automatically generates an e-mail with the subject line "MAWG Agenda" and states that the company has been recommended to be referred to the Market Actions Working Group (MAWG). It is sent to individuals within the reviewing state, as well as the CAD of the company's domiciliary state. However, the company does not get put on the MAWG agenda, nor is it referred to MAWG. The Focus Group decided to change the content of the e-mail to say that the company is being reviewed for possible referral to MAWG, and to remove the domiciliary CAD from the distribution list.

Ms. Krier said the Focus Group's proposed changes will be posted to the Web page, with a comment deadline of July 3.

6. Any Other Matters Before the Working Group

Mr. Hooker said he would like to discuss the NAIC staff study on the Market Information Systems (MIS). Ms. Krier said the study is posted on the Market Regulation and Consumer Affairs (D) Committee Web page. She told the Working Group that a link to the study will be sent to the Working Group and interested parties for review. Because some of the appendices of the report are for regulators only, those appendices will only be sent to the Working Group and interested regulators. Ms. Krier said that Kim Holland (OK) asked that comments be sent to Craig Leonard (NAIC) by July 10.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.

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Draft: 9/29/09

Consumer Connections (D) Working Group
Washington, DC
September 22, 2009

The Consumer Connections (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met in Washington, DC, Sept. 22, 2009. The following Working Group members participated: Wayne Goodwin, Chair, represented by Louis Belo (NC); Joel Ario, Vice Chair (PA); Joe Musgrove (AR); Leone Tiffany (CA); Peg Brown (CO); Barbara Spear (CT); Tom O'Meara (IA); Clarissa Preston (LA); Dudley Ewen (MD); Bruce Ramge (NE); Scott J. Kipper represented by Brett Barrett (NV); Anne Marie Narcini (NJ); Jack Chaskey and Gail Keren (NY); Lynette Baker (OH); Mark Young (OK); Suzette Green Wright (UT); JoAnne Scott (VA); Leslie Krier (WA); Andrew Pauley (WV); and Sean Dilweg (WI). Also participating were: Bob Lisson (NC); Cindy Fillman (PA); and Jo LeDuc (WI).

1. Receive Update on Insurance Contract Readability

Commissioner Dilweg provided an update on Wisconsin's Readability Working Group's efforts to review readability standards of policies and disclosure documents. He said policies and disclosure documents are being reviewed separately, and the Working Group is looking at all lines of insurance. He said Wisconsin had not reviewed its readability standards since 1980, and was currently reviewing readability standards scoring to obtain an understanding of the basis of readability scoring. He said Rudolf Flesch of Columbia University set standards in the 1940s for scoring of readability, and Flesch scoring is an easily used option built into Microsoft Word. He said the Flesch scoring method shows that in Wisconsin policies are being written at a first-year college level; however, the desired readability level of policies should be at an 8th grade level.

Commissioner Dilweg said Rhode Island requires that policies be written at an 8th grade level, which, in his opinion, may be too low. He said the District of Columbia has a plain English requirement. He asked when the last time was that the NAIC reviewed readability standards of policies, and he asked that the Working Group, in coordination with the NAIC, review the memo and the two handouts he provided and work on updating readability standards.

Mr. Belo said North Carolina has not addressed the issue of readability in years and believes there is room for improvement. Commissioner Dilweg said there is a fine line between needing legal language in a policy yet making content of a policy understandable for the consumer.

Daniel Schwarcz (University of Minnesota) said trying to force contract language to pass readability standards leads to ambiguity. He said the specific audience for insurance contract language is attorneys and lawyers—a sophisticated audience. He said there are benefits to not always changing legal language. He asked that the Working Group consider giving thought to making disclosures convey the type of information that needs to be given to consumers, and that readability standards should apply to disclosures rather than to contract language. He said that with content of disclosures, insurance carriers do not need to create legally binding language. He said content of disclosures does need to be consistent with the provisions of an insurance contract, yet provide a description of an insurance policy and highlight areas that the consumer needs to know. He asked that the Working Group consider that readability standards should therefore focus on disclosure documents.

Mr. Barrett asked what readability standard the Interstate Insurance Product Regulation Commission (IIPRC) is using for evaluating contract forms, and what kind of differences can be allowed in summary plan language versus actual contract language. Commissioner Dilweg said insurance contracts tend to be lengthy, and contract language tends to be targeted at the sophisticated reader; therefore, he feels that a college-level readability standard may be too high. Commissioner Dilweg said he doesn't know what standard is used by the IIPRC.

Ms. Fillman said the concern regarding having two separate documents is that what the consumer signs and understands is the insurance policy, not a summary or disclosure document. She said a disclosure or even a summary document does not necessarily contain the same language as an insurance contract. She said there is also the issue of consumers having too many documents to read. She said it is much more important to make insurance contracts more understandable to those individuals who are bound to them.

Ms. Brown said consumers need to know where and how to look for important information in an insurance policy, and they may not know to look at exclusions sections. She said the concern is not just about readability, but about hiding crucial

information that a consumer needs to know. Ms. Tiffany said that for states that do not necessarily exert control over contract language or review contract language extensively, implementing review of readability standards would be an immense undertaking. Mr. Belo said another issue is that an insured may not keep an insurance contract and summary (disclosure) document together.

Mr. Musgrove said telling consumers to just read a disclosure, not their policies, is not the message that regulators want to send. Mr. Ramge said the Working Group should ask NAIC staff to review readability standards currently in place. Ms. Preston said the Working Group should take a look at all of the comments made during this meeting and at what other states are doing. Commissioner Dilweg said he wants to have a national discussion on this issue first before entertaining a state-by-state discussion of how states are handling readability standards.

Dr. Brenda Cude (University of Georgia) said disclosures are not a summary that tells policyholders what is in the contract; rather, a disclosure is a document that directs a policyholder's attention to specific information they may need to know. Ms. Cude said the issue of good disclosures is about much more than readability; it is about more effective communication. Ms. Cude asked that the NAIC and the Working Group look at the issue in general and develop a recommendation with regard to readability standards. Mr. Lisson said Flesch scoring measures readability from the standpoint of word choice and sentence structure, but cannot assess whether the text being analyzed provides the reader with the necessary information to help him/her understand the insurance disclosure or policy.

Commissioner Dilweg made a motion that a subgroup be put together to examine the readability standards as they relate to insurance contracts and report back to the Working Group. Mr. McAndrew seconded. Mr. Belo recommended that NAIC staff pull the currently existing model regarding readability, and the subgroup work on updating the model. He added that the Working Group would like to see a specific end date with regard to the output of the subgroup before the Winter National Meeting. Ms. LeDuc volunteered to lead the subgroup. Mr. Belo said this item will be on the agenda of the Working Group's next conference call. Mr. Belo reminded the Working Group that minutes, comments and discussion on comments are only kept for Working Group conference calls, not subgroup calls. The motion passed.

2. Discuss Autism Coverage/Mandates Survey

Mr. Belo said this issue was discussed at the Summer National Meeting. He said the survey was merely the result of one state asking other states what they were doing with the issue of mandating autism coverage. He said the only purpose of the survey was to share the information received with other states. Mr. Belo said the State Insurance Advocacy Forum members recommended that the survey results be made public and asked the Working Group to determine whether or not the survey results should be made public. Mr. Chaskey made a motion that this survey be made public. Ms. Nelson seconded. The motion passed.

3. Discuss ICAE Complaint Data Analysis Position Paper

Mr. Lisson said the Insurance Consumer Affairs Exchange (ICAE) is made up of complaint handling personnel from insurance industry and from state insurance departments. He said the position paper contains four recommendations. The first recommendation is that a complaint reconciliation process be developed and implemented on a state–by-state basis. He said the purpose of complaint reconciliation is to give insurers an opportunity to reconcile their own complaint data with states' complaint data. He said standards regarding complaint reconciliation are written into the current accreditation standards proposal being reviewed and discussed by the Special Accreditation Standards Working Group.

Mr. Lisson said the other three recommendations are in regard to the content and format of complaint-related correspondence between regulators and regulated entities. Since the issue is not directly related to consumers, he asked if this issue fits within the Working Group's charges. Ms. Brown said this issue should be discussed at the Special Accreditation Standards Working Group, where the complaint reconciliation process is being established. She said another, perhaps less desirable, option may be to discuss the issue at the Market Analysis Procedures Working Group. Ms. Krier said the complaint reconciliation process, whenever it is finalized, needs to be incorporated into the *Market Regulation Handbook*. Mr. Chaskey made a motion that this issue be forwarded to the Market Regulation and Consumer Affairs Committee to determine which Working Group should be assigned the task of developing a complaint reconciliation process. Ms. Krier seconded. In response to an inquiry from Mr. Ewen, Ms. Brown said the recommendation is for the D Committee to review the entire ICAE paper, not just the first recommendation regarding complaint data reconciliation. The motion passed.

4. Discuss Complaint Reconciliation Survey – Next Steps

Mr. Belo said the survey is a compilation of all states that have responded to the survey question whether a complaint reconciliation process is in place in their state. He said the question put before the Working Group is whether a best practice regarding complaint reconciliation should be developed.

Ms. Brown said the survey shows that there is quite a range among state insurance departments of complaint reconciliation processes. She offered to present Colorado's complaint reconciliation process as a model for other states to follow. Mr. Ewen said this issue is in the current market regulation accreditation proposal being reviewed by the Special Accreditation Standards Working Group. He said the Working Group needs to determine the best place for discussion of this issue. Ms. Krier said this issue is not currently on the Market Analysis Procedures Working Group's agenda, and suggested that this issue be forwarded up to the D Committee for review and to determine what Working Group is the appropriate venue for discussion.

Commissioner Ario said that since complaints are a part of market analysis, guidance needs to be provided by the D Committee with regard to which Working Group will work on this issue. He said the same group that is reviewing the ICAE paper needs to review the complaint reconciliation survey as well. Commissioner Ario said that he would bring this up at the Special Accreditations Standards Working Group meeting Sept. 22, as well as to the Market Regulation and Consumer Affairs Committee for their consideration. He will report any discussion on this issue back to the Working Group at the next scheduled conference call. Mr. Belo said the Working Group can then proceed with how to form best practices with regard to complaint reconciliation.

5. Receive Brief Update on Consumer Information Source (CIS) Suggested Wording

Mr. Lisson said regulators from Colorado, New York and North Carolina and Dr. Brenda Cude are currently working on recommendations for simplification of the wording on the NAIC Consumer Information Source (CIS) Web page. He added that the recommendations will also include revisions to some of the statistics and how they are calculated. He said a draft document is currently circulating among the individuals working on this issue. Ms. Baker said her concern is that the language used on the CIS Web page does not match the content of the market analysis-related sections of the *Market Regulation Handbook.* Mr. Belo said this issue is not yet final and will continue to be analyzed by the individuals charged with this project.

6. Adoption of the Minutes of the Aug. 5 Conference Call

Ms. Brown moved to adopt the minutes of the Working Group Aug. 5 conference call, with one correction to change Mr. Brown to Ms. Brown within the minutes. Mr. McAndrew seconded. The minutes were unanimously adopted (Attachment Three-A).

Having no further business, the Consumer Connections (D) Working Group adjourned.

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Draft: 9/29/09

Consumer Connections (D) Working Group
Conference Call
August 5, 2009

The Consumer Connections (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Aug. 5, 2009. The following Working Group members participated: Wayne Goodwin, Chair, represented by Bob Lisson (NC); Joel Ario, Vice Chair, represented by Donna Flickinger and Peter Camacci (PA); Jay Bradford represented by Joe Musgrove (AR); Leone Tiffany (CA); Marcy Morrison represented by Peg Brown (CO); Thomas Sullivan represented by Gerard O'Sullivan (CT); Luther Ellis (DC); Kevin McCarty represented by Vicki Twogood (FL); Michael McRaith represented by Mary Peterson (IL); Susan Voss represented by Angel Robinson (IA); James Donelon represented by Cherise Forte, John Lamke and Clarissa Preston (LA); Ralph Tyler represented by Joy Hatchette (MD); Mila Kofman represented by Robert Wake (ME); Glenn Wilson represented by Tina Armstrong and Sherri Mortensen-Brown (MN); Mary Kempker (MO); Monica Lindeen (MT); Ann Frohman represented by Jane Francis (NE); Scott J. Kipper (NV); Neil Jasey represented by Anne Marie Narcini (NJ); Morris J. (Mo) Chavez represented by Melinda Silver (NM); Kermit Brooks represented by Sandra Anderson, Gail Keren and Sylvia Lawson (NY); Mary Jo Hudson represented by Anne Jewel (OH); Kim Holland represented by Susan Dobbins (OK); Teresa Miller represented by Ron Fredrickson (OR); Leslie Newman represented by Vickie Trice (TN); Mike Geeslin represented by Jack Evins (TX); Kent Michie represented by Tanji Northrup (UT); Paulette Thabault (VT); Jackie Myers represented by Althelia Battle (VA); Mike Kreidler represented by Leslie Krier (WA); Jane Cline represented by Tom Barton and Andrew Pauley (WV); and Sean Dilweg represented by Jo LeDuc, Brianna Olson and Jennifer Stegall (WI). Also participating was: Chad Bridges (MS).

1. Develop Agenda for Public Hearing on Usual, Customary and Reasonable (UCR) Issues

Mr. Lisson said that the primary agenda item for this call was to develop recommendations for the scope/agenda of the upcoming joint public hearing on usual, customary and reasonable (UCR) issues, and for possible invitees to provide testimony. Recommendations will be forwarded to Commissioner Holland, chair of the Market Regulation and Consumer Affairs (D) Committee, and Commissioner Sandy Praeger (KS), chair of the Health Insurance and Managed Care (B) Committee. Mr. Lisson also stated that, if the UCR hearing consumed all of the time on today's call, then the remaining agenda items would be addressed during the Working Group's meeting at the Fall National Meeting.

2. Scope

Mr. Lisson requested input from the Working Group regarding the agenda and whether the scope should be limited to health insurance or if it should also include property/casualty insurance. Mr. Lisson asked Lois Alexander (NAIC) if the Property and Casualty Insurance (C) Committee was aware that this joint hearing was scheduled for the Fall National Meeting. Ms. Alexander responded that the Committee was aware of it.

Ms. Brown said that UCR is tied to balance billing and that the bigger issue is balance billing, as well as the role UCR plays in controlling that issue. Mr. Wake agreed with Ms. Brown's statement. Mr. Lisson said that UCR and balance billing overlapped. He asked Ms. Alexander if balance billing could be included in the hearing format. Ms. Alexander said that would be possible, if the Working Group recommends it and the joint committees accept the Working Group's recommendation in this regard.

Mr. Musgrove asked it this was an access issue, rather than a balance billing or UCR issue. Ms. Brown said that, from a consumer perspective, it is not an access issue — but it is very much a UCR or balanced billing issue, because the consumer has verified with the carrier in advance that the surgeon is in-network and that the hospital is in-network. She said it is only reasonable for consumers to think that all of the providers serving in that hospital are also in-network; only to find out later when they receive a huge bill that some of the providers are not in-network. Mr. Musgrove said that providers are not subject to regulation by state insurance departments. Mr. Wake said that controlling balance billing is the responsibility of state insurance regulators, as is fighting for the rights of consumers when it can be shown that hospitals that are in-network have non-network providers (e.g., pathologists, specialists, x-ray technicians, anesthesiologists, etc.) performing services without the prior knowledge of its patients.

Mr. Musgrove asked if the scope of the hearing should include consumer-disclosure issues. Ms. Silver said the hearing should include consumer-disclosure issues, because consumers should be made aware of what they are required to pay prior

to receiving services. Ms. Keren asked if Working Group members knew of people in their state who had contracted for UCR that didn't receive UCR; or, if this is just a disclosure issue after all. Ms. Narcini said this hearing should serve to discover how, by definition, carriers determine UCR figures in order to answer the question regarding whether a consumer-disclosure standard needs to be developed by regulators. Mr. Lisson said that disclosure issues should not be tied to the UCR issue, because it deals with out-of-network charges. Mr. Lisson also said that the U.S. Senate staff report lays out the UCR issue in this manner, as well.

Mr. Musgrove said that changes in this area are not singular and would have a parallel effect on premiums. Mr. Wake said if one area is being short-changed on UCR fees, then another area is getting more than they should — it balances itself out. The area affected (up or down) could be an insurer, an insured, a provider, an uninsured or an underinsured.

3. Recommendations for Invitations to Testify

Mr. Lisson pointed out that the U.S. Senate Committee on Commerce, Science and Transportation held hearings related to the UCR issue in March and June of this year. Mr. Lisson read brief summary descriptions of these hearings and the names of witnesses who provided testimony (as posted on the Senate Committee's Web site), provided the Web site address and recommended that a member of U.S. Sen. Jay Rockefeller's (D-WV) staff be invited to testify at the hearing. Mr. Evins said that the National Conference of Insurance Legislators (NCOIL) held a roundtable discussion on balance billing during their Summer Meeting. Mr. Evins recommended that a representative from NCOIL be invited to testify at the hearing. Mr. Evins said he would send a clean copy of the NCOIL Summer Meeting Report to NAIC staff for distribution to the Working Group.

Ms. Silver made note of the Maine Health Accountability Tool presented during a recent state regulators conference. Ms. Silver recommended that someone from the Maine Bureau of Insurance be invited to testify at the hearing. Mr. Lisson and Ms. Alexander said that NAIC funded consumer representative Kevin Lucia, Georgetown University, had offered to testify at the hearing by sharing his paper on balance billing. The paper, *Unexpected Charges: What States are Doing about Balance Billing*, was written jointly by Mr. Lucia, Jack Hoadley and Sonya Schwartz (National Academy for State Health Policy) for the California HealthCare Foundation. Ms. Brown said that she was one of the regulators who participated with Mr. Lucia in the preparation of the balance billing paper and she strongly recommended that Mr. Lucia be invited to testify at the hearing. Ms. LeDuc agreed that asking Kevin Lucia to testify was an excellent idea.

Mr. Lisson noted that NAIC staff had prepared a table based on legislative research regarding UCR issues and updated with revisions from a survey of state insurance regulators. Mr. Lisson, Ms. Keren and Ms. Silver recommended that the survey be submitted as written testimony during the hearing. Ms. Brown and other regulators commented on the relationship between UCR and balance billing. The thrust of these comments was that the two issues are interrelated and that the end result of UCR disputes is non-par providers' balance-billing of consumers.

Ms. Brown recommended that provider/industry representatives — such as the American Medical Association (AMA) and America's Health Insurance Plans (AHIP) — be invited to testify. Mr. Lisson commented that the AMA had testified at the recent Senate hearing, and asked Marty Mitchell (AHIP) for comments on potential AHIP participation. Mr. Mitchell indicated AHIP's willingness to participate.

Mr. Musgrove suggested that a representative from the Academy of Actuaries be invited to testify at the hearing. He said that no discussion of the UCR issue would be complete without such testimony. Mr. Wake said that actuarial testimony should be presented at a later date, because the scope of this hearing was limited to basic fact-finding and information-gathering.

Mr. Lisson asked if there were any other comments. Chris Petersen (Morris, Manning & Martin) asked if the scope of the agenda would be determined before the hearing is held. Mr. Lisson said that the Health Insurance and Managed Care (B) Committee and the Market Regulation and Consumer Affairs (D) Committee would use the recommendations of the Working Group (as developed during this call) as a basis from which to define the scope of the agenda. These two committees will also issue invitations to testify.

Having no further business, the Consumer Connections (D) Working Group adjourned.

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Draft: 9/11/09

Market Conduct Examination Standards (D) Working Group
Conference Call
September 2, 2009

The Market Conduct Examination Standards (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Sept. 2, 2009. The following Working Group members participated: Bruce Ramge, Chair (NE); Andy Helm (CO); Barb Szumowski (FL); Mark Ossi (GA); Laura Cunningham (KY); Ron Musser (LA); Dudley Ewen (MD); Kevin Jones, Jim Mealer and Win Nickens (MO); Deborah Stone (NH); Tracy Miller Biehn (NC); Anne Marie Narcini (NJ); Lynette Baker (OH); Gregory Lee (VA); Leslie Krier (WA); Mark Hooker (WV); and Jo LeDuc (WI).

1. Adopt Minutes of July 30 Conference Call

Ms. Narcini made a motion to adopt the minutes of the Working Group's July 30 conference call. Mr. Mealer seconded the motion. The minutes were unanimously adopted (Attachment Four-A).

2. Review and Discuss Colorado's Sept. 1 Draft of Revised Chapter 18—Conducting the Title Insurance Company and Title Insurance Agent Examination

Mr. Ramge said that on Sept. 1, Mr. Helm had provided NAIC staff a draft of revised Chapter 18—Conducting the Title Insurance Company and Title Insurance Agent Examination, which incorporated verbal comments provided by Kent Dover (NH) and Ella Gower (American Land Title Association—ALTA) during the Working Group's July 30 conference call . Mr. Helm said that the draft chapter was e-mailed to the Working Group Sept. 2.

Mr. Ramge said the draft chapter already incorporated comments received in 2008 from Real Estate Services Providers Council (RESPRO), American Land Title Association (ALTA) and Old Republic National Title Insurance Company. Mr. Helm said he also added new language provided by Janette Adair (NE) for areas of missing text in Underwriting and Rating Standards 3, 4 and 5.

Ron Blitenthal (Old Republic Insurance Company) asked whether the interrogatory in Chapter 18 is to be followed verbatim or whether it is only a guideline. Mr. Ewen said that any review criteria found in the *Market Regulation Handbook* is used by a state as a suggested guideline. Mr. Helm agreed and said that the guidelines in the *Market Regulation Handbook* are to be applied where state laws are applicable, and the states can take out guidelines that do not apply.

Mr. Ramge said that the draft chapter will be considered for adoption at the next conference call, to give the Working Group, interested regulators and interested parties more time to review.

3. Review and Discuss New Jersey's July 30 Draft of Chapter 16—General Examination Standards, June 23 Draft of Chapter 17—Conducting the Property and Casualty Examination and June 23 E-mail

Ms. Narcini said she reviewed four property/casualty model laws that were adopted within the time period January 2007 to December 2008. She determined that the Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950) and the Automobile Insurance Fraud Guidelines (#1694) were not applicable to market conduct examination standards in the *Market Regulation Handbook.* She said that upon reviewing the Independent Adjuster Licensing Guidelines (#1224), she made revisions to the Producer Licensing section of Chapter 16 and the claims section of Chapter 17 regarding areas applicable to independent adjusters.

Ms. Narcini said her review of the Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970) resulted in drafting revisions to Standards 3–7 in Chapter 17—Conducting the Property and Casualty Examination. Although not related to the model law update, Ms. Narcini said she proposed revisions to language in the Producer Licensing section of Chapter 16 to reflect current law and process and to discourage collection of Social Security number data, particularly when the National Producer Number (NPN) is available.

Mr. Ewen made a motion to adopt the revisions to Chapter 16. Ms. Tracy Miller Biehn seconded the motion. The producer/adjuster licensing revisions to Chapter 16 were unanimously adopted (Attachment Four-B).

Mr. Hooker said he would review the Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950) to determine how to incorporate criteria into Chapter 17 to encompass regulator review of cancellation, rating and premium audit. Mr. Hooker said that he would be providing the Working Group with a draft for review and comment. Mr. Ramge said the comment period on the draft Chapter 17 would be extended until Oct. 1.

4. Review and Discuss Missouri's July 24 Drafts of Chapter 16—General Examination Standards, Chapter 19—Conducting the Life and Annuity Examination, Chapter 20—Conducting the Health Examination, Chapter 21—Conducting the Medical Supplement Examination and Chapter 22—Conducting the Long Term Care Examination

Mr. Mealer reported that he and Kevin Jones (MO) had reviewed the new and revised life and health-related models from the time period January 2007 to December 2008 and Chapters 16, 10, 20, 21 and 22 in the *Market Regulation Handbook*. Mr. Mealer said that he had added references to models in applicable standards within each chapter.

Mr. Mealer outlined the addition of models to Chapter 16 and his suggested revisions to the Producer Licensing Standard 2 to incorporate language requiring appropriate continuing education of producers. In the last paragraph of Section F.2.e., Declination Practices, Mr. Mealer provided language to complete the sentence. Mr. Mealer requested that NAIC staff add an additional model, the Unfair Trade Practices Act (#880), to the NAIC model references section of Underwriting and Rating Standard 7. Mr. Hooker made a motion to adopt Mr. Mealer's revisions to Chapter 16, with the addition of model #880 to the Underwriting and Rating Standard 7. Ms. Baker seconded the motion. The revisions to Chapter 16 were unanimously adopted (Attachment Four-C).

Mr. Mealer outlined the addition of models to Chapter 19 and his suggested revisions to regulator review procedures and criteria. Mr. Mealer added language to the review procedures and criteria section of Marketing and Sales Standard 1, stipulating that an examiner may review procedures a company has in place to monitor the use of senior-specific certifications or professional designations. Mr. Mealer also added language to Marketing and Sales Standard 1 regarding regulator review of the appropriateness of marketing and sales of life insurance and annuity products to members of the military. Mr. Mealer requested that NAIC staff add the word "with" to the language he had inserted into Marketing and Sales Standard 1 with regard to marketing and sales to military servicemembers. Mr. Mealer said that he had also included within Chapter 19 a new Marketing and Sales Standard 13 with regard to lawful travel restrictions. Mr. Ewen made a motion to adopt Mr. Mealer's revisions to Chapter 19, with the addition of the word "with" to Marketing and Sales Standard 1. Ms. Narcini seconded the motion. The revisions to Chapter 19 were unanimously adopted (Attachment Four-D).

Mr. Mealer outlined the addition of models to Chapter 20 and his suggested revisions regarding the addition of references to association group coverage and federally mandated benefits to the introductory paragraphs prior to Section A, Operations/Management. Mr. Mealer said he added revisions to Claims Standard 3 with regard to recent updates to the federal Mental Health Parity and Addiction Equity Act of 2008. Mr. Mealer said that he developed a new Claims Standard 4 that addresses the federal Women's Health and Cancer Rights Act of 1998. In Underwriting and Rating Standard 4, Mr. Mealer requested that NAIC staff add a reference to the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651). Mr. Hooker made a motion to adopt Mr. Mealer's revisions to Chapter 20, with the addition of the reference to model #651 to Underwriting and Rating Standard 4. Ms. Krier seconded the motion. The revisions to Chapter 20 were unanimously adopted (Attachment Four-E).

Mr. Mealer outlined the addition of a reference to the Review Procedures and Criteria section of the Marketing and Sales Standard in Chapter 21. Mr. Mealer said that he inserted language outlining restrictions on a regulatory entity that imposes waiting, elimination periods or probationary periods in replacement policies. Ms. Wallace said that the typographical error "eliminations periods" should be corrected to read "elimination periods." Ms. Narcini made a motion to adopt Mr. Mealer's revisions to Chapter 21, with the correction of the phrase "eliminations period" to "elimination period." Ms. LeDuc seconded the motion. The revisions to Chapter 21 were unanimously adopted (Attachment Four-F).

Mr. Mealer outlined the addition of a reference to the Review Procedures and Criteria section of the Operations/Management Standard 1 in Chapter 22 regarding the addition of a requirement for regulated entity proper procedures to ensure their producers are properly trained and that training meets the minimum standards established by applicable laws and regulations. Ms. Szumowski made a motion to adopt Mr. Mealer's revisions to Chapter 22. Mr. Ossi seconded the motion. The revisions to Chapter 22 were unanimously adopted (Attachment Four-G).

5. Review and Discuss Ohio Corporate Governance Documents

Mr. Ramge said that Ms. Baker had submitted documents for Working Group consideration containing proposed language regarding the addition of corporate governance (risk-focused) methodology to the *Market Regulation Handbook.* Mr. Ramge added that while Ohio's corporate governance documents are all posted on the Market Conduct Examination Standards Working Group Web page, two of the documents that were market-analysis related had been forwarded to the Market Analysis Procedures Working Group for review and comment. Mr. Ramge added that the two market analysis-related corporate governance documents were on the agenda for the Sept. 3 conference call of the Market Analysis Procedures Working Group.

Ms. Baker said that language regarding risk-focused methodology could be placed in Chapters 1, 2, 5, 8, 10, 12 and 16 of the *Market Regulation Handbook*. Mr. Ramge indicated that while this is a worthwhile effort, the recommended changes might not occur in 2009, because the language encompasses not just the examination standards and procedures in the *Market Regulation Handbook* but also the market-analysis related sections of the *Market Regulation Handbook.* Mr. Ramge asked that the Market Analysis Procedures Working Group review the documents and share any comments they might receive regarding the exposed documents with the Market Conduct Examination Standards Working Group, and he indicated that the Market Conduct Examination Standards Working Group would share any comments received with the Market Analysis Procedures Working Group.

Birny Birnbaum (Center for Economic Justice—CEJ) asked the Working Group for a better definition of the concept of "risk based." Mr. Birnbaum said that the documents presented by Ohio seem to describe an examination process rather than a market-analysis process. Mr. Birnbaum said that the purpose of market analysis is to get a picture of the marketplace and determine marketplace problems. Mr. Birnbaum asked whether the market analysis process would be replaced by the risk-focused approach to regulation. Mr. Birnbaum inquired of the Working Group what the trigger for a risk-focused surveillance approach would be. Mr. Birnbaum also asked whether the risk-focused methodology would be yet another tool in the regulator toolbox, and would the use of the risk-focused methodology on a regulated entity be prompted by indicators found during the regulators' market analysis process. Mr. Birnbaum recommended that the Working Group define a framework into which the risk-focused methodology would be incorporated.

Ms. Baker said that the risk-based approach is not an examination, and it does not replace the examination process. Ms. Baker said that when issues are known to the regulator, the corporate governance (risk-focused approach) is used to question the regulated entity regarding how they are overseeing, managing or auditing that particular area of concern.

Kelly Ireland (American Council of Life Insurers—ACLI) said that the surveillance approach outlined in Ohio's documents is similar to the approach utilized on the financial examination side. Ms. Ireland said that the financial examination process took several years to formulate, and that the development of a market surveillance process similar to the financial surveillance process would take years to accomplish.

Marty Mitchell (America's Health Insurance Plans—AHIP) said that he is also not clear regarding how the risk-focused approach ties into the current market regulation process. Mr. Mitchell, Ms. Ireland and Mr. Birnbaum said that they would be submitting comments to the Working Group regarding the risk-focused documents. Petra Wallace (NAIC) asked that all comments regarding risk-based methodology be forwarded to her so that the comments could posted online to share with the Market Analysis Procedures Working Group, interested regulators and interested parties.

6. Any Other Matters Before the Working Group

Mr. Ramge said that the Chapter 25—Conducting the Statistical Agent Examination had been adopted by the Property and Casualty Insurance (C) Committee in December 2008 and subsequently adopted by the Market Regulation and Consumer Affairs Committee at the Summer National Meeting. Mr. Ramge asked for a recommendation regarding how to make the revised chapter available to regulators. Ms. LeDuc suggested that it be posted as part of the *Market Regulation Handbook* reference documents on I-SITE/StateNet. Ms. Wallace said that NAIC staff would post the document there and would send regulators an e-mail notification once it had been posted.

Mr. Ramge said that there are a few areas within the *Market Regulation Handbook* where areas of missing text have been identified. Ms. Wallace indicated that the areas where text is missing (incomplete sentences and whole sections missing) go back several years, and the sections need regulator review and completion. Ms. Narcini and Mr. Mealer volunteered to help assist with this effort.

Mr. Ramge said the Working Group's next call would be Oct. 8. He added that the due date for comments on all currently exposed items has been extended to Oct. 1.

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

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Draft: 8/6/09

Market Conduct Examination Standards (D) Working Group
Conference Call
July 30, 2009

The Market Conduct Examination Standards (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call July 30, 2009. The following Working Group members participated: Bruce Ramge, Chair (NE); Carol O'Bryan, Jeff Olsen and Paula Sisneros (CO); Luther Ellis (DC); Charles Kelly (FL); Mark Ossi (GA); Laura Moore (KY); Ron Musser (LA); Paul Hanson (MN); Jim Mealer (MO); Tracy Miller Biehn (NC); J. Kent Dover, Jr. (NH); Anne Marie Narcini (NJ); Peter Camacci (PA); Gregory Lee (VA); Mark Hooker (WV); and Sue Ezalarab and Jo LeDuc (WI).

1. Adoption of Minutes of June 24, 2009, Conference Call

Mr. Hooker made a motion to adopt the minutes of the Working Group's June 24 conference call. Ms. Ezalarab seconded the motion. The minutes were unanimously adopted (Attachment Four-A1).

2. Review and Discuss Colorado's 6/24/09 Draft of Revised Chapter 18—Conducting the Title Insurance Company and Title Insurance Agent Examination

Mr. Ramge said a revised Chapter 18—Conducting the Title Insurance Company and Title Insurance Agent Examination was drafted by Andy Helm (CO). Mr. Ramge said the chapter incorporated comments received in 2008 from the Real Estate Services Providers Council (RESPRO), the American Land Title Association (ALTA) and Old Republic National Title Insurance Company. Mr. Ramge said Mr. Helm had also added new language provided by Janette Adair (NE) for areas of missing text in Underwriting and Rating Standards 3, 4 and 5.

Mr. Dover said the word "filings" should be added to the first sentence of the Review Procedures and Criteria section of Underwriting and Rating Standard 3 so that sentence would read, "Review a random sample of real estate transaction closing 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)."

Ella Gower (ALTA) asked that the Working Group consider revising the first paragraph of Section K Example Title Letter to increase the time period from 7 business days to 10-14 business days for a regulated entity to respond to the title letter. Ms. Gower asked that the Working Group consider placing the word "financial" in front of the word "pro forma" in Section L Example Title Interrogatory to clarify that only financial pro forma statements are required to be provided to regulators, upon request. Ms. Gower said ALTA had proposed three interrogatories to add to the subsection regarding settlement producers in Section L Example Title Interrogatory. She explained that the purpose of the proposed interrogatories is to identify where an affiliate of a title company is providing economic inducements to a producer to encourage a producer to refer business to a title company. She said ALTA's suggested interrogatories are referenced in page 6 of ALTA's August 18, 2008 letter. Ms. Gower requested that the Working Group consider changing the date of the postmark of the regulated entity response to the interrogatory from 20 calendar days to 40 calendar days.

Mr. Dover said changing the language to 40 days would allow too long of a time frame for the regulated entity's response. Mr. Mealer said that perhaps a provision could be added: "…unless such company or person demonstrates to the satisfaction of the commissioner that the requested records cannot be provided within X [the required number] of days." Mr. Mealer stated that this provision is currently found in Missouri law. Mr. Dover said this provision is found in New Hampshire law also. Mr. Ramge asked Ms. Gower to submit ALTA's comments directly to Mr. Helm, the author of the draft Chapter 18. Mr. Ramge asked that Mr. Helm address ALTA's comments and Mr. Dover's comments and provide a revised draft for the Working Group's consideration before the next Working Group conference call so this item can be adopted at the next call.

3. Review and Discuss 6/23/09 Draft Revised Commercial Property and Casualty Standardized Data Request and 6/23/09 Summary of Revisions

Ms. LeDuc said that on June 23 she had provided for Working Group consideration a revised draft commercial property and casualty standardized data request containing New Hampshire's 2008 comments, along with a document summarizing all changes.

Mr. Hooker referred to his submitted comments dated July 22 regarding the inclusion of workers' compensation fields to the draft standardized data request. Ms. LeDuc recommended that the workers' compensation fields Mr. Hooker submitted be incorporated into existing fields, with the stipulation that the field length be reduced to eight characters. Ms. LeDuc made a motion to adopt the revised commercial property and casualty standardized data request, with the reduction to eight-character-length fields, the incorporation of Mr. Hooker's workers' compensation fields into existing fields, and the incorporation of the workers' compensation claim feature code at the bottom of the claim feature codes section in the draft standardized data request. Petra Wallace (NAIC) volunteered to coordinate with Ms. LeDuc to make these technical changes. Mr. Dover seconded the motion. The revised commercial property and casualty standardized data request was unanimously adopted (Attachment Four-A2).

4. Draft Chapter 12—Scheduling, Coordinating and Communicating

Mr. Ramge said that on May 11 he had provided for Working Group consideration an exposure draft of Chapter 12—Scheduling, Coordinating and Communicating, which had been revised to include language regarding contract examiner oversight. Mr. Hooker referred to his submitted comments dated June 25 regarding the inclusion of a footnote to the new section titled "Internal Data Requested from Insurance Department." Mr. Hooker said the footnote would set forth that the information gathered does not have to be compiled prior to an examination being approved; rather, the information can be compiled as long as it is done before the examination starts.

Mr. Camacci recommended that the first item in Subsection 2.b.1, entitled Content of Notice in Section G Notice of Examination Reported to ETS, should be revised to read "The scope, intent and period to be covered by the examination and estimated examination time frame." Mr. Camacci also recommended that Subsection 5 of Section Q Post-Examination be revised to read, "This conference should be held at a mutually agreed upon location."

Ms. Narcini made a motion to adopt the revisions to Chapter 12, the inclusion of Mr. Hooker's footnote and the addition of Mr. Camacci's recommendations. Mr. Camacci seconded the motion. The revised Chapter 12 was unanimously adopted (Attachment Four-A3).

5. Review and Discuss WV Draft Medical Professional Liability-Related Standards

Mr. Hooker said he had incorporated a reference to the Medical Professional Liability Closed Claim Model Reporting Law into three separate examination standards, in order to reflect various options for the Working Group to consider. He said the most restrictive option would be to include the model in Claims Standard 3 of Chapter 17—Conducting the Property and Casualty Examination. He said a broader option would be to incorporate the model into the Operations and Management section of Chapter 17. He said the broadest option, and therefore the option he would recommend, would be to incorporate the model and draft language into the Operations and Management section of Chapter 16—General Examination Standards, as a new Standard 18.

Mr. Mealer made a motion to incorporate the new Standard 18 into the Operations and Management section of Chapter 16. Ms. Narcini seconded the motion. The new Standard 18 was unanimously adopted (Attachment Four-A4).

6. Review and Discuss New Jersey 6/23/09 Draft Chapter 16—General Examination Standards and Chapter 17—Conducting the Property and Casualty Examination

Ms. Narcini said she reviewed four property/casualty model laws that were adopted within the time period January 2007–December 2008. She determined that the Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950) and the Automobile Insurance Fraud Guidelines (#1694) were not applicable to market conduct examination standards in the *Market Regulation Handbook.* She said that upon reviewing the Independent Adjuster Licensing Guidelines (#1224), she made revisions to the Producer Licensing section of Chapter 16 and the claims section of Chapter 17 regarding areas applicable to independent adjusters.

Ms. Narcini said her review of the Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970) resulted in drafting revisions to Standards 3-7 in Chapter 17—Conducting the Property and Casualty Examination. Although not related to the model law update, Ms. Narcini said she proposed revisions to language in the Producer Licensing Section of Chapter 16 to reflect current law and process and to discourage collection of Social Security number data, particularly when the National Producer Number (NPN) is available.

Mr. Hooker said he would review the Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950) to determine if it needed to be incorporated into the chapters of the *Market Regulation Handbook*. Ms. Narcini added that she would be submitting additional revisions to Chapter 16 to correct references to National Producer Numbers. Mr. Ramge said the comment period on this item would be extended until Aug. 26.

7. Review and Discuss Ohio Corporate Governance Documents

Mr. Ramge said that Lynette Baker (OH) had submitted documents for Working Group consideration containing proposed language regarding the addition of corporate governance (risk-focused) methodology to the *Market Regulation Handbook.* Mr. Ramge reminded the Working Group of the scope of the Working Group's charges—to make revisions to examination standards and procedures. He said Ohio's currently submitted corporate governance document relating to examination standards/methodology (the revision of Chapter 8—Examination Introduction) will remain on the Working Group's agenda in 2009. He said the remainder of the Corporate Governance documents submitted by Ohio (two documents relating to market analysis) will be forwarded to the Market Analysis Procedures (D) Working Group for exposure, review and comment. Mr. Ramge said three documents will remain on the Working Group Web page so that they are exposed together until the next Working Group call.

8. Any Other Matters Before the Working Group

Mr. Mealer reported that he had been reviewing the life and health-related models and applicable chapters in the *Market Regulation Handbook*. He said he had provided NAIC staff with revisions to Chapters 16, 19, 20, 21 and 22. Ms. Wallace said an e-mail notification would be sent to the Working Group, interested regulators and interested parties when the drafts are posted on the Working Group Web page. Mr. Ramge asked that the Working Group review as soon as possible so the chapters can be adopted on the next conference call and proceed to the Market Regulation and Consumer Affairs (D) Committee for adoption at the Fall National Meeting.

Mr. Ramge said Commissioner Kim Holland (OK) had asked that the Working Group not proceed with the addition of any language from the Insurance Marketplace Standards Association—IMSA in the *Market Regulation Handbook*. Commissioner Holland said the Working Group should wait for the Suitability in Annuity Sales (A) Working Group to finish their work in this area before proceeding.

Mr. Ramge said the Working Group's next call would be September 2. He added that the due date for comments on all currently exposed items has been extended to Aug. 26. The due date for comments on all new drafts will also be Aug. 26.

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

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Draft: 7/14/09

Market Conduct Examination Standards (D) Working Group
Conference Call
June 24, 2009

The Market Conduct Examination Standards (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call June 24, 2009. The following Working Group members participated: Bruce Ramge, Chair (NE); Andy Helm and Paula Sisneros (CO); Luther Ellis (DC); Charles Kelly (FL); Mark Ossi (GA); Laura Moore (KY); Ron Musser (LA); Jim Mealer and Win Nickens (MO); Lalita Wells (NC); J. Kent Dover, Jr., and Edwin Pugsley (NH); Anne Marie Narcini (NJ); Angie Dingus (OH); and Sue Ezalarab and Jo LeDuc (WI).

1. Review 2008 Market Regulation Handbook (D) Working Group: Carry-Over Items

Mr. Ramge said a revised Chapter 18—Conducting the Title Insurance Company and Title Insurance Agent Examination was drafted by Mr. Helm and submitted to NAIC staff June 24. Mr. Helm said that the June 24 draft is a revised version of Colorado's November 2008 draft. Mr. Helm added that the differences between the two documents is that in Subsection 1 of Section H. Escrow, Settlement, Closing or Security Deposit Funds additional language suggested by the American Land Title Association (ALTA) was added, indicating that title agencies sometimes perform the function of escrow holder in certain jurisdictions. Mr. Helm said that in Standard 3 of Escrow, Settlement, Closing or Security Deposit Funds, per ALTA's comment, the word "unconditionally" was removed and the words "available for disbursement" were added.

Mr. Helm said that the language for the Underwriting and Rating Standards 3, 4 and 5 that had been exposed for comment had also been added to the June 24 draft. Ella Gower (ALTA) said that ALTA is reviewing Standards 3, 4 and 5 and will be submitting comments soon. Petra Wallace (NAIC) said that the June 24 draft would posted on the Working Group's Web page for review and comment.

Mr. Ramge said Ms. LeDuc completed a draft of a Commercial Property and Casualty Standardized Data Request, which was exposed and discussed by the Market Regulation Handbook (D) Working Group in 2008. Ms. LeDuc said that on June 23 she had submitted to NAIC staff a revised draft containing New Hampshire's comments, along with a summary document regarding the changes.

Mr. Hooker asked whether the scope of the Standardized Data Request included workers' compensation claims. Ms. LeDuc said that she added workers' compensation-related fields to the draft. Mr. Hooker said that he would review the draft and provide comments. Ms. Wallace said that the June 23 draft would be posted on the Working Group's Web page for review and comment.

3. Draft Chapter 12—Scheduling, Coordinating and Communicating

Mr. Ramge said that no comments had been received regarding the draft Chapter 12. Mr. Ramge indicated he had received an informal comment from a regulator asking about consistent usage of the phrase "market response" vs. "market action" throughout the chapter. Mr. Ramge said that he had received requests from regulators to extend the comment period on this item. Mr. Mealer said that he would be submitting comments on the draft.

4. Property/Casualty and Life/Health NAIC Models January 2007 – December 2008

Mr. Hooker said that he had reviewed the property/casualty model regarding medical malpractice loss statistical reporting and drafted three options for medical malpractice examination standards regarding the capture of data. Mr. Hooker said that the first option adds additional criteria to Claims Standard #3 in Chapter 16—General Examination Standards. Mr. Hooker said that the second option creates a new Operations and Management standard in Chapter 17 and the third option creates a new Operations and Management standard in Chapter 16. Mr. Hooker said that the drafts had only been posted for comment last week and, therefore, more time would be needed for regulators and interested parties to review the drafts and provide comments.

Ms. Narcini said that she reviewed four property/casualty model laws. She determined that the Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950) and the Automobile Insurance Fraud Guidelines (#1694) were not applicable to market conduct examination standards.

Ms. Narcini said that she had submitted a draft Chapter 16—General Examination Standards and Chapter 17—Conducting the Property and Casualty Examination to NAIC staff on July 23. Ms. Narcini said that her review of the Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970) resulted in drafting revisions to existing standards in Chapter 17—Conducting the Property and Casualty Examination. Ms. Narcini said that upon reviewing the Independent Adjuster Licensing Guidelines (#1224), she made revisions to existing standards in Chapter 16 and Chapter 17 regarding areas applicable to independent adjusters.

Ms. Narcini said that she also cleaned-up the producer-related examination standards in Chapter 16 to correspond with the direction provided by the most recent version of the Producer Licensing Model Act (#218). Ms. Wallace said that the June 23 drafts would posted on the Working Group's Web page for review and comment.

Mr. Mealer reported that he had been reviewing the life/health-related models and applicable chapters in the *Market Regulation Handbook*. Mr. Mealer said that he would provide draft revised market conduct examination standards to Ms. Narcini and Peter Camacci (PA) to review within a couple of weeks. Mr. Mealer said that he also will be asking John Humphries (AGI Services) to review revisions made to examination standards regarding inappropriate marketing practices targeting military servicemembers.

5. Any Other Matters Before the Working Group

Ms. Dingus said that Lynette Baker (OH) had submitted documents to NAIC staff June 24 containing proposed revisions regarding the addition of corporate governance methodology to Chapters 1, 2, 5, 8, 10, 12 and 16 of the *Market Regulation Handbook.* Ms. Wallace said that the June 24 draft would posted on the Working Group's Web page for review and comment.

Don Walters (Insurance Marketplace Standards Association—IMSA) said that over the past year, IMSA had conducted a survey, with the assistance of several state insurance departments, regarding annuity suitability supervision and monitoring practices. Mr. Walters said that some regulators had asked IMSA whether key findings of the survey could be made available in the *Market Regulation Handbook*.

Mr. Ramge said there are ongoing discussions with NAIC staff regarding how to present the IMSA information to the Working Group. Mr. Ramge said he would provide an update to the Working Group and to Don Walters regarding how to proceed on this issue.

Mr. Ramge said the Working Group's next call would be July 30. Mr. Ramge added that the due date for comments on all currently exposed items has been extended to July 23. The due date for comments on all new drafts also will be July 23. Ms. Wallace said that an e-mail notification would be sent to the Working Group, interested regulators and interested parties when submitted drafts are posted on the Working Group's Web page.

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

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Commercial Property and Casualty Standardized Data Request

NOTES for Commercial Lines Master Field List:

1) **The type and scope of each examination would determine which tables and fields to request.**
2) **The P&C Commercial Lines Master Data Call Field List~~ing~~ is a compilation of common data fields from which to select data ~~majority of~~ fields ~~that could~~ to be used in ~~requested in~~ an examination request. ~~Not all fields would be requested.~~ This listing is based on NAIC models and needs to be modified by individual states to capture data elements not listed but necessary to test compliance with ~~for~~ each state's own laws, regulations, audit procedures, examination scope, and the priorities of the examination.**
3) **The field sizes are a guide. Each Company may have different size fields in their databases or may not maintain a certain field in their database. The Company should provide a revised layout form indicating the differently sized fields or fields that are not maintained in their database. If fields are not maintained in Company databases, a determination should be made as to where and when the information would be available to the examiner or if the data is needed for the scope or type of examination.**
4) **Data received from the Company should be reconciled to a control total number of records sent to the examiner with the data files, and also reconciled, if possible, to any amounts that could be used as control totals. The data should be reviewed to make sure it is the correct data for the intended use and the data falls within the time frame of the examination.**

P&C Commercial Lines Master Data Call ~~Request Information~~Field List					
Field Name	**Length**	**Type**	**Deci-mals**	**Description**	**"R" = ~~Applicable~~ Suggested ~~to~~for Rating Data Call**
AddPrm	8	N	0	Additional Premium Needed to Meet Minimum Premium Requirement, if any	R
AdjFirst	15	A		Assigned adjuster's first name	
AdjLast	15	A		Assigned adjuster's last name	
AgtCode	10	A		Agent/Producer Company Code Number	
AmtPd	9	N	2	Amount of claim paid	
AppProDt	8	N		Date application processed	
ApprDt	8	N		Date of appraisal	

Commercial Property and Casualty Standardized Data Request

P&C Commercial Lines Master Data Call ~~Request Information~~Field List					
Field Name	**Length**	**Type**	**Deci-mals**	**Description**	**"R" = ~~Applicable~~ Suggested ~~to~~for Rating Data Call**
AppRecDt	8	N		Date application received	
Bclass	20	A		General Description of Business Type (i.e. Mercantile, Service, Retail, Manufacturing, etc…)	
BiDev	6	N	4	Bodily Injury or Combined Single Limit Liability Miscellaneous Deviation Factor (i.e. Package Credit) *[Repeat the BiDev field as necessary in order to list each bodily injury deviation factor applicable to the policy, name the new fields by adding the appropriate number to the end of the base field name, and include a revised file layout. For example, BiDev1, BiDev2, BiDev3, etc.]*	R
BIFLT	6	N	4	Bodily Injury or Combined Single Limit Liability Fleet Factor	R
BIILF	6	N	4	Bodily Injury or Combined Single Limit Liability Increased Limits Factor	R
BILC	6	N	2	Bodily Injury or Combined Single Limit Liability Loss Cost	R
BILCM	6	N	4	Bodily Injury or Combined Single Limit Liability Loss Cost Multiplier	R
BILmt	11	A		Bodily Injury (in thousands) or Combined Single Limit Liability Limit per person	R
BIMISC	6	N	2	Bodily Injury or Combined Single Limit Liability Flat Dollar Miscellaneous Fee, Charge or Credit	R
BIPRIM	6	N	4	Bodily Injury or Combined Single Limit Liability Primary Class Factor	R
BIsec	6	N	4	Bodily Injury or Combined Single Limit Liability Secondary Class Factor	R
BITrm	6	N	2	Bodily Injury or Combined Single Limit Liability Policy Term Factor	R
BrOff	30	A		The name or code for the branch office where the policy or claim file is located (if applicable). *Provide a list of codes*	

Commercial Property and Casualty Standardized Data Request

P&C Commercial Lines Master Data Call ~~Request Information~~Field List					
Field Name	**Length**	**Type**	**Deci-mals**	**Description**	**"R" = ~~Applicable~~ Suggested ~~to~~for Rating Data Call**
CClass	8	A		Classification Code for a Covered Classification Code. [*Repeat the CClass field as necessary in order to list a classification code for each classification appearing on the policy, name the new fields by adding the appropriate number after the base field name, and include a revised file layout. For example, CClass1, CClass2, CClass3, etc.]*	R
ClaimNo	9	A		Claim number	
Class	5	A		The Protection class assigned to the primary location.	R
ClDes	20	A		Classification Description for a Covered Classification Code. *[Repeat the ClDes field as necessary in order to list the classification description for each classification appearing on the policy, name the new fields by adding the appropriate number after the base field name, and include a revised file layout. For example, ClDes1, ClDes2, ClDes3, etc.]*	R
ClmClass	4	A		The class code applicable to the claim	
ClmPyrl	8	N		The amount of payroll associated with the class code applicable to the claim	
ClmType	3	A		Claim type (i.e. Denied Claim (DEN) or Closed Without Payment (CWP) to the insured/claimant) designator	
ClsdDt	8	N		Date claim closed (CCYYMMDD)	
CMnPrm	8	N	0	Coverage Minimum Premium *[Repeat the CMnPrm field as necessary in order to list each minimum premium applicable to a coverage included on the policy, name the new fields by adding the appropriate number after the base filed name, and include a revised file layout For example, CMnPrm1, CMnPrm2, CMnPrm3, etc].*	R
CmtFirst	25	A		Claimant first name (if applicable)	
CmtLast	25	A		Claimant last name (if applicable)	
CnDt	8	N		Cancellation or~~,~~ termination ~~or Nonrenewal~~ effective date (CCYYMMDD)	

Commercial Property and Casualty Standardized Data Request

P&C Commercial Lines Master Data Call ~~Request Information~~Field List					
Field Name	**Length**	**Type**	**Deci-mals**	**Description**	**"R" = ~~Applicable~~ Suggested ~~to~~for Rating Data Call**
CoCode	5	A		NAIC company code (if file contains more than one company)	
CoName	50	A		Name of the company the policy was written in (if file contains more than one company)~~.~~	
CoType	11	A		Company Type: (i.e. Individual, Corporation, Partnership, ABC Board or Other, etc.)	
CovLmt	9	N	0	Coverage limit, if applicable	R
DeclDte	8	N		Declination date (CCYYMMDD), the date the risk was declined	
DcReCd	3	A		Declination reason code *[Provide a list of reason codes]*	
Deduct	9	N	0	For when coverage limit is not applicable	R
DteCk	8	N		The date the claims feature was paid and closed *[Repeat for each opened, paid, and closed feature in the claim file]*	
Dev	6	N	4	Miscellaneous Deviation. *[Repeat the "Dev" field as necessary in order to list each miscellaneous deviation, name the new fields by adding the appropriate number after the base field name, and include a revised file layout. For example, Dev1, Dev2, Dev 3, etc.]*	R
Dlrdsc	10	N	2	Premium Discount in Dollars	R
DOL	8	N		Date of loss (CCYYMMDD)	
EaAcClmt	9	N	0	Bodily Injury Limit Per Accident	R
EaEmpLmt	9	N	0	Bodily Injury by Disease Per Employee	R
EffDt	8	N	0	Policy Effective Date (CCYYMMDD)	
Endors	10	A		Endorsements added to policy *[Repeat the Endors field as necessary in order to list each endorsement, name the new fields by adding the appropriate number after the base field name, and include a revised file layout. For example, Endors1, Endors2, Endors3, etc.]*	

Commercial Property and Casualty Standardized Data Request

P&C Commercial Lines Master Data Call ~~Request Information~~Field List					
Field Name	**Length**	**Type**	**Deci-mals**	**Description**	**"R" = ~~Applicable~~ Suggested ~~to~~for Rating Data Call**
EndRec	1	A		End of record marker. Please place an asterisk in this field to indicate the end of the record. *This must be in the same character position for every record in this table.*	
EstDt1	8	N		Date estimate received (first party)	
EstDt3	8	N		Date estimate received (third party)	
ExpCnst	8	N	0	Expense Constant	R
ExpDt	8	N		The expiration date of the policy. (CCYYMMDD)	
ExpMod	15	N		The experience modification applied to the policy, if any~~.~~	R
FeatCd	4	A		Type of claim feature code (use one of the claim feature codes listed below) *[Repeat the FeatCd field as necessary in order to list each feature within a claim, name the new fields by adding the appropriate number after the base field name, and include a revised file layout. For example, FeatCd1, FeatCd2, FeatCd3, etc.]*	
FNotDt	8	N		Date of first notice (CCYYMMDD)	
FPmtDt	8	N		Date of first payment (CCYYMMDD)	
FrstThrd	5	A		Whether it was a first or third party claim	
GovClss	6	A		The Governing classification code applicable to the policy~~.~~	R
IC	6	N	2	Loss Cost for a Covered Classification. *[Repeat the IC field as necessary in order to list each classification lost cost, name the new fields by adding the appropriate number after the base field name, and include a revised file layout. For example, IC1, IC2, IC3, etc.]*	R
ICity	25	A		Insured's City for the primary insured location	
ILF	6	N	4	Increased Limits Factor	R
IncpDt	8	N		Original policy inception date (CCYYMMDD)	
InsName	50	A		Named Insured	
InvsDt	8	N		Date investigation completed	

Commercial Property and Casualty Standardized Data Request

P&C Commercial Lines Master Data Call ~~Request Information~~Field List					
Field Name	**Length**	**Type**	**Deci-mals**	**Description**	**"R" = ~~Applicable~~ Suggested ~~to~~for Rating Data Call**
IState	2	A		Insured's State for the primary insured location.	
IStrt	25	A		Insured's Address for the primary insured location.	
IZip	9	A		Insured's zip code for the primary insured location.	
JudMod	5	N		Any other Judgmental modification made to the policy.	R
JudModCd	25	A		The type or name of the judgmental modification utilized. *[Provide a list of codes.]*	R
LCM	6	N	4	Loss Cost Multiplier	R
LiabLmt	10	A		Liability Coverage Occurrence Limit	R
LOB	20	A		Line of Business – Valid entries would include but not be limited to: "CMP" or "Commercial Liability", "WC" or Workers Comp", "BOP" or "Business Owners Policy", "CAU" or 'Commercial Auto", etc. *[Provide a list of codes if applicable.]*	
LPymtDt	8	N		Date of last payment was made to the insured (CCYYMMDD)	
MinPrem	10	N	2	Policy Minimum Premium, if applicable	R
MPBase	6	N	2	Medical Payments Base Premium	R
MPDev	6	N	4	Medical Payments Miscellaneous Deviation Factor (i.e. Package Credit) *[Repeat the MPDev field as necessary in order to list each Medical Payment Miscellaneous Deviation Factor applicable to the policy, name the new fields by adding the appropriate number after the base filed name, and include a revised file layout For example, MPDev1, MPDev2, MPDev3, etc].*	R
MPlmt	10	A		Medical Payments Limit	R
MPMISC	6	N	2	Medical Payments Flat Dollar Miscellaneous Fee, Charge or Credit	R
MPPRIM	6	N	4	Medical Payments Primary Class Factor	R
MPsec	6	N	4	Medical Payments Secondary Class Factor	R
MPTrm	6	N	2	Medical Payments Policy Term Factor	R
NARD	8	N		The normal anniversary rating date of the policy	R

Commercial Property and Casualty Standardized Data Request

P&C Commercial Lines Master Data Call ~~Request Information~~Field List					
Field Name	**Length**	**Type**	**Deci-mals**	**Description**	**"R" = ~~Applicable~~ Suggested ~~to~~for Rating Data Call**
NonReDt	8	N		The nonrenewal effective date	
NotDt	8	N		Date the Cancellation, termination or nonrenewal notice was mailed (CCYYMMDD)	
NotfDt	8	N		Date of the first notice of claim was received (CCYYMMDD)	
NoVeh	3	N		The number of vehicles insured under the policy~~.~~	R
OincpDt	8	N		Original policy inception date (CCYYMMDD)	R
~~OJudMod~~	~~15~~	~~N~~	-	~~Any other Judgmental modification made to the policy.~~	~~R~~
Pcoilf	6	N	4	Products/Completed Operations (Loss Cost Increased Limits Factor)	R
PcOlc	6	N	2	Products/Completed Operations Loss Cost	R
Pcolcm	6	N	4	Products/Completed Operations (Loss Cost Multiplier)	R
PcoMD	6	N	4	Products/Completed (Operations Miscellaneous Rate Modifier 1) [*Repeat the "PcoMD" fields as necessary, name the new field by adding the appropriate number after the base field name, and include a revised file layout. For example, PcoMD1, PcoMD2, PCOMD2, etc.]*	R
PCOXps	6	N	0	Products/Completed Operations Number of Exposures	R
PDDFPkg	6	N	4	Property Damage Liability Miscellaneous Deviation Factor (i.e. Package Credit)	R
PDDFSch	6	N	4	Property Damage Liability Miscellaneous Deviation Factor (i.e. Schedule or Experience Credit)	R
PDFLT	6	N	4	Property Damage Liability Fleet Factor	R
PDILF	6	N	4	Property Damage Liability Increased Limits Factor	R
PDLC	6	N	2	Property Damage Liability Loss Cost	R
PDLCM	6	N	4	Property Damage Liability Loss Cost Multiplier	R
PDlmt	10	A		Property Damage Liability Limit	R
PDMISC	6	N	2	Property Damage Liability Flat Dollar Miscellaneous Fee, Charge or Credit	R
PDPRIM	6	N	4	Property Damage Liability Primary Class Factor	R

Commercial Property and Casualty Standardized Data Request

P&C Commercial Lines Master Data Call ~~Request Information~~Field List					
Field Name	**Length**	**Type**	**Deci-mals**	**Description**	**"R" = ~~Applicable~~ Suggested ~~to~~for Rating Data Call**
PDsec	6	N	4	Property Damage Liability Secondary Class Factor	R
PDTrm	6	N	2	Property Damage Liability Policy Term Factor	R
PFormA	10	A	2	Policy form deductible amount *[Repeat the PFormA field as necessary in order to list each policy form deductible amount applicable to the policy, name the new fields by adding the appropriate number at the base field name, and include a revised file layout. For example, PFormA1, PFormA2, PFormA3, etc.]*	R
PFormL	10	A	2	Policy form limit of insurance [Repeat the PFormL field as necessary *in order to list each policy form limit applicable to the policy, name the new fields by adding the appropriate number at the base field name, and include a revised file layout. For example, PFormL1, PFormL2, PFormL3, etc.]*	R
PkgCr	5	N		The package credit applied to the policy.	R
POLC	6	N	2	Premises/Operations Loss Cost	R
PolCM	6	N	4	Premises/Operations Loss Cost Multiplier	R
PolDt	8	N		Policy effective date (CCYYMMDD)	
PolF	6	N	4	Premises/Operations Loss Cost Increased Limits Factor	R
PolForm	10	A		Policy coverage form	
PolLmt	9	N	0	Policy Limit for Bodily Injury by Disease	R
PolNo	15	A		Policy Number	
PolPrefx	4	A		Policy Prefix (if applicable)	
~~PolPrem~~	~~9~~	~~N~~	~~2~~	~~The policy premium for the term~~	
PolType	15	A		The policy type	

Commercial Property and Casualty Standardized Data Request

P&C Commercial Lines Master Data Call ~~Request Information~~Field List					
Field Name	**Length**	**Type**	**Deci-mals**	**Description**	**"R" = ~~Applicable~~ Suggested ~~to~~for Rating Data Call**
PoMD	6	N	4	Premises/Operations Miscellaneous (Rate Modifier 1) *[Repeat the "PoMD" field as necessary in order to list each miscellaneous Premises/Operations modifier applicable to the policy, name the new fields by adding the appropriate number after the base field name, and include a revised file layout. For example, PoMD1, PoMD2, PoMD3, etc.]*	R
PoXps	6	N	0	Premises/Operations Number of Exposures	R
PremChg	10	N	2	Amount of premium charged insured	R
PremDisc	8	N		The premium discount applied to the policy~~.~~	R
~~PremTot~~	~~10~~	~~N~~	~~2~~	~~Total Policy Premium~~	
PrmDsc	6	N	4	Premium Discount Factor	R
Program	50	A		The program within which the policy is written (if applicable)~~.~~	
PropLmt	10	A		Total of Building and Business Personal Property Coverage Limits	R
PyRll	10	N	2	Remuneration Payroll for 1st Covered Class. [*Repeat the PyRll field as necessary in order to list the remuneration payroll for each classification code, name the new fields by adding the appropriate number after the base field name, and include a revised file layout. For example, PyRll1, PyRll2, PyRoll3, etc.]*	R
Radius	25	A		Literal Description of Radius, Use & Weight of Vehicle (i.e. Local Service 25000)	R
RateFact	5	N	5	Prorate or short rate factor applied to premium refund	
RatePlan	9	A		Enter "Voluntary" "Facility" or "Other"	R
ReasClsd	25	A		Specific ~~R~~reason for the claim ~~closed~~ denial or reason code for the denial *[If the supplying a reason code instead of the specific reason, provide a list of reason codes]*	
ReasCode	20	A		Reason for the cancellation, termination or nonrenewal *[Provide list of reason codes]*	
RfnDt	8	N		Refund date (CCYYMMDD)	
RptDt	8	N		Date the claim was first reported (CCYYMMDD)	
Salvage	9	N	2	Amount of salvage recovered	

Commercial Property and Casualty Standardized Data Request

P&C Commercial Lines Master Data Call ~~Request Information~~Field List					
Field Name	**Length**	**Type**	**Deci-mals**	**Description**	**"R" = ~~Applicable~~ Suggested ~~to~~for Rating Data Call**
SchCrt	6	N~~n~~	4	Schedule Rating Credit Factor	R
SchMod	15	N		The schedule, IRPM or other merit rating modification applied to the policy~~.~~	R
Source	1	A		The source of the business, Producer (P) or Direct (D)	
SubAmt	10	N	2	Amount of subrogation reimbursed to insured	
SubCDt	8	N		Date subrogation was closed (CCYYMMDD)	
SubDt	8	N		Date of subrogation demand (CCYYMMDD)	
SubOwed	10	N	2	Amount of subrogation still owed to insured	
SubRDt	8	N		Date Subrogation Amount was reimbursed to insured (CCYYMMDD)	
SubRec	10	N	2	Amount recovered by company via subrogation	
Terr	6	A		Rating Territory	R
UMBase	6	N	2	Uninsured/Underinsured Motorist Bodily Injury Base Premium	R
UMDev	6	N	4	Uninsured/Underinsured Motorist Bodily Injury Miscellaneous Deviation Factor (i.e. Package Credit) *[Repeat the UMDev field as necessary in order to list each uninsured/underinsured motorist bodily injury miscellaneous deviation factor applicable to the policy, name the new fields by adding the appropriate number to the end of the base field name, and include a revised file layout. For example, UMDev1, UMDev2, UMDev3, etc.]*	R
UMLmt	11	A		Uninsured/Underinsured Motorist Bodily Injury Limit (in thousands)	R
UMMISC	6	N	2	Uninsured/Underinsured Motorist Bodily Injury Flat Dollar Miscellaneous Fee, Charge or Credit	R
UMTrm	6	N	2	Uninsured/Underinsured Motorist Bodily Injury Policy Term Factor	R
UP~~_lmt~~Lmt	10	A		Uninsured Motorist Property Damage Limit	R
UPBase	6	N	2	Uninsured Motorist Property Damage Base Premium	R

Commercial Property and Casualty Standardized Data Request

P&C Commercial Lines Master Data Call ~~Request Information~~Field List					
Field Name	**Length**	**Type**	**Deci-mals**	**Description**	**"R" = ~~Applicable~~ Suggested ~~to~~for Rating Data Call**
UPDev	6	N	4	Uninsured Motorist Property Damage Miscellaneous Deviation Factor (i.e. Package Credit) [*Repeat the UPDev field as necessary in order to list each UMPD miscellaneous deviation factor applicable to the policy, name the new fields by adding the appropriate number to the end of the base field name, and include a revised file layout. For example, UPDev1, UPDev2, UPDev3, etc.]*	R
VehClass	6	A		Vehicle Class Code	R
WCBenJur	2	A		Benefit Jurisdiction (State Postal Code for State Jurisdiction ;"US" for Federal Claims USL&H, Jones Act, Federal Black Lung)	
WCBPCode	2	A		Use NCCI (or equivalent) Stat plan Body Part Code	
WCCCode	2	A		Use NCCI (or equivalent) Stat plan Cause of Injury Code	
WCIndPD	7	N	2	Workers Compensation Indemnity Amount Paid	
WCIndRes	7	N	2	Workers Compensation Indemnity Amount Reserved	
WCIndTyp	3	A		Type of Workers Compensation Indemnity Paid :TTD (temporary total);NAP (non awarded partial);PPD (permanent partial); PTD (permanent total); FAT (fatal)	
WCInjTyp	2	A		Injury Type (OD= Occupational Disease or OI =Occupational Injury)	
WCLitFlg	1	A		Y/N flag indicating if claim was protested	
WCMedPD	7	N	2	Workers Compensation Medical Amount Paid	
WCMedRes	7	N	2	Workers Compensation Medical Amount Reserved	
WCNICode	2	A		Use NCCI (or equivalent) Stat plan Nature of Injury Code	

Commercial Property and Casualty Standardized Data Request

Claim Feature Codes

Auto Claims:
- Collision = (COL)
- Comprehensive = (COMP)
- Property Damage = (PD)
- Medical Payments = (MP)
- Bodily Injury = (BI)
- Uninsured/Underinsured Motorist = (UM)
- Combined Single Limit = (CSL)
- Garage Claims:
- Liability = (Lia)
- Medical Payment = (MP)
- Dealer Physical Damage = (DPD)
- Property Damage = (PD)

BOP Claims:
- Bodily Injury = (BI)
- Property Damage = (PD)
- Medical Payment = (MP)
- Building = (B)
- Contents = (C)
- Business Income Interruption/Extra Expense = (BII)

Package Claims:
- Property = (P) [building and contents]
- Inland Marine = (IM)
- Bodily Injury = (BI) [premises related on or off property]
- Property Damage = (PD) [premises related on or off property]
- Business Income Interruption/Extra Expense = (BII)

Workers Compensation:
- ~~Medical Payment = (MP~~Part 1 – Workers' Compensation = P1)
~~Indemnity = (I)~~
- ~~Employer's Liability (EL)~~Part 2 – Employer's Liability = P2

Chapter 12—Scheduling, Coordinating and Communicating

A. Company Selection

Company Selected

~~Each state should develop a standard planning process for its market conduct examinations that incorporates data from various sources including, but not limited to, annual statements, market share reports, complaint data, complaint indices, recent filings, department records/information, etc. A state will apply the criteria which it has established for calling examinations to the information developed from the standard planning process, in order to determine which insurers should be examined. An examination call sheet and supporting documentation should be collected at this time.~~

~~Please also refer to the items listed in the Market Conduct Uniform Examination Outline in Section R. and the Reasons for Examination in Section S. of this chapter.~~

Each state should develop a standard planning process for its market conduct examinations based upon statutory examination requirements, market analysis, participation with multi-state actions and unusual circumstances that require immediate investigation or examination. Consideration should also be given to developing a planning standard planning process for continuum responses, other than examinations, especially for responses that are more in-depth then inquiring about a single issue. A state will apply the criteria which it has established for calling examinations to the information developed from the standard planning process, in order to determine which insurers should be examined. An examination call sheet and supporting documentation should be collected at this time.

Please also refer to the items listed in the Market Conduct Uniform Examination Outline in Section R. and the Reasons for Examination in Section S. of this chapter.

Internal Data Requested from Insurance Department

Prior to an examination being approved, specific information should be compiled from the various sections within the insurance department. Examples of this information include: licensing (insurer lines of authority, producer/agency appointments); consumer complaints (number and types of complaints); market regulation and compliance history; rate and form filings; market analysis and financial analysis and examination. A notice (e.g., via e-mail) should be sent to the sections informing them that an examination of the company will commence and asking for any other relevant information. [1]

Justification of Examination or Continuum Response

~~A memorandum should be prepared by summarizing all relevant data used to determine the necessity of the examination. A call sheet should be prepared, along with the examination plan and estimated time sheet, and submitted to the appropriate insurance department personnel for his/her approval. The proposed examination memorandum is approved, disapproved or returned to staff with instructions to obtain additional information.~~

If not otherwise documented in the NAIC Market Analysis Review System (MARS), a memorandum should be prepared by summarizing all relevant data used to determine the necessity of the response or examination. For examinations, a call sheet should be prepared, along with the examination plan and

[1] In cases of routine examinations this information may be solicited from the various insurance department sections during the planning stages of the examination subsequent to the examination call letter being issued; however the information should be obtained prior to the commencement of any field work.

estimated time sheet, and submitted to the appropriate insurance department personnel for his/her approval. The proposed examination memorandum is approved, disapproved or returned to staff with instructions to obtain additional information.

~~**Internal Data Requested from Insurance Department**~~

~~Prior to an examination being approved, specific information should be compiled from the various sections within the insurance department. Examples of this information include: licensing (insurer lines of authority, producer/agency appointments); consumer complaints (number and types of complaints); market regulation and compliance history; rate and form filings; and financial analysis and examination. A notice (e.g., via e-mail) should be sent to the sections informing them that an examination of the company will commence and asking for any other relevant information.~~

Development and Monitoring of Examination Plan or Continuum Response Plan

A well planned written plan provides guidance for the examination team or employee, (whether contracted resources or employees are used) and the insurer's examination coordinator alike. An examination plan may include a primary document that is shared with the examinee and a supplemental document to provide further guidance to the examiners. The primary document may be incorporated into the examination coordinator's handbook.

The primary examination plan should address the following, where applicable:

- clear identification of the entity or entities to be examined, including locations or regional offices;
- stated objectives for the examination, that follow justification for calling the examination or performing the continuum response;
- estimated time frames and allowances that are allotted to each broad functional area being examined;
- budgeted expenses for examiner work time;
- estimated travel, lodging and meal expenses;
- estimated incidental or administrative costs and supplies directly associated with the examination;
- a list of factors that could potentially contribute to increased examination costs, such as delays in responding to examiners, unforeseen compliance matters;
- in the case of examinations, an explanation of expense reimbursement and invoicing process;
- if available, a brief discussion of potential ways to reduce examination costs such as conducting portions of the examination through secure electronic data processes; and
- contact information and procedures for addressing questions, concerns or appeals about the examination or response process, examination or response plan or subsequent examination related invoices.

The supplemental examination or continuum response planning document for the examination team or applicable examiner should be designed to focus the process on the specifically targeted areas of review. The materials provided with the supplemental document are likely to include more investigatory materials that constitute confidential investigatory materials and examination work papers. As such, the supplement should be treated accordingly. It should include:

- directions relating to which *Market Regulation Handbook* examination standards to be incorporated into the examination;
- market analysis related materials that offer insight into the nature of any issues or concerns to be examined;

- if not otherwise provided, work sheets and guidance for relating state-specific laws and regulations to examination handbook standards; and
- directions for accessing appropriate reference documents, bulletins, legal opinions, etc.

Additional considerations are appropriate for those states using contracted examiners. Prior to entering into any agreement for contracted services, it is important to consult with department of insurance legal staff to determine what applicable state requirements apply, such as "request for proposal" and contract bidding, execution and monitoring. Additionally, it is important to verify that use of contract services meets with department of insurance management approval. If not already addressed in the contract, it is appropriate to provide written directions for the contract examination team to address the following issues:

- provisions relating to confidentiality, data protection, ownership of examination work papers, and other relevant matters such as drug-free workplace rules which may have otherwise not been included in the contract;
- instructions for preparing billing invoices, including supporting documentation. It is generally a best practice to obtain detailed documentation of time and expense reimbursement for audit purposes. Practices may vary by state, but it is generally important to provide sufficient documentation to regulated entities required to reimburse examination expenses. That permits the regulated entity to maintain sufficient documentation for its internal and external audit purposes;
- timing for presentation of invoices and billings. In general more frequent invoices along with more frequent and detailed presentation to regulated entities required to reimburse expenses improves communication;
- guidance for expense reimbursement allotments and travel, including frequency of travel, such as those established by CONUS rates and/or GAO standards;
- guidance relating to whether or not holidays, sick leave and travel time are to be reimbursed; and
- provisions for communication and prior approval of any anticipated cost over-runs or proposal for alterations of the examination work plan.

B. Scheduling Examinations

The individual responsible for scheduling examinations should consider the following elements:

1. In determining priorities, the relative significance of the following indicators should be evaluated:
    a. Statutory examination requirements;
    b. Internal complaint analysis;
    c. Compliance with applicable statutes and regulations, including producer licensing;
    d. Rate and form review;
    e. Market share analysis;
    f. Exam findings from previous market conduct exams;
    g. Information from the commissioner of another jurisdiction;
    h. Reports and analysis from NAIC information systems, including RIRS, SAD, CDS, FAST and e-mail;
    i. Financial analysis and IRIS ratios;
    j. Information from other external sources;
    k. Changes in the control environment;
    l. Pre-admission;

m. Market Conduct Annual Statement; and
n. Findings from previous financial examinations.

When scheduling examinations, consideration should also be given to periodic examination of domestic insurers, even in instances where the domestic insurer is not active in the domestic market. In these instances, a multistate examination should be considered.

2. Document an explanation of the basis for calling the examination.

3. Review of current and previous examinations (exam history) for the specified company or companies as found in the NAIC Examination Tracking System (ETS).

C. Scope of Examinations

There are various market conduct areas, which may be covered in an examination. These include, but are not limited to:

1. Company Operations/Management;
2. Complaint Handling;
3. Marketing and Sales;
4. Producer Licensing;
5. Policyholder Service;
6. Underwriting and Rating; and
7. Claims.

The areas to be covered by the examination (e.g., underwriting only or claims only), the line(s) of business, as well as the time period under review must be clearly defined. The location of the examination must be determined—e.g., corporate headquarters or regional offices. The scope should include a preliminary estimate of timing and costs.

D. Selection of Examiner-in-Charge (EIC) and Team

The EIC is the on-site supervisor of the examination team. The examination team may be comprised of one or more examiners in addition to the EIC. When selecting the examination team, states should match examiners' areas of experience to the appropriate examination.

E. Estimating Time Requirements

1. Identify the subject area(s) of the examination in terms of the lines of business to be covered and the functional area (e.g., marketing and sales, underwriting, claims, etc.).

2. Identify the specific survey to be performed for each line of business; i.e., the steps to be carried out to collect the necessary information. Consideration should be given to the recordkeeping system of the company so that adjustments can be made in examination procedures to accommodate the data processing methods of the company as long as the integrity of the examination is not compromised.

3. Estimate the size of the field, obtain the data and determine the sample size for each survey.

4. Estimate the length of time required for the examination. A final examination plan, including an estimate of the duration and cost of the examination, should be completed by the EIC as soon as possible.

Final adjustments should be made within the first two weeks of the examination and communicated to the company. The examination plan needs to reflect actual field discoveries as to the quality and availability of data, the level of the company's cooperation, the location of the data, etc. As the examination matures, the EIC may need to adjust the examination plan. The company should be notified of any changes and the justification.

F. Calling the Examination

All jurisdictions are encouraged to utilize the NAIC Examination Tracking System (ETS) for announcing and providing detailed information about all insurance regulatory examinations.

Once the triggers, subject area and estimated duration have been identified, the examination should be entered and announced (called) via ETS.

ETS provides automatic notification and response to insurance regulatory examinations, both financial and market conduct. The system provides methods for tracking current and historical examination information of companies by capturing detailed exam information. Data maintained on each exam includes summarized findings. ETS also allows for generation of Market Analysis Profile (MAP) reports for any exam logged into the system. The MAP reports provide the basis for pre-exam analysis of a company's market performance, as well as financial elements as reported in the annual statement filings. Insurance departments are encouraged to log examination information using ETS for all types of exams conducted on all types of entities. It is particularly important to include all single state examinations, regardless of scope, so that other jurisdictions can coordinate their own examination efforts and avoid the unnecessary burden of simultaneous separate examinations by multiple jurisdictions. The NAIC provides a user's guide and training to help in learning and using ETS. Contact the NAIC Help Desk for a copy or more information.

Monitoring and follow-up
It is important to obtain periodic status updates from the examiner in charge or lead contract examiner to determine if the examination is on course with the examination work plan. In the event that the work plan needs to be altered, the market conduct supervisor should notify the regulated entity as soon as possible.

G. Notice of Examination Reported to ETS

Examinations need to be entered into the ETS no later than 60 days before the expected date of the on-site examination. Exceptions to this rule are examinations that are called to respond to more immediate concerns.

1. Notify Domiciliary State (ETS will automatically send an electronic notification to the state of domicile.)

2. Notification to Company

    a. Timing of Notice

At least sixty (60) days prior to the examination date, a notification letter should be sent to the company. This letter should specify the necessary information and arrangements referenced in Subsection (b) that follows.

If the company demonstrates a clear need for additional time to prepare for the examination, additional time may be granted prior to the commencement of the examination. These notice periods need not be followed if: (1) there is reason to believe that advance notification to the company might result in the destruction of important records; or (2) the interest of policyholders or claimants would be prejudiced by delaying the examination of company records.

b. Content of Notice (Some states may include this in the form of a coordinator's handbook or pre-examination packet.)

The notification letter should advise the company of the following information and arrangements:

1. The scope, intent and period to be covered by the examination and estimated ~~start and end date~~examination time frame. The duration of the examination may be adjusted based upon on-site conditions. If it becomes necessary to change the starting date, the company should be notified of the change;

2. The legal basis for examination and cost and billing procedures;

3. Arrangements for receiving copies of relevant company procedural guidelines, manuals, policy forms with notice of approval, advertising materials, producers' records, renewal material, methods used to solicit business, any required consumer complaint register and any other pertinent data;

4. Requests for data that require lead time to develop—e.g., claims runs, loss and expense ratios (acquisition, administrative and claim cost), policy runs, licensed producers runs—or any alternate and/or appropriate methods of isolating records, if necessary;

5. Office space, supplies and equipment required to conduct the examination;

6. A request that the company respond to the notification letter and furnish the name of its examination coordinator;

7. The parameters of examiner conduct, and the procedures by which companies can report complaints against examiners and resolve problems which may develop related to company examinations; and

8. Where the examination team expects to utilize audit software during the examination, the letter should include notification to the company of the intent to use the audit software. Information relative to the installation procedure should accompany the notification letter.

H. Company Identifies Examination Coordinator(s)

Prior to the commencement of the examination, the company must identify company personnel who will have the authority and responsibility to respond to the criticisms of the examiners, as well as provide additional information as needed.

The company responds to appendices/other requested information received.

The insurer is instructed to respond to the insurance department by a specified date with answers to various questionnaires or interrogatories contained within the preliminary packet as well as provide any other requested information by the date specified.

I. Examination Audit Plan Drafted

A state shall determine the phases and/or standards of the examination that are to be reviewed. An estimate of the amount of time required to conduct each phase of the examination should be made, with the understanding that additional time may be necessary depending upon the findings of the examination. The type of information to be included in an audit plan is as follows: the scope of the examination; the justification for the examination (summarized); the lines of business to be examined; company procedures to be examined/omitted and the reasons for doing so; a time estimate; and an identification of factors that will be included in the billing.

Determine the type of report to be prepared—either one by test or one by exception.

J. Initial Examination Team Meeting, Including Contractors (Optional)

States that use contract firms must determine goals, restrictions, procedures, oversight and billing procedures. It is recommended that the insurance department meet with the examination team prior to the team going on-site. To the extent possible, instructions provided to contractors should also be shared with the company.

K. Pre-Examination Contact

Under ordinary circumstances, the EIC will contact the company coordinator prior to the beginning of the examination and make all necessary arrangements. This contact may be by telephone, a letter or a pre-examination visit. It is during this pre-examination contact that the work space, data requests, necessary supplies, office equipment and other examination details should be discussed. The EIC will also make the necessary arrangements to begin the field portion of the examination.

L. Pre-Examination Procedures

1. Insurance Department Records Review

    a. The EIC of the scheduled examination should, prior to the examination, review the following:

        1. Prior examination reports with related correspondence directive to the company and the company's response, if any;

2. Information from other jurisdictions applicable to the examination;

3. Information available from the NAIC, including the following, should be reviewed:
   - Examination Jumpstart Reports;
   - Special Activities Database (SAD);
   - Regulatory Information Retrieval System (RIRS);
   - Complaints Database System (CDS) and Complaint Index Report;
   - Examination Tracking System (ETS); and
   - Financial Analysis and Solvency Tracking System (FAST).

   In addition to the above information, sharing of audit software applications designed for specific uses or entities should be accomplished through the use of the NAIC File Repository.

4. Consumer complaint records to determine any recent trends in the number or nature of complaints;

5. Producer licensing information; and

6. Rate and form filings.

b. The EIC should contact other department supervisors to develop additional information or guidelines for the examination. Necessary authority (e.g., warrant or subpoena) for the examination should also be secured.

c. To the extent that any of the information requested is available in the insurance department's office, it may not be necessary to obtain such information at the company office.

2. Pre-Examination Visit or Telephone Call

In addition to the notification letter, it is advisable to provide further detail to the company prior to the commencement of the examination. This additional communication can be accomplished through a pre-examination visit, telephone call or combination of both. The matters to be addressed include:

a. Discuss the examination process and expectations with company officials responsible for the areas to be examined and the designated company coordinator;

b. Review the company recordkeeping and computer systems. Identify normal market conduct procedures, which may require modification to accommodate the data processing methods of the company and to avoid unnecessary costs to the company. For companies that do not maintain hard copy files, those files must be accessible via Cathode Ray Tube (CRT), micrographics, imaging, microfiche or any other medium, and capable of duplication to hard copy if the examiners so request;

c. Request copies of previous examinations and internal audit reports;

d. Determine other branch locations, which handle business within the jurisdiction that may impact the examination;

e. Arrange for security access and working space for the examination team, along with required office supplies and equipment needed to conduct the examination;

f. Review materials requested in the notice; and

g. Discuss working hours and travel arrangements.

3. Instructions to the Examination Team

a. The EIC should contact all examiners scheduled for the examination and relate the following information:
    1. Name and location of company;
    2. Date and time the examination will begin;
    3. Specific instructions concerning the conduct and purpose of the examination and the time period under review;
    4. Name of designated company coordinator;
    5. Scope of the examination;
    6. Administrative issues, including working hours and travel arrangements;
    7. Develop an audit trail procedure for the examination; and
    8. Organization of workpapers.

b. Prior to the examination, the EIC should communicate with other members of the examination team to:
    1. Discuss all pre-examination findings and familiarize the examination team members with pertinent information developed;
    2. Outline each examiner's assignment to be completed during the examination;
    3. Receive input from the examination team as it pertains to ideas or suggestions for successful completion of the examination; and
    4. Discuss maintenance of working papers to provide a record of all conclusions and supporting analyses and data. The working papers should include:
        - Summary of conclusions and the analyses that support them;
        - Factual support for the analyses, including detailed worksheets indicating individual file data; and
        - Screen prints where media is electronic.
    5. The importance of properly documenting work papers and exceptions cannot be over-emphasized. Most jurisdictions document exceptions with the use of critique forms and photocopies of appropriate files and materials. Examiners should review insurance department guidelines concerning proper "chain-of-custody" for evidence, when noted exceptions might involve administrative, criminal or additional civil actions. Examiners should be aware of requirements for the handling of confidential materials; e.g., alcohol and drug abuse medical records.

M. Data/Files

Data Requests Are Provided to the Company
Detailed instructions for these data requests should be provided in the pre-examination packet. States should utilize the uniform data requests or inform the company that they will be supplying alternative data requests. The request should clearly state the file type, format and medium. Examples of data requests are policy types by policy number and issue date; claim types by claim number and date received; commissions paid by name, date and amount; producer contracts by name and effective date; policy forms by type and first date of use. Upon receipt, the examiner should validate these data.

Data Received from the Company
File selection may take place in advance of the examination team's arrival or upon arrival at the examination location. The EIC may instruct the company, prior to his/her arrival or upon arrival, of the files to be pulled or reports to be provided when the on-site examination begins.

EIC Reviews Appendices/Other Requested Information
The EIC should review the company's responses to the questionnaires and/or interrogatories and request any additional information needed.

Samples Determined
Depending on the circumstances, the examiners will use company-provided printouts, ACL or other methods necessary to select the files for the sample or census review.

N. On-Site Coordination

1. Once the examination team has arrived on-site, the EIC should take this opportunity to introduce him/herself and the team members. The EIC should explain the examination process to the company coordinator. If the examiners have any special needs or additional requests, now would be the time to communicate them to the company.

2. The EIC should notify the chief examiner of the start of the examination and report any changes or developments during the preliminary meetings with the company's representatives.

3. The EIC shall be responsible for timely progress reports, including adverse findings, to the insurance department and to the company, as may be advisable.

4. The EIC shall be responsible for the efficient conduct of the examination and supervision of the examination team.

O. Request for Information

When an examiner perceives a violation of a statute, regulation or policy provision—or a rating, underwriting, claim or producer licensing error—the company will be provided a written form requesting an explanation of the error or a written acknowledgment of the error. This form is commonly referred to as a criticism or a "crit" sheet. The criticism and the company's response becomes a part of the examination documentation. The company is allowed a specified time period to respond.

Summary of Findings
Upon completion of the file reviews, the examination team prepares a report of their findings. The examiners should share the summary with the company.

Final Examination Team Meeting
Upon completion of the field work of the examination, the EIC should offer to conduct an exit meeting with the company to discuss significant findings, explain the next steps in the examination process and allow the company to present any outstanding concerns. The EIC should not re-argue the findings of the team at this time.

P. Communicating with Company Management

1. The EIC should ensure that communication with company personnel is clear, concise and to the point.

2. The EIC should encourage an open line of communication between the examination team and company personnel.

3. The EIC should make it clear to company personnel that requests for documentation and other information should be provided in a timely manner.

4. The EIC should ensure that all communication with company personnel is well documented.

5. The EIC should deal directly with the company examination coordinator, but not allow this arrangement to restrict the examination process or excessively shield key personnel with whom examiners need to communicate.

6. The EIC should explain to company personnel that the timely completion of the examination depends on communication and cooperation.

Only through open communication between the examination team and company personnel will both parties be on the same page, thus leading to a "no surprises" wrap-up or exit conference.

Q. Post-Examination

Post-examination procedures may vary according to state examination laws or administrative procedures and requirements. General post-examination procedures are as follows:

1. Wrap-Up or Exit Conference

   A wrap-up or exit conference is initiated by the examination team at the completion of the on-site examination. The company's management personnel should be included in this conference. The examination team will summarize its findings and discuss issues pertinent to the report. The wrap-up or exit conference can be accomplished face-to-face, via teleconference or via written form.

   The EIC should advise company personnel of the resolution process utilized by his/her insurance department. The process should include the following:
   a. Process used to draft the report;

b. Timetable necessary for submitting the report to the company; and
c. Timetable designated for the company's review of the report.

2. Drafting of the Examination Report

The examination team will prepare the initial draft of the report. The format of the report should be in accordance with NAIC market conduct examination report guidelines and include a summary of all findings of the examination.

3. Review of the Examination Report

The report should be submitted to the insurance department and reviewed by designated personnel of the department.

4. Company Review and Acceptance of the Report

The report is sent to the company. Instructions relative to the resolution of the report should be included. The timetable given to the company for review of the report should be stipulated in the instructions. Items necessary for resolution may include one or more of the following:

a. A formal letter of acceptance;
b. A statement of corrective actions on developed issues;
c. A letter signed by each company director acknowledging the contents of the report, where required; and
d. Any other information or acknowledgment specifically required by statute.

5. Informal Conference on the Report

If all issues relating to the report are not mutually agreed upon, the company may request an informal conference with the insurance department. This conference should be held at ~~the department's office.~~at a mutually agreed upon location.

6. Formal Hearing on Report

If problems relating to the report continue to exist (following the informal conference), a formal hearing should be held to resolve the report.

7. Regulatory Action

Final regulatory disposition will be determined by the insurance department, not the examiner. Disposition may include one or more of the following items:

a. No further regulatory action;
b. Re-examination referencing issues noted in previous examination report;
c. Consent order;
d. Agreement or order of stipulation;
e. Payment of a monetary penalty; and
f. Waiver of right to a hearing.

8. Distribution of Report and Final Regulatory Action

   A copy of the report should be forwarded to the insurance commissioner of the domiciliary state. Examination results should be entered into the NAIC Examination Tracking System. Additionally, the NAIC Regulatory Information Retrieval System (RIRS) form, where applicable, should be completed and submitted electronically via RIRS.

9. Post-Examination Questionnaire

   The post-examination questionnaire is designed to aid in the evaluation of the examination team. It is important that the coordinator identify challenges as they arise and provide feedback that improves the examination process. The questionnaire should be completed by the company's examination coordinator at the conclusion of the examination field work. It may be included in the pre-examination packet or mailed to the company at the conclusion of the examination. A sample form is included at the end of this chapter.

R. Market Conduct Uniform Examination Outline

1. Examination Scheduling

   a. Each state shall prioritize examinations.

      1. Each state shall establish criteria for calling a market conduct examination. (See Section S. of this chapter for an example of items that may be considered.) States shall establish a priority or weight for each of the criterion being considered.
      2. Each state shall prepare a schedule of examinations and select a person responsible for developing and maintaining the schedule. Exceptions may be made when an examination is called as a "no-knock" examination.
      3. The trigger or reason for the examination shall be maintained in the examination documents, preferably the workpapers.

   b. States shall utilize the NAIC Exam Tracking System (ETS).

      1. As soon as scheduled, each state shall enter the examination into the ETS, which is administered by the NAIC.
      2. Each state shall adopt a system for ensuring proper implementation and maintenance of the ETS system. The NAIC will develop aids, such as a data entry checklist, that will assist in maintaining the ETS program.

   c. Timetable for maintenance of the ETS.

      1. Exams shall be entered into the ETS no later than 60 days before the expected date of the on-site examination. Exceptions to this rule are examinations that are called to respond to more immediate conditions.

2. Pre-Examination Planning

   a. Internal planning by states on companies selected for examination.

1. Each state shall develop a standard planning process. Many of the items reviewed may have been used in the examination priority process and may become the basis for the pre-examination planning. In addition to the items found in the examination scheduling, the following information may be considered:
    - Information from prior examinations;
    - NAIC databases;
    - Internal database, such as the complaint index;
    - Discussions with other insurance department personnel;
    - The financial statement;
    - Interview with the company; and
    - Information received from other states' examination.

2. The plan should be maintained in a manner that may be incorporated into the workpapers.

3. At the end of the planning process, the state shall determine the phases and/or standards of the examination that require more attention; the phases or standard that require average examination scrutiny or attention; and those that require a reduced emphasis or may be waived. See the following list:
    - Special Emphasis: Larger samples, more scrutiny, more examination time allotted;
    - Standard Emphasis: Initial sample follows NAIC guides, average scrutiny and examination time allotted; and
    - Reduced Emphasis: Smaller samples, review may be limited to procedures only, reduced scrutiny and examination time allocation.

4. Each state shall prepare an examination work plan prior to the examination. The work plan or planning memorandum shall include:
    - The scope of the examination;
    - The justification for the examination;
    - A time and cost estimate; and
    - An identification of factors that will be included in the billing.

b. Each state shall develop a system to announce the examination to the selected company.

1. The announcement of the examination should be sent to the company as soon as possible, but in no case not any later than 60 days before the estimated commencement of the on-site examination. The announcement notice should contain:
    - The name and address of the company or companies being examined;
    - The name and contact information of the Examiner-in-Charge;
    - The date the on-site examination is expected to begin;
    - The statutory authority for the examination;
    - The identification of items that will be billed to the company, if any;
    - A request for the company to name its examination coordinator; and
    - Additional information may be requested at a later date.

c. Each state shall develop a preliminary examination packet or handbook that should be sent to the examination coordinator as soon as possible, but in no case not any later than 30 days before the estimated commencement of the on-site examination.

1. The preliminary information shall contain the following information:
    - General instructions;
    - The scope of the examination;
    - The materials requested to perform the examination;
    - Data calls;
    - Requirements for accommodations and supplies, including modem requirements;
    - Time and cost estimates;
    - Travel information;
    - Specific instructions regarding sampling, communications with the company and other pertinent information;
    - Location of on-site examination;
    - Security arrangements; and
    - Billing procedures.

d. Data calls

1. States shall adopt a standardized data call. The data call will be broad and states may choose not to use all fields.
2. If a state deviates from the standardized data call, it will notify the company of the deviation and may want to allow additional time for the company to provide the information.

3. Examination Procedures

a. The state shall conduct a pre-examination conference with the company coordinator and key personnel to clarify expectations prior to the commencement of the examination.

b. The state shall develop a system for exchanging information with the company that advises them of the errors and other problems developed during the examination. The system could consist of "crit" sheets, summaries, or both. Any form of communication concerning errors should include the following information:
    1. Record numbers or other identifying factors;
    2. The examiner's statement of the problem or error and, if relevant, the applicable law and/or standard; and
    3. A request for signature and comment from the company.

c. Each state shall develop a procedure for document handling, including the removal of original documents to a location other than the state insurance department. To address the issue of confidentiality, original workpaper documents shall remain at the state insurance department, especially if the examiner is a contracted employee of the state department.

d. States shall use the NAIC sampling guidelines or develop their own scientifically based sampling program.
    1. All sampling methods should be random;
    2. If using a method other than the NAIC sampling guidelines, the method shall indicate the confidence levels, tolerable error rates and include extrapolation; and
    3. All sampling methods shall avoid pre-selection; however, stratified sampling is allowed.

(See the Sampling Chapter of this handbook for further discussion.)

e. Each state shall offer to conduct an exit conference at the end of an examination. The exit conference should offer the following:
   1. The examination status and proposed findings;
   2. The report process; and
   3. An explanation of any post-examination billing.

4. Examination Reports

a. The states shall utilize a standard format found in the NAIC handbook to include the following:
   1. Title page;
   2. Table of contents;
   3. Salutation;
   4. Foreword;
   5. Scope;
   6. Executive summary;
   7. Results of previous examinations;
   8. Pertinent facts of the current examination;
   9. Summarization; and
   10. Appendices.

The examination report may be written by test or by exception. States shall report the method utilized to the company and in the scope of the report.

b. States shall utilize a standardized timeline as required by the state's statute or the NAIC model as outlined below:
   1. The draft report is delivered to the company within 60 days of completion of the examination;
   2. The company must respond with comments to the state within 30 days;
   3. The insurance department has 30 days to informally resolve issues and prepare a final report (unless there is a mutual agreement to extend the deadline); and
   4. The company has 30 days to accept the final report or request a hearing.

c. The states shall include the company's response in the final report. The response may be included as an appendix or in the text of the examination report. If it is not in the final report, the report should indicate that a response is available. The company is not obligated to submit a response. Individuals involved in the examination should not be named in either the report or the response, except to acknowledge their involvement.

d. States shall publish examination reports as public documents where allowed by law. States should publish examination reports on the insurance departments' Web sites. States shall develop a process for releasing examination results to the public. A press release may be used.

e. States shall devise an enforcement strategy; specifically, the role of market conduct activities in that effort. The primary role of examiners is to be fact-finders when determining compliance, which can then be used by the insurance department to determine sanctions or

fines. An enforcement strategy would have to have a system in place to differentiate between willful actions and inadvertent ones, and consider appropriate administrative resolutions, whether financial or non-financial. States should also want to consider a methodology for determining the amounts of fines, based on a host of criteria—including the size of the company, the company's market share, whether the problems have been corrected and any host of mitigating or aggravating circumstances. States should also be certain to communicate the basis of any assessed penalty.

f. Each state shall establish a follow-up examination process.

S. Reasons for Examination

1. Complaint Index—States should review complaints to determine where problems exist. Insurance departments may develop an index for each company measuring the number of complaints to that company's market share by premium volume.

2. Recent Complaints—An increase in recent complaints filed against an insurance company may suggest concern. In order to address those complaints, an examination may be necessary in order to obtain remedial action.

3. Market Share—Due to its volume of premium, the practices of a particular insurance company can impact a large number of citizens. If the state needs to review a particular line of business or particular type of product, the state may choose those companies with the most premium volume.

4. Financial Examination—The financial examiners may discover an issue during an examination which warrants further review from a market conduct perspective. Such a market conduct examination may occur simultaneously with the financial examination. The financial examiners may incorporate the findings of the market conduct examiners into the financial examination report.

5. Information from Other States—Findings by other state regulators may generate a need to discover whether the same or similar practices are occurring in another state. One state may extend an invitation to the other states to participate in a multistate examination.

6. Legal Request—An insurance department's legal division may discover a particular illegal practice which warrants further discovery through an examination.

7. Shift in Business Practices—A company may change its product mix, resulting in a significant change in its operations. If a company has not adequately managed for such change, it may not have the expertise to properly and fairly treat its consumers. An examination may address problems before the problems become widespread.

8. Principals Involved—The state may become aware that individuals have had a past history of regulatory noncompliance. The NAIC maintains information systems identifying suspect individuals and past regulatory actions. An examination can identify improper activity prior to its impact on a large number of consumers.

9. Information from Statistics—States may maintain several databases. For example, Missouri law requires the reporting of certain information, such as financial statements, premium volume and amounts of claims paid categorized by ZIP code, malpractice claims, etc. Statistical tests evaluate aberrations that may necessitate further discovery by means of an examination. Many states are participating in the Market Conduct Annual Statement. Details regarding MCAS may be found on the NAIC Web site at http://www.naic.org/committees_d_mcas.htm.

10. Policy Approval Suggestions—The policy analyst may note a trend in policy form filings that may necessitate further discovery by means of an examination.

11. Request of the Director/Commissioner—The Director/Commissioner may ask for an evaluation of certain practices or certain products.

12. Result of Last Market Conduct Examination—Based upon a review of the findings of a prior examination, the state may determine the need for further review.

13. Industry Suggestion—Insurance company personnel may bring to the state's attention a particular practice or product that may need a further evaluation.

14. Member of Group Being Examined—Typically, many insurance companies operate under an umbrella holding company sharing the same personnel and similar operational management. While examining one insurance company, it may be more cost-effective to review several companies within the same group.

15. Periodic: Length of Time Since Last Examination—The mere passage of time without an examination, in conjunction with other factors, may indicate the need for an examination.

16. New Operation: Never Examined or Under New Management—Much like the shift in business practices described above, a new company or a new management team may not have the expertise to properly and fairly treat its consumers. An examination may address problems before the problems become widespread.

17. Re-Examination: Understanding at Time of Stipulation—In some cases, during the negotiation of an examination's resolution, the examined company and the insurance department will agree that some mitigating circumstance created the cited noncompliance. The company may indicate that it is now in compliance. In order to verify that remedial action has occurred and that the company has accomplished full compliance, the state may perform a second examination.

18. Evaluation of New Law—The state may target an examination in order to determine the compliance with and the effectiveness of recently enacted statutes.

19. Media—States may receive information through a news broadcast or trade journal that prompts further evaluation.

T. Market Conduct Examination Pre-Planning Checklist

Company Name: _____

NAIC Company Code: _____ NAIC Group Code: _____

Company Home Office Location: _____

Exam Site Locations: _____

I. COMPANY SELECTION

Complete	Date Completed	Examiner(s)	Due Date	Task
☐				1. Company selected
☐				2. Justification
☐				3. Internal data request
☐				4. Scope of examination
☐				5. Examiner-in-Charge (EIC) and team named
☐				6. Anticipated duration determined

II. COMPANY NOTIFICATION

Complete	Date Completed	Examiner(s)	Due Date	Task
☐				1. Notice of examination reported to ETS
☐				2. Notice of examination sent to company
☐				3. Pre-examination handbook sent to company
☐				4. Company appointed examination coordinator
☐				5. Company responded to appendices received

III. EXAMINATION TEAM

Complete	Date Completed	Examiner(s)	Due Date	Task
☐				1. Examination audit plan drafted
☐				2. Initial team meeting–contractors (optional)
☐				3. Pre-examination contact
☐				4. Pre-examination visit (optional)
☐				5. Completed all necessary travel arrangements

IV. DATA/FILES

Complete	Date Completed	Examiner(s)	Due Date	Task
☐				1. Data requests sent to company
☐				2. Data received from the company
☐				3. EIC review of appendices/other requested information completed
☐				4. Samples determined and sent to the company

V. EXAMINATION STAGE

Complete	Date Completed	Examiner(s)	Due Date	Task
☐				1. Request for information (crits)
☐				2. Interim conferences
☐				3. File sampling
☐				4. Summary of findings
☐				5. Final examination team meeting
☐				6. Offer to hold exit meeting

U. Market Conduct Examination Checklist

Company Name _____
NAIC Group and Company Code _____
State Certificate of Authority Number _____

Examination

✓	DATE	INITIAL	DESCRIPTION
☐	___/___/___	____	Examination Commences
☐	___/___/___	____	Examination Site Review by Section Chief
☐	___/___/___	____	Examiner-in-Charge (EIC) Weekly Report Week 1
☐	___/___/___	____	EIC Weekly Report Week 2
☐	___/___/___	____	EIC Weekly Report Week 3
☐	___/___/___	____	EIC Weekly Report Week 4
☐	___/___/___	____	EIC Weekly Report Week 5
☐	___/___/___	____	EIC Weekly Report Week 6
☐	___/___/___	____	EIC Weekly Report Week 7
☐	___/___/___	____	EIC Weekly Report Week 8
☐	___/___/___	____	EIC Weekly Report Week 9
☐	___/___/___	____	EIC Weekly Report Week 10
☐	___/___/___	____	EIC Weekly Report Week 11
☐	___/___/___	____	Examination Field Work Completed

Post-Examination

✓	DATE	INITIAL	DESCRIPTION
☐	___/___/___	____	Report of Examination Completed
☐	___/___/___	____	Peer Review of Exam Report Completed
☐	___/___/___	____	Report Extension Approved by Director/Commissioner (optional extension of 60 days)
☐	___/___/___	____	Report of Examination Filed with Insurance Department
☐	___/___/___	____	Notice to Examinee with Proposed Report (within 60 days of completion of field work)
☐	___/___/___	____	Response from Examinee Received (within 30 days of receipt of proposed report)
☐	___/___/___	____	30 Days for Rebuttal Expires
☐	___/___/___	____	Director/Commissioner's Review Completed (within 30 days of rebuttal expiration)

☐	___/___/___	____	Order to Approve, Reject/Reopen, Hearing
☐	___/___/___	____	Final Report to Examinee with Director/Commissioner's Order
☐	___/___/___	____	Update NAIC Examination Tracking System (ETS)
			Company Directory Affidavits Completed and Received (within 30 days of receipt of final report)

U. Market Conduct Examination Checklist, cont'd

Company Name _____
NAIC Group and Company Code _____
State Certificate of Authority Number _____

✓	DATE	INITIAL	DESCRIPTION
☐	___/___/___	____	Billing Completed Month 1
☐	___/___/___	____	Billing Completed Month 2
☐	___/___/___	____	Billing Completed Month 3
☐	___/___/___	____	Billing Completed Month 4
☐	___/___/___	____	Circulation
☐	___/___/___	____	Exam File Copy
☐	___/___/___	____	Insurance Department Staff Copy
☐	___/___/___	____	Insurance Department Staff Copy #2 (if more than one office)
☐	___/___/___	____	Market Conduct Book Copy
☐	___/___/___	____	State of Domicile Copy
☐	___/___/___	____	NAIC Copy
☐	___/___/___	____	Other Interested States' Copies
☐	___/___/___	____	_____
☐	___/___/___	____	_____
☐	___/___/___	____	_____
☐	___/___/___	____	_____
☐	___/___/___	____	_____
☐	___/___/___	____	_____

V. Post-Examination Questionnaire

<Date>

<Name>
<Title>
<Name of Company>
<Address>
<City> <State> <ZIP>

Dear **<Name>**

RE: Post-Examination Questionnaire
<Examination #>
<Name of Company>

The (State) Department of Insurance has recently completed a market conduct examination of your company. The attached Post-Examination Questionnaire is designed to give us your perception of our performance during the recent examination of your company. It will allow us to evaluate our current procedures, as well as strive for improvement that should be mutually beneficial.

I appreciate you taking a few moments of your busy schedule to complete the questionnaire. As coordinator for that examination, your insight into the professionalism and efficiency with which the examination was conducted would be helpful. Please be assured your responses will only be shared with the Director's management team. To assure confidentiality, return the form to my attention with "Personal and Confidential" marked on the envelope. Please return the questionnaire to my attention at (State) Department of Insurance, P.O. Box 12345, 444 State Avenue, Anywhere, State 55555-3456 by **<Date>**. Thank you.

Very truly yours,

X. Sammy Nation, CIE
(Market Conduct Chief Examiner)

Post-Examination Questionnaire
Market Conduct Examination Evaluation
<Examination #>
<NAIC> <Name of Company>
<Date>

Examiner-in-Charge _____

Participating Examiners: _____

_____

_____

1. Did the materials provided prior to the examination provide sufficient information to allow you to adequately prepare for the presence of the examiners? ☐ Yes ☐ No
   Comments_____
   _____
2. Did the pre-examination conference help in facilitating the examination process: ☐ Yes ☐ No
   Comments_____
   _____
3. Did the examiners observe company restrictions on non-smoking areas? ☐ Yes ☐ No
   Comments_____
   _____
4. Did the examiners observe proper working hours, dress codes, use of parking facilities, use of facilities and any other company procedures (security check-in, security check-out, equipment care, maintenance, etc.) that you asked to be observed? ☐ Yes ☐ No
   Comments_____
   _____
5. Were the examiners punctual in attending to their duties? ☐ Yes ☐ No
   Comments_____
   _____
6. Did the examiner properly use the resources of the company in a considerate and ethical manner (examination-only use of telephone, copy equipment, computers, etc.)? ☐ Yes ☐ No
   Comments_____
   _____
7. Were the examiners professional in demeanor and appearance when on the job? ☐ Yes ☐ No
   Comments_____
   _____

Post-Examination Questionnaire
Market Conduct Examination Evaluation
<examination #>
<NAIC> <Name of Company>
<Date>

8. Were the examiners positive in manner, helpful in the response to your questions, and courteous and respectful in their contact and communications with you and your staff? ☐ Yes ☐ No
   Comments_____
   _____

9. Were the examiners properly directed and supervised by the Examiner-in-Charge so that the examination was as orderly as could be expected? ☐ Yes ☐ No
   Comments_____
   _____

10. Did the examiners appear to you to work efficiently on the files sampled? ☐ Yes ☐ No
    Comments_____
    _____

11. Were sufficient documents requested and retained at one time so as to remain busy at all times?
    ☐ Yes ☐ No
    Comments_____
    _____

12. Did the examiners appear knowledgeable in the lines of business reviewed and in the work and procedures performed? ☐ Yes ☐ No
    Comments_____
    _____

13. Have you benefited from the examination performed by the examiners? ☐ Yes ☐ No
    Comments_____
    _____

14. Other constructive criticism you wish to offer (use additional paper if needed):
    _____
    _____

Questionnaire completed by:

Signature _____

Name: _____

Title/Position _____

The following is a new standard to be inserted in the Operations/Management section of Chapter 16-General Examination Standards of the *Market Regulation Handbook*

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 submissions

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

Others Reviewed

_____ _____

_____ _____

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 (#77)
Market Conduct Surveillance Model Law (#693)
Statutory or regulatory authority for state-specific data requests

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 calls; 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 calls 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 standard data request.

THE FOLLOWING SIX STANDARDS ARE EXCERPTED FROM SECTION D OF CHAPTER 16—GENERAL EXAMINATION STANDARDS OF THE *MARKET REGULATION HANDBOOK*

STANDARDS
PRODUCER AND ADJUSTER LICENSING REQUIREMENTS

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's listing of currently licensed and/or appointed producers and, if applicable, adjusters

_____ Regulated entity's 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 hard copy 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 divisions 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 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 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, or 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 or 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 or 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's license/appointment dates to see if commissions were earned prior to license/appointment date; 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 number, 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 and the internal regulated entity/employee number.

STANDARDS
PRODUCER LICENSING

Standard 2
The producers are properly licensed and appointed (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's listing of all currently licensed and/or appointed producers

_____ Notice of appointment

_____ Regulated entity's procedures for appointing a producer

_____ Regulated entity's 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)

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 fifteen 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.

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, 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)r or, if unavailable, Social Security number, 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, 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 exam 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 contract 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 NIPR to ensure accuracy in 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's 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's listings of terminated producers for examination review period

_____ Regulated entity's 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.

THE FOLLOWING SECTION C MARKETING AND SALES, SECTION D PRODUCER LICENSING AND SECTION F UNDERWRITING AND RATING ARE EXCERPTED FROM CHAPTER 16—GENERAL EXAMINATION STANDARDS OF THE *MARKET REGULATION HANDBOOK*

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, 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 NAIC Unfair Trade Practices Act) 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

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

_____ Policy forms as they coincide with advertising and sales materials

_____ Producer's own advertising and sales materials

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 8C
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 (#118)
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 (#630)
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 Medicare Supplement Insurance Minimum Standards Model Act (#651)

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 Internet Web sites with the following questions in mind:

- Does the Web site disclose who is selling/advertising/servicing for the Web site?
- Does the Web site disclose what is being sold or advertised?
- If required by statutes, rules or regulations, does the Web site reveal the physical location of the regulated entity/entities?
- Does the Web site 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.

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)
Advertising of Accident and Sickness Insurance Model Regulation (#40)
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 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 Standard #1 when referencing advertising and sales.

Determine if the regulated entity uses e-mail to communicate with producers. The examiner should ask to review saved, stored or archived e-mail 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 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 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 or the SPLD (State Producer Licensing Database)

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

_____ Regulated entity's 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)

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 Producer Database, the examiner may validate the producer's licensure status through the Producer Database in lieu of obtaining a hard copy of the producer's license.

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

Refer discrepancies to appropriate divisions 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. Include the producer's Social Security number, National Insurance Producer Registry (NIPR) 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 Social Security 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 licensing list to the insurance department's licensed producers list, by comparing Social Security 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 Social Security 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's license/appointment dates to see if commissions were earned prior to license/appointment date; and

- Compare the regulated entity's new business written list to the insurance department's licensed producers list, by comparing Social Security numbers or internal regulated entity/employee number, 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 Social Security number 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 Producer Database

_____ Copy of producer's license or electronic verification of producer's license via the Producer Database

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

_____ Notice of appointment

_____ Regulated entity's procedures for appointing a producer

_____ Regulated entity's 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 form. Determine if the appointment forms were properly completed and completed prior to 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 the required continuing education 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 Social Security 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 Social Security 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 Social Security 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 exam 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 contract 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 NIPR to ensure accuracy in 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 by producer's business ZIP code

_____ Listing of terminations by line of business by producer's business ZIP code

_____ Regulated entity's 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 Social Security 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's listings of terminated producers for examination review period

_____ Regulated entity's 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 Social Security 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.

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 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 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 Applications Dictionary/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. Inherent 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 so obtained may be useful in drafting legislation or regulations.

In some lines of business, a survey of nonstandard (e.g., surplus lines markets and 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.

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 (File and Use Version) (#775)
Property and Casualty Model Rating Law (Prior Approval Version) (#780)
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)

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.

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 these 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

_____ 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 Individual Health 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 5
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 (#240)
Charitable Gift Annuities Exemption Model Act (#241)
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 (#~~100~~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)

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.

For 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 thirty (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.

For 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 three (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.

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/log

_____ 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 documented 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 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
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 Model Act (#170)
Group Health Insurance Standards Model Act (#100)

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 the regulated entity does not discriminate against individuals by using any of the 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 the regulated entity's procedures are in compliance with the Genetic Information Nondiscrimination Act.

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 intentioned, 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 5
All forms, including contracts, riders, 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

_____ New business application

_____ Policy determination page

_____ Regulated entity's approval register

_____ Insurance department's approval for forms and endorsements

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Policy Rate and Form Model [Act] [Regulation] (#165)
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)

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.

STANDARDS
UNDERWRITING AND RATING

Standard 6
Policies, riders 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

_____ 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 (#720)
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 (#180), 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 (#37), 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 Model Act (#170)
Group Health Insurance Standards Model Act (#100)

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.

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

Insurance Information and Privacy Protection Model Act (#670), Sections 10-12
Small Employer and Individual Health Insurance Model Act (#170)
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)

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 uses 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.

STANDARDS
UNDERWRITING AND RATING

Standard 8
Cancellation/nonrenewal, discontinuance and declination notices comply with policy 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

_____ Policy contract

_____ Notice of cancellation/nonrenewal

_____ Agent/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 8A
Unfair Trade Practices Act (#880)
Group Coverage Discontinuance and Replacement Model Regulation (#110)
Individual Health Insurance Portability Model Act (#37), 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 Model Act (#170)
Group Health Insurance Standards Model Act (#100)

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.

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.

THE FOLLOWING SECTION C MARKETING AND SALES IS EXCERPTED FROM CHAPTER 19—CONDUCTING THE LIFE AND ANNUITY EXAMINATION OF THE *MARKET REGULATION HANDBOOK*

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) 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.

Certain questions regarding life illustration requirements are addressed by the NAIC Questions and Answers Life Illustration Model Regulation. The questions and answers document is not an official pronouncement of the NAIC but, rather, an official statement of the Life Disclosure (A) Working Group that is offered as assistance to any state that chooses to use it.

There may be special requirements for applicants age sixty (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 recent 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 insurance regulator is only responsible for the conduct of insurance producers and conduct which requires an insurance producer license.

The NAIC 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" NAIC Replacement Model 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 NAIC 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 recent amendments removed all references to "senior." This model has been adopted in some states in various forms. Both versions of the model impose a duty on insurers and producers, or the entities they subcontract with, to perform certain duties to collect information from consumers and make reasonable recommendations based on all the circumstances actually known to the insurer or insurance producer at the time of the recommendation.

Market regulators should also be aware that sales of products, such as fixed-index annuities (formerly referred to as equity-indexed annuities) and index life insurance products (such as universal index life insurance) continue to increase. These products typically include features

that require an understanding of bonuses, guaranteed elements and an array of interest-crediting methods. In some cases, existing NAIC model laws and regulations may not give specific guidance on all aspects of all products. In such instances, examiners may rely on general principles found in the NAIC Unfair Trade Practices Act and the NAIC Annuity Disclosure Model Regulation.

3. Tests and Standards

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

STANDARDS
MARKETING AND SALES

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

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ All company advertising and sales materials, including radio and audiovisual items, such as television commercials, telemarketing scripts and pictorial materials

_____ Policy forms, including any required buyers' guides as they coincide with advertising and sales materials

_____ Producers' own advertising and sales materials

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

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 four (4) years or until the filing of the next regular report on examination of the company, whichever is the longer period of time.

Review advertising materials in conjunction with the appropriate policy form.

Materials should not:

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

- Exaggerate the fact, suggest or imply that competing insurers or insurance producers may not be licensed, if the advertisement states that an insurer or insurance producer is licensed in the state where the advertisement appears;
- Create the impression that the insurer, its financial condition or status, the payment of its claims or the merits, desirability or advisability of its policy forms or kinds of plans of insurance are recommended or endorsed by any governmental entity. However, where a governmental entity has recommended or endorsed a policy form or plan, that fact may be stated, if the entity authorizes its recommendation or endorsement to be used in an advertisement;
- State or imply that prospective insureds are or become members of a special class, group or quasi-group and enjoy special rates, dividends or underwriting privileges, unless that is a fact;
- Contain an assertion, representation or statement with regard to the risk-based capital levels of any insurer or of any component derived in the calculation;
- Use the existence of the insurance guaranty association for the purpose of sales, solicitation or inducement to purchase any form of insurance covered by the association;
- Misrepresent the dividends or share of the surplus to be received on any policy;
- Make a false or misleading statement as to the dividends or share of surplus previously paid on a policy;
- Misrepresent any policy as being shares of stock; and
- Illustrations of benefits payable under any modified guaranteed life insurance[27] 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

[27] "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.

- The sales material for any modified guaranteed life insurance must clearly illustrate there can be both upward and downward adjustments to nonforfeiture benefits, due to the application of the market value adjustment formula.

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

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

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

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

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

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

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

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

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

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

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

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

- Does the Web site disclose who is selling/advertising/servicing for the Web site?
- Does the Web site disclose what is being sold or advertised?
- If required by statutes, rules or regulations, does the Web site reveal the physical location of the company/entity?
- Does the Web site 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.

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

_____ Policy/Underwriting file

_____ Loan and surrender files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Life Insurance and Annuities Replacement Model Regulation (as adopted 1998) (#613)
Suitability in Annuity Transactions Model Regulation (#275)
Suitability of Sales of Life Insurance and Annuities White Paper
Military Sales Practices Model Regulation (#568)

Review Procedures and Criteria

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

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

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

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

STANDARDS
MARKETING AND SALES

Standard 3
The insurer's rules pertaining to insurer 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

_____ Policy/Underwriting file

_____ 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)

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 insurers 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.

STANDARDS
MARKETING AND SALES

Standard 4
An illustration used in the sale of a policy contains all required information and is delivered in accordance with statutes, rules and regulations.

Apply to: All life products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Actuarial records

_____ Underwriting file

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Life Insurance Illustrations Model Regulation (#582)
Universal Life Insurance Model Regulation (#585)
Variable Life Insurance Model Regulation (#270)
Life Insurance Disclosure Model Regulation (#580)
Disclosure for Small Face Amount Life Insurance Policies Model Act (#605)

Review Procedures and Criteria

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

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

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

- Represent the policy as anything other than a life insurance policy;
- Use or describe non-guaranteed elements in a manner that is misleading or has the capacity or tendency to mislead;
- State or imply that the payment or amount of non-guaranteed elements is guaranteed;
- Use an illustration that does not comply with statutes;
- Use an illustration that at any policy duration depicts policy performance more favorable to the policyowner than that produced by the illustrated scale of the insurer whose policy is being illustrated;

- Provide an applicant with an incomplete illustration;
- Represent in any way that premium payments will not be required for each year of the policy in order to maintain the illustrated death benefits, unless that is the fact;
- Use the terms "vanish," "vanishing premium" or a similar terms that imply that the policy becomes paid-up, to describe a plan for using non-guaranteed elements to pay a portion of future premiums;
- Except for policies that can never develop nonforfeiture values, use an illustration that is "lapse-supported"; or
- Use an illustration that is not "self-supporting."

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

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 NAIC Universal Life Insurance Model Regulation. 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 three (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 three (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: Recommended

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

Review Procedures and Criteria

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

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

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

Determine if negative enrollment practices are permitted and used.

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

For variable life, ensure the regulated entity maintains a written statement specifying the standards of suitability used by the insurer. 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 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

_____ 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 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[28] 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

_____ Underwriting manuals

_____ Policy 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 FDIC or any agency of

[28] Please refer to the bulletin for a detailed explanation of what constitutes a covered person.

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.)

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 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 file

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 whether the insurer has elected to supervise its producers directly or whether the insurer has contracted with a third-party contractor to directly supervise its producers, and then apply the following review procedures accordingly. For purposes of this standard, "insurer" refers to whichever party (i.e., the insurer or third-party contractor) that is responsible for direct supervision of the producers.

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 or exchange of an annuity resulting from a recommendation, an insurance producer obtained information concerning:

- The consumer's financial status;
- The consumer's tax status;

- The consumer's investment objectives; and
- Such other information used or considered to be reasonable by the insurance producer, in making recommendations to the consumer.

Examine for effectiveness the insurer's system of recording or monitoring whether an insurance producer proceeded with a sale that either may have violated the insurer's suitability procedures.

Examine for effectiveness the insurer's system for review or oversight of sales transactions subject to a suitability requirement in cases where no suitability analysis was performed because the consumer:

- Refused to provide relevant information requested by the insurance producer;
- Decided to enter into an insurance transaction that was not based on a recommendation of the insurance producer; or
- Failed to provide complete or accurate information.

Review completed annuity transactions and compare the information obtained by the insurance producer to the type of product purchased to determine if the insurance producer had reasonable grounds for believing that the product was suitable 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.

STANDARDS
MARKETING AND SALES

Standard 10
Insurer rules pertaining to requirements in connection with 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 file

_____ Agency correspondence file/Agency bulletins

_____ Agency procedural manual

_____ Claim files

_____ Complaint log

_____ Agency sales/lapse records

_____ Regulated entity's systems manual

_____ Regulated entity's producer training materials

_____ Contracts with third-party vendors with compliance responsibilities

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Review Procedures and Criteria

Determine whether the insurer has elected to supervise its producers directly or whether the insurer has contracted with a third-party vendor to directly supervise its producers and then apply the following review procedures accordingly. For purposes of this standard, "insurer" refers to whichever party (i.e., the insurer or third-party contractor) that is responsible for direct supervision of the producers.

Determine if the insurer has advised its producers of its suitability policy.

Determine if the insurer has the capacity to produce data required by the suitability regulation.

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 or third-party contractor's system of verifying 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.

Examine for effectiveness the insurer or third-party contractor's system of verifying that, prior to the execution of a purchase or exchange of an annuity resulting from a recommendation, an insurance producer or an insurer where no producer is involved, shall make reasonable efforts to obtain information concerning:

- The consumer's financial status;
- The consumer's tax status;
- The consumer's investment objectives; and
- Such other information used or considered to be reasonable by the insurance producer or the insurer where no producer is involved, in making recommendations to the consumer.

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

- Refused to provide relevant information requested by the insurer or insurance producer;
- Decided to enter into an insurance transaction that was not based on a recommendation of the insurer or insurance producer; or
- Failed to provide complete or accurate information.

Determine if the insurer or third-party contractor is the supervising party. Verify that a system is established and maintained to supervise recommendations that are reasonably designed to achieve compliance. Verify whether the insurer annually obtains a certification from a third-party senior manager who has responsibility for the delegated functions that the manager has a reasonable basis to represent, and does represent, that the third party is performing the required functions. The system should at a minimum include maintaining written procedures and conducting periodic reviews of its records that are reasonably designed to assist in detecting and preventing violations.

If the insurer is not the supervising party, review any contracts with a third party retained by the insurer to establish and maintain a system of supervision of suitability procedures with respect to insurance producers under contract with or employed by the third party.

Review the insurer's methods for making inquiries to monitor the third party's compliance with the insurer's suitability procedures.

If the third-party contractor has elected to comply with National Association of Securities Dealers Conduct (NASD)/Financial Industry Regulatory Authority (FINRA) rules, review how the insurer verifies that necessary compliance procedures are in place and are maintained.

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.

STANDARDS
MARKETING AND SALES

Standard 11
The insurer has procedures in place to educate and monitor insurance producers and 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 12
The insurer has procedures in place to educate and monitor insurance producers and to provide full disclosure to consumers regarding all sales of products involving index life, and all sales are in compliance with applicable statutes, rules and regulations.

Apply to: All index life products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy/Underwriting file

_____ Agency correspondence file/Agency bulletins

_____ Agency procedural manual

_____ Claim files

_____ Complaint log

_____ Agency sales/lapse records

_____ Regulated entity's systems manual

_____ Regulated entity's producer training materials

_____ Contracts with third-party vendors with compliance responsibilities

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Advertisements of Life Insurance and Annuities Model Regulation (#570), Section 3B
Life Insurance Disclosure Model Regulation (#580), Section 8C
Unfair Trade Practices Act (#880)
Life Insurance Illustrations Model Regulation (#582)

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 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 13
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,

A. The risk of loss for individuals who travel to a specified destination at a specific time is reasonably anticipated to be greater than if the individuals did not travel to that destination at the time; and

B. The risk classification is based on sound actuarial principles and actual or reasonably anticipated experience.

Examples of sections A and B above are future lawful travel plans to areas where the Centers for Disease Control and Prevention has issued a highest level alert including a recommendation for non-essential travel or to areas where 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 context regarding past and future lawful travel plans.

THE FOLLOWING INTRODUCTORY PARAGRAPHS AND SECTION C MARKETING AND SALES, SECTION F UNDERWRITING AND RATING AND SECTION G CLAIMS ARE EXCERPTED FROM CHAPTER 20—CONDUCTING THE HEALTH EXAMINATION OF THE *MARKET REGULATION HANDBOOK*

Chapter 20—Conducting the Health 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 guideline to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in Chapter 1—Introduction.

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

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

A. Operations/Management
B. Complaint Handling
C. Marketing and Sales
D. Producer Licensing
E. Policyholder Service
F. Underwriting and Rating
G. Claims
H. Grievance Procedures
I. Network Adequacy
J. Provider Credentialing
K. Quality Assessment and Improvement
L. Utilization Review
M. External Review
(A special checklist is available in Section N of this chapter)
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 managed care plans. The manner in which a state may define or distinguish a managed care 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 managed care plans. For instance, the NAIC definition of managed care is broad; i.e., "managed care 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 managed care 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 NAIC 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; ~~and~~
- 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

C. Marketing and Sales

Use the standards for this business area that are listed in Chapter 16—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 9(A) and 9(B)
~~Group Coverage Discontinuance and Replacement Model Regulation (#110)~~

Review Procedures and Criteria

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

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

Review replacement forms for compliance.

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

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

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; i.e., limits on coverage, determination of suitability, detection of predatory sales practices, etc.

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

Determine if negative enrollment practices are permitted and used.

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

F. Underwriting and Rating

Use the standards for this business area that are listed in Chapter 16—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 five (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 market.

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 twenty-nine (29) months of coverage under COBRA if they become disabled during the first sixty (60) days of COBRA coverage. The twenty-nine (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 and 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 54
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)
Medical/Lifestyle Questions and Underwriting Guidelines (#60)
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~~5~~
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 Model Act (#170)

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 six (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 twelve (12) months or eighteen (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 thirty (30) days.

Continuous coverage is required as follows:

- Issuers are not required to count coverage as creditable if it existed before a sixty-three (63) day break in coverage (NAIC model allows a ninety (90) day break); and
- Creditable coverage must be in effect for twelve (12) months or eighteen (18) months for a late enrollee to fully preempt preexisting conditions. (NAIC model allows six (6) months or twelve (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;
  - 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; 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 sixty-three (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 76~~6~~
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 Model Act (#170)

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 eighteen (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 sixty-three (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 arms 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~~7~~
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 two (2) to fifty (50), but allows states to add groups of one (1) and/or groups of more than fifty (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~~8~~
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 (#35), 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 10/1 to 9/30, 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~~9~~
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 16—General Examination Standards, in addition to the standards set forth below.

STANDARDS
CLAIMS

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

Apply to: All health products
Disability income products

Priority: Essential

Documents to be Reviewed

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

_____ Company claim procedure manuals

_____ Claim training manuals

_____ Internal company claim audit reports

_____ Claim bulletins, UCR guidelines and procedure manuals

_____ Company claim forms manual

_____ Claim files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

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

Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

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

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

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

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

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

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

Determine if claim files are handled according to policy provisions.

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

Determine if claim handling includes proper referral of suspicious claims.

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

In jurisdictions that have adopted the Health Examination Benefits Availability Act, ascertain that benefits are provided by group expense-incurred health plans for routine periodic physical examinations on an annual basis for covered persons over age sixteen and for “child health supervision services” for children less than sixteen (16).

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

_____ _____

_____ _____

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, and, 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 forty-eight (48) hours for a normal vaginal delivery and ninety-six (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

_____ _____

_____ _____

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.

MHPA requirements do not apply to: 1) small employer groups of two (2) to fifty (50) employees; or 2) any group health plan where the required federal notice has been filed, documenting that actual costs increased ~~one~~ two (~~1~~2) 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. ~~for at least six (6) consecutive months (special rules apply to plans that are in a combined pool for rating purposes)~~. ~~The law does not affect the terms and conditions (such as cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration or scope of mental~~

~~health benefits.~~ 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.

~~Verify that group health plans, health insurance issuers, insurance companies and managed care organizations offering mental health benefits do not set annual or lifetime dollar limits on mental health benefits that are lower than any such dollar limits for medical and surgical benefits.~~

~~Verify that a group health plan or policy that does not impose an annual or lifetime dollar limit on medical and surgical benefits does not impose such a limit on mental health benefits.~~

~~Note: MHPA protections apply to benefits for mental health services as defined under the terms of the health plan contract or policy, but do not extend to benefits for substance abuse or chemical dependency. MHPA does not apply to policies sold in the individual market.~~

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

_____ _____

_____ _____

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.

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 54
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.

**THE FOLLOWING STANDARD IS EXCERPTED FROM
CHAPTER 21—CONDUCTING THE MEDICARE SUPPLEMENT EXAMINATION
OF THE *MARKET REGULATION HANDBOOK***

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.

**THE FOLLOWING STANDARD IS EXCERPTED FROM
CHAPTER 22—CONDUCTING THE LONG TERM CARE EXAMINATION
OF THE *MARKET REGULATION HANDBOOK***

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 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.

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 (3) 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 submits certification that the associations to which it issues or markets long term care insurance comply with the requirements set forth by statutes, rules and regulations.

Ensure that any association offering long term care to its members discloses the following information in any solicitation materials:

- 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.