The 2014 Summer National Meeting

Market Regulation and Consumer Affairs (D) Committee

Excerpt from the Proceedings of the NAIC

Louisville, KY
August 16 – 19, 2014
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ISBN:

Printed in the United States of America

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MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

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Market Regulation and Consumer Affairs (D) Committee  
Louisville, Kentucky  
August 18, 2014

The Market Regulation and Consumer Affairs (D) Committee met in Louisville, KY, Aug. 18, 2014. The following Committee members participated: Stephen W. Robertson, Chair (IN); Therese M. Goldsmith, Vice Chair (MD); Jay Bradford represented by Ashley Fisher (AR); Chester A. McPherson and Lee Backus (DC); Sharon P. Clark (KY); Wayne Goodwin represented by Tracy Biehn (NC); Bruce R. Ramge and Martin Swanson (NE); Laura N. Cali (OR); Susan L. Donegan (VT); Michael D. Riley and Mark Hooker (WV); and Tom C. Hirsig (WY). Also participating were: Ted Clark (KS); Chuck Vanasdalan (NH); and Leslie Krier (WA).

1. **Adopted its June 23 and May 5 Minutes**

Commissioner Riley made a motion, seconded by Commissioner Donegan, to adopt the Committee’s June 23 minutes (Attachment One) and its May 5 minutes (see NAIC Proceedings – Summer 2014, Property and Casualty Insurance (C) Committee, Attachment One). The Committee also met in regulator-to-regulator session April 21 pursuant to paragraph 8 (consideration of strategic planning issues relating to federal legislative and regulatory matters or international regulatory matters) of the NAIC Policy Statement on Open Meetings. The motion was unanimously adopted.

2. **Received Update on Market Regulation Summit**

Commissioner Robertson said a list of action items the Committee decided to pursue from the Market Regulation Summit was included in the materials. Subsequent to the Committee’s June 23 call, NAIC staff worked with the respective chairs of the Working Groups to determine appropriate deadlines to complete each action item. Commissioner Robertson suggested the Committee review the list of action items at each NAIC national meeting and coordinate with each working group to make sure the items are moving forward on a coordinated basis. Director Ramge asked if there were plans to hold the Market Regulation Summit again in 2015. Commissioner Robertson said his intention is that the Market Regulation Summit be an annual event.

3. **Adopted the Report and Recommendations of the Model Law Review Initiative (D) Subgroup**

Commissioner Robertson said that, as part of the NAIC’s Model Law Review Initiative, the Committee appointed the Model Law Review Initiative (D) Subgroup, chaired by Commissioner Rothman, to recommend whether the following NAIC market regulation-related models should be retained as a model law, amended, converted to a guideline or archived: 1) the *Military Sales Practices Model Regulation* (#568); 2) the *Authorization for Criminal History Record Check Model Act* (#222); and 3) the *Unauthorized Transaction of Insurance Criminal Model Act* (#890).

Commissioner Robertson said that because the Committee had already recommended that Model #568 be retained, the work of the Subgroup focused on Model #222 (Attachment Two) and Model #890 (Attachment Three). Commissioner Robertson said the Subgroup met July 29 to discuss the models. He said that, because there were no comments received that the models should be archived, the Subgroup decided to poll the Subgroup members for recommendations and all members recommended the models be retained.

Commissioner Riley made a motion, seconded by Commissioner Cali, to adopt the report and recommendations of the Model Law Review Initiative (D) Subgroup (Attachment Four). The motion was unanimously adopted.

4. **Adopted ACA Market Conduct Examination Standards**

Director Ramge said that, since the Spring National Meeting, the Market Conduct Examination Standards (D) Working Group adopted five health reform-related market conduct examination standards: 1) prohibition of rescissions (Attachment Five); 2) extension of dependent coverage to age 26 (Attachment Six); 3) guaranteed availability (Attachment Seven); 4) guaranteed renewability (Attachment Eight); and 5) coverage of individuals participating in approved clinical trials (Attachment Nine).
Director Ramge said the Working Group has been working since 2012 on drafting market conduct examination standards for the immediate health reforms of the federal Affordable Care Act (ACA), as well as for the health reforms effective Jan. 1, 2014. He said these examination standards, once adopted by the Executive (EX) Committee and Plenary, will be included in the Market Regulation Handbook. Director Ramge said recognizing that jurisdictions have varying policy directions regarding the enforcement of the federal Affordable Care Act (ACA), the examination standards the Working Group have adopted to date and additional examination standards the Working Group will be developing to address other health reforms, are designed to provide uniform guidance to insurance regulators in their oversight of regulated entity activity as appropriate for consumers in their jurisdiction.

Director Ramge made a motion, seconded by Ms. Biehn, to adopt the following five health reform-related market conduct examination standards: 1) prohibition of rescissions; 2) extension of dependent coverage to age 26; 3) guaranteed availability; 4) guaranteed renewability; and 5) coverage of individuals participating in approved clinical trials. The motion was unanimously adopted.

5. Adopted the Report of the Antifraud (D) Task Force

Mr. Clark said the Antifraud (D) Task Force adopted the Information Sharing and Technology (D) Working Group’s July 29 and May 29 minutes. He said the Task Force received a report on the NAIC’s participation as a partner in the Healthcare Fraud Prevention Partnership. He said the Task Force also received a report on the Online Fraud Reporting System (OFRS), which included an update on the outstanding OFRS Uniform System Enhancement Request (USER) forms. He said the Task Force received a report on the 2014 antifraud education programs. He said there was interest from industry representatives regarding the education programs. He said the Task Force discussed the Antifraud Resources Report data updates for 2014. He said the Task Force will be amending the report to update the type of data collected. He said the Task Force will solicit comments and suggestions from its members, interested regulators and interested parties on the information published in the report. He said the Task Force also heard reports from the following organizations: Coalition Against Insurance Fraud; National Health Care Anti-Fraud Association; and National Insurance Crime Bureau. Commissioner McPherson made a motion, seconded by Commissioner Clark, to adopt the report of the Antifraud (D) Task Force. The report was unanimously adopted.


Ms. Krier said the Market Information Systems (D) Task Force adopted the Market Information Systems Research and Development (D) Working Group report of the action it has taken during its interim conference calls. She said the Working Group is monitoring the progress on the four remaining State Survey Project Action Plan initiatives through the USER form status report, along with other outstanding requests in progress. She said the Task Force also adopted the Regulatory Information Retrieval System (D) Subgroup report of the action it has taken during its interim conference calls. She said the Subgroup reviewed definitions for each of the codes and business processes for multi-state and multi-company regulatory actions, with comments requested by Aug. 22. She said the Task Force received an update on the Examination Tracking System Continuum Action Support project, which was approved during the Spring National Meeting, noting that an interim call will be scheduled for the Task Force to review the high-level business requirements. She said the Task Force reviewed and adopted its 2014 Market Regulation Summit action items, recommending that action item #4, “Investigate ways to better tie complaints to premium amounts,” may be better suited for the Market Analysis Procedures (D) Working Group to address. She said most of the action items can be addressed with the Task Force’s current charges; however, 2015 Proposed Charges have been adopted to address the remaining action items. She said the Task Force agreed that analysis to address the Market Regulation Summit action item #5, which is to “Review the NAIC Market Information Systems and develop a way that analysis can be performed on an insurance group basis instead of limited to the individual company basis,” may be leveraged for a next step to address one of its public data charges. Finally, she said the Task Force adopted its proposed 2015 charges. She said of particular note was the discussion the Task Force had in regard to charge #5, which is to evaluate the Market Information Systems data that is considered confidential and determine what can be made publicly available. She said that, because most of the issues with this charge relate to public policy rather than technical or information systems issues, the Task Force recommends that this Committee consider addressing this charge first. She said that once the policy decisions are made, the Task Force will address the technical implementation.

Commissioner Goldsmith made a motion, seconded by Director Ramge, to adopt the report of the Market Information Systems (D) Task Force, including the Task Force’s 2015 Proposed Charges (see NAIC Proceedings – Summer 2014, Market Information Systems (D) Task Force, Attachment Eight). The motion was unanimously adopted.

Director Ramge said the Market Conduct Examination Standards (D) Working Group adopted its July 30 minutes. He said the Working Group adopted five health reform-related market conduct examination standards: 1) prohibition of rescissions; 2) extension of dependent coverage to age 26; 3) guaranteed availability; 4) guaranteed renewability; and 5) coverage of individuals participating in approved clinical trials. He said the Working Group reviewed and discussed health reform-related market conduct examination standards regarding the prohibition on excessive waiting periods and reviewed and discussed revisions related to core competencies related to state insurance department oversight of contract examiners and overall updates needed to the core competencies. He said the Working Group reviewed and discussed revisions to Section D. Standards of Chapter 14—Sampling of the Market Regulation Handbook. Director Ramge made a motion, seconded by Commissioner Riley, to adopt the report of the Market Conduct Examination Standards (D) Working Group (Attachment Ten). The motion was unanimously adopted.

8. **Adopted the Report of the Auto Insurance (C/D) Study Group**

Commissioner Hirsig said the Auto Insurance (C/D) Study Group adopted its July 28 minutes and discussed the NAIC comment letter regarding Federal Insurance Office (FIO) request on affordability issues. He said the Study Group heard from industry and consumer groups concerning affordability issues. He said the Study Group discussed the issue of price optimization and agreed to have NAIC staff consult with the Casualty Actuarial and Statistical (C) Task Force on which group should handle the issue. He said the Study Group heard an update on car-sharing and ride-sharing issues, including a draft consumer alert on ride-sharing. He said the Study Group voted to expose a draft data template for a 45-day public comment period. Mr. Hirsig made a motion, seconded by Commissioner Goldsmith, to adopt the report of the Auto Insurance (C/D) Study Group (see NAIC Proceedings – Summer 2014, Property and Casualty Insurance (C) Committee, Attachment Seven). The motion was unanimously adopted.

Birny Birnbaum (Center for Economic Justice—CEJ) said the May 5 minutes show Commissioner Robertson had stressed that the adoption of “Compendium of Reports on the Pricing of Personal Automobile Insurance” would not mean that regulators are endorsing all viewpoints within the document. However, just a few weeks after the May 5 call, Mr. Birnbaum said the NAIC officers sent a letter to the FIO in response to a request for information, metrics and data on affordability and availability, which indicated that the report is to serve as a resource as the NAIC continues to evaluate the affordability and availability in the states. Mr. Birnbaum said the minutes indicate that Joel Lucher (CA) said he agrees with concerns that the report lacks balance by including industry perspectives. He said the minutes show Commissioner Goldsmith said the letters from the industry within the compendium are industry responses to the Study Group’s invitation for information on insurer initiatives. He said that was not the way the report is structured. Mr. Birnbaum said that the report includes statements from industry trade associations, such as the National Association of Mutual Insurance Companies (NAMIC) and the Property Casualty Insurers Association of American (PCI), that state there are no problems related to the affordability and availability of insurance. Mr. Birnbaum said he would like the compendium to be pulled from the Executive (EX) Committee and Plenary agenda for consideration of adoption because the compendium fails to include a balance of all perspectives.

Commissioner Hirsig asked if Mr. Birnbaum believes there were things excluded from the report that should not have been excluded. Mr. Birnbaum said the report fails to provide a proper balance between industry and consumer perspectives, because the report fails to include the consumer perspectives. Commissioner Robertson said he would review the report and determine the appropriate next steps.


Mr. Vanasdalan said the Market Analysis Procedures (D) Working Group adopted its July 10 minutes. He said the Working Group adopted a process for choosing new Market Conduct Annual Statement (MCAS) lines of business and a revised MCAS attestation form. He said the Working Group discussed the draft of a health company survey to assess company compliance with federal Affordable Care Act (ACA) requirements and the draft of a health company data call to assess company compliance with ACA requirements. He said the Working Group agreed to organize regulator-led webinars to discuss the baseline process. Ms. Biehn made a motion, seconded by Commissioner Cali, to adopt the report of the Market Analysis Procedures (D) Working Group (Attachment Eleven), including the revised MCAS attestation language (Attachment Twelve) and the process for choosing a new line of business for the MCAS (Attachment Thirteen). The motion was unanimously adopted.
10. Received the Report of the Market Actions (D) Working Group

Commissioner Robertson reported that the Market Actions (D) Working Group would meet in regulator-to-regulator session Aug. 18 pursuant to paragraph 3 (specific companies, entities or individuals, including, but not limited to, collaborative financial and market conduct examinations and analysis) of the NAIC Policy Statement on Open Meetings. The Working Group also met in regulator-to-regulator session July 1, June 3 and May 13 pursuant to paragraph 3 of the NAIC Policy Statement on Open Meetings.

11. Appointed the Market Regulation Accreditation (D) Working Group

Commissioner Goldsmith said the market conduct accreditation charge, which the Market Regulation and Consumer Affairs (D) Committee adopted during the Spring National Meeting, will be considered for adoption by the Executive (EX) Committee and Plenary during their joint session at this national meeting. She said the charge is to “develop a formal market regulation accreditation proposal for consideration by NAIC membership by providing recommendations for the following: 1) accreditation standards; 2) process for state implementation of the standards; 3) process to measure state compliance with the standards; and 4) process for future revisions to the standards.” She said that, assuming the charge is adopted, one possible next step is to appoint a subgroup of Committee members to develop a draft proposal to be distributed at the Fall National Meeting.

Commissioner Donegan urged support of the market conduct accreditation discussion and process. She said that, while the U.S. has a good reputation internationally, the adoption of an accreditation program will enhance that reputation. She urged Committee members and all participating states to consider how to fully participate in such an accreditation program. Director Ramge said the Committee already has a good start toward accreditation with the information in the Market Regulation Handbook and the Market Information Systems. Commissioner Robertson said that an accreditation program would be beneficial as conversations continue with the National Conference of Insurance Legislators (NCOIL). He said the relationship between the NAIC and NCOIL is important in the discussions about accreditation.

Mr. Birnbaum said the primary goal of an accreditation program should be that of effectiveness, which will lead to greater efficiency. He said the program should focus on the resources needed for the states to have effective market regulation programs. He said the concept of “domestic deference” should immediately be identified as a flawed concept for market regulation and taken off the table for any further discussion. He said that the development of additional procedures does not necessarily lead to effectiveness and efficiencies. He said the focus of an accreditation program should be on the analysis of the insurance market so examiners can focus their efforts on the companies with issues.

Commissioner Clark said the market conduct accreditation charge has the full support of the NAIC officers and that an effective market conduct accreditation program would be a good thing for the insurance industry and insurance consumers. Commissioner Clark made a motion, seconded by Commissioner Donegan, to appoint a Market Conduct Accreditation (D) Working Group to be chaired by Commissioner Goldsmith and include representation from all NAIC zones. The motion was unanimously adopted.

12. Heard Request Regarding ACA Audits

Greg Martino (Aetna) said that as the states begin to conduct audits related to the ACA, Aetna is hoping the examinations are streamlined. He said that, because the standards are the same for all states, it would be a good opportunity to for the NAIC and the U.S. Center for Consumer Information and Insurance Oversight (CCIIO) to look for efficiencies with coordinated efforts.

13. Heard Report on Federal Activities

Tony Cotto (NAIC) said he would be contacting the Market Regulation and Consumer Affairs (D) Committee for assistance on conference calls with the U.S. Government Accountability Office (GAO) regarding regulatory duplication and lender-placed insurance. He also said that the housing finance bill discussed at the Spring National Meeting, which had heavy backing from the White House and the FIO, was voted out of committee on a 13-9 vote. However, because the close vote indicated to U.S. Senate leadership that the bill was not ready for the Senate floor, it will not be discussed with the current Congress. However, he said it will probably be discussed immediately during the next Congress. He said another issue is the proposed privacy notice rule, which modifies the federal Gramm-Leach-Bliley Act (GLBA) requirement to notify consumers of their privacy rights. He said it would allow for an electronic notification and that comments are being accepted on the
change. Finally, he said the issue of cybersecurity is a critical consumer issue and there are almost daily reports of security breaches. He said the NAIC is participating on the Financial and Banking Information Infrastructure Committee (FBIIC). Commissioner Clark said the cybersecurity issue is going to be an important topic for the NAIC. She said that if the NAIC or the FBIIC identifies an issue regarding insurance carriers, they will notify the other group through Commissioner Goldsmith, who will serve as the official NAIC liaison to the FBIIC.

14. Discussed Timeline for Consideration of its 2015 Proposed Charges

Tim Mullen (NAIC) said that, according to the NAIC timeline for the adoption of the 2015 Proposed Charges, all NAIC task forces are to adopt their 2015 Proposed Charges by Sept. 18 and all committees are to adopt their 2015 Proposed Charges by Oct. 27. He said that, in the coming weeks, the Committee’s 2015 Proposed Charges will be compiled so input can be solicited from the Committee and all interested parties. The Committee will then meet via conference call to consider adoption of its 2015 Proposed Charges before Oct. 27.

15. Recognized Contributions of Former NAIC President Woodyard

Commissioner Robertson requested that the minutes reflect the recent passing of former NAIC President (1981) and Arkansas Insurance Commissioner William H.L. Woodyard, III. He said the Committee would like to show its respect for Mr. Woodyard and his contribution to insurance regulation, as well as extend condolences to Mr. Woodyard’s family.

Having no further business, the Market Regulation and Consumer Affairs (D) Committee adjourned.
Market Regulation and Consumer Affairs (D) Committee  
Conference Call  
June 23, 2014

The Market Regulation and Consumer Affairs (D) Committee met via conference call June 23, 2014. The following Committee members participated: Stephen W. Robertson, Chair (IN); Therese M. Goldsmith, Vice Chair (MD); Jay Bradford represented by Ashley Fisher (AR); Chester A. McPherson represented by Lee Bachus (DC); Sharon P. Clark (KY); Mike Rothman (MN); Bruce R. Ramee (NE); Wayne Goodwin represented by Tracy Biehn (NC); Laura N. Cali represented by Russell Latham (OR); Susan L. Donegan (VT); Michael D. Riley (WV); and Tom C. Hirsig (WY).

1. **Adopted the Prioritization of Action Items from the 2014 Market Regulation Summit**

Commissioner Robertson said the Market Regulation Summit was held March 10–12 in Kansas City, MO. The purpose of the Market Regulation Summit was to provide a regulator-only forum for state insurance regulators to engage in training regarding market conduct regulation priorities, exchange perspectives on best practices for market conduct regulation, discuss challenges facing state market conduct regulators and strategic policy solutions to these challenges, and discuss company marketplace practices. The Market Regulation Summit was attended by 52 regulators from 43 jurisdictions.

Commissioner Robertson said the purpose of the call is to receive additional feedback to determine what potential action items should be pursued. To begin this process, Commissioner Robertson said each potential action item was tentatively assigned to this Committee, a task force, a working group, or NAIC staff. The attendees of the Market Regulation Summit were asked to rank each item as a high priority, medium priority, low priority, or as an item that should not be pursued. The potential action items have been prioritized by the number of respondents who ranked an item as a high priority (Attachment One-A).

Commissioner Robertson said the potential action item to continue the NAIC partnership with the National Conference of Insurance Legislators (NCOIL), which was established by Commissioner Clark in 2012, will be pursued because he considers this a high priority. The Committee expressed agreement with this assessment and offered their support for continuing to partner with NCOIL.

As suggested by California through written comments, Commissioner Goldsmith offered her support to pursue action item #4 under the Market Regulation and Consumer Affairs (D) Committee, action item #2 under the Market Information Systems (D) Task Force and action item #2 under Market Analysis Procedures (D) Working Group.

Commissioner Donegan suggested the Committee should consider all of the actions items related to the Federal Insurance Office. Commissioner Donegan also suggested there may be other action items that should be pursued because they were categorized as a high or medium priority by most of the attendees of the Market Regulation Summit.

Commissioner Robertson suggested that any potential action item that was categorized as either a high priority or a medium priority by at least 75% of the attendees of the Market Regulation Summit should be pursued. Birny Birnbaum (Center for Economic Justice—CEJ) said this criterion would eliminate future discussions on the possibility of a pilot program for the use of transactional data. Mr. Birnbaum said his recommendation is to include an action item to utilize existing transactional data, evaluate the potential for improvements in market analysis and market regulation compared to market analysis based on the current Market Conduct Annual Statement. Mr. Birnbaum said this would only involve the resources of a couple of states working with NAIC staff.

Commissioner Rothman made a motion that the potential action items, which at least 75% of Market Regulation Summit attendees categorized as a high priority or medium priority, be pursued with the understanding that NAIC staff will provide feedback on a feasible timeline to complete each item. Commissioner Donegan seconded the motion.

Mr. Birnbaum said this would exclude the pursuit of additional discussions about the collection of transactional data and suggested this should be pursued. Commissioner Robertson said this issue would be excluded from this prioritization but future discussion of transactional data would not be stopped based on the prioritization of the items from the Market Regulation Summit.
Commissioner Robertson asked for a roll-call vote. The following jurisdictions voted in favor of the motion: Maryland, Arkansas, District of Columbia, Kentucky, Minnesota, Nebraska, North Carolina, Oregon, Vermont, West Virginia and Wyoming. No jurisdictions voted against the motion. The motion carried.

2. **Discussed Other Matters**

Commissioner Robertson said it is not appropriate for him to individually meet with members of the industry on issues before the Committee, because all the Committee members should have an opportunity to participate in these discussions. Commissioner Robertson said interested parties are encouraged to bring issues to the Committee as a whole.

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

## Action Items of the 2014 Market Regulation Summit

**JUNE 23, 2014**

## Action Items and Deadlines for Completion

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<thead>
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<th>8-31</th>
<th>9-30</th>
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<th>11-30</th>
<th>12-31</th>
<th>2015</th>
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<tbody>
<tr>
<td>1. In response to Federal Insurance Office (FIO) recommendations, provide FIO information regarding how states use the Handbook and how it is updated.</td>
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<td>2. In response to FIO recommendations, provide FIO detail on how states share information with each other: NAIC systems, NAIC bulletin boards, PICS notifications, informal conversations at meetings, review of publicly available resources, etc.</td>
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<td>3. In response to FIO recommendations, develop specific minimum qualifications for contractors.</td>
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<td>4. In response to FIO recommendations, review and update core competency addressing contract examiners.</td>
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<td>5. In response to FIO recommendations, recognize the evolution of states’ market conduct examiners to market conduct specialists.</td>
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<td>6. In response to FIO recommendations, ensure contractors are required to provide status reports to state insurance regulators, and send a state employee to visit contractors on site at examination.</td>
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<td>7. In response to FIO recommendations, develop a list of contractors for registration at the NAIC similar to what is done for financial contract examiners.</td>
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<td>8. Continue the NAIC partnership with the National Conference of Insurance Legislators (NCOIL).</td>
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<td>9. Focus on creating a uniform process and state accountability to the process as a starting point for market regulation accreditation.</td>
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<td>10. Obtain state statutes that reference the use of the <em>Market Regulation Handbook</em>.</td>
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### Market Information Systems (D) Task Force

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<th>Action Items and Deadlines for Completion</th>
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<tbody>
<tr>
<td><strong>Action Items</strong></td>
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<tr>
<td>1. Ensure completion of Market Information Systems (D) Task Force action plan.</td>
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<td>2. Develop a system/database that better shares information on actions other than examinations.</td>
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<td>3. Analyze the data currently in the NAIC Market Information Systems to see what was entered and what training needs to occur to ensure better data quality (if needed.)</td>
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<td>4. Investigate ways to better tie complaints to premium amounts. <em>(The Task Force recommends re-assignment to the Market Analysis Procedures (D) Working Group.)</em></td>
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<td>5. Review the NAIC Market Information Systems and develop a way that analysis can be performed on an insurance group basis instead of limited to the individual company (CoCode) basis.</td>
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<td>6. Find a way to allow state users of I-SITE data to query the NAIC Market Information Systems.</td>
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<td>7. Monitor how state data entry to the NAIC Market Information Systems has changed after the action plan has been implemented.</td>
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### Market Conduct Examination Standards (D) Working Group

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<th>Action Items and Deadlines for Completion</th>
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<tr>
<td><strong>Action Items</strong></td>
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<tr>
<td>1. Review the Core Competencies to determine which competencies need to be updated.</td>
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<tr>
<td>2. Update the core competency addressing contract examiners. Ensure contractors are required to provide status reports to state insurance regulators, and send state employees to visit contractors on site at examinations.</td>
</tr>
<tr>
<td>3. Consider revising the sampling procedures outlined in the <em>Market Regulation Handbook</em> to provide for greater flexibility, as appropriate.</td>
</tr>
<tr>
<td>4. Collect and then post a list of best practices for state use of the <em>Market Regulation</em></td>
</tr>
</tbody>
</table>
5. Review Chapter 16 of the Market Regulation Handbook (General Examination Standards), and determine which standards would not be applicable to all exams so they can be moved to the appropriate chapters.

6. Reevaluate the use of the 10% and 7% tolerance thresholds outlined in the Market Regulation Handbook.

### Market Analysis Procedures (D) Working Group

#### Action Items and Deadlines for Completion

<table>
<thead>
<tr>
<th>Action Items</th>
<th>7-31</th>
<th>8-31</th>
<th>9-30</th>
<th>10-30</th>
<th>11-30</th>
<th>12-30</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Develop routine trending reports for the analysis of Market Conduct Annual Statement (MCAS) data.</td>
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<tr>
<td>2. Develop a standard process for determining MCAS outliers at the state level.</td>
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<tr>
<td>3. Identify ways to notify companies that they are attesting to the accuracy of MCAS data and that entering incorrect data may result in regulatory actions. This may include a review of the attestation language. (Because many incorrect filings are related to life insurance, MAP should notify ACLI of potential regulatory actions for incorrect filings.)</td>
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<td>4. Explore ways to obtain more current market regulation data.</td>
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<tr>
<td>5. Establish a process for the better coordination between states when issues are identified during the analysis of the MCAS data.</td>
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<tr>
<td>6. Establish a process for the better coordination between states when validation issues are identified during the MCAS filing process.</td>
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<tr>
<td>7. Review the market analysis process, and determine what analysis can be done on a more frequent basis than annually.</td>
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<tr>
<td>8. Review analysis-related chapters of the Market Regulation Handbook on a rotating basis to ensure information is current.</td>
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</table>
**Market Actions (D) Working Group**

<table>
<thead>
<tr>
<th>Action Items</th>
<th>7-31</th>
<th>8-31</th>
<th>9-30</th>
<th>10-30</th>
<th>11-30</th>
<th>12-30</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Distribute the Market Actions (D) Working Group policies and procedures to all regulators who participated in the Summit, and make sure the procedures are available on MyNAIC.org.</td>
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<tr>
<td>2. Make sure a summary of ongoing actions is available to Collaborative Action Designees after each Working Group meeting or call.</td>
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<tr>
<td>3. Discuss ways to make the annual National Analysis Project more of an ongoing process.</td>
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<td>4. Explore ways to make the Working Group more proactive rather than reactive, such as increasing Working Group-dedicated resources.</td>
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<tr>
<td>5. Develop a process to fast-track referrals to the Working Group that are close to settlement.</td>
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<tr>
<td>6. Prepare a summary report of the National Analysis Process that shows what activities occurred because of the national analysis.</td>
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<tr>
<td>7. Explore ways to look at groups (and not just individual companies) on a national level.</td>
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<tr>
<td>8. Consider ways to increase participation of all states, such as (a) clarifying that a state’s referral to the Working Group does not commit the referring state to a role as a lead or managing lead state and (b) combining the NAIC’s Exam Tracking Systems and Market Initiative Tracking System for enhanced collaboration through the Working Group.</td>
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<tr>
<td>9. Discuss the Working Group’s structure and membership to evaluate whether membership on a rotational basis would be desirable.</td>
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<tr>
<td>10. Review collaborative actions-related chapters of the Market Regulation Handbook on a rotating basis to ensure information is current.</td>
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</tbody>
</table>
### NAIC Education & Training Department

<table>
<thead>
<tr>
<th>Action Item and Deadline for Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Action Item</strong></td>
</tr>
<tr>
<td>1. Develop a training program on how to properly use the <em>Market Regulation Handbook</em>.</td>
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</tbody>
</table>

### NAIC Market Regulation Department

<table>
<thead>
<tr>
<th>Action Items and Deadlines for Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Action Items</strong></td>
</tr>
<tr>
<td>2. Conduct a webinar regarding Market Actions (D) Working Group policies and procedures.</td>
</tr>
</tbody>
</table>

### NAIC Information Systems Division

<table>
<thead>
<tr>
<th>Action Items and Deadlines for Completion</th>
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</thead>
<tbody>
<tr>
<td><strong>Action Items</strong></td>
</tr>
<tr>
<td>1. Train states on ways to query the data in the NAIC Market Information Systems.</td>
</tr>
<tr>
<td>2. Develop training and webinars regarding submission of data to each of the NAIC Market Information Systems.</td>
</tr>
<tr>
<td>3. Identify and maintain a list of NAIC and state contacts responsible for data entry.</td>
</tr>
</tbody>
</table>
AUTHORIZATION FOR CRIMINAL HISTORY RECORD CHECK MODEL ACT (#222)

2014 Model Review Criteria Worksheet

The purpose of this document is to provide necessary background information to NAIC and state insurance regulators to aid in reviewing model laws for compliance with model law criteria.

1. Parent Committee/Task Force/Working Group Responsible for Model Law:

   Market Regulation and Consumer Affairs (D) Committee

2. Staff Support Contact Information:

   Tim Mullen, tmullen@naic.org, (816) 783-8260.
   Craig L. Leonard, cleonard@naic.org, (816) 783-8268.

3. Short Summary of Model Law:

   The purpose of Model #222 is to set forth the requirements for the states to obtain access to the Criminal Justice Information Services Division of the Federal Bureau of Investigation (FBI) criminal history record information and secure information or reports from the Criminal Justice Information Services Division of the FBI.

4. Date Originally Adopted by the NAIC:

   Model #222 was first adopted in the second quarter of 2006.

5. Date Last Amended by the NAIC:

   N/A.

6. Number of States that Have Adopted Current Model:

   Two states have adopted the current model.

   Thirty-two states have taken “related state activity.” Examples of “related state activity” include, but are not limited to, enacting an older version of the NAIC model, legislation or regulation derived from other sources such as bulletins or administrative rulings.

7. Number of States that Have Adopted a Previous Version of Model:

   N/A.

8. Record of Last State Legislative/Regulatory Action for Model:

   One state took action in 2007 and one state took action in 2009.

9. Record of Last State Legislative/Regulatory Action on Topic Covered by Model (Related Activity):

   Three states took action in 2010, one state took action in 2011 and one state took action in 2012.
10. Relationship to IIPRC Standard, if Any:

None

11. Is This Model Law Referenced or Contained, in Whole or in Part, in Any Other NAIC Guidance, Manual or Handbook?

Yes; the model is referenced on Page 30 of the 2013 State Licensing Handbook:

The [Producer Licensing (EX) Working Group] has adopted model language that will allow a state to access federal databases. (See NAIC Model 222, Authorization for Criminal History Record Check.) States are encouraged to adopt this language.”

12. Significance or Reason Why This Model Should Be Retained:

The provisions of Model #222 are still relevant to the current regulatory environment and address an issue that requires legislative action at the state level.

The model contains language the FBI approved to authorize a state identification bureau to submit fingerprints on behalf of its applicants in conjunction with licensing and employment. The importance of this language is recognized in the State Licensing Handbook, which encourages the states to adopt this model language.

The NAIC’s Uniform Licensing Standards include the following standard for background checks. Background checks will be conducted through the following three steps:

A. States will ask and review the answers to the standard background questions contained on the Uniform Applications;
B. States will run a check against the NAIC [Regulatory Information Retrieval System (RIRS)/State Producer Licensing Database (SPLD) and State Actions Database (SAD)]; and
C.1 States will fingerprint their resident producer applicants for major lines of authority, and crop and where required, designated responsible producers for limited lines business entities and conduct state and federal criminal background checks on new resident producer applicants; or
C.2 If a state lacks the authority or resources to accept and receive data from the FBI, it shall conduct a statewide criminal history background check through the appropriate governmental agency for new resident producer applicants for major lines of authority, and crop and where required, designated responsible producers for limited lines business entities until such time as it obtains the appropriate authority.

In order to be fully compliant with this standard, a state must fingerprint and conduct state and federal criminal history background checks on their new resident applicants. Although electronic fingerprinting is strongly encouraged, a state will be compliant with this requirement if the fingerprints are obtained through paper when electronic means are unavailable.

A state may, but is not required to, fingerprint resident producers not previously fingerprinted at the time of application or when adding additional lines of authority to their license. The states shall not fingerprint nonresident applicants.
UNAUTHORIZED TRANSACTION OF INSURANCE CRIMINAL MODEL ACT (#890)

2014 Model Review Criteria Worksheet

The purpose of this document is to provide necessary background information to NAIC and state insurance regulators to aid in reviewing model laws for compliance with model law criteria.

1. Parent Committee/Task Force/Working Group Responsible for Model Law:

   D Committee

2. Staff Support Contact Information:

   Tim Mullen, tmullen@naic.org, (816) 783-8260.
   Craig L. Leonard, cleonard@naic.org, (816) 783-8268.

3. Short Summary of Model Law:

   Model #890 prescribes penalties for those engaging in the unauthorized transaction of insurance or health coverage. It also sets out penalties for assisting an unauthorized insurer, as well as for engaging in repeated violations of this model.

4. Date Originally Adopted By NAIC:

   Model #890 was originally adopted in the fourth quarter of 2006.

5. Date Last Amended by NAIC:

   N/A.

6. Number of States that Have Adopted Current Model:

   None. Ten states have taken “related state activity.” Examples of “related state activity” include, but are not limited to, enacting legislation or regulation derived from other sources such as bulletins or administrative rulings.

7. Number of States that Have Adopted a Previous Version of Model:

   N/A.

8. Record of Last State Legislative/Regulatory Action for Model:

   None.

9. Record of Last State Legislative/Regulatory Action on Topic Covered by Model (Related Activity):

   One state took action in 2011.
10. Relationship to IIPRC Standard, if Any:

None.

11. Is this Model Law referenced or Contained, in Whole or in Part, in Any Other NAIC Guidance, Manual or Handbook?

No

12. Significance or Reason Why This Model Should Be Retained:

The drafting of this model was initiated after two U.S. Government Accountability Office (GAO) reports focusing on unauthorized entities operating in the health insurance marketplace were issued in 2004.

- PRIVATE HEALTH INSURANCE: Employers and Individuals Are Vulnerable to Unauthorized or Bogus Entities Selling Coverage (Feb. 27, 2004) – This report noted the following: “After identifying the unauthorized entities, the primary mechanism states used to stop them from continuing to operate was the issuance of cease and desist orders.”

- PRIVATE HEALTH INSURANCE: Unauthorized or Bogus Entities Have Exploited Employers and Individuals Seeking Affordable Coverage (March 3, 2004) – A concluding observation of this report included the following: “As many employers and individuals continue to seek affordable health coverage alternatives in this environment of rising premiums, it is especially important that federal and state governments remain vigilant in identifying, stopping, and preventing the establishment of these entities and continue to caution individuals, employers, and their agents to verify the legitimacy of entities offering coverage.”

The minutes of the Antifraud (D) Task Force from September 2003 reflect a request from Mila Kofman, who was with Georgetown University and an NAIC funded consumer representative in 2003. The request was for the NAIC to develop model language making it a first class felony to operate and sell unauthorized insurance.
Model Law Review Initiative (D) Subgroup
Conference Call
July 29, 2014

The Model Law Review Initiative (D) Subgroup of the Market Regulation and Consumer Affairs (D) Committee met via conference call July 29, 2014. The following Subgroup members participated: Mike Rothman (MN), Chair; and Laura N. Cali (OR). Also participating were: Amy Groszos (FL); Carol Roy (MT); Bruce R. Ramge (NE); Denise Lamy (NH); Bill Michels (WA); and Leslie Krier (WA).

1. **Reviewed Model Review Criteria Worksheet of Model #222**

Tim Mullen (NAIC) said the *Authorization for Criminal History Record Check Model Act (#222)* was adopted in 2006 for the purpose of setting forth requirements for states to obtain access to criminal history record information at the Criminal Justice Information Services Division of the Federal Bureau of Investigation (FBI). Mr. Mullen said two states have adopted the Model #222, and 32 states have “related state activity.” Mr. Mullen said subsection 3A of the model contains language the FBI approved to authorize a state to submit fingerprints on behalf of producer applicants.

Commissioner Rothman said he recommends the retention of Model #222 because of the importance of subsection 3A and the “related state activity.” Mr. Odiorne said Washington supports the retention of Model #22. There were no other comments from regulators or interested parties.

2. **Reviewed Model Review Criteria Worksheet of the Model #890**

Mr. Mullen said the *Unauthorized Transaction of Insurance Criminal Model Act (#890)* was adopted in 2006 for the purpose of setting forth penalties for individuals and companies engaging in the unauthorized transaction of insurance and for assisting an unauthorized insurer. Mr. Mullen said the model was developed after the U.S. Government Accountability Office (GAO) issued two reports focusing on unauthorized entities operating in the health insurance marketplace. Mr. Mullen said no states have adopted the model, but 10 states have adopted “related state activity.”

Commissioner Rothman said he recommends the retention of Model #890 because it was developed subsequent to formal reports from the GAO and the “related state activity” of 10 states.

Wesley Bissett (Independent Insurance Agents and Brokers of America—IIABA) said the IIABA does not oppose the purposes and goals of Model #890, but it has concerns with the manner in which elements of the proposal are drafted. Mr. Bissett said the model potentially subjects a person, such as a licensed insurance producer, to regulatory penalties if he/she indirectly aids an unauthorized insurer, even if the person has no knowledge that the entity is unauthorized and has no reason to believe it to be so. Mr. Bissett said a person who was not acting as an unauthorized insurer, had no knowledge or reason to believe that he/she was aiding an unauthorized insurer, and was never criminally charged or convicted could be jointly and severally liable for the payment of claims due to the activities of an unauthorized insurer.

Commissioner Rothman said he appreciates these comments, but said revising Model #890 is beyond the scope of the current charge at this time. Commissioner Rothman recommended Model #890 be retained in its current form.

Hearing no other comments, Commissioner Rothman asked Mr. Mullen to provide a summary of the call and to obtain additional feedback from the Subgroup, so that final recommendations of the Subgroup can be provided to the Market Regulation and Consumer Affairs (D) Committee at the Summer National Meeting. Commissioner Rothman said the Committee would then make a decision on whether the models should be retained, converted to a guideline or archived.

Having no further business, the Model Law Review Initiative (D) Subgroup adjourned.
Chapter XX—Health Reform

Federal law defers enforcement of health reform to state insurance regulators. To help ensure strong consumer protections remain in place, state insurance regulators are developing new tools and methods for comprehensive oversight of the health insurance marketplace.

Examination Standards –
States are developing examination standards for the immediate mandates of health reform. Since the immediate mandates are new to the marketplace and regulators, each examination standard includes introductory language setting forth the appropriate health reform provision title, citation, effective date, summary of the provision, background, and cross references to FAQs. The introductory language is followed by the examination standards for the health reform mandate formatted for the NAIC’s Market Regulation Handbook.

Examination Checklist –
Once the examination standards are finalized, the standards will be placed into an examination checklist for use by state insurance regulators and health carriers. The examination checklist will serve as a uniform tool through which states and health carriers can measure compliance.

Additional Data Collection –
As the examination standards and checklist are developed, additional data may need to be collected for monitoring and oversight of the marketplace.

Collaboration Methodology –
The final component of state market conduct compliance tools for health reform is enhanced state collaboration which would provide consistent interpretation and review of the health reform standards.
# MARKET CONDUCT EXAMINATION STANDARDS

<table>
<thead>
<tr>
<th>Provision Title</th>
<th>ACA Citation</th>
<th>Page</th>
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<tbody>
<tr>
<td>Rescissions</td>
<td>PHSA 2712</td>
<td>3</td>
</tr>
</tbody>
</table>
**PROVISION TITLE:** Rescissions

**CITATION:** PHSA § 2712

**EFFECTIVE DATE:** Plan years, and in the individual market, policy years beginning on or after September 23, 2010

**PROVISION:** The provisions of the health reform act prohibit health carriers from rescinding policies unless a rescission is based upon fraud or intentional misrepresentation of material fact.

**BACKGROUND:** Regulations and associated FAQs, issued by the Department of Health and Human Services (HHS), the Department of Labor (DOL) and the Treasury set forth the requirement that a rescission is a cancellation or discontinuance of coverage that has a retroactive effect; this includes a cancellation that treats a policy as void from the time of the group’s enrollment or a cancellation that voids benefits paid up to one year before the cancellation. A rescission is not the cancellation or discontinuance of coverage that has only a prospective effect; or the cancellation or discontinuance of coverage if effective retroactively to the extent it is based on a failure to timely pay required premiums or contributions towards the cost of coverage.

This provision applies to all health carriers in the individual market and to small group employer plans. This provision applies to both grandfathered and non-grandfathered group health plans.

A group health benefit plan and a health carrier offering group or individual health insurance coverage may not rescind such plan or coverage with respect to a plan enrollee (in the individual market, primary subscriber) once the enrollee (plan subscriber) is covered under such plan or coverage, except that provision shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage.

Such plan or coverage may not be cancelled except with prior notice to the plan enrollee (in the individual market, primary subscriber), and only as permitted under applicable sections of HHS, DOL and Treasury regulations.

**FAQs:** See HHS website for guidance.

**NOTES:**
Standard 1
A health carrier may not retrospectively rescind individual or group coverage (including family coverage in which the individual is included) unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact.

Apply To: All group health products, (grandfathered and non-grandfathered products) for plan years beginning on or after September 23, 2010

All individual health products (grandfathered and non-grandfathered products) for policy years beginning on or after September 23, 2010

Priority: Essential

Documents to be Reviewed

____ Health carrier underwriting policies and procedures related to rescissions
____ Underwriting files and supporting documentation regarding rescissions, including letters, notices, telephone scripts, etc.
____ Rescinded policies
____ Reformations/counteroffers
____ Complaint register/logs/files
____ Health carrier complaint records concerning rescissions (supporting documentation, including, but not limited to written and phone records of inquiries, complaints, complainant correspondence and health carrier response)
____ Claims files
____ Internal appeals/grievances files
____ Applicable external appeals based on rescissions, external appeal resolution and associated documentation
____ Health carrier form approvals (policy language, enrollment materials, and advertising materials, as required under state statutes, rules and regulations)
____ Health carrier marketing and sales policies and procedures’ references to rescissions
____ Health carrier communication and educational materials related to rescissions, provided to applicants, enrollees, policyholders, certificateholders and beneficiaries
____ Training materials
____ Producer records
____ Applicable state statutes, rules and regulations

NAIC References

Model Language for Prohibition on Rescissions of Coverage (#930-F)
Other References

_____ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding the prohibition of rescissions in accordance with final regulations established by HHS, DOL and the Treasury.

Review health carrier underwriting policies and procedures related to rescissions to verify adequate and appropriate policies/procedures are in place to ensure rescissions issued by the health carrier are in compliance with final regulations established by HHS, DOL and the Treasury.

Review rescinded policies to verify that the health carrier does not inappropriately rescind coverage.

Review reformations and/or counteroffers to determine if the reformation or counteroffer resulted in any inappropriate rescissions of coverage.

Examiner Note: Carrier rescissions should be reviewed to ensure that carrier rescissions are not based on actions taken or statements made by enrollees on the basis of errors or misrepresentations on the part of carriers, exchanges, producers, navigators, or assisters. (See CMS guidance on errors and misrepresentations.)

Review rescission notices to verify that notices set out clearly the specific fraudulent act, practice, or omission or intentional misrepresentation of material fact on which the rescission is based, the terms of the plan or coverage that supports the rescission, and the factual basis for rescinding coverage.

Review complaint register/logs and complaint files to identify complaints pertaining to rescission.

Review complaint records, to verify that, when coverage has been rescinded inappropriately, the health carrier has taken appropriate corrective action/adjustments regarding the reinstatement of coverage in a timely and accurate manner.

Ascertain if the health carrier error could have been the result of some systemic issue (e.g. programming or processing error). If so, determine if the health carrier implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to an individual whose coverage was inappropriately rescinded.

Review health carrier claim files to identify any coverage denials for claimants on inappropriately rescinded coverage.

Review health carrier internal appeals/grievance files to identify any coverage denials for individuals on inappropriately rescinded coverage.

Review procedures should also require review of any external appeal requests and of the conclusions of external appeals addressing rescissions.

Review policy form files to ensure approval(s) from the applicable state and, (if applicable) from the marketplace.
Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about rescissions.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about rescissions.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and Treasury provisions and final regulations pertaining to rescissions.

Review health carrier training materials to verify that information provided therein is complete and accurate with regard to rescissions.

Determine if the health carrier monitors producer-generated rescissions. Review producer records of rescissions for compliance with final regulations established by HHS, DOL and the Treasury.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or creates a more generous benefit, and thus not preempted, as set forth in federal law.
Standard 2
A health carrier offering group or individual health insurance coverage shall provide at least 30 days advance written notice to each plan enrollee (in the individual market, primary subscriber) who would be affected before coverage may be rescinded.

Apply To: All group health products, (grandfathered and non-grandfathered products) for plan years beginning on or after September 23, 2010

All individual health products (grandfathered and non-grandfathered products) for policy years beginning on or after September 23, 2010

Priority: Essential

Documents to be Reviewed:

___ Health carrier underwriting policies and procedures related to rescissions

___ Underwriting files and supporting documentation regarding rescissions, including letters, notices, telephone scripts, etc.

___ Rescinded policies

___ Complaint register/logs/files

___ Health carrier complaint records concerning rescissions (supporting documentation, including, but not limited to written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

___ Training materials

___ Producer records

___ Applicable state statutes, rules and regulations

NAIC References

Model Language for Prohibition on Rescissions of Coverage (#930-F)

Other References

___ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding providing advance notice of rescissions in accordance with final regulations established by HHS, DOL and the Treasury.

Review health carrier’s underwriting policies and procedures related to advance written notice of rescissions to verify that adequate and appropriate policies/procedures are in place to ensure the health carrier issues advance written notice of rescissions in compliance with final regulations established by HHS, DOL and the Treasury.
Review rescinded policies to verify that the health carrier provides 30-day advance written notice to a plan enrollee, or, in the individual market, a primary subscriber.
Review complaint register/logs and complaint files to identify complaints pertaining to improper advance written notice of rescission.

Review complaint records, to verify that, when 30 days’ advance written notice of rescission has not been provided, the health carrier has taken appropriate corrective action/adjustments regarding the reinstatement of coverage in a timely and accurate manner.

Ascertain if the health carrier error could have been the result of some systemic issue (e.g. programming or processing error). If so, determine if the health carrier implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to an individual where advance written notice of rescission was inappropriately performed.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and Treasury provisions and final regulations pertaining to advance written notice of rescissions.

Review health carrier training materials to verify that information provided therein is complete and accurate with regard to advance written notice of rescissions.

Determine if the health carrier monitors producer-generated rescissions. Review producer records of rescissions for compliance with advance written notice provisions set forth in final regulations established by HHS, DOL and the Treasury.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or creates a more generous benefit, and thus not preempted, as set forth in federal law.
Chapter XX—Health Reform

Federal law defers enforcement of health reform to state insurance regulators. To help ensure strong consumer protections remain in place, state insurance regulators are developing new tools and methods for comprehensive oversight of the health insurance marketplace.

Examination Standards –
States are developing examination standards for the immediate mandates of health reform. Since the immediate mandates are new to the marketplace and regulators, each examination standard includes introductory language setting forth the appropriate health reform provision title, citation, effective date, summary of the provision, background, and cross references to FAQs. The introductory language is followed by the examination standards for the health reform mandate formatted for the NAIC’s Market Regulation Handbook.

Examination Checklist –
Once the examination standards are finalized, the standards will be placed into an examination checklist for use by state insurance regulators and health carriers. The examination checklist will serve as a uniform tool through which states and health carriers can measure compliance.

Additional Data Collection –
As the examination standards and checklist are developed, additional data may need to be collected for monitoring and oversight of the marketplace.

Collaboration Methodology –
The final component of state market conduct compliance tools for health reform is enhanced state collaboration which would provide consistent interpretation and review of the health reform standards.
MARKET CONDUCT EXAMINATION STANDARDS

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**PROVISION TITLE:** Extension of Dependent Coverage to Age 26

**CITATION:** PHSA § 2714

**EFFECTIVE DATE:** Plan years and, in the individual market, policy years beginning on or after September 23, 2010

**PROVISION:** The provisions of the health reform act established a requirement that a health carrier that makes available dependent coverage of children must make that coverage available for children until attainment of 26 years of age.

**BACKGROUND:** Regulations and associated FAQs, issued by the Department of Health and Human Services (HHS), the Department of Labor (DOL) and the Treasury set forth the requirement that group health plans and health carriers offering dependent coverage must make that coverage available until a child reaches the age of 26. This is the case even if a young adult no longer lives with his or her parents, is not a dependent on a parent’s tax return, or is no longer a student. These provisions apply to both married and unmarried children; affected children’s spouses and children do not qualify for this coverage extension.

This provision applies to all health carriers in the individual market and to small group employer plans. This provision applies to both grandfathered and non-grandfathered group health plans.

**DENTAL & VISION PLANS:**

The extension of dependent coverage to age 26 provision applies to medical, behavioral, and pharmacy benefits. The provision does not apply to employer-sponsored dental or vision benefits if they are in a separate dental or vision policy. If the dental or vision plan is not a separate plan, but part of the employer-sponsored medical plan, the health reform provisions apply to the entire plan, including the dental and vision coverage.

**FAQs:** See HHS website for guidance.

**NOTES:**
Standard 1
A group health plan, or a health carrier offering group or individual health insurance coverage, that makes available dependent coverage of children, shall make such coverage available for children until attainment of 26 years of age.

Apply To: All group health products, (grandfathered and non-grandfathered products) for plan years beginning on or after September 23, 2010

All individual health products (grandfathered and non-grandfathered products) for policy years beginning on or after September 23, 2010

Priority: Essential

Documents to be Reviewed

___ Health carrier underwriting policies and procedures related to extension of dependent coverage for individuals to age of 26

___ Underwriting files and supporting documentation regarding extension of dependent coverage for individuals to age of 26, including letters, notices, telephone scripts, etc.

___ Health carrier notices issued addressing opportunity to enroll in dependent coverage to age 26

___ Complaint register/logs/files

___ Health carrier complaint records concerning extension of dependent coverage for individuals to age of 26 (supporting documentation, including, but not limited to written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

___ Claims files

___ Internal appeals/grievances

___ Health carrier form approvals (policy language, enrollment materials, and advertising materials, as required under state statutes, rules and regulations)

___ Health carrier marketing and sales policies and procedures’ references to extension of dependent coverage for individuals to age of 26

___ Health carrier communication and educational materials related to extension of dependent coverage for individuals to age of 26, provided to applicants, enrollees, policyholders, certificateholders and beneficiaries

___ Training materials

___ Producer records

___ Applicable state statutes, rules and regulations

NAIC References

Model Language for Dependent Coverage for Individuals to Age of 26 (#930-B)
Other References

____ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding extension of dependent coverage for individuals to age 26 in accordance with final regulations established by HHS, DOL and the Treasury.

Review health carrier underwriting policies and procedures related to extension of dependent coverage for individuals to age 26, to verify adequate and appropriate policies/procedures are in place to ensure the health carrier extends dependent coverage for individuals to age 26 in compliance with final regulations established by HHS, DOL and the Treasury.

Review health carrier underwriting policies and procedures regarding extension of dependent coverage for individuals to age 26 to verify the health carrier does not define dependent, for the purposes of eligibility for dependent coverage of children, other than in the terms of a relationship between a child and the plan participant, and in the individual market, a primary subscriber.

Review health carrier underwriting policies and procedures regarding extension of dependent coverage for individuals to age 26 to verify the health carrier does not deny or restrict coverage for a dependent child, who has not attained 26 years of age, based upon the following factors:

- The presence or absence of the child’s financial dependency upon the plan participant, primary subscriber or any other person;
- Residency with the plan participant and in the individual market, the primary subscriber or with any other person;
- Marital status;
- Student status;
- Employment; or
- Any combination thereof.

Review health carrier underwriting files to verify that the terms of coverage in a health benefit plan offered by a health carrier providing dependent coverage of children do not vary based upon age, except for dependent children who are 26 years of age or older.

Examiner Notes:

- A health carrier is not required to make coverage available for a child of a child receiving dependent coverage, unless a grandparent becomes the legal guardian or adoptive parent of that grandchild; and
- HHS, DOL and Treasury preemption standards permit states to establish more stringent consumer protection requirements, such as requiring health carriers who provide dependent coverage to extend dependent coverage to unmarried disabled unmarried dependent children who are over the age of 26. Applicable state statutes, rules and regulations regarding extension of coverage, including, but not limited to extension of coverage to disabled unmarried dependent children who are over the age of 26 may apply.
**Individuals Whose Coverage Ended by Reason of Cessation of Dependent Status**

Review health carrier underwriting files and claim files to verify that the health carrier does not deny or restrict coverage for a dependent child:

- Whose coverage ended;
- Who was denied coverage; or
- Who was not eligible for group health insurance coverage or individual health insurance coverage under a health benefit plan because, under the terms of coverage, the availability of dependent coverage for a child ended before the child attained 26 years of age.

Review health carrier underwriting files and claim files to verify the health carrier does not deny or restrict coverage for any individual who became eligible, or were required to become eligible, for coverage on the first day of the first plan year, and, in the individual market, the first day of the first policy year, beginning on or after September 23, 2010 in accordance with final regulations established by HHS, DOL and Treasury.

Review health carrier underwriting files to verify the health carrier provides a dependent child with at least a 30-day written notice of the opportunity to enroll in a health benefit plan. Verify that the 30-day written notice is provided in the following instances:

- To any child whose coverage ended, or who was denied coverage, or who was not eligible for group health insurance coverage or individual health insurance coverage under a health benefit plan because, under the terms of coverage, the availability of dependent coverage of a child ended before the child attained 26 years of age; and
- To any child who becomes eligible, or is required to become eligible, for coverage on the first day of the first plan year, and, in the individual market, the first day of the first policy year, beginning on or after September 23, 2010.

Review the health carrier’s underwriting files to verify the health carrier provides a dependent child with a written notice of opportunity to enroll, beginning, in the group health plan market, not later than the first day of the first plan year and, in the individual market, the first day of the first policy year, beginning on or after September 23, 2010.

Review the health carrier’s written notices to verify that each written notice of opportunity to enroll includes a statement that dependent children whose coverage ended, who were denied coverage or who were not eligible for coverage, because the availability of dependent coverage of children ended, before the dependent child attained 26 years of age, are eligible to enroll in health coverage.

**Examiner Notes:**

- The health carrier written notice of opportunity to enroll may be provided to an employee on behalf of the employee’s child, and in the individual market, to the primary subscriber on behalf of the primary subscriber’s child; and
- With regard to group health insurance coverage:
  - The written notice of opportunity to enroll may be included with other enrollment materials that the health carrier distributes to employees, provided the statement is prominent; and
  - If a written notice satisfying the requirements of HHS, DOL and the Treasury final regulations is provided to an employee whose child is entitled to an enrollment opportunity under HHS, DOL and Treasury provisions, the obligation to provide the notice of enrollment opportunity with respect to that child is satisfied for both the plan and health carrier.

Review the health carrier’s written notices of opportunity to enroll to verify notices are provided beginning not later than the first day of the first plan year and, in the individual market, the first day of the first policy year, beginning on or after Sept. 23, 2010.
Review the health carrier’s underwriting files to verify that, for any dependent child who enrolls under the provisions of the HHS, DOL and the Treasury, the coverage for that dependent child takes effect no later than the first day of the first plan year and, in the individual market, the first day of the first policy year, beginning on or after September 23, 2010.

**Individuals Whose Coverage Ended by Reason of Cessation of Dependent Status – Group Health Plan Special Enrollees**

Review the health carrier’s underwriting files to verify that a dependent child enrolling in group health insurance coverage is treated as a special enrollee, as provided under final regulations established by HHS, DOL and Treasury.

Review the health carrier’s underwriting files to verify that a dependent child, and, if the child would not be a participant once enrolled, the participant or primary subscriber through whom the child is otherwise eligible for coverage under the plan, is offered all the benefit packages available to similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

Examiner Note: Any difference in benefits or cost-sharing requirements offered by the health carrier to plan participants, or, in the individual market, primary subscribers, constitutes a different benefits package.

Review the health carrier’s underwriting files to verify that the health carrier does not require a child to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

**Grandfathered Group Health Plans—Applicability**

Examiner Notes:
- For plan years beginning before January 1, 2014, a group health plan providing group health insurance coverage that is a grandfathered plan and makes available dependent coverage of children, may exclude an adult child who has not attained 26 years of age from coverage only if the adult child is eligible to enroll in an eligible employer-sponsored group health plan, as defined in section 5000A(f)(2) of the Internal Revenue Code, other than the group employer-sponsored health plan of a parent.
- For plan years beginning on or after January 1, 2014, a group health plan providing group health insurance coverage that is a grandfathered plan shall comply with the requirements of HHS, DOL and Treasury final regulations regarding extension of dependent coverage for individuals to age of 26. Applicable state statutes, rules and regulations including but not limited to extension of coverage to disabled unmarried dependent children who are over the age of 26 may apply. For plan years beginning on or after January 1, 2014, a group health plan may no longer exclude an adult child who is eligible to enroll in an eligible employer-sponsored group health plan.

**General Review Procedures and Criteria**

Review complaint register/logs and complaint files to identify complaints pertaining to extension of dependent coverage to age 26.

Review complaint records, to verify that, if the health carrier has inappropriately denied or restricted coverage for a dependent child, the health carrier has taken appropriate corrective action/adjustments regarding the reinstatement of coverage in a timely and accurate manner.

Ascertain if the health carrier error could have been the result of some systemic issue (e.g. programming or processing error). If so, determine if the health carrier implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.
Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to a dependent child whose coverage ended, or who was denied coverage, or was not eligible for group health insurance coverage or individual insurance coverage under a health benefit plan because, under the terms of coverage, the availability of dependent coverage of a child ended before the child attained 26 years of age.

Review health carrier claim files to identify any inappropriate coverage denials for claimants whose coverage ended by reason of cessation of dependent status.

Review health carrier internal appeals/grievance files to identify any inappropriate coverage denials for claimants whose coverage ended by reason of cessation of dependent status.

Review policy form files to ensure approval(s) from the applicable state and, (if applicable) from the marketplace.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about extension of dependent coverage for individuals to age 26.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about extension of dependent coverage for individuals to age of 26.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and the Treasury provisions and final regulations pertaining to extension of dependent coverage for individuals to age 26.

Review health carrier training materials to verify that information provided therein is complete and accurate with regard to extension of dependent coverage for individuals to age 26.

Determine if the health carrier monitors producer-generated coverage denials/restrictions of coverage for dependent children. Review producer records of coverage denials/restrictions of coverage for dependent children for compliance with final regulations established by HHS, DOL and the Treasury.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or creates a more generous benefit, and thus not preempted, as set forth in federal law.
Chapter XX—Health Reform

Federal law defers enforcement of health reform to state insurance regulators. To help ensure strong consumer protections remain in place, state insurance regulators are developing new tools and methods for comprehensive oversight of the health insurance marketplace.

Examination Standards –
States are developing examination standards for the immediate mandates of health reform. Since the immediate mandates are new to the marketplace and regulators, each examination standard includes introductory language setting forth the appropriate health reform provision title, citation, effective date, summary of the provision, background, and cross references to FAQs. The introductory language is followed by the examination standards for the health reform mandate formatted for the NAIC’s Market Regulation Handbook.

Examination Checklist –
Once the examination standards are finalized, the standards will be placed into an examination checklist for use by state insurance regulators and health carriers. The examination checklist will serve as a uniform tool through which states and health carriers can measure compliance.

Additional Data Collection –
As the examination standards and checklist are developed, additional data may need to be collected for monitoring and oversight of the marketplace.

Collaboration Methodology –
The final component of state market conduct compliance tools for health reform is enhanced state collaboration which would provide consistent interpretation and review of the health reform standards.
**MARKET CONDUCT EXAMINATION STANDARDS**

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PROVISION TITLE: Guaranteed Availability of Coverage (Individual and Small Group Market Health Insurance)

CITATION: PHSA §2702

EFFECTIVE DATE: Plan years and, in the individual market, policy years beginning on or after January 1, 2014

PROVISION: The provisions of the health reform act established a requirement that a health carrier offering health insurance coverage in the individual and small group market in a state must offer to any individual or employer in the applicable state all products approved for sale in the applicable market, and must accept any eligible individual or small group employer applying for any of those products.

BACKGROUND: Regulations and associated FAQs, issued by the Department of Health and Human Services (HHS), the Department of Labor (DOL) and the Treasury set forth the requirement that a health carrier offering health insurance coverage in the individual and small group market in a state must accept for coverage, in the applicable state, every eligible individual and small employer that (1) applies for the plan; (2) agrees to make the required premium payments; and (3) agrees to satisfy the other reasonable provisions of the health benefit plan that are not inconsistent with final regulations.

Health carriers are permitted to limit enrollment to annual open and designated special enrollment periods.

This provision applies to all health carriers in the individual market and to small group employer plans. This provision applies to non-grandfathered group health plans.

FAQs: See HHS website for guidance.

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

Apply To: All individual health products (non-grandfathered products) for policy years beginning on or after January 1, 2014

This standard does not apply to grandfathered health plans in accordance with §147.140

This standard does not apply to transitional plans.

Priority: Essential

Documents to be Reviewed

_____ Health carrier underwriting policies and procedures related to guaranteed availability of coverage

_____ Underwriting files and supporting documentation regarding guaranteed availability of coverage, including letters, notices, telephone scripts, etc.

_____ Complaint register/logs/files

_____ Health carrier complaint records concerning guaranteed availability of coverage (supporting documentation, including, but not limited to written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Health carrier form approvals (policy language, enrollment materials, and advertising materials, as required under state statutes, rules and regulations)

_____ Health carrier marketing and sales policies and procedures’ references to guaranteed availability of coverage

_____ Health carrier communication and educational materials related to guaranteed availability of coverage provided to applicants, enrollees, policyholders, certificate holders and beneficiaries

_____ Training materials

_____ Producer records

_____ Applicable state statutes, rules and regulations

NAIC References

Individual Market Health Insurance Coverage Model Act (#36)

Other References

_____ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials
Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding guaranteed availability of individual market health insurance coverage in accordance with final regulations established by HHS, DOL and the Treasury.

Review health carrier underwriting policies and procedures related to guaranteed availability to verify adequate and appropriate policies and procedures are in place to ensure the health carrier makes individual market health insurance coverage available on a guaranteed availability basis to eligible plan applicants in compliance with final regulations established by HHS, DOL and the Treasury.

A health carrier may restrict enrollment in coverage as described above to open or special enrollment periods and coverage issued during an open or special enrollment period must become effective consistent with the dates set forth in federal regulations. However, a carrier may be subject to allow for continuous open enrollment based upon certain circumstances of failing to file rates and forms and have them approved prior to open enrollment period. Review health carrier underwriting files to verify that the health carrier establishes special enrollment periods for qualifying events as specified in final regulations established by HHS, DOL and the Treasury.

Examiner Note: A health carrier subject to the guaranteed availability provisions of the final regulations established by HHS, DOL and the Treasury is not required to provide coverage if:

- For any period of time the carrier demonstrates, and the commissioner determines, the health carrier does not have the financial reserves necessary to underwrite additional coverage; and
- The health carrier cannot offer coverage for reason of lack of financial reserves and is applying that reason uniformly to all individuals in the individual market in the applicable state consistent with applicable state statutes, rules and regulations and without regard to the claims experience of an individual and their dependents or any health status-related factor relating to such individual and their dependents.

With regard to a health carrier denying coverage for reason of lack of financial reserves, review the health carrier underwriting files to verify the health carrier does not offer coverage in the individual market in the applicable state until the later of:

- A period of 180 days after the date the coverage is denied; or
- Until the health carrier has demonstrated to the commissioner that it has sufficient financial reserves to underwrite additional coverage.

Network Plans

Examiner Notes: With respect to coverage offered through a network plan, a health carrier is not required to offer individual market health insurance coverage under that plan or accept applications for that plan in the case of the following:

- To an individual, when the individual does not live or reside within the health carrier’s established geographic service area for such network plan; or
- Within the geographic service area for such network plan where the health carrier reasonably anticipates, and demonstrates to the satisfaction of the commissioner, that it will not have the capacity within its established geographic service area to deliver service adequately to any additional individuals because of its obligations to existing enrollees.

Review health carrier underwriting files to verify that a health carrier, that cannot offer coverage for reason of lack of network capacity, does not offer coverage in the individual market in the applicable geographic service to new individuals or to any enrollees until the later of 180 days following each such refusal or the date on which the health carrier notifies the commissioner of the applicable state that it has regained capacity to deliver services.
Review health carrier underwriting files to verify that the health carrier is applying its noncompliance with guaranteed availability requirements for reason of lack of network capacity, on a uniform basis, to all individuals without regard to the claims experience of those individuals and their dependents or any health status-related factor relating to such individuals and their dependents.

Examiner Notes:

- The provisions set forth in the final regulations established by HHS, DOL and the Treasury should not be construed to require that a health carrier offering group health benefit plans must offer health benefit plans in the individual market.
- A health carrier offering only student health insurance coverage is not required to otherwise offer coverage in the individual market so long as the health carrier is offering student health insurance coverage consistent with the HHS, DOL and the Treasury definition of “student health insurance coverage.” In accordance with 45 CFR 147.145, student health insurance is exempt from the requirement to establish open enrollment periods and coverage effective dates based on a calendar policy year.
- A health carrier, at the time of renewal, may modify coverage under a health benefit plan offering individual market health insurance coverage so long as such modification is consistent with applicable state statutes, rules and regulations and effective on a uniform basis among all individuals covered under the health benefit plan.

Review complaint register/logs and complaint files to identify complaints pertaining to restriction of guaranteed availability of coverage.

Review complaint records, to verify, if the health carrier has not offered health insurance coverage on a guaranteed availability basis to eligible plan applicants, the above reasons for noncompliance notwithstanding, the health carrier has taken appropriate corrective action/adjustments regarding making an offer of coverage in a timely and accurate manner.

Ascertain if the health carrier error could have been the result of some systemic issue (e.g. programming or processing error). If so, determine if the health carrier implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to an eligible plan applicant who was not offered health insurance coverage on a guaranteed availability basis.

Review policy form files to ensure approval(s) from the applicable state and, (if applicable) from the marketplace.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about guaranteed availability of individual market health insurance coverage.

Verify that a health insurance issuer and its officials, employees, agents and representatives comply with any applicable statutes, rules and regulations regarding marketing by health insurance issuers and does not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions.
Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provides complete and accurate information about guaranteed availability of individual market health insurance coverage.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and the Treasury provisions and final regulations pertaining to guaranteed availability of individual market health insurance coverage.

Review health carrier training materials to verify that information provided therein is complete and accurate with regard to guaranteed availability of individual market health insurance coverage.

Determine if the health carrier monitors producer-generated notices which deny or restrict coverage. Review producer records of such notices for compliance with the guaranteed availability provisions in final regulations established by HHS, DOL and the Treasury.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or creates a more generous benefit, and thus not preempted, as set forth in federal law.
Standard 2
A health carrier offering small group market health insurance coverage shall issue any applicable health benefit plan to any eligible small group employer that (1) applies for the plan; (2) agrees to make the required premium payments; and (3) agrees to satisfy the other reasonable provisions of the health benefit plan that are not inconsistent with final regulations established by the federal Department of Health and Human Services (HHS), the Department of Labor (DOL) and the Treasury.

Apply To: All small group health products (non-grandfathered products) for policy years beginning on or after January 1, 2014

This standard does not apply to grandfathered health plans in accordance with §147.140

This standard does not apply to transitional plans.

Priority: Essential

Documents to be Reviewed

_____ Health carrier underwriting policies and procedures related to guaranteed availability of coverage

_____ Underwriting files and supporting documentation regarding guaranteed availability of coverage, including letters, notices, telephone scripts, etc.

_____ Complaint register/logs/files

_____ Health carrier complaint records concerning guaranteed availability of coverage (supporting documentation, including, but not limited to written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Health carrier form approvals (policy language, enrollment materials, and advertising materials, as required under state statutes, rules and regulations)

_____ Health carrier marketing and sales policies and procedures’ references to guaranteed availability of coverage

_____ Health carrier communication and educational materials related to guaranteed availability of coverage provided to applicants, enrollees, policyholders, certificateholders and beneficiaries

_____ Training materials

_____ Producer records

_____ Applicable state statutes, rules and regulations

NAIC References

Small Group Market Health Insurance Coverage Model Act (#106)

Other References

_____ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials
Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding guaranteed availability of small group market health insurance coverage in accordance with final regulations provided by HHS, DOL and the Treasury.

Review health carrier underwriting policies and procedures related to guaranteed availability to verify that adequate and appropriate policies and procedures are in place to ensure the health carrier makes small group market health insurance coverage available on a guaranteed availability basis to eligible small employers in compliance with final regulations provided by HHS, DOL and the Treasury.

Review health carrier underwriting policies and procedures to verify the health carrier:
- Offers coverage to all eligible employees of the eligible small employer, and their dependents who apply for enrollment during the period in which the employee first becomes eligible to enroll under the terms of the plan; and
- Does not limit the offer of coverage to only certain individuals or dependents in the small group or to only part of the small group.

A health carrier may restrict enrollment in coverage as described above to open or special enrollment periods.

Review the health carrier’s underwriting files to verify that the health carrier establishes special enrollment periods for qualifying events as specified in final regulations established by HHS, DOL and the Treasury.

Review health carrier underwriting policies and procedures to verify the health carrier does not apply any waiting period, (consistent with the HHS, DOL and the Treasury definition of “waiting period”), which exceeds 90 days.

Review the health carrier’s underwriting files to verify the requirements used by a health carrier in determining whether to provide coverage to a small employer, are applied uniformly among all small employers applying for coverage or receiving coverage from the health carrier.

Review health carrier underwriting files to verify the health carrier does not, with regard to small employers, require a minimum participation level greater than:
- 100% of eligible employees working for groups of 3 or fewer employees; and
- 75% of eligible employees working for groups with more than 3 employees.

Review health carrier underwriting files to verify the health carrier, in applying minimum participation requirements with respect to a small employer, does not consider employees or dependents of employees who have creditable coverage in determining whether the applicable percentage of participation is met.

In applying minimum participation requirements with respect to a small employer, review health carrier underwriting files to verify the health carrier does not consider individuals eligible for coverage under a COBRA continuation provision as eligible employees in determining whether the applicable percentage of participation is met.

Review health carrier underwriting files to verify the health carrier does not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.
Examiner Note: A health carrier subject to the guaranteed availability provisions of the final regulations established by HHS, DOL and the Treasury is not required to provide coverage if:

- For any period of time the health carrier demonstrates, and the commissioner determines, the health carrier does not have the financial reserves necessary to underwrite additional coverage; and
- The health carrier cannot offer coverage for reason of lack of financial reserves and is applying that reason uniformly to all small employers in the small group market in the applicable state consistent with applicable state statutes, rules and regulations and without regard to the claims experience of a small employer and its employees and their dependents or any health status-related factor relating to such employees and their dependents.

With regard to a health carrier that denies coverage for reason of lack of financial reserves, review the health carrier underwriting files to verify the health carrier does not offer coverage in the small group market in the applicable state until the later of:

- A period of 180 days after the date the coverage is denied; or
- Until the health carrier has demonstrated to the commissioner that it has sufficient financial reserves to underwrite additional coverage.

Network Plans

Examiner Notes: With respect to coverage offered through a network plan, a health carrier is not required to offer small group market health insurance coverage under that plan or accept applications for that plan in the case of the following:

- In an area outside of the health carrier’s established geographic service area for such network plan;
- To an employee, when the employee does not live, work or reside within the health carrier’s established geographic service area for such network plan; or
- Within the geographic service area for such network plan where the health carrier reasonably anticipates, and demonstrates to the satisfaction of the commissioner, that it will not have the capacity within its established geographic service area to deliver service adequately to the members of such groups because of its obligations to existing group certificateholders and covered persons.

Review health carrier underwriting files to verify that a health carrier, that cannot offer coverage for reason of lack of network capacity, does not offer coverage in the small group market in the applicable geographic service area to new cases of small employer groups or to any small employer groups until the later of 180 days following each such refusal or the date on which the carrier notifies the commissioner that it has regained capacity to deliver services.

Review health carrier underwriting files to verify the health carrier is applying its noncompliance with guaranteed availability requirements for reason of lack of network capacity, on a uniform basis, to all small employers without regard to the claims experience of the small employer and its employees and their dependents or any health status-related factor relating to such employees and their dependents and their dependents or any health status-related factor relating to such individuals and their dependents.

Examiner Notes:

- A health carrier subject to the guaranteed availability provisions of the final regulations established by HHS, DOL and the Treasury is not required to provide small group market health insurance coverage if the health carrier elects not to offer new coverage to small employers in the applicable state.
- A health carrier that elects not to offer new coverage may be allowed, as determined by the commissioner, to maintain its existing policies in this state.
Review health carrier underwriting files to verify that a health carrier that elects not to offer new coverage to small employers in the applicable state has provided notice of its election to the commissioner and does not write new business in the small group market in the applicable state for a period of five years beginning on the date the carrier ceased offering new coverage in the applicable state.

General Review Procedures and Criteria
Review complaint register/logs and complaint files to identify complaints pertaining to restriction of guaranteed availability of coverage.

Review complaint records, to verify that, if the health carrier has not offered health insurance coverage on a guaranteed availability basis to an eligible small employer, the above reasons for noncompliance notwithstanding, the health carrier has taken appropriate corrective action/adjustments regarding making an offer of coverage in a timely and accurate manner.

Ascertain if the health carrier error could have been the result of some systemic issue (e.g. programming or processing error). If so, determine if the health carrier implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to an eligible small employer who was not offered health insurance coverage on a guaranteed availability basis.

Review policy form files to ensure approval(s) from the applicable state and, (if applicable) from the marketplace.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about guaranteed availability of small group market health insurance coverage.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about guaranteed availability of small group market health insurance coverage.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and the Treasury provisions and final regulations pertaining to guaranteed availability of small group market health insurance coverage.

Review health carrier training materials to verify that information provided therein is complete and accurate with regard to guaranteed availability of small group market health insurance coverage.

Determine if the health carrier monitors producer-generated notices which deny or restrict coverage. Review producer records of such notices for compliance with the guaranteed availability provisions in final regulations established by HHS, DOL and the Treasury.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or creates a more generous benefit, and thus not preempted, as set forth in federal law.

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Chapter XX—Health Reform

Federal law defers enforcement of health reform to state insurance regulators. To help ensure strong consumer protections remain in place, state insurance regulators are developing new tools and methods for comprehensive oversight of the health insurance marketplace.

Examination Standards –
States are developing examination standards for the immediate mandates of health reform. Since the immediate mandates are new to the marketplace and regulators, each examination standard includes introductory language setting forth the appropriate health reform provision title, citation, effective date, summary of the provision, background, and cross references to FAQs. The introductory language is followed by the examination standards for the health reform mandate formatted for the NAIC’s Market Regulation Handbook.

Examination Checklist –
Once the examination standards are finalized, the standards will be placed into an examination checklist for use by state insurance regulators and health carriers. The examination checklist will serve as a uniform tool through which states and health carriers can measure compliance.

Additional Data Collection –
As the examination standards and checklist are developed, additional data may need to be collected for monitoring and oversight of the marketplace.

Collaboration Methodology –
The final component of state market conduct compliance tools for health reform is enhanced state collaboration which would provide consistent interpretation and review of the health reform standards.
## MARKET CONDUCT EXAMINATION STANDARDS

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**PROVISION TITLE:** Guaranteed Renewability of Coverage (Individual and Small Group Market Health Insurance)

**CITATION:** PHSA §2703

**EFFECTIVE DATE:** Plan years and, in the individual market, policy years beginning on or after January 1, 2014

**PROVISION:** The provisions of the health reform act established a requirement that a health carrier offering health insurance coverage in the individual and small group market in a state is required to renew or continue in force the coverage at the option of the individual or small employer, as applicable.

**BACKGROUND:** Regulations and associated FAQs, issued by the Department of Health and Human Services (HHS), the Department of Labor (DOL) and the Treasury set forth the requirement that a health carrier offering health insurance coverage in the individual, small group, or large group market is required to renew or continue in force the coverage at the option of the plan sponsor.

There are numerous exceptions to the guaranteed renewability requirements, such as failure to pay premiums or contributions, fraud, violation of participation or contribution rules, termination of the plan, enrollees’ movement outside of the service area, ceasing of association membership, discontinuation of a particular product, or the discontinuance of all coverage.

This provision applies to all health carriers in the individual market and to small group employer plans. This provision applies to non-grandfathered group health plans.

**FAQs:** See HHS website for guidance.
Standard 1
A health carrier offering individual market health insurance coverage shall renew or continue in force the coverage, at the option of the policyholder, subject to final regulations established by the federal Department of Health and Human Services (HHS), the Department of Labor (DOL) and the Treasury.

Apply To: All individual health products (non-grandfathered products) for policy years beginning on or after January 1, 2014

This standard does not apply to grandfathered health plans in accordance with §147.140

This standard does not apply to transitional plans.

Priority: Essential

Documents to be Reviewed

_____ Health carrier underwriting policies and procedures related to guaranteed renewability of coverage

_____ Underwriting files and supporting documentation regarding guaranteed renewability of coverage, including letters, notices, telephone scripts, etc.

_____ Complaint register/logs/files

_____ Health carrier complaint records concerning guaranteed renewability of coverage (supporting documentation, including, but not limited to written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Health carrier form approvals (policy language, enrollment materials, and advertising materials, as required under state statutes, rules and regulations)

_____ Health carrier marketing and sales policies and procedures’ references to guaranteed renewability of coverage

_____ Health carrier communication and educational materials related to guaranteed renewability of coverage provided to applicants, enrollees, policyholders, certificateholders and beneficiaries

_____ Training materials

_____ Producer records

_____ Applicable state statutes, rules and regulations

NAIC References

*Individual Market Health Insurance Coverage Model Act (#36)*

Other References

_____ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials
Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding guaranteed renewability of individual market health insurance coverage in accordance with final regulations established by HHS, DOL and the Treasury.

Review health carrier underwriting policies and procedures related to guaranteed renewability to verify adequate and appropriate policies and procedures are in place to ensure the health carrier renews, or continues in force, at the option of the policyholder, individual market health insurance coverage, in compliance with final regulations established by HHS, DOL and the Treasury.

Review health carrier underwriting files to verify that health carrier nonrenewal or discontinuance of coverage of a health benefit plan, subject to guarantee renewability provisions established by HHS, DOL and the Treasury final regulations, are performed only as follows:

- The policyholder has failed to pay premiums or contributions in accordance with the terms of the health benefit plan or the health carrier has not received timely premium payments;
- The policyholder or the policyholder’s representative has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of coverage;
- The health carrier elects to cease offering individual market health insurance coverage in the applicable state in accordance with HHS, DOL and the Treasury final regulations and other applicable state law;
- In the case of a health carrier that offers coverage through a network plan, the policyholder no longer lives or resides within the health carrier’s established geographic service area and the health carrier would deny enrollment in the plan pursuant to lack of capacity as defined in final regulations established by HHS, DOL and the Treasury;
- The commissioner, in accordance with state law:
  - Finds that the continuation of the coverage would not be in the best interests of the covered persons or would impair the health carrier’s ability to meet its contractual obligations; and
  - Assists affected covered persons in finding replacement coverage;
  - (Examiner Note: health carriers that fail to renew coverage under this exception must do so in a nondiscriminatory fashion)
- In the case of health benefit plans that are made available in the individual market only through one or more bona fide associations, the membership of a policyholder in the association on the basis of which the coverage is provided ceases, provided the coverage is terminated for reason of lack of policyholder association membership uniformly, without regard to any health status-related factor related to any covered person;
- In the case of health benefit plans that are made available in the individual market as student health insurance coverage, the student policyholder covered under the coverage ceases to be a student at the institution of higher education through which the student health insurance coverage is offered, provided the coverage for reason of cessation of student status is terminated uniformly without regard to any health status-related factor related to any covered person; or
- The commissioner finds that the product form is obsolete and is being replaced with comparable coverage and the health carrier decides to discontinue offering that particular type of health benefit plan (obsolete product form) in the applicable state’s individual market, only if the health carrier:
  - Provides advance notice of its decision to discontinue offering the obsolete health benefit plan to the commissioner in the applicable state in which it is licensed;
• Provides notice of the decision to nonrenew coverage at least 180 days prior to the nonrenewal of any health benefit plans to:
  • All affected policyholders; and
  • The commissioner in the applicable state in which an affected policyholder is known to reside, provided the notice is sent to the commissioner at least three 3 working days prior to the date the notice is sent to the affected policyholders;
• Provides notice to each enrollee issued that particular type of health benefit plan (obsolete product form) that the policyholder has the option to purchase all other health benefit plans currently being offered by the health carrier in the individual market in the applicable state; and
• In exercising the option to discontinue that particular type of health benefit plan (obsolete product form) and in offering the option of coverage to purchase all other health benefit plans currently being offered by the health carrier in the individual market in the applicable state, acts uniformly, without regard to the claims experience of those covered persons or any other health status-related factor relating to any covered person who may become eligible for coverage.

Review health carrier underwriting files to verify that if a health carrier decides to discontinue offering a particular type of health benefit plan of individual market health insurance coverage, the health carrier discontinues coverage only in accordance with applicable state statutes, rules and regulations and only if the health carrier:
• Provides advance notice of its decision to discontinue offering a health benefit plan to the commissioner in the applicable state in which it is licensed;
• Provides notice of the decision to nonrenew coverage at least 90 days prior to the nonrenewal of the health benefit plan to:
  • All affected policyholders; and
  • The commissioner in the applicable state in which an affected policyholder is known to reside, provided the notice to the commissioner is sent at least three 3 working days prior to the date the notice is sent to affected policyholders;
• Provides notice to each enrollee issued that particular type of health benefit plan, that the policyholder has the option to purchase all other health benefit plans providing individual market health insurance coverage currently being offered by the health carrier in the applicable state; and
• Acts uniformly, in exercising the option to discontinue a health benefit plan and offer the option of coverage to purchase all other health benefit plans providing individual market health insurance coverage currently being offered in the applicable state, without regard to the claims experience of those policyholders or any health status-related factor relating to any policyholder or dependent of a policyholder or new policyholders and their dependents who may become eligible for coverage.

Review health carrier underwriting files to verify that if a health carrier elects to discontinue offering health insurance coverage under health benefit plans in the individual market, or all markets, in the applicable state, the health carrier discontinues such coverage only in accordance with applicable state statutes, rules and regulations and only if the health carrier:
• Provides advance notice of its decision to discontinue offering health insurance coverage under health benefit plans in the individual market, or all markets, to the commissioner in each state in which it is licensed; and
• Provides notice of the decision to nonrenew coverage at least 180 days prior to the nonrenewal of any health benefit plans to:
  • All affected policyholders; and
  • The commissioner in each state in which an affected policyholder is known to reside, provided the notice sent to the commissioner at least 3 working days prior to the date the notice is sent to affected policyholders.
Review health carrier underwriting files to verify that, in the case of a discontinuance, the health carrier has ceased writing new business in the market in the applicable state for a period of 5 years beginning on the date the health carrier ceased offering new coverage in the applicable state. Depending upon the state, if a plan that is guaranteed renewable is modified by the health carrier, then that plan typically would need to have been reviewed and approved by the state insurance department.

Review health carrier underwriting files to verify that, in the case of a discontinuance, the health carrier, as determined by the commissioner, may renew its existing business in the market in the applicable state or may be required to nonrenew all of its existing business in the market in the applicable state.

Examiner Note: In the case of a health carrier doing business in one established geographic service area of the applicable state, the guaranteed renewability provisions established by HHS, DOL and the Treasury shall apply only to the health carrier’s operations in that service area. Examiners should also be aware of the rating areas and the service areas that have been approved by the applicable state.

General Review Procedures and Criteria
Review complaint register/logs and complaint files to identify complaints pertaining to restriction of guaranteed renewability of coverage.

Review complaint records, to verify that, if the health carrier has improperly nonrenewed, or discontinued a health benefit plan providing individual market health insurance coverage, the health carrier has taken appropriate corrective action/adjustments regarding renewal of coverage, or continuation of coverage, in a timely and accurate manner.

Ascertaining if the health carrier error could have been the result of some systemic issue (e.g. programming or processing error). If so, determine if the health carrier implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to a policyholder whose health benefit plan providing individual market health insurance coverage was nonrenewed or discontinued.

Review policy form files to ensure approval(s) from the applicable state and, (if applicable) from the marketplace.

Verify that any marketing materials provided to insureds, prospective purchasers and policyholders by the health carrier provide complete and accurate information about guaranteed renewability of individual market health insurance coverage.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provides complete and accurate information about guaranteed renewability of individual market health insurance coverage.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and the Treasury provisions and final regulations pertaining to guaranteed renewability of individual market health insurance coverage.

Review health carrier training materials to verify that information provided therein is complete and accurate with regard to guaranteed renewability of individual market health insurance coverage.
Determine if the health carrier monitors producer-generated notices which nonrenew or discontinue coverage. Review producer records of such notices for compliance with the guaranteed renewability provisions in final regulations established by HHS, DOL and the Treasury.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or creates a more generous benefit, and thus not preempted, as set forth in federal law.
**Standard 2**
A health carrier offering small group market health insurance coverage shall renew or continue in force the coverage, at the option of the small employer subject to final regulations established by the federal Department of Health and Human Services (HHS), the Department of Labor (DOL) and the Treasury.

**Apply To:** All small group health products, (non-grandfathered products) for plan years beginning on or after January 1, 2014

This standard does not apply to grandfathered health plans in accordance with §147.140

This standard does not apply to transitional plans.

**Priority:** Essential

**Documents to be Reviewed**

- Health carrier underwriting policies and procedures related to guaranteed renewability of coverage
- Underwriting files and supporting documentation regarding guaranteed renewability of coverage, including letters, notices, telephone scripts, etc.
- Complaint register/logs/files
- Health carrier complaint records concerning guaranteed renewability of coverage (supporting documentation, including, but not limited to written and phone records of inquiries, complaints, complainant correspondence and health carrier response)
- Health carrier form approvals (policy language, enrollment materials, and advertising materials, as required under state statutes, rules and regulations)
- Health carrier marketing and sales policies and procedures’ references to guaranteed renewability of coverage
- Health carrier communication and educational materials related to guaranteed renewability of coverage provided to applicants, enrollees, policyholders, certificateholders and beneficiaries
- Training materials
- Producer records
- Applicable state statutes, rules and regulations

**NAIC References**

*Small Group Market Health Insurance Coverage Model Act* (#106)

**Other References**

- HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials
Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding guaranteed renewability of small group market health insurance coverage in accordance with final regulations established by HHS, DOL and the Treasury.

Review health carrier underwriting policies and procedures related to guaranteed renewability to verify that adequate and appropriate policies and procedures are in place to ensure the health carrier renews, or continues in force, at the option of the small employer, small group market health insurance coverage, in compliance with final regulations established by HHS, DOL and the Treasury.

Review health carrier underwriting files to verify that health carrier nonrenewal or discontinuance of coverage of a health benefit plan, subject to guarantee renewability provisions established by HHS, DOL and the Treasury final regulations, are performed only as follows:

- The plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health benefit plan or the health carrier has not received timely premium payments;
- The plan sponsor has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of coverage;
- Noncompliance with the health carrier minimum participation requirements;
- Noncompliance with the health carrier’s employer contribution requirements;
- The health carrier elects to cease offering small group market health insurance coverage in the applicable state in accordance with HHS, DOL and the Treasury final regulations and other applicable state law;
- In the case of a health carrier that offers coverage through a network plan, there is no longer any employee living, working or residing within the health carrier’s established geographic service area and the health carrier would deny enrollment in the plan pursuant to lack of capacity as set forth in HHS, DOL and the Treasury final regulations;
- In the case of a health carrier that offers coverage in the small group market only through one or more bona fide associations, the membership of the small employer in the association (on the basis of which the coverage is provided) ceases, but only if such coverage is terminated for reason of lack of policyholder association membership uniformly, without regard to any health status-related factor relating to any covered person;
- The commissioner, in accordance with state law:
  - Finds that the continuation of the coverage would not be in the best interests of the certificateholders or would impair the health carrier’s ability to meet its contractual obligations; and
  - Assists affected covered persons in finding replacement coverage; or (Examiner Note: health carriers that fail to renew coverage under this exception must do so in a nondiscriminatory fashion)
- The commissioner finds that the product form is obsolete and is being replaced with comparable coverage and the health carrier decides to discontinue offering that particular type of health benefit plan (obsolete product form) in the applicable state’s small group market, if the health carrier:
  - Provides advance notice of its decision to discontinue offering that particular type of health benefit plan (obsolete product form) in the applicable state’s small group market, to the commissioner in the applicable state in which it is licensed;
• Provides notice of the decision to nonrenew coverage at least 180 days prior to the nonrenewal of any health benefit plans to:
  • All affected plan sponsors and employees and their dependents; and
  • The commissioner in the applicable state in which an affected insured individual is known to reside, provided the notice sent to the commissioner at least three 3 working days prior to the date the notice is sent to the affected plan sponsors and employees and their dependents;

• Provides notice to each plan sponsor issued that particular type of health benefit plan (obsolete product form) that the plan sponsor has the option to purchase all other health benefit plans currently being offered by the health carrier in the small group market in the applicable state; and

• In exercising the option to discontinue that particular type of health benefit plan (obsolete product form), acts uniformly without regard to the claims experience of any small employer or any other health status-related factor relating to any employee or dependent of an employee or new employees and their dependents who may become eligible for coverage.

Examiner Note: A health carrier that elects to nonrenew small group market health insurance coverage under a health benefit plan because of the plan sponsor’s fraud or intentional misrepresentation of material fact under the terms of coverage, may choose not to issue a health benefit plan to that plan sponsor for one year after the date of nonrenewal. This provision shall not be construed to affect guaranteed renewability requirements pertaining to other health carriers to issue coverage under any health benefit plan to the plan sponsor.

Review health carrier underwriting files to verify that if a health carrier decides to discontinue offering a particular type of health benefit plan of small group market health insurance coverage, the health carrier discontinues coverage only in accordance with applicable state statutes, rules and regulations and only if the health carrier:
• Provides advance notice of its decision to discontinue offering a particular type of health benefit plan of small group market health insurance coverage to the commissioner in each state in which it is licensed; and

• Provides notice of the decision to nonrenew coverage at least 90 days prior to the nonrenewal of the health benefit plan to:
  • All affected plan sponsors and employees and their dependents; and
  • The commissioner in the applicable state in which an affected insured individual is known to reside, provided the notice to the commissioner is sent at least 3 working days prior to the date the notice is sent to affected plan sponsors and employees and their dependents;

• Provides notice to each plan sponsor issued that particular type of health benefit plan that the plan sponsor has the option to purchase all other health benefit plans providing small group market health insurance coverage currently being offered by the health carrier in the applicable state; and

• In exercising the option to discontinue that particular type of health benefit plan, acts uniformly without regard to the claims experience of any small employer or any health status-related factor relating to any employee or dependent of an employee or new employees and their dependents who may become eligible for coverage.

Review health carrier underwriting files to verify that if a health carrier elects to discontinue offering small group market health insurance coverage in the small group market, or all markets, in the applicable state, the health carrier discontinues such coverage only in accordance with applicable state law and only if:
• The health carrier provides advance notice of its decision to discontinue offering small group market health insurance coverage in the small group market, or all markets, to the commissioner in each state in which it is licensed; and
• Provides notice of the decision to nonrenew coverage at least 180 days prior to the nonrenewal of any health benefit plans to:
  • All affected plan sponsors and employees and their dependents; and
  • The commissioner in each state in which an affected insured individual is known to reside, provided the notice sent to the commissioner is sent at least 3 working days prior to the date the notice is sent to affected plan sponsors and employees and their dependents.
• In the case of a discontinuance, the health carrier shall be prohibited from writing new business in the market in the applicable state for a period of 5 years beginning on the date the health carrier ceased offering new coverage in the applicable state.
• In the case of a discontinuance, the health carrier, as determined by the commissioner, may renew its existing business in the market in the applicable state or may be required to nonrenew all of its existing business in the market in the applicable state.

Review health carrier underwriting policies and procedures to verify that, at the time of coverage renewal, a health carrier may modify the coverage for a product offered in the small group market if, for coverage that is available in such market other than only through one or more bona fide associations, such modification is consistent with applicable state law and effective on a uniform basis among small group health plans within that market.

Examiner Note: In the case of a health carrier doing business in one established geographic service area of the applicable state, the guaranteed renewability provisions established by HHS, DOL and the Treasury shall apply only to the health carrier’s operations in that service area. Examiners should also be aware of the rating areas and the service areas that have been approved by the applicable state.

General Review Procedures and Criteria
Review complaint register/logs and complaint files to identify complaints pertaining to restriction of guaranteed renewability of coverage.

Review complaint records, to verify that, if the health carrier has improperly nonrenewed, or discontinued a health benefit plan providing small group market health insurance coverage, the health carrier has taken appropriate corrective action/adjustments regarding renewal of coverage, or continuation of coverage, in a timely and accurate manner.

Ascertain if the health carrier error could have been the result of some systemic issue (e.g. programming or processing error). If so, determine if the health carrier implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to a policyholder whose health benefit plan providing small group market health insurance coverage was nonrenewed or discontinued.

Review policy form files to ensure approval(s) from the applicable state and, (if applicable) from the marketplace.

Verify that any marketing materials provided to insureds, prospective purchasers and policyholders by the health carrier provide complete and accurate information about guaranteed renewability of small group market health insurance coverage.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provides complete and accurate information about guaranteed renewability of small group market health insurance coverage.
Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and the Treasury provisions and final regulations pertaining to guaranteed renewability of small group market health insurance coverage.

Review health carrier training materials to verify that information provided therein is complete and accurate with regard to guaranteed renewability of small group market health insurance coverage. Determine if the health carrier monitors producer-generated notices which nonrenew or discontinue coverage. Review producer records of such notices for compliance with the guaranteed renewability provisions in final regulations established by HHS, DOL and the Treasury.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or creates a more generous benefit, and thus not preempted, as set forth in federal law.
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Federal law defers enforcement of health reform to state insurance regulators. To help ensure strong consumer protections remain in place, state insurance regulators are developing new tools and methods for comprehensive oversight of the health insurance marketplace.

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States are developing examination standards for the immediate mandates of health reform. Since the immediate mandates are new to the marketplace and regulators, each examination standard includes introductory language setting forth the appropriate health reform provision title, citation, effective date, summary of the provision, background, and cross references to FAQs. The introductory language is followed by the examination standards for the health reform mandate formatted for the NAIC’s Market Regulation Handbook.

Examination Checklist –
Once the examination standards are finalized, the standards will be placed into an examination checklist for use by state insurance regulators and health carriers. The examination checklist will serve as a uniform tool through which states and health carriers can measure compliance.

Additional Data Collection –
As the examination standards and checklist are developed, additional data may need to be collected for monitoring and oversight of the marketplace.

Collaboration Methodology –
The final component of state market conduct compliance tools for health reform is enhanced state collaboration which would provide consistent interpretation and review of the health reform standards.
### MARKET CONDUCT EXAMINATION STANDARDS

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**PROVISION TITLE:** Coverage for Individuals Participating in Approved Clinical Trials

**CITATION:** PHSA §2709

**EFFECTIVE DATE:** Plan years, and in the individual market, policy years beginning on or after January 1, 2014

**PROVISION:** The provisions of PHSA §2709 provide that if a group health plan or health carrier provides coverage to a "qualified individual," then the plan or health carrier:

- May not deny the individual participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition;
- May not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and
- May not discriminate against the individual on the basis of the individual's participation in such trial.

**BACKGROUND:** Regulations and associated FAQs, issued by the Department of Health and Human Services (HHS), the Department of Labor (DOL) and the Treasury set forth the requirement that if a group health plan or health insurance issuer in the group and individual health insurance market provides coverage to a qualified individual (as defined under PHSA 2709(b)), then such plan or issuer: (1) may not deny the qualified individual participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition; (2) may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and (3) may not discriminate against the individual on the basis of the individual’s participation in the trial.

A qualified individual under PHSA 2709(b) is generally a participant or beneficiary who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition; and either: (1) the referring health care professional is a participating provider and has concluded that the individual’s participation in such trial would be appropriate; or (2) the participant or beneficiary provides medical and scientific information establishing that the individual’s participation in such trial would be appropriate.

This provision applies to all health carriers in the individual market and to small group employer plans. This provision applies to non-grandfathered group health plans.

**FAQs:** See HHS website for guidance.

**NOTES:**

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Standard 1
A health carrier may not deny coverage or restrict coverage for qualified individuals, as defined in applicable statutes, rules and regulations, who participate in approved clinical trials.

Apply To:
All group health products, (non-grandfathered products) for plan years beginning on or after January 1, 2014

All individual health products (non-grandfathered products) for policy years beginning on or after January 1, 2014

Priority: Essential

Documents to be Reviewed

_____ Health carrier claim handling policies and procedures related to individuals participating in approved clinical trials

_____ Claim files and supporting documentation regarding coverage of individuals participating in approved clinical trials, including letters, notices, telephone scripts, etc.

_____ Complaint register/logs/files

_____ Health carrier complaint records concerning coverage denial or restriction of coverage of individuals participating in approved clinical trials (supporting documentation, including, but not limited to written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Claims files

_____ Health carrier prior authorization policies

_____ Internal appeals/grievances files

_____ Applicable external appeals related to individuals participating in approved clinical trials, external appeal resolution and associated documentation

_____ Health carrier form approvals (policy language, enrollment materials, and advertising materials, as required under state statutes, rules and regulations)

_____ Health carrier marketing and sales policies and procedures’ references to coverage of individuals participating in approved clinical trials

_____ Health carrier communication and educational materials related to coverage of individuals participating in approved clinical trials, provided to applicants, enrollees, policyholders, certificateholders and beneficiaries

_____ Training materials

_____ Producer records

_____ Applicable state statutes, rules and regulations
NAIC References

*Individual Market Health Insurance Coverage Model Act* (#36)

*Small Group Market Health Insurance Coverage Model Act* (#106)

Other References

______ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding the prohibition of denial and restriction of coverage for qualified individuals participating in approved clinical trials in accordance with statute and regulatory guidance established by HHS, DOL and the Treasury.

Review health carrier underwriting policies and procedures related to coverage of individuals participating in clinical trials to verify adequate and appropriate policies/procedures are in place to ensure the health carrier does not deny or impose restrictions on coverage for qualified individuals participating in approved clinical trials in compliance with statute and regulatory guidance established by HHS, DOL and the Treasury.

Review health carrier claim files to verify the health carrier does not:

- Deny participation by a qualified individual in an approved clinical trial;
- Deny, limit or impose additional conditions on the coverage of routine patient costs for items or services furnished in connection with participation in a trial; or;
- Discriminate against an individual on the basis of the individual’s participation in an approved clinical trial.

Examiner Notes: A network plan may require a qualified individual who wishes to participate in an approved clinical trial that is offered through a health care provider who is part of the network plan if the provider is participating in the trial and the provider accepts the individual as a participant in the trial.

This provision applies to any qualified individual who participates in an approved clinical trial that is conducted outside of the state in which the individual resides.

A health carrier is not required to offer individual market or small group market health insurance coverage through a network plan to provide benefits for routine patient costs if the services are provided outside of the plan’s network unless the out-of-network benefits are otherwise provided under the coverage.

Review complaint register/logs and complaint files to identify complaints pertaining to coverage denial/restriction of coverage imposed upon individuals participating in approved clinical trials.

Review complaint records to verify that, when a health carrier has inappropriately restricted or denied coverage for a qualified individual who participated in an approved clinical trial, the health carrier has taken appropriate corrective action/adjustments in a timely and accurate manner.

Ascertain if the health carrier error could have been the result of some systemic issue (e.g. programming or processing error). If so, determine if the health carrier implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.
Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to an individual for whom coverage for participation in an approved clinical trial was inappropriately restricted or denied.

Review health carrier claim files to identify any coverage denials for claimants for whom coverage of participation in an approved clinical trial was inappropriately restricted or denied.

Review prior authorization policies to verify that insurers are not inappropriately denying or restricting coverage for qualified individuals participating in approved clinical trials.

Review health carrier internal appeals/grievance files to identify any coverage denials for individuals for whom coverage of participation in an approved clinical trial was inappropriately restricted or denied.

Review procedures should also require review of any external appeal requests and of the conclusions of external appeals addressing coverage of participation in approved clinical trials.

Review policy form files to ensure approval(s) from the applicable state and, (if applicable) from the marketplace.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about coverage for individuals participating in approved clinical trials.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about coverage for individuals participating in approved clinical trials.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and Treasury provisions and statute and regulatory guidance pertaining to coverage for individuals participating in approved clinical trials.

Review health carrier training materials to verify that information provided therein is complete and accurate with regard to coverage for individuals participating in approved clinical trials.

Determine if the health carrier monitors producer-generated coverage denials/restrictions of coverage pertaining to qualified individuals participating in approved clinical trials. Review any such producer records of coverage denials/restrictions of coverage for compliance with statute and regulatory guidance established by HHS, DOL and the Treasury.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or creates a more generous benefit, and thus not preempted, as set forth in federal law.

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The Market Conduct Examination Standards (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met in Louisville, KY, Aug. 16, 2014. The following Working Group members participated: Bruce R. Ramge, Chair (NE); Jim Mealer, Vice Chair (MO); Jeff Olson (CO); Margaret Schruender and Sharon Shipp (DC); Debra Peirce (GA); Russ Hamblen (KY); Sandra Castagna (MD); Martin Fleischhacker (MN); Win Pugsley and Chuck Vanasdalan (NH); Tracy Miller Biehn (NC); Angela Dingus and Todd Oberholtzer (OH); Brian Gabbert (OK); Chris Monahan (PA); Christina Rouleau (VT); Leslie Krier (WA); Mark Hooker (WV); and Cari Lee and Susan Ezalarab (WI). Also participating were: Joan Dutill (MO), Kurt Swan (CT) and Martin Swanson (NE).

1. **Adopted its July 30 Minutes**

Ms. Biehn made a motion, seconded by Mr. Mealer, to adopt the Working Group’s July 30 minutes (Attachment Ten-A). The minutes were unanimously adopted.

2. **Reviewed and Discussed Health Reform Examination Standards – Prohibition on Excessive Waiting Periods, Aug. 11 Draft**

Director Ramge said that the examination standards relating to this agenda item, which addresses one of the health reforms effective Jan. 1, 2014, were distributed on Aug. 11 to the Working Group, interested regulators and interested parties for review and comment. The draft examination standards contain many of the revisions discussed on the July 30 Working Group call, as well as additional language that corresponds to Aug. 4 revisions to the new Small Group Market Health Insurance Coverage Model Regulation, currently under review by the Regulatory Framework (B) Task Force.

Timothy S. Jost (Washington and Lee University School of Law) said that the draft addressed most of the issues raised in the NAIC consumer representatives’ Aug. 6 comments. Mr. Jost said that he would submit suggested language to the Working Group with regard to including examiner guidance relating to benefit-specific waiting periods, and he suggested that the standard also clarify that waiting periods in the non-group market may only be applied outside of an open enrollment period and in a manner that is nondiscriminatory. Director Ramge asked Mr. Jost to provide suggested language for these revisions.

Director Ramge said that the comment period would be extended to Sept. 15 on the excessive waiting periods draft examination standards and discussed on the next Working Group call.

3. **Adopted Health Reform Examination Standards – Coverage of Individuals Participating in Approved Clinical Trials, Aug. 11 Draft**

Director Ramge said that the examination standards relating to this agenda item, which addresses another one of the health reforms effective Jan. 1, were distributed on Aug. 11 to the Working Group, interested regulators and interested parties for review and comment. The draft examination standards contain many of the revisions discussed on the July 30 Working Group call. Mr. Jost said that the revisions to the draft addressed all of the issues raised in the NAIC consumer representatives’ Aug. 6 comments.

Ms. Krier made a motion, seconded by Mr. Hamblen, to adopt the health reform examination standards relating to coverage of individuals participating in approved clinical trials. The examination standards were unanimously adopted.
4. Reviewed and Discussed Updates/Revisions to Core Competencies, Aug. 11 Draft

Director Ramge said that a revised draft of the core competencies was circulated to the Working Group, interested regulators and interested parties for review and comment Aug. 11. Director Ramge said that on the Market Regulation and Consumer Affairs (D) Committee’s June 23 conference call, feedback was received from Committee members, who asked that the Working Group perform a review of the core competencies: 1) to update the core competencies regarding state insurance department oversight of contract examiners, in response to one of the recommendations made in the December 2013 Federal Insurance Office (FIO) report; and 2) to determine which core competencies may need to be updated.

Director Ramge said that there is already regulator guidance in place, in the core competencies, regarding contract examiners. To address the FIO recommendation, additional language shown in redline has been added regarding state insurance department oversight of contract examiners to Standard 5 of the Contract Examiner section of the core competencies: “Departments of insurance shall require contract examiners to provide status reports to insurance regulators and, for examinations that are scheduled to last 5 business days or longer, departments of insurance shall send state insurance regulators to visit contract examiners on-site at examinations.”

Director Ramge said that the Aug. 7 comments received from West Virginia on the draft core competencies were incorporated into the draft. Mr. Hooker asked that West Virginia’s suggested revisions regarding professional designations be placed not only in Standard Five of the Contract Examiner section of the core competencies, but also in Standard Two of the Staff and Training section of the core competencies.

Marty Mitchell (America’s Health Insurance Plans—AHIP) said that state insurance department resources may need to be appropriately allocated; regulators may need to exercise discretion with regard to on-site visits of contract examiners because not all on-site examinations are five days in length, and not all examinations conducted by contract examiners may require an on-site visit. Director Ramge asked Mr. Mitchell to provide suggested language for this revision.

Mr. Jost said that the core competency draft needs additional guidelines regarding contract examiner conflict of interest with regard to contract examiners who work for both regulators and insurance companies, as raised in the NAIC consumer representatives’ Aug. 6 comments. Mr. Jost said that stronger requirements should be in place: 1) to prohibit regulators from using contractors, who also work for industry, to conduct examinations; or 2) if this is not possible, to ensure strict separation of staff and functions within such contractors to rule out any possibility of interest conflicts. Director Ramge asked Mr. Jost to provide suggested language for this revision.

Director Ramge said that the Market Regulation and Consumer Affairs (D) Committee will be considering adoption of a charge to develop a formal market regulation accreditation proposal for further consideration by the NAIC membership. Director Ramge said the Committee would likely be having some general discussions about the concept of market regulation accreditation during its Aug. 18 meeting. Director Ramge asked that any issues or questions about how the core competencies relate to the discussions about market regulation accreditation be raised for discussion at the meeting.

Director Ramge said that the comment period would be extended to Sept. 15 on the draft core competencies and discussed on the next Working Group call. He asked that the Working Group be ready to consider adoption of the draft contract examiner language by Sept. 30, which is the date by when the Market Regulation and Consumer Affairs (D) Committee had asked the Working Group to complete the task.

Director Ramge said that the Committee also asked the Working Group to identify the core competencies that may need to be updated. Director Ramge said that actual revisions to the core competencies will occur at a later date. Mr. Mealer said that as the Working Group identifies core competencies that may need to be updated, other items may also be flagged for updates, such as the standardized data requests, which are referred to in the core competencies and have not been updated in some time. Director Ramge said that in addition to identifying the core competencies that need to be updated, the Working Group can also create a list of to-do items that also need to be updated, such as areas of the Market Regulation Handbook, the standardized data requests or other reference documents. Director Ramge said that he and NAIC staff would be working together on the use of “should” versus “shall” and “verify” versus “ensure” in the core competencies. Mr. Hooker recommended that the review of core competencies be a continuing charge of the Working Group.
5. Reviewed and Discussed Updates/Revisions to Section D. Standards of Chapter 14—Sampling of the Market Regulation Handbook

Director Ramge said another recommendation made by the Market Regulation and Consumer Affairs (D) Committee on June 23 is to: 1) consider revising the sampling procedures outlined in the Market Regulation Handbook to provide for greater flexibility, as appropriate; and 2) re-evaluate the use of the 7% and 10% tolerance thresholds outlined in the Market Regulation Handbook.

Ms. Dingus said that the 10% tolerance threshold for auditing trade practices other than claims is too high. Ms. Dingus said the Working Group should consider lowering the threshold for auditing trade practices to less than 10% as the threshold of 10% was established before many insurance company practices were fully automated. Mr. Jost agreed that the 10% tolerance threshold for auditing trade practices is too lenient. Mr. Mealer volunteered the assistance of Brent Kabler (MO), who has expertise in the subject of sampling and was the author of Chapter 14—Sampling of the Market Regulation Handbook.

Director Ramge said that the comment period would be extended to Sept. 15 on the draft Section D. Standards of the Chapter 14 and discussed on the next Working Group call. He asked that the Working Group be prepared to evaluate and discuss possible revisions to sampling procedures and tolerance thresholds. The date by when the Market Regulation and Consumer Affairs (D) Committee had asked the Working Group to complete the task of considering revisions and re-evaluating tolerance thresholds is Nov. 30.

Director Ramge said that the next Working Group conference call is scheduled for Sept. 23.

Having no further business, the Market Conduct Examination Standards (D) Working Group adjourned.
The Market Conduct Examination Standards (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call July 30, 2014. The following Working Group members participated: Bruce R. Ramge, Chair (NE); Jim Mealer, Vice Chair (MO); Jeff Olson (CO); Debra Peirce (GA); Maggie Woods (KY); Matt Regan (MA); Sherri Mortensen Brown (MN); Tracy Miller Biehn and Lalita Wells (NC); Win Pugsley and Chuck Vanasdalan (NH); Cliff Day (NJ); Kyla Dombowski and Molly Porto (OH); Brian Gabbert (OK); Chris Monahan (PA); Laura Kianian (VA); Christina Rouleau (VT); Carla Bailey and Jeanette Plitt (WA); Sue Ezalarab and Marcia Zimmer (WI); and Mark Hooker (WV). Also participating were: Stephen King and Cindy Williamson (NE).

1. **Adopted its June 17 Minutes**

Ms. Bailey made a motion, seconded by Ms. Biehn, to adopt the minutes of the Working Group’s June 17 conference call (Attachment Ten-A1). The minutes were unanimously adopted.

2. **Discussed Prohibition of Excessive Waiting Periods Health Reform Examination Standards (July 22 Draft)**

Director Ramge said the draft standards, which address one of the Jan. 1, 2014, health reforms, were distributed July 24 to the Working Group, interested regulators and interested parties for review and comment.

Timothy S. Jost (Washington and Lee University School of Law) provided a synopsis of comments that Stephanie Mohl (American Heart Association) will be submitting regarding the examination standards. Mr. Jost suggested that the last paragraph of the section titled “Background” be revised so that the standard applies to all health carriers offering group health insurance plans.

Mr. Jost said that under the frequently asked questions (FAQ) document issued May 16 by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury, with respect to plans that are required to provide coverage of essential health benefits, health carriers are not allowed to impose benefit-specific waiting periods, even if those waiting periods are 90 days or less. Mr. Jost suggested that language be added to the standard that examiners should verify if such benefit-specific waiting periods are being imposed upon prospective insureds.

Mr. Jost said that language should be added to the standard to reflect the provisions of a new HHS final rule 45 CFR Part 147 published June 25, 2014, which provides that the maximum length of a bona fide employment-based orientation period is one month, and a bona fide orientation period may be added to a 90-day waiting period.

Marty Mitchell (America’s Health Insurance Plans—AHIP) asked whether the states have the authority to regulate large group health plans or if state regulatory authority is preempted by federal regulation (ERISA-preempted large group market health insurance plans). Director Ramge asked Mr. Mitchell to provide a preamble to the standard or language that may be added to the standard that would address this issue.

Director Ramge said that because the language in the draft is based on the new Small Group Market Health Insurance Coverage Model Regulation currently under development by the Regulatory Framework (B) Task Force, the Working Group will re-review the model, after it is adopted by the Regulatory Framework (B) Task Force and by the Executive (EX) Committee and Plenary to see if any additional changes need to be made to the excessive waiting periods examination standards.
3. **Discussed Coverage of Individuals Participating in Approved Clinical Trials Health Reform Examination Standards (July 22 Draft)**

Director Ramge said the draft standards, which address another of the Jan. 1, 2014, health reforms, were distributed July 24 to the Working Group, interested regulators and interested parties for review and comment. The language of the standard is based on the language found in the *Individual Market Health Insurance Coverage Model Act* (#36) and the *Small Group Market Health Insurance Coverage Model Act* (#106).

Ms. Mohl said that, although the draft examination standards refer to final regulations, HHS has not issued proposed regulations, nor does it plan to issue final regulations regarding coverage of qualified individuals in approved clinical trials. HHS considers this federal health reform provision to be self-implementing; it expects group health plans and health carriers to implement the requirements of the federal Public Health Service Act (PHSA) Section 2709 using a good faith, reasonable interpretation of the law. Ms. Mohl suggested that the language of the standard be revised to reference the HHS guidance, in lieu of HHS final regulations.

Ms. Mohl asked that “prior authorization policies” be added to the “Documents to be Reviewed” section of the standard. She said that examiner review of prior authorization policies would assist in verifying that health carriers are providing coverage of clinical trials. Mr. Hooker asked that, in addition to “prior authorization policies,” utilization management policies and other utilization review documentation should be reviewed by examiners, as appropriate.


Director Ramge said the listing of Jan. 1, 2014, health reform standards had been on the Working Group’s agenda since May 8, and because no comments have been received on the draft listing, the Working Group will consider the listing to be final. The document is a listing of market regulation-related health reforms effective Jan. 1, 2014, to help the Working Group focus on the health reform standards that still need to be adopted. As the document serves as a Working Group resource, not an exposure draft for inclusion in the *Market Regulation Handbook*, the Working Group did not adopt the document. Director Ramge said that should any additional health reform provisions need to be added, the Working Group can re-review the document at a later date.

5. **Discussed Updates/Revisions to Core Competencies (July 22 Draft)**

Director Ramge said that the core competency document was distributed July 24 to the Working Group, interested regulators and interested parties for review and comment. Director Ramge said that, on the Market Regulation and Consumer Affairs (D) Committee conference call held June 23, feedback was received from Committee members, who asked that the Working Group perform a review of the core competencies: 1) to update the core competencies regarding state insurance department oversight of contract examiners, in response to one of the recommendations found in the December 2013 Federal Insurance Office (FIO) report; and 2) to determine which core competencies may need to be updated.

Director Ramge provided a description and a brief history of the core competencies. Director Ramge said the FIO report recommended that state insurance regulators develop standards and protocols for contract market conduct examiners. Director Ramge said that there already are core competencies in place regarding state insurance department oversight of contract market conduct examiners. Director Ramge asked for comments regarding the additional draft language, which added two new provisions to Standard Five of the Contract Examiner subsection of the Resources section of the core competencies: “Departments of insurance shall require contract examiners to provide status reports to insurance regulators and departments of insurance shall send state insurance regulators to visit contract examiners on-site at examinations.”

Birny Birnbaum (Center for Economic Justice—CEJ) suggested that clarifying language, such as “for examinations that last five business days or longer,” be added so that regulators could exercise judgment regarding performing on-site visits with respect to the length of time scheduled for an examination. Mr. Birnbaum said that regulators should verify that contract examiners do not have a conflict of interest that may compromise the integrity of an examination. Director Ramge said that the conflict of interest provision is in place in Standard One of the Contract Examiner subsection of the Resources section of the core competencies, although perhaps the Working Group could draft a higher standard relating to contract examiner conflict of interest.
Director Ramge said that, in addition to adding language to the Contract Examiner subsection of the core competencies, the Market Regulation and Consumer Affairs (D) Committee also asked the Working Group to identify the core competencies that may need to be updated. The Committee asked the Working Group to complete both of the assigned tasks prior to the Fall National Meeting.

Mr. Hooker suggested that the number of educational designations set forth in the contract examiner section of the core competencies be reduced to a smaller list. David Korsh (Blue Cross and Blue Shield Association—BCBSA) asked the Working Group if the use of the word “shall” versus “should” is of significance in the core competencies.Ms. Wallace said the use of the two words may have arisen from different authors and/or different times of review and/or revisions.

Director Ramge said that the core competencies would be redistributed to the Working Group, interested regulators, interested parties, and also to market conduct chief examiners for review and comment. Director Ramge asked the Working Group to submit comments regarding the draft contract examiner language and suggestions about which core competencies should be updated.

Director Ramge said the comment deadline for all drafts is Aug. 22. Director Ramge said that, if comments are received prior to the Summer National Meeting, NAIC staff will attempt to distribute them prior to the national meeting. Director Ramge said any comments received that the Working Group agreed upon during today’s call would be incorporated into the drafts for review at the Summer National Meeting. Director Ramge said that, if there are no outstanding issues after discussion at the national meeting, the Working Group may consider all exposure drafts ready for consideration of adoption.

6. Discussed Other Matters

Ms. Mohl said she will submit comments to present all issues that Mr. Jost summarized during the call regarding the prohibition of excessive waiting periods and coverage of clinical trials exposure drafts.

Director Ramge said the Working Group is scheduled to meet Saturday, Aug. 16, at the Summer National Meeting.

Having no further business, the Market Conduct Examination Standards (D) Working Group adjourned.
The Market Conduct Examination Standards (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call June 17, 2014. The following Working Group members participated: Bruce R. Ramge, Chair (NE); Jeff Olson (CO); Lee Backus (DC); Debra Peirce and Teresa Winer (GA); Lori Cunningham (KY); Matt Regan (MA); Nour Benchaaboun (MD); Jim Mealer (MO) Tracy Miller Biehn and Shane Quinlan (NC); Win Pugsley and Chuck Vanasdalan (NH); Cliff Day (NJ); Angela Dingus (OH); Brian Gabbert (OK); Chris Monahan (PA); Laura Klanian (VA); Christina Rouleau (VT); Carla Bailey and Jeanette Plitt (WA); John Pegelow (WI); and Mark Hooker (WV). Also participating was: Cindy Williamson (NE).

1. **Adopted its May 8 Minutes**

Ms. Plitt made a motion, seconded by Ms. Biehn, to adopt the minutes of the Working Group’s May 8 conference call (Attachment Ten-A1a). The minutes were unanimously adopted.

2. **Adopted the Health Reform Guaranteed Availability Examination Draft Standards, May 8 Draft**

Director Ramge said NAIC staff incorporated edits that Timothy S. Jost (Washington and Lee University School of Law) suggested in a May 13 comment letter. Andrea Routh (Missouri Health Advocacy Alliance) said Mr. Jost indicated that the revisions made to the draft addressed the issues raised in his comments.

David Korsh (Blue Cross and Blue Shield Association—BCBSA) asked whether links to relevant federal citations would be included in the draft. Director Ramge said that since URLs change over time, they would not be placed within the document. Mary Nugent (U.S. Center for Consumer Information and Insurance Oversight—CCIIO) suggested that the words “both grandfathered and” be deleted from the third paragraph of the section titled Background.

The Working Group agreed to remove the word “state” from the phrase “applicable state rules and regulations” in the sixth to last paragraph of Standard 1. Ms. Plitt made a motion to adopt the health reform guaranteed availability examination standards draft, with the incorporation of the changes made during the conference call. Mr. Monahan seconded the motion. The draft guaranteed availability examination standards were unanimously adopted.

3. **Adopted the Health Reform Guaranteed Renewability Examination Draft Standards, May 8 Draft**

Director Ramge said NAIC staff incorporated edits suggested by Mr. Jost in his May 13 comment letter. Mr. Pegelow suggested that the words “both grandfathered and” be deleted from the third paragraph of the section titled “Background.”

Petra Wallace (NAIC) provided an update regarding the origin of the exception to guaranteed renewability found in Standards 1 and 2. The language is not contained in federal regulation. However, the language is in NAIC models that most states have adopted, such as the Individual Market Health Insurance Coverage Model Act (#36) and the Small Group Market Health Insurance Coverage Model Act (#106), and is also found in the draft Individual Market Health Insurance Coverage Model Regulation and the draft Small Group Market Health Insurance Coverage Model Regulation, both of which are currently being developed by the Regulatory Framework (B) Task Force.

“The commissioner:
- Finds that the continuation of the coverage would not be in the best interests of the certificateholders or would impair the health carrier’s ability to meet its contractual obligations; and
- Assists affected covered persons in finding replacement coverage.”

Mr. Hooker suggested that the words “in accordance with state law” be added after the words “The commissioner” where this language occurs within the third paragraph of the Review Procedures and Criteria section of Standard 1, and the eighth paragraph of the Review Procedures and Criteria section of Standard 2. Director Ramge agreed and indicated that this exception to guaranteed renewability would be used at the discretion of a commissioner, in the event of financial instability of an insurer, and is therefore a consumer protection-related issue.
Mr. Hooker made a motion, seconded by Mr. Backus, to adopt the May 8 draft of the guaranteed renewability examination draft standards, with the incorporation of the changes made during the conference call. The draft guaranteed renewability examination standards were unanimously adopted.


Director Ramge said no comments were received on the draft listing of health reform standards. Working Group members, interested regulators and interested parties were encouraged to submit any revisions to Ms. Wallace. The list will be used to streamline the Working Group’s efforts on additional health reform exam standards addressing Jan. 1 reforms that will need to be drafted for Working Group review, on future conference calls.

5. **Discussed Other Matters**

Director Ramge said that the health reform examination standards the Working Group will review at the next conference call include standards regarding the prohibition of excessive waiting periods and coverage of qualified individuals in approved clinical trials. Ms. Wallace will forward the exposure drafts for review and comment prior to the next call. The next Working Group conference call will be scheduled for the week of July 28.

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

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The Market Conduct Examination Standards (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call May 8, 2014. The following Working Group members participated: Bruce R. Ramge, Chair (NE); Jeff Olson (CO); Lee Backus (DC); Debra Peirce and Theresa Weiner (GA); Maggie Woods (KY); Matt Regan, III (MA); Megan Mason (MD); Sherry Mortensen Brown (MN); Martin Swanson and Cynthia Williamson (NE); Win Pugsley (NH); Angela Dingus and Katherine Melton (OH); Laura Klanian (VA); Christina Rouleau (VT); Leslie Krier and Jeanette Plitt (WA); Jo LeDuc and Marcia Zimmer (WI); and Martha Morris (WV).

1. **Adopted the Health Reform Rescissions Examination Draft Standards, May 2 Draft**

Director Ramge said NAIC staff incorporated the following changes discussed during the Spring National Meeting and comments received after the Spring National Meeting into the revised rescissions draft standards circulated on May 2: 1) Missouri comments regarding reformation/counteroffers; and 2) consumer representatives’ revised language addressing the requirement that health carrier rescissions should not be based on actions taken/statements made by enrollees on the basis of errors/misrepresentations.

Timothy Stoltzfus Jost (Washington and Lee University School of Law) said the following review procedure should be included within Standard 1: “Review rescission notices to verify that notices set out clearly the specific fraudulent act, practice, or omission or intentional misrepresentation of material fact on which the rescission is based, the terms of the plan or coverage that supports the rescission, and the factual basis for rescinding coverage.” He said the section in Standard 1 titled “Documents to be Reviewed” should include “applicable external appeals based on rescissions, external appeal resolution and associated documentation” and the “Review Procedures and Criteria” section in Standard 1 should include “Review procedures should also require review of any external appeal requests and of the conclusions of external appeals addressing rescissions.”

Ms. Plitt made a motion to adopt the May 2 draft of the rescissions examination standards, to include the revisions discussed on the May 8 conference call. Mr. Olson seconded the motion. The examination standards were unanimously adopted.

2. **Adopted the Health Reform Dependent to Age 26 Examination Draft Standards, March 25 Draft**

Mr. Jost suggested the following be added to the second bullet point in the section titled Grandfathered Group Health Plans—Applicability in Standard 1: “For plan years beginning on or after January 1, 2014, a group health plan may no longer exclude an adult child who is eligible to enroll in an eligible employer sponsored group health plan.”

Mr. Backus made a motion to adopt the March 25 draft of the dependent to age 26 examination standards, to include the revisions discussed on the May 8 conference call. Ms. Plitt seconded the motion. The examination standards were unanimously adopted.

3. **Reviewed and Discussed the Health Reform Guaranteed Availability of Coverage Standards (Individual and Small Group), May 2 Draft**

Director Ramge said NAIC staff had incorporated changes discussed during the Spring National Meeting and comments received after the Spring National Meeting into the revised guaranteed availability draft standards circulated on May 2: Nebraska comments regarding 1) transitional plans; 2) a requirement that a health carrier provide continuous open enrollment based on certain circumstances of a health carrier failing to file rates and forms and obtain insurance department approval prior to an open enrollment period; and 3) Wisconsin comments regarding student health coverage and open enrollment plans.

Mr. Jost suggested that the second sentence in the area titled “Background” refer to “designated special enrollment periods” rather than “special enrollment periods for those with qualifying lifetime events,” in order to recognize that some special enrollment periods, such as those dealing with errors or exceptional circumstances, do not depend on “lifetime events.”

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said the first sentence of the third paragraph of Standard 1 should read: “A health carrier may restrict enrollment in coverage as described above to open or special enrollment periods and coverage issued during an open or special enrollment period must become effective consistent with the dates set forth in federal regulations.” Professor Jost suggested that the paragraph regarding bona fide associations be removed from the Examiner Notes section in Standard 1.

Director Ramge said the removal of bona fide association language would be held open for further comment.

Mr. Jost said that language should be added to address that in accordance with federal regulations, in the small group market, a health carrier may limit the availability of coverage to an annual enrollment period (Nov. 15 – Dec. 15) of each year in the event that a plan sponsor is unable to comply with provisions relating to group participation rules and employer contribution requirements.

Director Ramge said Mr. Swanson would analyze the group participation requirement issue and report back to the Working Group regarding the interpretation of the applicable federal requirements regarding guarantee availability set forth in 45 CFR § 147.104(b)(1)(i).

Mr. Jost suggested that a paragraph referencing the provisions of 45 CFR § 147.104(e), prohibiting discriminatory marketing, be added to Standard 1 that examiners should verify that a health insurance issuer and its officials, employees, agents and representatives 1) comply with any applicable state statutes, rules and regulations regarding marketing by health insurance issuers; and 2) do not employ marketing practices or benefit designs that have or will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual’s race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health condition.

Director Ramge said that this issue may relate to the marketing and sales business area and should perhaps be addressed separately, in a marketing and sales-specific examination standard.

Mr. Swanson said that the language suggested by Mr. Jost could be left within the current standard, and an asterisk could be inserted directing the reader to separate additional guidance regarding marketing and sales. The Working Group decided the issue merited further discussion.

Director Ramge extended the comment due date for the guaranteed availability draft standards to May 29.

4. Discussed the Health Reform Guaranteed Renewability of Coverage Standards (Individual and Small Group), May 2 Draft

Director Ramge said NAIC staff incorporated changes discussed during the Spring National Meeting and comments received after the Spring National Meeting into the guaranteed renewability draft standards circulated on May 2, which included: Nebraska comments regarding 1) transitional plans; and 2) a requirement that a health carrier should obtain approval by a state insurance department, if applicable, of a guaranteed renewable plan that has been modified by the health carrier.

Mr. Jost said that he was unable to locate a corresponding federal rule to support the exception for guaranteed renewability found in Standard 1 where:

“… the commissioner finds that the continuation of the coverage would not be in the best interests of the covered persons or would impair the health carrier’s ability to meet its contractual obligations; and assists affected covered persons in finding replacement coverage.”

He said if this exception to guaranteed renewability remains in the draft standard, clarification should be added that where this exception is applied, a health carrier is prohibited from renewing coverage in a discriminatory fashion.

Ms. Wallace said she would consult NAIC staff who drafted the corresponding model language to seek clarification of the exception, and report on this issue at the next Working Group conference call.

Director Ramge extended the comment due date for the guaranteed renewability draft standards to May 29.
5. **Discussed Draft Listing of the Health Reform Standards Effective Jan. 1, 2014**

Director Ramge said a listing of health care reforms effective Jan. 1 was posted on the Working Group Web page on April 23 and was circulated on May 5. He asked that any changes to the list be submitted to Ms. Wallace. Additional health reform exam standards addressing Jan. 1 reforms will be drafted for Working Group review on future conference calls.

Director Ramge said that Cindy Yen of the Plan Management division of the U.S. Center for Consumer Information and Insurance Oversight (CCIIO) had indicated that CCIIO will be sharing results of FFM compliance reviews with the states once they are completed. He said that Ms. Yen would welcome states’ comments on the results once they are available. Director Ramge said that he had responded to Ms. Yen, indicating that CCIIO should coordinate its oversight efforts with the states regarding market conduct activities.

6. **Discussed Other Matters**

Director Ramge said that, with regard to immediate reforms, the preexisting conditions standards the Working Group previously adopted need to be modified to apply to all individuals. He said NAIC staff would make those revisions for the Working Group’s review and consideration of adoption.

NAIC staff will pull out previously adopted examination standards adopted by the Working Group in 2012 addressing the immediate health reforms: 1) lifetime/annual limits; 2) preventive care; 3) grievance procedures; and 4) utilization review into stand-alone health reform-related chapters.

Director Ramge asked the Working Group to be prepared to consider adoption of the guaranteed issue exam standards prior to the Summer National Meeting.

The next Working Group conference call is scheduled for June 17.

Having no further business, the Market Conduct Examination Standards (D) Working Group adjourned.
The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met in Louisville, KY, Aug. 17, 2014. The following Working Group members participated: Chuck Vanasdalan, Chair (NH); Leslie Krier, Vice Chair (WA); Ashley Fisher (AR); Maria Ailor (AZ); Pam O’Connell (CA); Kurt Swan (CT); Lee Backus (DC); Tim Flott (KS); Russ Hamblen (KY); Craig Gardner (LA); Kendra Coates (ME); Sandra Castagna (MD); Matt Regan (MA); Jean Boven (MI); Paul Hanson (MN); Jim Mealer (MO); Tracy Biehn (NC); Martin Swanson (NE); Angela Dingus (OH); Brian Gabbert and Eli Snowbarger (OK); Russell Latham (OR); Chris Monahan and Arthur McNulty (PA); Suzette Green-Wright (VT); Bob Grissom (VA); Christine Rouleau (VT); Mark Hooker (WV); and Susan Ezalarab and Cari Lee (WI).

1. **Adopted its July 10 Minutes**

   Upon a motion by Ms. Krier, seconded by Ms. Green-Wright, the Working Group unanimously adopted its July 10 minutes (Attachment Eleven-A).

2. **Adopted the Revised MCAS Attestation Language**

   Mr. Vanasdalan said that the revised Market Conduct Annual Statement (MCAS) attestation language was posted to the Working Group’s Web page, and comments were received through Aug. 8. He said that because Ms. Krier and Mr. Mealer led the effort to come up with the final draft, he would ask Ms. Krier to describe the revisions and the comments received.

   Ms. Krier said that two states made comments on the draft revisions. She said that Nebraska recommended adding a notes section to the attestation where the company could describe its processes for tracking and validating the data. Ms. Krier said that the suggestion would require re-opening the discussion and comment period, so she thought it was better to consider a notes section in a second phase if the revised attestation does not accomplish its purpose. She said that Maryland also submitted comments requesting that the words “complete and truthful” be added to the attestation because that specific wording is required by Maryland’s regulations to be on a written certification for any data submitted to its commissioner. Ms. Krier said that the current recommended language for the attestation already conveys that same meaning.

   Paul Tetrault (National Association of Mutual Insurance Companies—NAMIC) said that its members were concerned about the required signature of a responsible information technology (IT) person because there may not be an IT person who actually pulls the data together and verifies it. He also said it is concerned that the word “material” in paragraph 4 does not also modify the words “inaccurate and incomplete.” He said this could result in actions taken by regulators even if the data is only technically inaccurate or incomplete.

   Lisa Tate (American Council of Life Insurers—ACLI) said that the ACLI also believes the wording of paragraph 4 should be removed or changed because, as worded, it allows for action on immaterial inaccuracies. She said paragraph 4 should apply only to data that is materially false, misleading or omissive. She also said that having an IT person sign the attestation is difficult for companies because IT is not responsible for the content of the data. She said that IT operates as a vendor for the company and cannot speak to the correctness or accuracy of the data that it provides to the company employees who are putting the MCAS submission together. She recommended having only one signature of someone who can attest to the accuracy of the data.

   Lisa Brown (Property Casualty Insurers Association of America—PCI) also said that the requirement for an IT person to sign the attestation should be removed. She suggested that the signature requirement say it is permissible to have an IT representative sign the attestation.

   Mr. Vanasdalan said that the idea to add an IT signature to the attestation arose from the fact that some companies were unable to recreate how they arrived at the data submitted on the MCAS. Mr. Hamblen said that IT is involved in the process...
of gathering the data, and he was not comfortable with having just one signature on the attestation. Ms. Brown suggested that perhaps IT could sign the attestation but not in regard to the accuracy or completeness of the data.

Birny Birnbaum (Center for Economic Justice—CEJ) said it is appropriate to have an IT person attest to the accuracy and completeness of the MCAS data, because the IT person is responsible for coding and producing the reports as per the instructions he or she was given. He said it is unacceptable for anyone responsible for a report to say that he or she was only following a process without regard to accuracy or quality.

Ms. Krier suggested removing the comma after the word “jurisdiction” in paragraph 4 to address the concern expressed about immaterial inaccuracies being subject to action by jurisdictions. She also suggested changing the last sentence in the “Note regarding signature requirements” to read, “We recommend that the second person should be a responsible IT person that participated in the creation of the data in the filing.” Mr. Mealer said it is not necessary, but expressed agreement with the suggested changes.

Upon a motion by Ms. Krier, seconded by Mr. Mealer, the Working Group unanimously adopted the revised MCAS attestation language with the suggested edits to paragraph 4 and the change to the last sentence in the “Note regarding signature requirements” attestation.

3. Discussed the Baseline Analysis Process

Mr. Vanasdalan said that after the Working Group surveyed the states regarding their use of the Market Analysis Prioritization Tool (MAPT) in the baseline analysis process, it decided to conduct two training webinars for market analysts: 1) a webinar that serves as a basic introduction to baseline and MAPT; and 2) a webinar discussing advanced techniques for doing baseline. He said that no one has volunteered to lead or participate in either of these webinars. He said he would ask the two people who indicated they would be willing to lead a webinar if no other volunteers stepped forward. He said that anyone who would like to volunteer should contact Randy Helder (NAIC).

4. Discussed the Health Company Survey

Mr. Vanasdalan said that before the end of the year, he would like to have both the health company survey and the health company data call adopted and made available for use, as needed. He said that John Haworth (WA) and he reviewed all the comments regarding both documents, and new draft versions that have taken all the comments into consideration were posted on the Working Group’s Web page.

Mr. Vanasdalan said that regarding the health survey, he wanted to provide time in this meeting for all interested regulators and interested parties to have a say in regard to the draft version. He said that all the written and verbal comments will be reviewed, and a draft for adoption will be posted on the Working Group’s Web page before the next conference call.

Mr. Vanasdalan said that Mr. Haworth and he had two goals in mind while creating this draft of the survey: 1) to make the survey less state-specific so that it could be used in collaborative efforts; and 2) to consolidate the questions as much as possible in order to make the task of completing the survey less daunting than it already will be. He said he recognized that in the process of consolidating the survey questions and making it more national in scope, some of the details may have been compromised or some areas of the survey inadvertently eliminated. He said that the comments that have been received since it was posted in July have been helpful.

Mr. Vanasdalan said that Nebraska had a few comments regarding the wording of some of the questions, as well as breaking question 36 into two distinct parts so that neither part of the question is missed. He agreed with Nebraska’s comments and said they would be incorporated into the final draft.

Mr. Vanasdalan said America’s Health Insurance Plans (AHIP) also submitted comments. He said that, among its comments, AHIP requested that the Working Group reconsider the use of the term “appointed” when asking about whether training has been provided to employees and appointed producers. He said that AHIP expressed concern that this will create an obligation to train producers that are mandatorily appointed in states where mandatory appointments are required. He said that he was
not certain that the phrasing of this question actually imposes an obligation on the insurer, but he agreed that it could be confusing. He said he was open to suggestions for changing the wording. Mr. Vanasdalan suggested that the questions could just refer to employees of the company.

Mr. Vanasdalan said that, regarding Section IV, AHIP expressed concern that by combining into one section all the subsections concerning specific preventive services required by the federal Affordable Care Act (ACA), the survey may miss future preventive service requirement changes. He said that AHIP suggested breaking out each preventive service and making changes each year as required. Mr. Vanasdalan said that by phrasing the question this way, it not only reduces the number of questions that need to be asked, but also precludes the need to constantly revise the survey each time the preventive services requirements are changed.

Mr. Vanasdalan said that section VI of the survey concerns internal and external reviews. He said that the draft survey combines into one set of questions both the federal external review requirements and the requirements of the Uniform Health Carrier External Review Model Act (§76). The draft survey allows the company to respond accordingly depending on which regulations might apply in any given state. He said that AHIP suggested that the two questions remain distinct to allow a state to choose which question is applicable for its state. Mr. Vanasdalan said that the two questions were combined in order to create a survey that can be used collaboratively. He said that within the question itself, companies are asked to specify any differences from state to state, where applicable. He noted that in the draft, this very issue was posed as a question for the Working Group. In the same section, he said that the Working Group is also asked whether subsection D through subsection G, which address the appeals procedures as laid out by the secretary of the U.S. Department of Labor (DOL), should be combined with this federal external review question.

Mr. Vanasdalan said that AHIP also questioned whether the questions concerning compliance with the standards regarding the DOL secretary were appropriate for individually purchased health coverage. Mr. Vanasdalan suggested that they may not be, and he looked for guidance from the Working Group and interested parties.

Mr. Vanasdalan said that throughout the redlined version of the survey, some questions were asked for the consideration of the Working Group. He said the first question was whether a group should be able to make one response on behalf of all its companies. He said he thought that this may be a survey that could be used by the Market Actions (D) Working Group in a collaborative effort, and it may be more useful to have the information on a group basis. For the states that do not enforce the Patient Protection and Affordable Care Act (PPACA), a collaborative effort through the Market Actions (D) Working Group may be the only way that their market regulation departments will get the information about the health companies.

Mr. Vanasdalan also pointed out that, on Page 3, Page 7 and Page 11—regarding the sections on rescissions, annual and lifetime limits, and guaranteed issuance—the Working Group is asked whether these sections are necessary because coverage must now be guaranteed issuance, and no policy can be written with annual or lifetime limits.

Mr. Hooker said that the survey had limited utility because it only includes “yes” or “no” questions. He said that whichever group decides to use the survey should consider requesting the production of documents to support the answers. Mr. Vanasdalan pointed out that there were comment boxes available and would be a decision for the regulator whether or not to follow up on any of the answers provided by the company.

Marty Mitchell (AHIP) said that he is asking that the Working Group to withdraw any questions pertaining to training of non-employees of the company. He said that would create an overlapping burden for companies that use the same agent. He said it should be made clear that a company is responsible for training its own employees. He said that the survey was only informational; he was not as concerned about the use of the word “appointed.”

Andrea Routh (Missouri Health Advocacy Alliance) said that the survey should provide baseline information for regulators and that by allowing a parent company to answer once on behalf of all its companies may not provide the data that the regulators need. She said that regarding the use of the term “appointed producers,” the survey does not put an obligation on companies to provide training to agents that are mandatorily appointed, but if a company did provide such training, it would be important for regulators to know that. Mr. Mitchell said for companies under the same parent that use the same platforms and processes, the filings would be identical.
Mr. Mealer compared the requirement to train appointed producers about PPACA requirements with the requirement for companies to train appointed producers about the suitability requirement before they solicit business on any of the company’s products. He said this was information that regulators would like to know. He suggested that the question be rephrased to make it clear that it is asking about training provided to appointed agents prior to solicitation. Ms. Ezalarab said that insurers have an obligation to verify that agents have completed the federal agent training before they can sell plans on the federal exchange. She suggested that the Working Group review the requirements for that training.

Ms. Routh said that it would be valuable to have the U.S. Center for Consumer Information and Insurance Oversight (CCIIO) involved in the discussion since it might want to use this survey in states where it has enforcement obligations. Mr. Vanasdal said that he has invited the CCIIO to participate.

Mr. Vanasdal said that he would have a draft to consider for adoption on the Sept. 25 conference call posted to the Working Group’s Web page. He asked for comments on the draft by Sept. 12.

5. Discussed the Health Company Data Call

Mr. Vanasdal said that in conjunction with the health survey, the Working Group is also working on a health data call. He said it was posted to the Working Group’s Web page July 22. He said that as with the survey, the goal was to create a document: 1) that incorporated the comments received on the initial draft; 2) that could be used collaboratively; and 3) that was not too burdensome or duplicative.

Mr. Vanasdal said that, since it has been posted, three written comments have been received. He said Nebraska is requesting stratification by days for internal and external reviews be added to the data call because it has time requirements for handling grievances. Mr. Vanasdal said that both West Virginia and AHIP have suggested a variety of ACA-related ratios. He said that AHIP’s advice is that ratios should be developed first so that the Working Group has a better idea of which data elements are needed.

Mr. Hooker said that the ratios he suggested were not exhaustive, and they duplicate the types of ratios available in the MCAS. He also said that he agreed with Ms. Routh that the CCHO should participate so that the Working Group could know whether the questions properly reflect the requirements of PPACA and also to know whether the data is collected and available elsewhere so as not to be duplicative.

Mr. Mitchell said it is important to know what data needs to be collected and how it will be used. He said, for example, that in the first year of collection, asking for claims by metal level will not be informative. He also recommended that the data call ask for data that is already collected by the companies.

Timothy S. Jost (Washington and Lee University School of Law) said that, in response to a question regarding what additional types of plans should be included in the data call, short-term or short-duration plans and disease policies should be considered. He also asked why complaint questions were dropped from the data call. Mr. Hooker said that states already have the complaint data, but it is important to collect data about internal grievances and procedures.

6. Discussed the Market Regulation Summit Action Items

Mr. Vanasdal said he would send an email to the Working Group that outlines his thoughts regarding how the Working Group should address all the action items assigned from the Market Regulation and Consumer Affairs (D) Committee.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.
Market Analysis Procedures (D) Working Group
Conference Call
July 10, 2014

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call July 10, 2014. The following Working Group members participated: Chuck Vanasdalan, Chair (NH); John Haworth, Vice Chair (WA); Maria Ailor (AZ); Pam O’Connell (CA); Damion Hughes (CO); Kurt Swan (CT); Pamela Lovell (FL); Jim Stephens (IL); Lori Cunningham (KY); Benjamin Darnell (LA); Matthew Regan (MA); James Williams (ME); Nour Benchaaboun (MD); Sherry Barrett (MI); Jim Mealer (MO); Carol Roy (MT); Tracy Bieln (NC); Reva Vandevoorde (NE); Allison Conklin (OH); Brian Gabbert (OK); Andrew McNulty (PA); Michael Bailes (SC); Suzette Green-Wright (UT); Julie Fairbanks (VA); Mark Hooker (WV); and John Pegelow (WI). Also participating was: Leslie Krier (WA).

1. **Adopted its June 5 Minutes**

Ms. Biehn made a motion, seconded by Mr. Haworth, to adopt the Working Group’s June 5 minutes (Attachment Eleven-A1). The minutes were adopted unanimously.

2. **Discussed Revisions to MCAS Attestation Form**

Ms. Krier said that she and Mr. Mealer drafted the revised Market Conduct Annual Statement Attestation Form based on the comments received regarding the original draft. She said the changes were minor and primarily isolated to item #4 and item #5 of the attestation.

Mr. Benchaaboun said that Maryland regulations require that an attestation include language that the document being attested to is “complete and truthful.” He suggested that the clause “complete and truthful” be added to item #3. Lisa Brown (American Insurance Association—AIA) said that if that language was added to item #3, then the words “…inaccurate, incomplete…” should be removed from item #4. Mr. Mealer said that item #4 specifies actions that could be taken if the conditions in item #3 are not met. He said that adding language to item #3 does not require similar language to be removed from item #4.

Ms. Krier said the revised attestation does not require that the attester be an officer of the company. It does, however, require two attesters: 1) an IT person who was responsible in the creation and validation of the filing; and 2) a person with operational responsibility from the claims, underwriting or compliance department of the company. Both of the attesters should participate in the review and validation of the data before it is filed. Ms. Brown said that most company IT departments insist they are not responsible for content.

Marty Mitchell (America’s Health Insurance Plans—AHIP) said that item #5 of the attestation, which requires the company to be able to recreate the data, will be difficult for health insurance companies to comply with, especially regarding claims data. He said there are so many adjustments and changes that occur between any two specific dates that any re-creation of claims data back to specific date is uncertain. He said it would be easier for companies to provide an audit trail that shows how the data was pulled and what data tables it came from. Ms. Krier said that when she did examinations of health companies they could usually provide data as of a certain date. She asked how health companies would respond to a similar request concerning their financial reporting. Mr. Mitchell said that on examinations the companies are providing specific data on specific files, but it is more difficult with aggregated data.

Mr. Vanasdalan said that comments on the attestation will be accepted by the Working Group until Aug. 1.
3. **Discussed Baseline Analysis Process**

Mr. Vanasdalan said the Working Group is looking at how the jurisdictions begin their market analysis processes. He said the Working Group surveyed a number of jurisdictions, and is now planning to do a series of regulator webinars demonstrating some of the ways baseline analysis is done. The Working Group is beginning the process of recruiting presenters and scheduling the webinars. Mr. Haworth said there would be webinars covering the basics of baseline analysis and webinars for more advanced baseline techniques. Mr. Vanasdalan asked that anyone who would like to volunteer to be a presenter should contact Randy Helder (NAIC) or him.

4. **Discussed the Health Reform Survey and Health Data Call**

Mr. Vanasdalan said that, because developing the revised Health Reform Survey took longer than anticipated and was only exposed three days before this conference call, he did not think it would be fair to try to review all the changes at this time. In order to give all interested parties a chance to review the revisions, comments can be sent to the Working Group until Aug. 1.

Mr. Vanasdalan said that the biggest change was in the style and content of the questions. He said that the survey flows better if one question, such as “Did the company do X, Y and Z?” is substituted for three separate questions regarding the three items. He said the original document was more than 80 pages and is now just 40 pages.

Mr. Vanasdalan said that he, Mr. Haworth and Mr. Helder will begin working on the Health Data Call document by reviewing the comments and developing a recommended Health Data Call for discussion on a future conference call.

Mr. Hooker asked if the U.S. Center for Consumer Information and Insurance Oversight (CCIIO) has been asked to review the survey, data call and revisions. He said it is important that CCIIO representatives be included in the discussions because data-collection requirements are part of the federal Affordable Care Act (ACA). Mr. Vanasdalan said that the CCIIO has been contacted and asked if representatives will participate on the Working Group’s conference calls.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.
Market Analysis Procedures (D) Working Group
Conference Call
June 5, 2014

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call June 5, 2014. The following Working Group members participated: Chuck Vanasdalan, Chair (NH); John Haworth, Vice Chair (WA); Ashley Fisher (AR); Maria Ailor (AZ); Don McKinley (CA); Damion Hughes (CO); Kurt Swan (CT); Amy Groszos (FL); Robert Rapp (IL); Russ Hamblen (KY); John Raymond (LA); Matthew Regan (MA); Kendra Coates (ME); Nour Benchaaboun (MD); Sherry Barrett (MI); Jim Mealer (MO); Tracy Biehn (NC); Reva Vandevoorde (NE); Clifton Day (NJ); Angela Dingus (OH); Brian Gabbert (OK); Jeffrey Arnold (PA); Michael Bailes (SC); Laura Klanian (VA); and Jo LeDuc (WI). Also participating was: Leslie Krier (WA).

1. **Adopted its May 8 Minutes**

Mr. Haworth made a motion, seconded by Mr. Hamblen, to adopt the Working Group’s May 8 minutes (Attachment Eleven-A1a). The minutes were adopted unanimously.

2. **Discussed Baseline Analysis Process**

Mr. Vanasdalan said that regulators were recently surveyed regarding their use of the Market Analysis Prioritization Tool (MAPT) in their baseline market analysis. He said that 32 states provided responses. Of those who responded, 25 states said they conduct baseline market analysis and seven said they do not. Three states said they do not conduct baseline analysis because of staffing concerns; two states stopped doing baseline analysis when the Market Analysis Review System (MARS) Level 1 requirements were eliminated and one state said their market analysis unit is new. All of the states that said they conduct baseline market analysis use MAPT in their analysis.

Mr. Vanasdalan said the states identified the most useful characteristics of MAPT as the quantity of data provided; its flexibility in sorting and filtering; the scoring; and the ability to trend the data. The least useful characteristics identified by these states included the overwhelming amount of data; the lack of explanation for the data elements; that it does not effectively identify outliers; the weighting; that it is limited to one state at a time and that it has too few lines of business; that there is no ability to drill down in the data; that the data does not export well to ACL. He said some states questioned the accuracy of the data in MAPT.

Mr. Vanasdalan said that 22 states incorporate the Market Conduct Annual Statement (MCAS)-MAPT into their baseline analysis. Eleven states check to see if a company is an outlier in both the MCAS-MAPT and the MAPT. Those that do not use the MCAS-MAPT say that it only contains current year data or that the ability to trend data was limited due to recent changes in the ratios. He said that 19 states indicated that they use other tools in combination with MAPT to conduct their baseline analysis. These other tools included MCAS results (eight states), departmental complaint data (eight states), financial and premium information (four states), and MARS Level 1 and Level 2 reviews (three states). Two or fewer states referenced using State Based System (SBS) information, agency and producer information, company complaint logs, and information from the System for Electronic Rate and Form Filing (SERFF).

Mr. Vanasdalan said that based on the survey results, the Working Group will conduct two types of training webinars. The first will be an introductory level training webinar, and the other will be an advanced level webinar providing training on advanced techniques used by those states that have strong baseline analysis processes. He said that because the content of the training will include MAPT data and scoring of actual companies, the training will be held in regulator-to-regulator session. He said there may be more than one of each webinar presented to allow more opportunities to participate and they may be recorded for future training. He said no dates are set yet.

3. **Discussed the Health Company Survey and Data Call**

Mr. Vanasdalan said that having the Working Group do a line-by-line review of the Health Survey was not a good use of the Working Group’s time. He said that he, Mr. Haworth and Randy Helder (NAIC) will review the entire survey and all comments and provide a recommendation to the Working Group. The recommendation will be posted to the Working Group’s Web page before the next conference call. This will allow time for comments prior to the conference call.
4. **Discussed Revised MCAS Attestation Language**

Mr. Vanasdalan said that there are two proposals for revising the MCAS attestation language. Both proposals were posted on the Working Group’s Web page. He said the Working Group received comments from the American Insurance Association (AIA).

Lisa Brown (AIA) said that the members of the AIA saw no rationale for the assertion that companies are not taking MCAS seriously and, therefore, do not see a need to revise the attestation language. She said it was not clear if inaccurate reporting is endemic or only involves a handful of companies. She said that the many comments and questions that she receives during the MCAS filing period shows that companies do take the filing seriously. She said that regarding the suggestion of having an officer’s name on the attestation, it would be difficult for large companies to have an officer be so involved in the details of the MCAS to be able to attest that they are completely knowledgeable and have reviewed all the information contained in all of the company’s MCAS filings. Regarding the suggestion that each company attest that it maintains an audit trail, she said that rather than use the term “audit trail,” the attestation, if adopted, should read, that “the company has information to support its submission and trace the data to its source within the company.” This allows more flexibility for the insurer to retain data in accordance with its retention policies. Ms. Brown also said that adding “inaccurate” and “incomplete” alongside “materially false, misleading or omissive” is unnecessarily heavy handed. She said inaccurate and incomplete data can be expected to be appropriately addressed without objection by companies. Ms. Brown said the second option includes the language that the company should document every employee or contractor that is involved in gathering and reporting the data including their role in the process and the education that they received. She said that requirement would be burdensome due to the number of people involved in preparing the MCAS.

Paul Tetrault (National Association of Mutual Insurance Companies—NAMIC) and Deidre Manna (Property Casualty Insurers Association of America—PCI) agreed with Ms. Brown.

Mr. Vanasdalan said the requirement for an audit trail was the result of many companies being unable to recreate the MCAS data when asked to do so by MCAS jurisdictions. Ms. Brown said that AIA has no problem with companies being required to recreate their data, but that referring to an “audit trail” will reduce the flexibility in the way companies may track the data for MCAS. Mr. Mealer said companies need to be accountable and that it is a problem when a company cannot recreate its work, but said he is agreeable to amending the audit trail language similar to the AIA’s suggestion.

Mr. Vanasdalan said the goal is to get the data as accurate as possible when it is first submitted. He said that in discussions during the Market Analysis (D) Working Group meeting at the Spring National Meeting and during the recent Market Regulation Summit, it was noted that data errors continue to frequently occur and companies are continually being asked to re-file their data. He said that if taken at face value, without considering the possibility of an error in reporting, some of the reported data could lead to an examination. He said most of the interactions with companies regarding the data are done with continuum actions, but sometimes they have led to examinations.

Ms. Krier said she does not believe the revisions to the attestation are a result of companies not taking MCAS seriously, but she said it seems clear from reviewing some of the data errors that if a knowledgeable employee of the company had reviewed the data prior to submission, then some of these errors would have been quickly noticed. As an example, she said a few companies have reported that the median days to settlement was zero says for some types of claims. That would stand out as inaccurate to someone who is knowledgeable about claims.

Birny Birnbaum (Center for Economic Justice—CEJ) said the fact that some companies call on the trade associations about MCAS is not an indication that companies take MCAS seriously. He said the Working Group would have to talk directly to the companies. He said the data quality issues reflect the nature of how MCAS is collected. Because it is collected on a high level, aggregated basis, it is bound to have compilation and coding errors. He said that an audit trail would only show the company records, not how the data was compiled. Mr. Birnbaum said that if the data was collected at a more granular level, there would be no problems arising from compiling the data and interpreting the definitions.

Richard Bates (State Farm) said State Farms takes the MCAS seriously and agrees with the AIA’s comments. He said State Farm understands that, by signing the attestation, the company and potentially the individual named on the attestation can be subject to penalties. Mr. Vanasdalan said that any action taken is a state-by-state decision based, in most cases, on the state’s examination authority.
Mr. Vanasdalan said there are four possible MCAS attestation options the Working Group could move forward with. The first option would be to make no changes. The second option would to make the attestation language stronger without adding an audit trail requirement. The third option would be to only add an audit trail requirement, and the fourth option would be to add a combination of stronger language along with an audit trail requirement.

Mr. Tetrault said that changing the MCAS attestation is a new idea for the industry and he requested more time for consideration. Ms. Krier said the Working Group seems to be looking at revising the attestation language and adding an audit trail requirement. She said that, based on the discussion, the language should be rewritten. She also said that the Working Group needs to consider who can attest for the company and suggested that perhaps a specific role be designated to be the attester, such as the governmental relations contact. She said that whoever attests to the data should be able to explain the data. As an alternative, she said that perhaps a statement could be added so that companies are required to identify to whom MCAS questions should be addressed. She also suggested that the audit trail requirement be revised to “the company is responsible to be able to recreate the MCAS data.” Mr. Mealer suggested that the audit trail requirement be rephrased as “the company is responsible to trace and recreate the MCAS data.”

Mr. Vanasdalan asked that Ms. Krier and Mr. Mealer draft an attestation for consideration that can be posted for comments prior to the next conference call.

5. **Discussed Other Matters**

Mr. Vanasdalan reminded everyone that long-term care insurance will be added to the MCAS and that companies should be working on collecting their 2014 data year information for reporting by April 30, 2015.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.
Market Analysis Procedures (D) Working Group
Conference Call
May 8, 2014

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call May 8, 2014. The following Working Group members participated: Chuck Vanasdalan, Chair (NH); John Haworth, Vice Chair (WA); Maria Ailor (AZ); Don McKinley (CA); Damion Hughes (CO); Kurt Swan (CT); Pamela Lovell (FL); Robert Rapp (IL); Stacy Rinehart (KS); John Raymond (LA); Matthew Regan (MA); Allan Armstrong (ME); Nour Benchaaboun (MD); Sherry Barrett (MI); Carol Roy (MT); Shane Quinlan (NC); Cathy Hoban (NE); Robert Greenfield (NJ); Angela Dingus (OH); Brian Gabbert (OK); Ronald Fredrickson (OR); Michael Bailes (SC); Laura Kalian (VA); Mark Hooker (WV); and Jo LeDuc (WI).

1. **Adopted the Process for Choosing a New MCAS Line of Business**

   Mr. Vanasdalan said a final draft of the process for choosing a new line of business in the Market Conduct Annual Statement (MCAS) was posted to the Working Group’s Web page. Ms. Krier said the final draft incorporated most of the suggestions from the joint industry trade comments and regulator comments. She said this process will assist in prioritizing which lines of business should be added to MCAS.

   Ms. Krier made a motion, seconded by Ms. Roy, to adopt the documented process for choosing a new line of business in MCAS.

   Birny Birnbaum (Center for Economic Justice—CEJ) said that in his previous comments to the Working Group during meetings and in writing, he has noted that much of the requested information is not necessary for making the decision regarding adding a particular line of business to MCAS. They are assumptions that do not need to be reiterated each time a new line of business is being considered. As an example, Mr. Birnbaum said the consideration of how the collection of data will benefit consumers is another assumption of MCAS that does not need to be part of a recommendation. The assumption of MCAS is that effective analysis can only be done with data rather than without. The goal of MCAS is to improve market analysis in order to protect consumers. Regarding the consideration of the cost of collecting and analyzing the data, Mr. Birnbaum said the cost is not quantifiable until the types of data are identified, and cost should not be considered in isolation but needs to be weighed against the benefits.

   Mr. Vanasdalan said that having a process would avoid the appearance that a line of business is being added just because a few vocal jurisdictions are behind the addition. Mr. Birnbaum said that there would be no credence to any accusation that the Working Group is moving too fast to add lines of business to MCAS. He said only one line has been added in five years. He said the process needs to be more expeditious, not slowed down.

   Lisa Brown (American Insurance Association—AIA) said the AIA’s recommendations were not meant to prevent adding lines of business to MCAS, but intended to facilitate prioritization.

   The Working Group unanimously adopted the documented process for choosing a new line of business in MCAS (Attachment Thirteen).

2. **Discussed Baseline Analysis Process**

   Mr. Vanasdalan said a series of training webinars are planned to assist the NAIC jurisdictions in understanding how other jurisdictions are doing baseline analysis and using the Market Analysis Prioritization Tool (MAPT) in their baseline analysis. If the states are not doing baseline analysis or using MAPT, they are being asked why they are not doing so and whether there are other processes being used to accomplish the same goals. He said a Working Group member from each NAIC zone is contacting the jurisdictions in their zone to learn how baseline analysis is done in their states. These members will meet again May 13 to discuss what was learned. Ms. Krier said that she has been amazed at how well these discussions have gone and said there are valid reasons for not using MAPT. Mr. Vanasdalan said the results of these training webinars will be reported back to the Working Group.
3. **Discussed Revised MCAS Attestation Language**

Mr. Vanasdalan said concerns have been raised about the accuracy of MCAS data. He said that when some companies are questioned concerning how the data was derived, they were unable to recreate how they arrived at the values. This issue has been referred to this Working Group because it is related to MCAS. He said that there are two proposals for revising the MCAS attestation language. Both proposals are posted on the Working Group’s Web page, with a comment deadline of May 30. He said one of three outcomes is anticipated: 1) no change to the attestation and the issue of inaccurate data is addressed in other ways; 2) the attestation language is strengthened; or 3) the attestation language is tightened and a clause is added requiring the company to maintain an audit trail.

Mr. Haworth said there have been circumstances in which neither the MCAS contact nor the MCAS attester was familiar with the data in their company’s MCAS filing. He said that anyone signing off on the MCAS data should be familiar with it. Ms. Barrett gave an example of an instance where Michigan received MCAS data from a company that was highly unusual. In response, the insurance department sent interrogatories, which, in turn, provided helpful information. As it turned out, the company was unable to collect the data and needed to make a change to the way it captured the data. She said the new attestation language would be ineffective in a similar situation.

Marty Mitchell (America’s Health Insurance Plans—AHIP) asked if the attestation is worthwhile to keep if it does nothing to assure the regulator of the accuracy of the data. He said that simply having an attestation does not guarantee accurate data. Ms. Krier said that an attestation is important. She noted that the financial annual statement requires that a chief financial officer or vice president who works with the financials of the company be responsible for the data reported on the financial annual statement. However, with market data, it is more difficult to determine who should be responsible for the filing. She asked the industry to provide in their comments information on who within the company should be the attester of the accuracy of the submitted MCAS data.

Mr. Regan said a company should be able to show that it independently tested the data prior to submission. Ms. Lovell agreed and said she would like to see the company be required to memorialize the steps they followed to create its filing. She said she is not interested in the names and titles of the people in each step, but if a jurisdiction questions a carrier about the data, the carrier should be able to produce a document showing the steps it took to obtain the data.

4. **Discussed the Health Company Survey and Data Call**

Mr. Vanasdalan said the task to develop a health company survey and data call arose during the 2013 Spring National Meeting. He said the Market Regulation and Consumer Affairs (D) Committee has asked Director Bruce R. Ramge (NE) to oversee a group to determine data collection needs to support an audit checklist to monitor compliance with the requirements of the federal Affordable Care Act (ACA). This group developed the draft templates that were referred to the Working Group to complete. He said Director Ramge believes this is a good opportunity for multi-state collaboration to find a way so that a company needs to only file once. This may also require looking for information from other sources.

Mr. Vanasdalan said that he would like the Working Group to discuss how to proceed with this task and determine whether the focus of the survey and data call should be on ACA compliance or on the broader topic of health insurance. He said he views the survey as an ACA checklist and the data call as more broad. He said the information on the survey could be collected through the Market Actions (D) Working Group. That way, the survey information could be collected once and not multiple times by different jurisdictions. He said the information on the survey would not need to be collected annually and may become out-of-date as new reforms are implemented in the ACA. He said the data call should become the next MCAS line of business. He said the Working Group now has a procedure with deadlines for the approval of a new MCAS blank, and those deadlines are designed to allow companies time to prepare for the collection and submission of the data. He said he does not agree with developing a health insurance data call that would eventually be an MCAS line of business, but not call it an MCAS blank in order to bypass those established deadlines. Ms. Dingus asked what the original intent for these documents was. Mr. Vanasdalan said they were originally intended as additions to the Market Regulation Handbook that could be used by any state as needed; i.e., a state could pick and choose from the content of either. He said that, as the data call was developed, it began to look more like an MCAS blank.

Mr. Hooker agreed with developing the data call as a health line of business for MCAS. He said it could be used by the states that can regulate ACA compliance, as well as those who cannot. He said there is some health insurance company behavior that is important to analyze regardless of the ACA. He suggested that the Working Group solicited input from the U.S. Center for Consumer Information and Insurance Oversight (CCIIIO) and the U.S. Centers for Medicare and Medicaid Services.
(CMS). Regarding the survey, he said that it only had questions regarding the 2010 reforms, not the 2014 reforms. He said it could be used collaboratively or as interrogatories for examinations. He said that West Virginia would collect this information under its examination authority.

Mr. Mitchell said that, under the provisions of the federal Public Health Service Act (PHSA), if the states want to remain the primary regulator of the health markets in their states, they must enforce the requirements of the ACA; if not, the federal government would assume the regulation of the health market. He agreed that the survey needs to be updated to include the 2014 reforms. He said the survey should be packaged together with the data call so that the states can demonstrate they are complying with their requirements under the PHSA.

Andrea Routh (Missouri Health Advocacy Alliance) agreed that the states need to be concerned with whether they are enforcing the ACA requirements, noting that the survey and data call are helpful tools to achieve this. She said the Working Group should proceed quickly. She said the consumer representatives want health added as a line of business in MCAS, but they do not want efforts in that direction to slow down the collect of health insurance data. She said the issue is not just the threat of federal enforcement, but consumers need to be protected and they rely on the market conduct divisions of the state insurance departments to do that. Additionally, she said that adding the 2014 reforms to the survey should be easy to do because the same questions are asked for each reform. Mr. Vanasdalan said he does not want to take what is essentially an MCAS line of business and call it a data call just so the timelines can be bypassed. He asked what the Working Group could do in the meantime to collect the needed data while it is working on this data call. Ms. Routh suggested that the Working Group could begin looking for other sources of data and request experts to speak to the Working Group regarding what types of data are needed and how to collect them.

Mr. Birnbaum said that utilizing the MCAS process is too slow. He said that developing a health data call for MCAS would delay the collection until 2017 for 2016 data. He said the individual states and the federal government would not wait for that to happen. Mr. Vanasdalan said the data call could be developed to address specific issues as they come up, but he does not want to develop an MCAS-style data call to be required by companies within such a short time frame. Mr. Birnbaum said the ACA is qualitatively different and data collection cannot wait for the normal MCAS process and time frames. Mr. Vanasdalan said the states will use pieces of the data call, as needed, while the MCAS blank is being developed.

Mr. Birnbaum also said the survey is a checklist asking whether policies and procedures are in place to ensure that compliance with the ACA requirements is in place. He asked who would attest to the accuracy of the responses. He said the only way to verify the accuracy would be on-site, detailed market conduct examination or data collection designed to verify the survey. Mr. Vanasdalan confirmed that was the original intent of the survey and data call, but as the discussion proceeded on these documents, it became clear that it was evolving into a broader health line of business in MCAS.

Mr. Mitchell said the industry is not pushing to wait for collection until 2018. He said there is a lot of information that is already available through such sources as the National Committee for Quality Assurance (NCQA) that can used to supplement the survey to get a picture of company compliance. He said that, before multiple data calls are issued by the states, it is important to find out what is currently reported and what can be used by the states. He said that, where there is data that is needed but not already collected elsewhere, data calls can be used to supplement what is already collected.

Mr. Birnbaum said that, rather than trying to find all the sources of data, it would make more sense to first determine what types of data are needed and then try to find where that data is already collected. Mr. Hooker said that regardless of where the other data can be found, it has to be in a format useable by the states and market analysts.

Mr. Vanasdalan said that he sees this task as having three parts: 1) the survey, which focuses on ACA requirements; 2) an ACA-related data call that can be used immediately; and 3) a health blank in MCAS.

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

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Market Conduct Annual Statement Attestation Form

By checking the "I attest" box below, I understand, agree and certify on behalf of the named company that:

1. I am authorized to submit the Market Conduct Annual Statement (MCAS) on behalf of the named company and to bind the company to the statements in this attestation;

2. I am knowledgeable of the information required to be provided in the MCAS filed by this company and have reviewed this filing;

3. To the best of my knowledge and belief, this filing represents a full and accurate statement of the information required to be provided in the MCAS pursuant to the applicable instructions; and

4. I am aware that the state insurance department(s) receiving the data may initiate regulatory action as authorized by law in a specific jurisdiction if the data submitted in the MCAS is inaccurate, incomplete, or found to be materially false, misleading or omissive.

5. I affirm that the company is able to accurately trace the data as reported to its source within the company and if necessary recreate the MCAS results as reported in this filing.

___  I attest to the above statements.

Signed by: ____________________________ Date: ________________

Company: ____________________________

Title: ________________________________

Address: ____________________________________________

Email: ____________________________ Phone: ________________

___  I attest to the above statements.

Signed by: ____________________________ Date: ________________

Company: ____________________________

Title: ________________________________

Address: ____________________________________________
Email: ___________________________ Phone: ___________________________

**NOTE regarding signature requirements:** The company must provide the name and contact information for at least two individuals who are able to attest that the criteria listed above have been met, and attest to the overall accuracy of the MCAS filing. Both attesters should have participated in the review and validation of the filing. We recommend that one person be the individual with operational responsibility for the source data such as a responsible individual from claims, underwriting or compliance. We recommend that the second person should be a responsible IT person that participated in the creation of the data in the filing.
Procedure for Selecting New MCAS Lines of Business

The Market Analysis Procedures (MAP) Working Group is charged with oversight of the Market Conduct Annual Statement (MCAS) program. As part of this assignment, MAP considers recommendations for additional lines of business to be added to the MCAS data collection process. Additionally, from time to time, the Market Regulation and Consumer Affairs (D) Committee may direct MAP through a specific charge or other direction to evaluate a new line of business for MCAS collection. D Committee may also direct MAP to evaluate established lines of business for continued need of specific MCAS data collection.

The following document establishes the process for receiving and evaluating recommendations for additional MCAS lines of business.

1. Requests to add additional lines of business for MCAS are to be submitted to the MAP Chair in writing. Recommendations can be made by regulators or interested parties.

2. All recommendations must include a concise statement containing the following:
   a. A statement explaining how this line of business will further the objectives of and improve efficiency of market regulation in general;
   b. Why collecting data in this formation is the most expeditious manner to do so (for example, rather than a one time data call for a specific situation);
   c. How the addition of this line of business will benefit the consumer;
   d. Evidence that addition of this line of business is cost effective.

3. Supporting documentation must accompany the request for consideration. This documentation will contain the following Qualitative Factors:
   a. Is this line/product subject to regulation by any other agency such as the IRES, NASD, SEC, HHS? If so, which one(s)?
   b. Is this line/product currently reporting data on a periodic basis to any state(s)? If yes, which one(s) and what is being reported

4. The supporting documentation must also contain the following Quantitative Factors:
   a. The number of carriers writing premium for this line;
   b. The in-force premium and new premium volume for each of the last 5 – 10 years;
   c. The number of policies in-force in each of the last 5 – 10 years;
   d. The number of policyholders for each of the last 5 – 10 years;
   e. The number of claims paid each year for the last 5 – 10 years;
   f. The total number of complaints or inquiries received nationally in each year for the last 5 – 10 years.
   g. A list of states/jurisdictions in which the line/product is sold;
   h. Any other data specific to the line/product that would support recommendation.

   Note: the number of years reported for items 4a – 4g should be consistent.

5. MAP will request several volunteer states to review the recommendation and supporting documents. The volunteers will summarize the pros and cons of the recommendation for MAP’s consideration whether to accept or reject the recommendation.

6. MAP will vote to accept or reject the recommendation in accordance with current NAIC committee standards. If MAP votes to approve, then the recommendation will move on to the D Committee for approval.

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ANTIFRAUD (D) TASK FORCE

Antifraud (D) Task Force Aug. 17, 2014, Minutes ................................................................. 9-92
Information Sharing and Technology (D) Working Group July 29, 2014, Minutes (Attachment One)............... 9-95
Information Sharing and Technology (D) Working Group May 29, 2014, Minutes (Attachment Two)............... 9-96
Outstanding Uniform System Enhancement Request (USER) Forms as of May 27, 2014
(Attachment Two-A) .................................................................................................................. 9-97
The Antifraud (D) Task Force met in Louisville, KY, Aug. 17, 2014. The following Task Force members participated: Sandy Praeger, Chair, represented by Ted Clark (KS); Wayne Goodwin, Vice Chair, represented by Shane Gyuant (NC); Lori K. Wing-Heir represented by Linda Brunette (AK); Jay Bradford represented by William Lacy (AR); Dave Jones represented by Kim Johnson (CA); Thomas B. Leonard represented by Kurt Swan (CT); Chester A. McPherson represented by Greg Marsillo (DC); Ralph T. Hudgens represented by Margaret Witten (GA); Stephen W. Robertson represented by Karl Knable (IN); Sharon P. Clark represented by Ray Perry (KY); James J. Donelon represented by Matthew Stewart (LA); Therese M. Goldsmith represented by Catherine Grason (MD); Mike Rothman represented by Paul Hanson (MN); Mike Chaney represented by Jon Hornback (MS); John M. Huff represented by Carrie Couch (MO); Monica J. Lindeen represented by Greg Dahl (MT); Bruce R. Ramge represented by Martin Swanson (NE); Roger A. Sevigny represented by Barbara Richardson (NH); Adam Hamm represented by Kelvin Zimmer (ND); Benjamin M. Lawsky represented by Rolf Kaumann (NY); Mary Taylor represented by Michelle Brugh Rafeld (OH); John D. Doak represented by Buddy Combs (OK); Michael F. Consedine represented by Chris Monahan (PA); Angela Weyne represented by David Castro (PR); Todd E. Kiser represented by Bret Barratt (UT); Jacqueline K. Cunningham represented by Mike Beavers (VA); and Michael D. Riley represented by Andrew Pauley (WV).

1. **Adopted the Information Sharing and Technology (D) Working Group’s July 29 and May 29 Minutes**

Upon a motion by Ms. Brunette and seconded by Ms. Richardson, the Task Force unanimously adopted the Working Group’s July 29 (Attachment One) and May 29 (Attachment Two) minutes.

2. **Heard a Report on the HFPP**

Mr. Clark said the Task Force has continued participating in the executive board meetings of the Health Care Fraud Prevention Partnership (HFPP). Mr. Clark said the HFPP is a sponsored entity by the U.S. Centers for Medicare & Medicaid Services (CMS) in an effort to bring the public and private sector together for prevention of fraud.

Mr. Clark said the HFPP has completed four major projects, which will be summarized and distributed soon. Mr. Clark said the HFPP has formed two subgroups: 1) the Data Analysis and Review Committee (DARC), which is a technical subgroup; and 2) the Information Sharing Committee (ISC), which is a law enforcement subgroup. At this time, Ms. Rafeld is involved in the DARC subgroup.

3. **Received a Report on the 2013 Antifraud Education Programs**

Ms. Rafeld said the Antifraud Training and Seminar (D) Working Group had a successful 2013. She said the Working Group held an “Insurance Department Investigator Safety Guidelines” webinar for regulators, which was well received and had good participation. She said due to the number of requests for an encore of that webinar, the course will be offered again in November of 2014; the exact date is pending at this time. Mr. Rafeld said there was some discussion regarding an industry version of the webinar considering the amount of investigations that companies have their staff complete in a year. Mr. Rafeld said that there were some Ohio trade associations dealing with fraud that came forward and agreed to work with NAIC and the Working Group to develop an industry Investigator Safety Course.

Ms. Rafeld said the safety training will also be altered appropriately and offered to the industry. Ms. Rafeld said the Working Group encourages any suggestions for possible training in 2014.

4. **Discussed the OFRS USER Form Status**

Greg Welker (NAIC) updated the Task Force on the Uniform System Enhancement Request (USER) process. Mr. Welker said the USER forms will be used to track and report on requests for enhancements to the Online Fraud Reporting System (OFRS), using a process that is similar to the one that the Market Information Systems (D) Task Force uses. This process will
help ensure that 1) all requests are acknowledged and tracked; 2) NAIC application development staff understand the request and are working on the right priorities; and 3) changes made to the OFRS are open and transparent for everyone.

Mr. Welker said the status chart (Attachment Three) shows USER Form 100, Form 101, Form 106, Form 107, Form 108, Form 109 and Form 110. He said Form 106 and Form 107 are in production; Form 100 and Form 101 are in “detailed analysis,” and the NAIC is currently awaiting additional information from the National Insurance Crime Bureau (NICB); Form 108 and Form 109 are in “development” stage, with the NAIC Information Systems Division working with the Information Sharing and Technology (D) Working Group; and Form 110 is in “preliminary analysis” as the Information Sharing and Technology (D) Working Group is reviewing it.

Mr. Clark said that he spoke with the NICB regarding Form 100 and Form 101. Mr. Clark said Alan Haskins (NICB) verified that Form 100 addressing the displaying of “Claim Status” was reported less than 1%, and Form 101 addressing the display of “Dollar Amounts” was reported at 1.5%. Mr. Clark said it is important for the Task Force to discuss that if the reporting of these numbers is so low, is it a waste of resources for the Task Force to ask that it matches the OFRS to the NICB’s system for each. The Task Force discussed and agreed that the discussion should not be whether to request these enhancements at this time, but rather to gather more information from the NICB as to why the reporting rate is so low. The Task Force agreed to table the Form 100 and Form 101 progress at this time and follow up with the NICB to determine why there is a low percentage of reporting for both forms.

5. Discussed the Antifraud Resources Report

Mr. Clark said that each year for the past few years, the Task Force has distributed a list of survey questions to the individual state fraud bureaus. The Task Force has then compiled that fraud data into one report called the Antifraud Resources Report. Mr. Clark said that, due to the continued changes in the types of fraud that are witnessed, in addition to common or repetitive fraud actions that fraud directors experience, it is important that the information gathered is relevant. He said that to ensure the relevant material is updated properly, the list of survey questions will be opened for suggested revisions by the Task Force members, interested regulators and interested parties. Mr. Clark said the Task Force will review the revisions and consider adoption of the new questions. Once the new questions have been adopted, the Task Force will use them to create the 2015 Antifraud Resources Report.

6. Heard Reports from Interested Parties

a. Coalition Against Insurance Fraud

Howard Goldblatt (Coalition Against Insurance Fraud—CAIF) said the CAIF has worked with states on many legislative trends. In particular, Mr. Goldblatt said the CAIF has been working with Colorado, Maryland and New Hampshire on fraud bills. Mr. Goldblatt said the CAIF has also been working with the states on a counterfeit airbag bill. Mr. Goldblatt said the CAIF has set up a monthly call with the CMS to address possible fraud issues that may be surrounding the federal Affordable Care Act (ACA). Mr. Goldblatt said there has not been a large amount of fraud surrounding the ACA at this time.

b. National Health Care Anti-Fraud Association

Leigh McKenna (National Health Care Anti-Fraud Association—NHCAA) said next year marks the association’s 30th anniversary. Ms. McKenna said the NHCAA was founded as a public-private partnership made up of the public sector, law enforcement and regulatory agencies.

Ms. McKenna said the NHCAA offers several educational tools, including a service called Smart Brief, which provides updates on health care fraud. She said that NHCAA offers several education opportunities and information sharing. Ms. McKenna said the NHCAA has only one education conference left for 2014: the NHCAA Annual Training Conference, Nov. 18–21 in Dallas. Ms. McKenna said the NHCAA is working on education for 2015 and will have that information out soon.

Additionally, Ms. McKenna said the NHCAA offers several information sharing options, including its Special Investigation Resource and Intelligence System (SIRIS) database, which is an online database for provider investigations, health care fraud schemes and requests for investigation assistance. She said the NHCAA also distributes two newsletters: Inside SIRIS and The Company. Ms. McKenna said the final information-sharing source comes from the case discussion roundtable meetings that coincide with its national education and training meetings.
Ms. McKenna said Louis Saccoccio, NHCAA executive director, stays involved with information that takes place in Washington, DC. Ms. McKenna said the U.S. Senate has asked Mr. Saccoccio to testify on separate occasions, and he will continue to stay on top of items as they move forward.

c. NICB

Mr. Clark said that he received an update from the NICB since Alan Haskins (NICB) was unable to attend. Mr. Clark said the NICB would like the Task Force to be aware of the Colorado Insurance Fraud and Vehicle Theft Summit it is hosting Oct. 15 in Littleton, CO. Mr. Clark said the NICB also will be hosting a boot camp for new prosecutors Dec. 3–5 in Austin, TX.

Having no further business, the Antifraud (D) Task Force adjourned.
The Information Sharing (ED) Working Group of the Antifraud (D) Task Force met via conference call July 29, 2014. The following Working Group members participated: Cindy Schmell, Chair (IA); Ted Clark (KS); Shane Guyant (NC); Michelle Rafeld (OH); Jeff Kirk (TX); and Armand Glick (UT)

1. **Heard an Update on USER Forms 106, 108 and 109**

Ms. Schmell said USER Form 106 is a request to display all of the role code descriptions from the National Insurance Crime Bureau (NICB) in the Online Fraud Reporting System (OFRS). The USER Form Status Report shows that this request is in production and moving forward.

Ms. Schmell said USER Form 108 is a request to provide a recurring search function to retrieve previously searched entities if data is captured after the initial search, and USER Form 109 is a request to expand search functions within the I-SITE report for more dynamic reporting. Ms. Schmell said both forms are being deferred to 2015 due to further discussion that is required by the Antifraud (D) Task Force.

2. **Discussed USER Forms 100, 101 and 107, 108**

Ms. Schmell said USER Form 100 states that the NICB is not currently passing the claim status value through the NAIC’s existing Web services. The USER Form Status Report indicates that it is pending feedback from the NICB on the NAIC staff’s recommendation for Option 1: The NICB will send the overall status of the report, at a record level, to the NAIC. The Working Group discussed the issue with Alan Haskins (NICB) and determined that it will be necessary for further technical discussions to take place before a final decision can be made. Mr. Haskins said the NICB has the data collected; however, there is no spot for the NICB to send that information at this time. The Working Group discussed and determined that further technical discussions would be necessary between the NICB and the NAIC. In addition, the Working Group agreed that, because the analyst work is completed, the Antifraud (D) Task Force would need to determine if this is a necessary request to proceed forward or if it should be closed and removed so that resources can be used toward a different USER form request.

Ms. Schmell said USER Form 101 is a request to display dollar amounts from the NICB in the OFRS. The USER Form Status Report shows that the Working Group is waiting on a response from the NICB. Mr. Haskins said he is waiting to hear back from the industry to determine the amounts available and how many times it is provided. The Working Group discussed and agreed the time in a claim for when the information is submitted is important and that the total dollar amount is important to help determine the level of claim that has been submitted.

Ms. Schmell said USER Form 107 is a request to display the subject of investigation from the NICB in the OFRS. She said the USER Form Status Report indicates that this request is currently at the detailed analysis stage. Ms. Schmell said that, in previous discussions, it was questioned whether to add “yes or no” to the subject area. The Working Group agreed that every entity should have the option to have a “yes or no” field. The decision was that NAIC staff would need to further review what is being displayed and determine if it is still necessary to be completed.

3. **Discussed New Request: USER Form 110**

Greg Welker (NAIC) said a new request was created asking for user security to be in place that would give the states the ability to prohibit specific others from viewing their details shown in the OFRS. Mr. Welker advised that this new request would need to be submitted on an NAIC USER form and sponsored by a specific regulator. Mr. Glick volunteered to sponsor the request, which will be submitted as USER Form 110.

Having no further business, the Information Sharing and Technology (D) Working Group adjourned.
The Information Sharing (ED) Working Group of the Antifraud (D) Task Force met via conference call May 29, 2014. The following Working Group members participated: Cindy Schmell, Chair (IA); Ted Clark (KS); Shane Guyant (NC); Michelle Rafeld (OH); and Jeff Kirk (TX).

1. Discussed the USER Form Process

Greg Welker (NAIC) provided an update on the Uniform System Enhancement Request (USER) form process. Mr. Welker said the Antifraud (D) Task Force adopted the USER form process in 2013 to track and report on requests for enhancements to the Online Fraud Reporting System (OFRS). This USER form process will ensure that all requests are acknowledged and tracked; that NAIC application development staff understand the request and are working on the right priorities; and that changes made to the OFRS are open and transparent.

Ms. Schmell said the Working Group would be meeting monthly, or more frequently if needed, to review and discuss the USER form request(s) and to review the progress of any outstanding items. Ms. Schmell said the Working Group members were provided with a USER form status report, which will be updated regularly to show progress and monitor outstanding issues.

2. Heard an Update on USER Forms 102, 103, 104 and 105

Ms. Schmell provided an overview of several USER forms that have completed and are currently in production: USER Form 102, which requested a display of evidence data from the NICB; USER Form 103, which requested a display of fraud types; USER Form 104, which requested a display of one fraud report with multiple incidents in the OFRS, instead of multiple fraud reports; and USER Form 105, which requested a display of multiple phone numbers have been completed and are currently in production.

3. Discussed USER Forms 100, 101 and 107

Ms. Schmell said USER Form 100 and USER Form 101 are requesting to display claim status and the dollar amounts from the National Insurance Crime Bureau/Insurance Services Office database to the OFRS. Chris Witt (NAIC) said the NAIC would need to change the data model; however, a new version of the Web server would need to be created in order to do that. Mr. Witt said changing the Web server would be a big issue, because it is used by many organizations the NAIC shares information with on a regular basis.

Alan Haskins (National Insurance Crime Bureau—NICB) said that NICB could supply the information requested in USER Form 100 and USER Form 101; however, the NAIC has no place to input the data in the OFRS. Mr. Haskins said the Insurance Service Offices (ISO) collects the data at an individual level and that the OFRS collects this data by each claim, not by individual. Marian Drape (NAIC) asked if the NICB would be able to supply the information, but it would be an inaccurate amount for the OFRS to display because the NICB collects the information by individual, not by claim. Mr. Haskins said the NICB and the ISO have a “settlement value,” which shows this amount as a total value. Mr. Haskins said the amount total varies from state to state depending on what laws are in place to collect the settlement value. Ms. Drape inquired if NICB could input the information into the OFRS. The Working Group discussed and decided that User Form 100 would be tabled at this time and further testing would be required for User Form 101.

Ms. Schmell said USER Form 107 requests to add a “yes or no” box for the subject of investigation. Mr. Haskins said he would look into details that the NICB and the ISO collects and what questions are being asked.


Ms. Schmell said USER Form 106 requests that all role code descriptions be displayed. Mr. Witt verified that issues were due to the limited space available to display the role code. Mr. Witt said the prototype completed adjusted other fields to accommodate this required room. Ms. Schmell said that, during the Spring National Meeting, the Antifraud (D) Task Force discussed adding information to the role codes section to include navigator, Web broker and certified application counselor (CAC). It was confirmed that this request from the Task Force would be incorporated into USER Form 106.

Ms. Schmell said USER Form 108 requests that a recurring search function be implemented so that users can retrieve previously searched entities if data is captured after the initial search is completed. Ms. Drape asked the NAIC is ready to move forward with this request after direction is provided by the Working Group. Ms. Schmell said USER Form 109 requests that the search functions within the I-SITE report be expanded for more dynamic reporting.

Mr. Clark made a motion, seconded by Ms. Rafeld, to adopt USER Form 106, USER Form 108 and USER Form 109 and move them to development. The motion carried.

Having no further business, the Information Sharing and Technology (D) Working Group adjourned.

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## Information Sharing and Technology (D) Working Group
### Outstanding USER (Uniform System Enhancement Request) Forms

As of May 27, 2014

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<tr>
<th>USER #</th>
<th>Requestor</th>
<th>Request Summary</th>
<th>Phase</th>
<th>NAIC Recommendation</th>
<th>Target End Date</th>
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<tr>
<td>100</td>
<td>Cindy Schmell (IA)</td>
<td>Display claim status from NICB in OFRS.</td>
<td>Detailed Analysis</td>
<td>Pending feedback from NICB on NAIC staff's recommendation for Option 1: NICB will send the overall status of the report, at a record level, to the NAIC.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>101</td>
<td>Cindy Schmell (IA)</td>
<td>Display dollar amounts from NICB in OFRS.</td>
<td>Detailed Analysis</td>
<td>Pending feedback from NICB on NAIC staff's recommendation for Option 1: NICB will roll up their existing data and send it to the NAIC.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>102</td>
<td>Cindy Schmell (IA)</td>
<td>Display evidence data from NICB in OFRS.</td>
<td>Complete</td>
<td>In production. Evidence data from NICB is now being displayed in OFRS.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>103</td>
<td>Cindy Schmell (IA)</td>
<td>Display fraud types from NICB in OFRS.</td>
<td>Complete</td>
<td>In production. Fraud types from NICB are now being displayed in OFRS.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>104</td>
<td>Cindy Schmell (IA)</td>
<td>Display one fraud report with multiple incidents in OFRS instead of multiple fraud reports.</td>
<td>Complete</td>
<td>In production. Fraud reports with multiple incidents from NICB are now being displayed in OFRS.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>105</td>
<td>Cindy Schmell (IA)</td>
<td>Display multiple phone numbers from NICB in OFRS.</td>
<td>Complete</td>
<td>In production. Multiple phone numbers from NICB are now being displayed in OFRS.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>106</td>
<td>Cindy Schmell (IA)</td>
<td>Display all role code descriptions from NICB in OFRS.</td>
<td>2nd Consideration</td>
<td>Move forward to development with Option 2</td>
<td>Pending Working Group decision</td>
<td></td>
</tr>
<tr>
<td>107</td>
<td>Cindy Schmell (IA)</td>
<td>Display subject of investigation from NICB in OFRS.</td>
<td>Detailed Analysis</td>
<td>NICB should submit the subject of investigation field</td>
<td>Pending feedback from NICB on NAIC staff's recommendation that NICB submit the subject of investigation to the NAIC.</td>
<td></td>
</tr>
<tr>
<td>108</td>
<td>Cindy Schmell (IA)</td>
<td>Provide reoccurring search function to retrieve previously searched entities if data is captured after the initial search.</td>
<td>2nd Consideration</td>
<td>Move forward to development</td>
<td>Pending Working Group decision.</td>
<td></td>
</tr>
<tr>
<td>109</td>
<td>Cindy Schmell (IA)</td>
<td>Expand search functions within the I-SITE report for more dynamic reporting.</td>
<td>1st Consideration</td>
<td>Move forward to detailed analysis</td>
<td>Pending Working Group decision.</td>
<td></td>
</tr>
</tbody>
</table>

**Diagram:**

- **USER Form Cycle**
  - Preliminary Analysis (NAIC Staff)
  - 1st Consideration (Task Force)
  - Detailed Analysis (NAIC Staff)
  - 2nd Consideration (Task Force)
  - Development (NAIC Staff)
  - Testing (NAIC Staff)
  - Withdrawn/Pending/Complete
### Information Sharing and Technology (D) Working Group

**USER (Uniform System Enhancement Request) Forms Status Report**

As of August 14, 2014

#### Outstanding Requests

<table>
<thead>
<tr>
<th>USER #</th>
<th>Requestor</th>
<th>Request Summary</th>
<th>Phase</th>
<th>NAIC Recommendation</th>
<th>Target End Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Cindy Schmell (IA)</td>
<td>Display claim status from NICB in OFRS.</td>
<td>Detailed Analysis</td>
<td>Option 1</td>
<td>Pending feedback from NICB on NAIC staff’s recommendation for Option 1: NICB will send the overall status of the report, at a record level, to the NAIC.</td>
<td></td>
</tr>
<tr>
<td>101</td>
<td>Cindy Schmell (IA)</td>
<td>Display dollar amounts from NICB in OFRS.</td>
<td>Detailed Analysis</td>
<td>Option 1</td>
<td>Pending feedback from NICB on NAIC staff’s recommendation for Option 1: NICB will roll up their existing data and send it to the NAIC.</td>
<td></td>
</tr>
<tr>
<td>106</td>
<td>Cindy Schmell (IA)</td>
<td>Display all role code descriptions from NICB in OFRS.</td>
<td>Production</td>
<td></td>
<td>In production as of July 17, 2014.</td>
<td></td>
</tr>
<tr>
<td>107</td>
<td>Cindy Schmell (IA)</td>
<td>Display subject of investigation from NICB in OFRS.</td>
<td>Production</td>
<td></td>
<td>In production as of July 29, 2014, per NICB.</td>
<td></td>
</tr>
<tr>
<td>108</td>
<td>Cindy Schmell (IA)</td>
<td>Provide recurring search function to retrieve previously searched entities if data is captured after the initial search.</td>
<td>Development</td>
<td></td>
<td>NAIC staff will continue to discuss this with the Working Group as development gets underway (Q1 2015). USER form 109 may mitigate the need for this request.</td>
<td></td>
</tr>
<tr>
<td>109</td>
<td>Cindy Schmell (IA)</td>
<td>Expand search functions within the I-SITE report for more dynamic reporting.</td>
<td>Development</td>
<td></td>
<td>NAIC staff may ask for more detailed feedback and verification of requirements from the Working Group as development gets underway (Q1 2015).</td>
<td></td>
</tr>
<tr>
<td>110</td>
<td>Armand Glick (UT)</td>
<td>Develop state specific roles for access to OFRS in I-SITE.</td>
<td>Preliminary Analysis</td>
<td></td>
<td>NAIC staff is reviewing request.</td>
<td></td>
</tr>
</tbody>
</table>

---

![USER Form Cycle Diagram](image-url)
INVESTIGATIONS OF LIFE INSURANCE AND ANNUITY CLAIMS SETTLEMENT PRACTICES (D) TASK FORCE

The Investigations of Life Insurance and Annuity Claims Settlement Practices (D) Task Force did not meet at the Summer National Meeting.
MARKET INFORMATION SYSTEMS (D) TASK FORCE

Market Information Systems Research and Development (D) Working Group April 9, 2014, Minutes (Attachment One) .................................................................................................................. 9-103
Status of Outstanding Uniform System Enhancement Request (USER) Forms, July 3, 2014 (Attachment Two) .................................................................................................................. 9-105
Regulatory Information Retrieval System (D) Subgroup July 30, 2014, Minutes (Attachment Four) .................................................................................................................. 9-114
Regulatory Information Retrieval System (D) Subgroup June 25, 2014, Minutes (Attachment Five) .................................................................................................................. 9-116
Action Items of the 2014 Market Regulation Summit, July 14, 2014 (Attachment Six) .................................................................................................................. 9-118
Comment Letters on Public Data Charges (Attachment Seven) .................................................................................................................. 9-119
2015 Proposed Charges (Attachment Eight) .................................................................................................................. 9-131
The Market Information Systems (D) Task Force met in Louisville, KY, Aug. 16, 2014. The following Task Force members participated: Mike Kreidler, Chair, Leslie Krier and Bill Michels (WA); Michael D. Riley, Vice Chair, and Mark Hooker (WV); Dave Jones represented by Pam O’Connell (CA); Thomas B. Leonardi represented by Kurt Swan (CT); Chester A. McPherson represented by Margaret Schruender (DC); Karen Weldon Stewart represented by Carol Jones (DE); Stephen W. Robertson represented by Karl Knable (IN); Sharon P. Clark represented by Russ Hamblen (KY); James J. Donelon represented by Craig Gardner (LA); Ann Flood represented by Jean Boven (MI); Mike Rothman represented by Paul Hanson (MN); John M. Huff represented by Jim Mealer (MO); Wayne Goodwin represented by Tracy Biehn (NC); Roger A. Sevigny represented by Chuck Vanasdalan (NH); Mary Taylor represented by Angela Dingus (OH); John D. Doak represented by Brian Gabbert (OK); and Ted Nickel represented by Sue Ezalarab and Cari Lee (WI).


Mr. Hooker reported that the Market Information Systems Research and Development (D) Working Group met July 9 and June 11 in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities or individuals, including, but not limited to, collaborative financial and market conduct examinations and analysis) of the NAIC Policy Statement on Open Meetings. The Working Group also met April 9 in open session (Attachment One). The Working Group received updates on the outstanding Uniform System Enhancement Request (USER) forms (Attachment Two) and the State Survey Project Action Plan (Attachment Three). The Working Group adopted recommendations to move forward to detailed analysis for enhancement requests to the Complaints Database System (CDS), Examination Tracking System (ETS), Market Analysis Review System (MARS), Market Analysis Prioritization Tool (MAPT) and Market Conduct Annual Statement (MCAS). The Working Group also adopted recommendations to move forward to development for enhancement requests to ETS, MARS, MCAS and MAPT.

Mr. Hooker made a motion, seconded by Ms. O’Connell, to adopt the report of the Market Information Systems Research and Development (D) Working Group. The motion was adopted unanimously.

2. Adopted the Report of the Regulatory Information Retrieval System (D) Subgroup

Mr. Mealer reported that the Regulatory Information Retrieval System (D) Subgroup met July 30 (Attachment Four) and June 25 (Attachment Five). The Subgroup accepted volunteers to draft definitions for Regulatory Information Retrieval System (RIRS) codes for type, line of business, origin, reason and disposition of action. The Subgroup reviewed definitions for RIRS reason for action and disposition of action codes. It also reviewed business processes for the entry of multi-state regulatory actions and single state multi-company regulatory actions with aggregate penalty amounts. The Subgroup agreed to meet with the Producer Licensing (EX) Working Group and the Financial Analysis Research and Development (E) Working Group to discuss proposed changes to RIRS and to solicit input. The Subgroup requested comments on definitions and business processes by Aug. 22, for discussion on the next Subgroup conference call.

Mr. Mealer made a motion, seconded by Ms. Biehn, to adopt the report of the Regulatory Information Retrieval System (D) Subgroup. The motion was adopted unanimously.

3. Received an Update on the ETS Continuum Action Support Project

Ginny Ewing (NAIC) provided an update on the ETS Continuum Action Support project. The project team is defining the business requirements working with ETS subject-matter expert regulators. The working name for the new system is the Market Action Tracking System. The project team has discussed adding focused inquiry and non-examination regulatory intervention as new actions; new reports; plans to migrate Market Initiative Tracking System data; and the ability to specify relationships between entities and/or actions. The high-level requirements will be ready for the Task Force to review during an interim conference call.
4. **Adopted its 2014 Market Regulation Summit Action Items**

Commissioner Kreidler explained that the Market Regulation and Consumer Affairs (D) Committee selected and prioritized action items identified during the 2014 Market Regulation Summit. The Task Force reviewed the action items assigned to it (Attachment Six) and discussed whether the items can be addressed within its existing charges.

Mr. Gardner made a motion, seconded by Commissioner Riley, to adopt the 2014 Market Regulation Summit action items, recommending that action item #4 “Investigate ways to better tie complaints to premium amounts” be reassigned to the Market Analysis Procedures (D) Working Group. The motion was adopted unanimously.

5. **Discussed Next Steps to Address Public Data Charges**

Commissioner Kreidler explained that, during its March 29 meeting, the Task Force requested comments regarding next steps to address its public data charges, and several comment letters were received (Attachment Seven). In addition, he noted that as a first step toward addressing the charges, links to the states’ market conduct exam and regulatory action websites were added to the Consumer Information Source (CIS). Ms. Ewing provided an update on the follow-up with the 10 states that, in the public data survey conducted in 2013, indicated they do not consider MCAS data confidential. Eight of the 10 states do consider individual company MCAS data confidential and treat it accordingly. The majority of those states publish state aggregate MCAS data, but not individual company data. The remaining two states have not yet responded. A suggestion made at the March 29 Task Force meeting was to determine the best method to present data so that the results reflect the marketplace, such as by group rather than by individual company. Ms. Ewing suggested that the analysis planned to address a USER form to add an option to provide the Complaint Index Report by group code may be leveraged for a CIS enhancement to provide similar functionality.

Regarding the Task Force charge to evaluate Market Information Systems data that is considered confidential and determine what can be made publicly available, Commissioner Kreidler noted that most of the issues relate to public policy rather than technical or information system issues. He suggested that this charge be referred to the Market Regulation and Consumer Affairs (D) Committee to address. Once the policy decisions are made, the Task Force will address the technical implementation.

6. **Adopted its 2015 Proposed Charges**

Ms. Ewing provided an overview of the Task Force’s 2015 Proposed Charges (Attachment Eight). In addition to editorial changes, the following were included: an addition to charge #1 to monitor state data entry to the NAIC Market Information Systems in order to evaluate the impact of the system enhancements; new charge #6 to analyze the data in the NAIC Market Information Systems and, if needed, recommend methods to ensure better data quality; and new charge #7 to determine how to effectively provide state users query access to NAIC Market Information Systems data.

Commissioner Riley made a motion, seconded by Mr. Mealer, to adopt the Task Force’s 2015 Proposed Charges, with a recommendation that charge #5 be referred to the Market Regulation and Consumer Affairs (D) Committee. The motion was adopted unanimously.

Having no further business, the Market Information Systems (D) Task Force adjourned.

W:\National Meetings\2014\Summer\TF\MIS\08-16MISTFmin.docx
The Market Information Systems Research and Development (D) Working Group met via conference call April 9, 2014. The following Working Group members participated: Brent Kabler, Chair (MO); Mark Hooker, Vice Chair (WV); Cheryl Hawley (AZ); Don McKinley and Pam O’Connell (CA); Ethan Kennedy and Doug Ommen (IA); Angela Dingus (OH); Suzette Green-Wright (UT); John Haworth (WA); and Jo LeDuc (WI).

1. Reviewed its 2014 Charge

Mr. Kabler reviewed the Working Group’s 2014 charge, which is to “serve as the business partner to review and prioritize submitted Uniform System Enhancement Request (USER) forms to ensure an efficient use of available NAIC staffing and resources.” He explained that the Working Group will work autonomously and will not need approval from the Market Information Systems (D) Task Force, regarding minor technical system changes. The Task Force will provide direction, particularly on larger issues, as necessary. He also noted that the Working Group is accepting additional members. The Working Group will meet monthly via conference call.

2. Received an Update on Outstanding State Survey Project Action Plan Initiatives

Ginny Ewing (NAIC) provided an update on the State Survey Project Action Plan. She said 19 of the 25 initiatives have been completed or addressed in another initiative. To address the Complaints Database System (CDS) “Report Implementation” initiative, a new Closed Complaint Record Detail File report was released to production on March 28. System changes to support new lines of business, areas of scrutiny and market findings, and multiple lines of business are being implemented to address the Examination Tracking System (ETS) “Implement Handbook Standards” initiative. In addition, an enhancement to allow upload of supporting documents any time after an exam is called in the system is being implemented to address the ETS “Support for Attachments” initiative. Communication and training plans regarding these system changes are being developed. A late April production release is scheduled. The ETS “Implement ETS Web Service in SBS” initiative is pending the completion of Web service changes necessary to support the ETS “Continuum Action Support” initiative. At the Spring National Meeting, the Task Force and the Market Regulation and Consumer Affairs (D) Committee approved a Project Request to address the ETS “Continuum Action Support,” “Eliminate MITS,” “Add ETS PICS” and “ETS Link to RIRS Actions” initiatives. The Regulatory Information Retrieval System (RIRS) Subgroup is addressing the Regulatory Information Retrieval System (RIRS) “Review RIRS Codes” initiative and providing input for the “Support for Attachments” initiative. The Working Group directed NAIC staff to create USER forms for the outstanding initiatives and track them on the USER form status report.

3. Received Update on Outstanding Uniform System Enhancement Request (USER) Forms and Adopted Recommendations for USER Forms 10035, 10036, 10039, 10040, 10041 and 10042

Marian Drape (NAIC) reviewed the outstanding USER form status report. USER forms 10037, new health reform-related codes for Complaints Database System (CDS), and 10038, new Consumer Information System maps that provide links to state insurance department market conduct examinations and regulatory actions, have been completed. Target release dates have been established for USER forms 10023, 10024, 10025, 10026, 10028, 10030 and 10031. Detailed analysis has been completed for USER forms 10035, 10036 and 10039. Preliminary analysis has been completed for USER forms 10040, 10041 and 10042. Preliminary analysis has begun for several new USER forms.

Mr. Kabler made a motion to adopt the NAIC staff recommendation to move forward with development of USER forms 10035, 10036 and 10039, and to move forward to detailed analysis for USER forms 10040, 10041 and 10042. Ms. Green-Wright seconded the motion, and it passed unanimously.
4. Discussed Other Matters

Mr. Hooker noted that there is a need to isolate major medical data in some of the systems, particularly the Market Analysis Prioritization Tool. Mr. Hooker and Mr. Haworth agreed to work together to draft a USER form.

Having no further business, the Market Information Systems Research and Development (D) Working Group adjourned.
### Market Information Systems Research and Development (D) Working Group

**Status of Outstanding USER (Uniform System Enhancement Request) Forms**

As of July 3, 2014

**Application Key:**
- CDS – Complaints Database System
- CIS – Consumer Information Source
- ETS – Exam Tracking System
- MAMS – Market Analysis Market Share
- MAPT – Market Analysis Prioritization Tool
- MARS – Market Analysis Review System
- MCAS – Market Conduct Annual Statement
- MITS – Market Initiative Tracking System
- RIRS – Regulatory Information Retrieval System

<table>
<thead>
<tr>
<th>User Form #</th>
<th>Application</th>
<th>Requestor</th>
<th>Request Summary</th>
<th>NAIC Recommendation</th>
<th>Phase</th>
<th>Target End Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>10019</td>
<td>MARS</td>
<td>Chuck Vanasdlan NH</td>
<td>Generate a reminder notification for future analysis.</td>
<td>Do not proceed</td>
<td>Pending</td>
<td></td>
<td>Future enhancement</td>
</tr>
<tr>
<td>10022</td>
<td>MARS</td>
<td>Arthur Dodd VA</td>
<td>Loss ratio data tables provided as part of question 11 in a Level 1 incorporate state page data to be comparable to MAPT data.</td>
<td>Defer to MAP (D) Working Group</td>
<td>Pending</td>
<td></td>
<td>MAP (D) WG decision</td>
</tr>
<tr>
<td>10035</td>
<td>MARS</td>
<td>Randy Helder NAIC</td>
<td>Display Health FAST scores whenever they are available when the analyst is reviewing the A&amp;H Line of Business. If both Life and A&amp;H are being reviewed, both the Life and the Health FAST scores should be displayed if both scores are available.</td>
<td>Development</td>
<td>11/6/2014</td>
<td></td>
<td>On schedule</td>
</tr>
<tr>
<td>10036</td>
<td>MCAS</td>
<td>Randy Helder NAIC</td>
<td>Display a message in the MCAS submission tool whenever a user attempts to “submit with warning” but there are no comments in the submission, advising the user to address the warnings.</td>
<td>Development</td>
<td>11/6/2014</td>
<td></td>
<td>On schedule</td>
</tr>
<tr>
<td>10040</td>
<td>MCAS</td>
<td>Mark Hooker WV</td>
<td>Provide another drop-down box under the “Report Criteria” section to allow for the selection of “Year.” Limit “Year” to current year and prior two years.</td>
<td>Development</td>
<td>11/6/2014</td>
<td></td>
<td>On schedule</td>
</tr>
<tr>
<td>10041</td>
<td>ETS</td>
<td>David Moskowitz TX</td>
<td>Add ability to indicate if exam will be conducted by contract examiner or DOI staff.</td>
<td>Development</td>
<td>11/6/2014</td>
<td></td>
<td>On schedule</td>
</tr>
<tr>
<td>10042</td>
<td>MARS</td>
<td>MAP (D) WG Randy Helder NAIC</td>
<td>Rephrase questions in MARS; provide link to the FAST scores; change label of ‘Market Share.’</td>
<td>Move forward to Development</td>
<td>2nd Consideration</td>
<td></td>
<td>MIS R&amp;D WG review</td>
</tr>
</tbody>
</table>
### Market Information Systems Research and Development (D) Working Group

**Status of Outstanding USER (Uniform System Enhancement Request) Forms**

As of July 3, 2014

**Application Key:**

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<thead>
<tr>
<th>Application</th>
<th>Requestor</th>
<th>Request Summary</th>
<th>NAIC Recommendation</th>
<th>Phase</th>
<th>Target End Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>MARS</td>
<td>Randy Helder NAIC</td>
<td>Import the average industry loss ratio and expense ratio.</td>
<td>Development</td>
<td>11/6/2014</td>
<td>On schedule</td>
<td></td>
</tr>
<tr>
<td>MARS</td>
<td>Randy Helder NAIC</td>
<td>Change the data value displayed in Question 12 for Life lines of business.</td>
<td>Move forward to Development</td>
<td>2nd Consideration</td>
<td>MIS R&amp;D WG review</td>
<td></td>
</tr>
<tr>
<td>MARS</td>
<td>Randy Helder NAIC</td>
<td>Change the data displayed in Question 12 for Health lines of business.</td>
<td>Move forward to Development</td>
<td>2nd Consideration</td>
<td>MIS R&amp;D WG review</td>
<td></td>
</tr>
<tr>
<td>MARS</td>
<td>Randy Helder NAIC</td>
<td>Change the data displayed in Question 12 for Property/Casualty lines of business.</td>
<td>Move forward to Development</td>
<td>2nd Consideration</td>
<td>MIS R&amp;D WG review</td>
<td></td>
</tr>
<tr>
<td>MAPT</td>
<td>Mark Hooker WV</td>
<td>Add option to display data by group code.</td>
<td>Detailed Analysis</td>
<td>NAIC staff working on Detailed Analysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CDS</td>
<td>Mark Hooker WV</td>
<td>Add option to run Complaint Index Report by group code.</td>
<td>Detailed Analysis</td>
<td>NAIC staff working on Detailed Analysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ETS</td>
<td>Melissa Nelson KY</td>
<td>Add an icon (paper clip) to exams listed in the Market Exam Search Results Page that have attachments in the File Repository.</td>
<td>Move forward to Development</td>
<td>2nd Consideration</td>
<td>MIS R&amp;D WG review</td>
<td></td>
</tr>
</tbody>
</table>
**Market Information Systems Research and Development (D) Working Group**

**Status of Outstanding USER (Uniform System Enhancement Request) Forms**

As of July 3, 2014

**Application Key:**


<table>
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<tr>
<th>User Form #</th>
<th>Application</th>
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</tr>
</thead>
<tbody>
<tr>
<td>10050</td>
<td>ETS</td>
<td>Lynn Clark CT</td>
<td>When opening an Exam in ETS, make it possible to highlight and check ALL the boxes in the Market Findings' area under Scrutiny and simply uncheck the areas not being scrutinized.</td>
<td>Move forward to Development with Option 3</td>
<td>2nd Consideration</td>
<td>MIS R&amp;D WG review</td>
<td></td>
</tr>
<tr>
<td>10051</td>
<td>ETS</td>
<td>MISTF State Survey Project Action Plan #9</td>
<td>Implement ETS Web Service in SBS: Provide SBS Examination module integration for automated submission of information to ETS.</td>
<td></td>
<td></td>
<td>Defer until after ETS #11 or SBS Rewrite</td>
<td></td>
</tr>
<tr>
<td>10053</td>
<td>RIRS</td>
<td>MISTF State Survey Project Action Plan #22</td>
<td>Review of RIRS Codes: Review of RIRS codes by the RIRS Code Review Working Group to clarify definitions for consistent usage and provide recommendations for revisions.</td>
<td></td>
<td>Preliminary Analysis</td>
<td>RIRS (D) Subgroup is considering this as part of their review of RIRS.</td>
<td></td>
</tr>
</tbody>
</table>
## Market Information Systems Research and Development (D) Working Group

Status of Outstanding USER (Uniform System Enhancement Request) Forms

As of July 3, 2014

**Application Key:**
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<th>Target End Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>10054</td>
<td>RIRS</td>
<td>MISTF</td>
<td>Support for Attachments: Facilitate submission of supporting documentation. (ex: orders)</td>
<td>Preliminary Analysis</td>
<td>Preliminary Analysis</td>
<td>RIRS (D) Subgroup is considering this as part of their review of RIRS.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>State</td>
<td>USER Form 10021: Allow entry of multiple state regulatory actions in RIRS. (added 3/20/13)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### USER Form Cycle

1. Preliminary Analysis
2. 1st Consideration
3. Detailed Analysis
4. 2nd Consideration
5. Development
6. Testing
7. Pending Production
8. Withdrawn / Pending / Complete

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W:\National Meetings\2014\Summer\TF\MISR\MISRD\Monthly Calls\07 - July USER Form Status Report July 3, 2014.docx
# Market Information Systems (D) Task Force
State Survey Project Action Plan Status

June 4, 2014

<table>
<thead>
<tr>
<th>#</th>
<th>System</th>
<th>Initiative</th>
<th>Status</th>
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<tr>
<td>1</td>
<td>Complaints Database System (CDS)</td>
<td>Legal Analysis: Determine what data can be displayed and at what level of granularity, including reason and disposition.</td>
<td>Completed 1/29/13: Verified with NAIC Legal department.</td>
</tr>
<tr>
<td>3</td>
<td>Electronic Forums (aka Bulletin Boards)</td>
<td>Extend Retention: Allow forum information to be available beyond current one-year limit through either archival or longer retention.</td>
<td>Completed 8/7/13: To provide market regulators the necessary detail of the bulletin board posts, while eliminating the retention of the actual discussions, which may not be intended for longer retention, NAIC staff will monitor the Market Analysis and Market Regulation Bulletin Boards and summarize the discussions. These summaries will be available to forum members upon request for three years.</td>
</tr>
<tr>
<td>4</td>
<td>Electronic Forums (aka Bulletin Boards)</td>
<td>Promote Electronic Forum Use: Clarify usage guidelines and encourage use of Market Regulation and Market Analysis forums for information sharing.</td>
<td>Completed 1/18/13: Notification of, and link to, tutorial was sent to Task Force members and interested regulators and to the Market Regulation Bulletin Board.</td>
</tr>
<tr>
<td>5</td>
<td>Examination Tracking System (ETS)</td>
<td>Enhance Statuses: Implement additional statuses. (ex: In Settlement)</td>
<td>Completed 5/31/13: New statuses were introduced with 5/31 production release.</td>
</tr>
<tr>
<td>6</td>
<td>Examination Tracking System (ETS)</td>
<td>Promote ETS Web Service: Ensure state awareness of the ETS Web Service for automated submission of information to ETS.</td>
<td>Completed 1/25/13: Promotion was sent to Task Force members and interested regulators and to the Market Regulation Bulletin Board.</td>
</tr>
</tbody>
</table>

Shaded initiatives have been completed or are no longer active

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# Market Information Systems (D) Task Force
## State Survey Project Action Plan Status
### June 4, 2014

<table>
<thead>
<tr>
<th>#</th>
<th>System</th>
<th>Initiative</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.</td>
<td>Examination Tracking System</td>
<td>Focus on Risk Bearing Entities Only: Will allow future reduction of system complexity and level of effort to implement system enhancements. <em>(NAIC staff recommendation proposed for consideration.)</em></td>
<td>Completed 2/22/13: Code change to restrict new exams to risk-bearing entities only released to production.</td>
</tr>
<tr>
<td></td>
<td>(ETS)</td>
<td></td>
<td></td>
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<tr>
<td>8.</td>
<td>Examination Tracking System</td>
<td>Implement Handbook Standards: Consistent options for Line of Business, Scrutiny, and Findings.</td>
<td>Completed 4/25/14: New lines of business and areas of scrutiny/market findings consistent with the Market Regulation Handbook were implemented. In addition, the ability to enter an exam for multiple lines of business was added.</td>
</tr>
<tr>
<td></td>
<td>(ETS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Examination Tracking System</td>
<td>Implement ETS Web Service in SBS: Provide SBS Examination module integration for automated submission of information to ETS.</td>
<td>Moved to USER Form 10051: After evaluating the effort to implement the web service, considering the certainty that a second implementation will be necessary after the implementation of the ETS initiative #11 and that currently only 2 states will benefit from this initiative, NAIC staff recommends deferring this until the implementation of ETS initiative #11 and possibly until after the SBS rewrite depending on its timeline.</td>
</tr>
<tr>
<td></td>
<td>(ETS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Examination Tracking System</td>
<td>Add ETS Link in PICS: Provide a link from the monthly open exam PICS notification to navigate to the exam in ETS. <em>(Note: this was expanded to include all ETS PICS events.)</em></td>
<td>Completed 3/15/13: Code change to add links in ETS PICS notifications directly to exams in ETS released to production.</td>
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<tr>
<td></td>
<td>(ETS)</td>
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<tbody>
<tr>
<td>11</td>
<td>Examination Tracking System</td>
<td>Continuum Action Support: System revisions to allow tracking and communication of key continuum activity. (ex: interrogatories, data calls)</td>
<td>Moved to USER Form 10052: On 3/29 and 3/31/14 respectfully, the Task Force and D Committee approved a Project Request to enhance ETS to support non-exam initiatives and address initiatives #12 and #14. Review by the Technical Consulting (EX1) Working Group and approval of the Executive (EX) Committee are needed before the project can proceed.</td>
</tr>
<tr>
<td></td>
<td>(ETS)</td>
<td>Eliminate MITS (formerly initiative #19): Identify need for information sharing of key continuum activity and evaluate alternatives to facilitate MITS elimination. (added 2/13/13)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Add ETS PICS (formerly initiative #14): Develop PICS notification for submission of Exam Call Letter. (added 3/27/13)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>ETS Link to RIRS Actions (formerly initiative #12): Provide ability to link regulatory actions to specific exams in ETS. (added 4/12/13)</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Examination Tracking System</td>
<td>ETS Link to RIRS Actions: Provide ability to link regulatory actions to specific exams in ETS.</td>
<td>To be Included in scope of ETS initiative #11</td>
</tr>
<tr>
<td></td>
<td>(ETS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Examination Tracking System</td>
<td>Support for Attachments: Facilitate submission of supporting documentation. (ex: Examination Call Letters)</td>
<td>Completed 4/25/14: An enhancement to allow upload of any exam document any time after an exam is called in the system was implemented.</td>
</tr>
<tr>
<td></td>
<td>(ETS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Examination Tracking System</td>
<td>Add ETS PICS: Develop PICS notification for submission of Exam Call Letter.</td>
<td>To be Included in scope of ETS initiative #11</td>
</tr>
<tr>
<td></td>
<td>(ETS)</td>
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<tr>
<td>16.</td>
<td>Market Analysis Reporting System (MARS)</td>
<td>Level 2 Options: Eliminate requirement to complete all six core areas. <em>(Coordinate with MAP Working Group.)</em></td>
<td>Completed 3/18/13: Based on feedback from the Market Analysis Review System (MARS) subject matter expert group, as of March 18th, the MARS application only requires the completion of the Complaint section for Level 2 analysis. All other sections are optional.</td>
</tr>
<tr>
<td>17.</td>
<td>Market Analysis Reporting System (MARS)</td>
<td>Support for Attachments: Facilitate submission of supporting documentation, as needed.</td>
<td>Withdrawn 4/7/13: The subject matter expert group determined there is no need for attachments in MARS. Therefore, it was recommended this initiative be withdrawn. The Task Force adopted a motion to withdraw at its April 7, 2013 meeting.</td>
</tr>
<tr>
<td>18.</td>
<td>Market Initiative Tracking System (MITS)</td>
<td>Eliminate Expectation of State Data Entry: States would be able to use the system as desired for tracking and information sharing purposes, but without expectation of its use.</td>
<td>Completed 2/20/13: Memos were sent to Task Force members, Interested Regulators, Collaborative Action Designees, and Market Analysis Chiefs.</td>
</tr>
<tr>
<td>19.</td>
<td>Market Initiative Tracking System (MITS)</td>
<td>Eliminate MITS: Identify need for information sharing of key continuum activity and evaluate alternatives to facilitate MITS elimination.</td>
<td>To be Included in scope of ETS initiative #11</td>
</tr>
</tbody>
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<tr>
<td>21</td>
<td>Regulatory Information Retrieval System (RIRS)</td>
<td>Appoint RIRS Code Review Working Group: Following its appointment this group would review the data codes used for RIRS and recommend revision of data fields.</td>
<td>Completed 3/5/13: The RIRS subject matter expert regulator group was formed to address the RIRS action plan initiatives.</td>
</tr>
<tr>
<td>22</td>
<td>Regulatory Information Retrieval System (RIRS)</td>
<td>Review of RIRS Codes: Review of RIRS codes by the RIRS Code Review Working Group to clarify definitions for consistent usage and provide recommendations for revisions.</td>
<td>Moved to USER Form 10053: The RIRS Subgroup last met on 3/14/14. The deadline to recommend changes to RIRS and to comment on proposed enhancements was extended to 4/15. In order to ensure financial and producer codes are reviewed, the Subgroup is reaching out to appropriate regulator groups.</td>
</tr>
<tr>
<td>23</td>
<td>Regulatory Information Retrieval System (RIRS)</td>
<td>Support for Attachments: Facilitate submission of supporting documentation. (ex: orders) USER Form 10021: Allow entry of multiple state regulatory actions in RIRS. (added 3/20/13)</td>
<td>Moved to USER Form 10054: High-level requirements and estimates have been documented for capturing via Transaction Utility (TU) as part of the upcoming TU Rewrite project. Further evaluation is in progress to determine impact to the NAIC back-end processes (e.g. Loads, Common Architecture) and the state back-office systems that submit data to them (e.g. State-Based Systems, Sircon).</td>
</tr>
<tr>
<td>24</td>
<td>Regulatory Information Retrieval System (RIRS)</td>
<td>Evaluate RIRS Submission Alternatives via SBS: Evaluate SBS Enforcement module use as a stand-alone module for electronic submission of regulatory actions.</td>
<td>Completed 5/15/13: NAIC staff is confident that states are aware of the available automated data submission options. The Market Information Systems team will follow-up with the states interested in Common Arch regarding conversion in the future.</td>
</tr>
<tr>
<td>25</td>
<td>Special Activities Database (SAD)</td>
<td>Reduce State Data Entry: Limit state entry to only 1033/1034 activity, continue NAIC staff entry of FINRA actions. (Coordinate with Anti-Fraud Task Force.)</td>
<td>Completed 2/20/13: Memo was sent to Antifraud Task Force members, State Antifraud Directors, Producer Licensing Directors, and Collaborative Action Designees.</td>
</tr>
</tbody>
</table>

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The Regulatory Information Retrieval System (D) Subgroup of the Market Information Systems (D) Task Force met via conference call July 30, 2014. The following Subgroup members participated: Jim Mealer, Chair, and Brent Kabler (MO); Helene Tomme (AZ); Holly Williams (IN); Rob Stroup (OH); Katie Johnson (VA); John Haworth (WA); and Mark Hooker (WV).

1. Reviewed Definitions of the RIRS Disposition Codes

Because the proposed definitions of the RIRS disposition codes had just been posted to the Subgroup’s Web page for review earlier that day, Mr. Mealer said there would be minimal discussion of that issue on this call. He asked the Subgroup to review and submit written comments by Aug. 22, so that a more detailed discussion could on the Subgroup’s next conference call. Mr. Haworth and Mr. Hooker, who developed the definitions, suggested that the NAIC Legal Division review the terms used in the document for accuracy. Ms. Drape said she would ask the NAIC Legal Division to review the terms.

2. Reviewed Definitions of the RIRS Reason Codes

Mr. Mealer said the definitions for RIRS reason codes, which were developed by Mr. Kabler, were also just posted for review to the Subgroup’s Web page earlier that day. He asked the Subgroup to review and submit written comments by Aug. 22. Mr. Kabler said he used the same definitions of the areas of scrutiny in the Examination Tracking System (ETS) as the basis for the definitions of the RIRS reason codes, rewording them as violations. He noted that inconsistencies he identified between the definitions in ETS and RIRS are highlighted on the document. He suggested it would be beneficial to solicit input from the Producer Licensing (EX) Working Group and the Financial Analysis Research and Development (E) Working Group to develop definitions for reason codes not related to market analysis.

3. Discussed Business Process for Regulatory Actions with Aggregate Penalty Amounts

Mr. Mealer reviewed two options for entering regulatory actions with aggregate penalty amounts. For the first option, he said a user would enter one examination in ETS and one multi-respondent regulatory action in RIRS. The user would then link the examination and the regulatory action, and enter the same aggregate penalty amount for each respondent in the regulatory action. For the second option, Mr. Mealer said the user would enter one examination in ETS, enter multiple regulatory actions in RIRS (one for each respondent) and enter the same aggregate penalty amount for each regulatory action. The user would also link the multiple regulatory actions with the examination. In both options, RIRS must clearly show that the amount entered as a penalty is an aggregate amount that has been applied to all respondents and not to each respondent. Doing so, and linking all regulatory actions, will help ensure that market analysts do not apply the penalty amount to each respondent, thereby overstating the penalty amount.

Mr. Haworth said the enforcement action order clearly states that the penalty amount is an aggregate and should not be applied to each respondent. Mr. Hooker added that it would be helpful to have the enforcement action order available in the Market Analysis Profile Tool (MAPT) as an attachment that the analyst could easily reference.

Ms. Johnson asked if it is difficult to link actions. Mr. Mealer responded that the regulators must present the requirement to link actions, then let the NAIC technical departments that support back-office systems determine the feasibility of how to implement the requirement. He continued that regulators working on business requirements for the Market Actions Tracking System (MATS), which is a combination of ETS and the Market Initiatives Tracking System, have also discussed being able to link examinations, regulatory actions and other initiatives.

Ms. Johnson asked if MATS will automatically populate RIRS to minimize duplicate entry. Ginny Ewing (NAIC) responded that the scope of the MATS project does not include automatically populating RIRS. She continued that the states’ back office enforcement modules currently upload regulatory actions automatically to RIRS, which prevents duplicate data entry, and that the creation of a Web service to populate MATS from the states’ back-office systems is within the scope of the project. This will also prevent duplicate data entry. Mr. Mealer asked for written comments on these scenarios by Aug. 22.
4. Discussed Business Process for Multi-State Regulatory Actions

Mr. Mealer reviewed three options for entering multi-state regulatory actions. In the first option, he said the lead state would enter all of the regulatory action data for all participating states as one action and assign one RIRS identifier. In the second option, he said the lead state would provide each participating state with a RIRS identifier, which each participating state would use to enter its own regulatory action data. In the third option, Mr. Mealer said the lead state would provide each participating state with a RIRS identifier, which each participating state would use to enter its own regulatory action, the same as the second option. Additionally, the lead state would also be able to enter the states that are part of the multi-state regulatory action. This information would then be used to determine when all participating states have entered their regulatory actions. It will also allow the lead state to follow up with participating states, if necessary. In the third option, Mr. Mealer said the lead state would get an alert when a participating state enters its regulatory action data, which would also assist the lead state in monitoring the timeliness and completeness of the data.

Ms. Drape asked if the states enter regulatory actions in RIRS for multiple respondents as one action or as separate actions for each respondent. Mr. Hooker and Mr. Mealer responded that it depends on the enforcement action order. If one order includes actions for multiple respondents, then the data is entered into RIRS as one action with multiple respondents. If there are separate orders for each respondent, then multiple regulatory actions are entered in RIRS with one respondent each.

Mr. Mealer asked for written comments on these scenarios by Aug. 22.

Having no further business, the Regulatory Information Retrieval System (D) Subgroup adjourned.
The Regulatory Information Retrieval System (D) Subgroup of the Market Information Systems (D) Task Force met via conference call June 25, 2014. The following Subgroup members participated: Jim Mealer, Chair, and Brent Kabler (MO); Sarah McNair-Grove (AK); Helene Tomme (AZ); Holly Williams (IN); Angela Dingus (OH); Katie C. Johnson (VA); John Haworth (WA); and Mark Hooker (WV).

1. Reviewed Proposed Changes to Codes in the RIRS

Mr. Mealer said that each regulatory action in the Regulatory Information Retrieval System (RIRS) currently has codes associated with the origin of action, reason for action, disposition of the action and the entity’s function. He noted that the Subgroup has received proposals to add codes for type of action and for the entity’s line of business. He stated the Subgroup must now develop definitions for current and proposed codes, and document the business processes to ensure that all Subgroup members fully understand the changes.

Mr. Mealer said the codes proposed for type of regulatory action are market, financial, company licensing and producer. These codes will allow filtering of actions that have less impact on market analysis in applications such as the Market Analysis Priority Tool in I-SITE. Mr. Mealer asked if the type of action should be based on who entered it. Mr. Kabler said that he uses the disposition of the action as a filter and asked if a type of action attribute was valuable. He added that the origin of the action also provides information from which the type of action can be determined. Ms. Johnson said that the type of action may be used as a high-level filter to sort financial actions from market actions, but the reason for the action is most important. Mr. Mealer agreed to document business processes that would use type of action so that the Subgroup can further discuss its significance.

Mr. Mealer said the proposed line of business codes are the same as those in the Examination Tracking System (ETS) in I-SITE. Ms. Johnson asked if additional lines could be added since the dwelling fire line of business is not included. Mr. Hooker noted that major medical is also not included. Mr. Mealer said that regulators could request additional lines of business to ETS now by completing a Uniform System Enhancement Request (USER) form and submitting it to the Market Information Systems Research and Development (D) Working Group for consideration. Mr. Kabler asked members to consider how to designate a line of business if a regulatory action is not tied to a specific one.

Ms. Drape explained that the current entity function codes in RIRS, which are also referred to as role codes, are the same as those in the Complaints Database System (CDS). However, the RIRS form does not reflect this. She said that the usage of the entity function codes has not been analyzed in years. She asked the Subgroup if it would analyze usage, especially use of Other and Unknown codes, and recommend the ones to keep for RIRS. Mr. Mealer added that the Subgroup should reach out to other regulatory groups to determine if some of the entity function codes are useful to them.

Mr. Mealer noted that the Subgroup previously proposed several changes to the origin of action codes, including adding a new one to designate a multi-state regulatory action. He said the Subgroup needs to define each origin code and document possible business processes for the submission of multi-state actions, after which all members will discuss in detail.

Ms. Drape said the proposed reason codes related to market examinations in ETS are the same as the codes recently implemented in ETS in April. Mr. Mealer asked Ms. Drape to distribute the definitions of these codes, which regulators developed prior to the ETS implementation. Mr. Mealer said that regulators used the Market Conduct Examiners Handbook to determine which codes to include. Because there was concern about having too many codes, Mr. Mealer said they excluded and combined some codes to make them more manageable. For reason codes not related to market examinations, Mr. Mealer said the Subgroup must meet with other regulatory groups before any changes can be made.

Mr. Mealer pointed out the Subgroup previously discussed disposition codes, specifically code 3103, Aggregate Monetary Penalty. Ms. Johnson said that in Virginia, they may apply an aggregate monetary penalty to all companies involved in an examination, not each individual company. Mr. Hooker said that the Market Analysis Prioritization Tool (MAPT) may need revision to ensure it reflects this business process. He added that state regulators may need additional training on this issue if the application of code 3103 is not consistent among states. Mr. Mealer noted that the Subgroup should also determine which
disposition codes can only be used when adding new regulatory actions; which disposition codes can only be used when updating regulatory actions, such as rescission or suspension extended; and which disposition codes can only be used to indicate that the state is still monitoring an entity’s regulatory activity.

Mr. Mealer and Mr. Kabler volunteered to develop code definitions for types of actions, lines of business, origins of action and entity functions. Ms. McNair-Grove and Mr. Kabler volunteered to develop reason code definitions. Mr. Hooker and Mr. Haworth volunteered to develop disposition code definitions. Ms. Drape said that all definitions will be posted on the Regulatory Information Retrieval System (D) Subgroup website. Mr. Mealer asked for comments before the next Subgroup conference call.

2. Discussed RIRS Changes with Other Working Groups

Ms. Drape said that the Regulatory Information Retrieval System (D) Subgroup should meet with the Financial Analysis Research and Development (E) Working Group and the Producer Licensing (D) Working Group to discuss the Subgroup’s recommendation for RIRS changes and to solicit their input. Mr. Mealer said that he would contact them and attend one of their meetings/conference calls soon.

3. Discussed Business Process for Multi-State Regulatory Actions

Mr. Mealer noted that the Subgroup previously discussed two options for the submission of multi-state regulatory actions. The first option is to have the lead state enter the data for all of the states participating in a multi-state action. The second option is for each state to enter its own regulatory action and then link its action with other states’ actions. Mr. Hooker suggested that the ability to link regulatory actions to examinations in ETS was critical. Mr. Mealer suggested that an email alert could be sent to the lead state after each state submitted its action. Additionally, Mr. Mealer suggested that NAIC staff monitor multi-state actions for timeliness and completeness. The details of each option have not been determined or evaluated. Mr. Mealer said that he and Mr. Kabler would document each option to identify advantages and disadvantages for the Subgroup to review on its next call.

The Regulatory Information Retrieval System (D) Subgroup members agreed to meet via conference call July 30 to discuss the regulators’ definitions of codes and business processes.

Having no further business, the Regulatory Information Retrieval System (D) Subgroup adjourned.
Market Information Systems (D) Task Force

<table>
<thead>
<tr>
<th>Action Items</th>
<th>7-31</th>
<th>8-31</th>
<th>9-30</th>
<th>10-30</th>
<th>11-30</th>
<th>12-30</th>
<th>2015</th>
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<tbody>
<tr>
<td>2. Develop a system/database that better shares information on actions other than examinations.</td>
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<td>X</td>
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<tr>
<td>3. Analyze the data currently in the NAIC Market Information Systems to see what was entered and what training needs to occur to ensure better data quality (if needed.)</td>
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<td>4. Investigate ways to better tie complaints to premium amounts. Proposed reassigning to Market Analysis Procedures (D) Working Group</td>
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<tr>
<td>5. Review the NAIC Market Information Systems and develop a way that analysis can be performed on an insurance group basis instead of limited to the individual company (cocode) basis.</td>
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<td>6. Find a way to allow state users of I-SITE data to query the NAIC Market Information Systems.</td>
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<tr>
<td>7. Monitor how state data entry to the NAIC Market Information Systems has changed after the Action Plan has been implemented.</td>
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</table>
Lisa Tate  
*Vice President & Associate General Counsel*

July 18, 2014

Via E-mail

Ginny Ewing  
c/o Market Information Systems (D) Task Force  
National Association of Insurance Commissioners (NAIC)  
*Market Information Systems (D) Task Force Staff Support*  
gewing@naic.org

Subject: 2014 MISTF Charges regarding Wider Accessibility of Data Collected on NAIC Market Information Systems

Dear Ms. Ewing:

On behalf of our member companies, the American Council of Life Insurers (ACLI) responds to a request for comments released by the NAIC Market Information Systems (D) Task Force (MISTF or, alternatively, the Task Force), soliciting suggestions to address the following 2014 Task Force charges:

- Develop a plan for making more widely available the public data collected in the NAIC Market Information Systems.
- Evaluate all data currently collected in the NAIC Market Information Systems and considered confidential to determine what, if any, can be made more widely available.¹

ACLI welcomes the opportunity to submit these comments. Our members have strong reservations toward any approach that may diminish insurers’ legal protections regarding data collection. Our members have a substantial interest in seeing that the well-reasoned conclusions underlying current confidentiality requirements for certain data collected on NAIC Market Information Systems (MIS) are preserved.²

***

**Overview**

The 2014 charges set forth a seemingly uncontroversial proposition: wider access to MCAS data will assist consumers in making decisions about their insurance and insurance company. However, most State Legislatures have already made the determination that a balance must be struck between public disclosure and commercial confidentiality. These Legislatures have determined that the public is best served when commercial interests are provided with certain confidentiality protections. For insurers, many of these protections exist in the confidentiality extended to data collected under an insurance supervisor’s market conduct examination authority and State trade secret statutes.

¹ The American Council of Life Insurers (ACLI) is a Washington, D.C.-based trade association with approximately 300 legal reserve life insurer and fraternal benefit society member companies operating in the United States. ACLI advocates in federal, state and international forums. Its members represent more than 90 percent of the assets and premiums of the U.S. life insurance and annuity industry. In addition to life insurance, annuities and other individual and workplace retirement plans, ACLI members offer long-term care and disability income insurance, and reinsurance.

² Hereinafter referred to as Market Conduct Annual Statement (MCAS) data.
In addition to existing protections provided by the individual States, NAIC addressed this balancing of private and public concerns 14 years ago in a section titled “Distinguishing Access by Regulators from Access by Third Parties” in its White Paper, “Regulatory Access to Insurer Information: The Issues of Confidentiality and Privilege.” (Adopted March 2000) NAIC stated:

One issue in the Plain Dealer case…was whether the financial examination work papers of a regulated insurance entity should be available for publication by a newspaper. The NAIC intervened as amicus curiae, stating in its legal brief as follows: “Maintaining a confidential record of this examination process is necessary to ensure a thorough examination.”

NAIC further quotes from its legal brief, after acknowledging in the brief that “the insurance superintendent should not be prevented from reviewing examination documents if they are relevant to the superintendent’s other duties.” NAIC continued:

One of an insurance supervisor’s primary goals is to protect the policyholders. In some cases, the public release of sensitive examination work papers could cause a “run-on-the-bank,” meaning that a large number of policyholders cash in their policies, threatening the financial viability of the insurer and jeopardizing the claims of the remaining policyholders.

ACLI believes that these conclusions, when applied in the context of market conduct examinations, remain as pertinent today as in 2000 for both insurers and insurance supervisors.

Concerns regarding Insurers

ACLI below briefly sets forth a number of its reservations toward any effort that would, to the detriment of existing State confidentiality statutory protections, inappropriately expand public accessibility to MCAS data. Among these are:

- The charges, if not implemented with care, will inappropriately preempt laws in virtually every State that were enacted by the Legislatures to protect confidential data collected as trade secrets or under a market conduct examination authority by making public information that is, however re-characterized, materially identical to the protected information.

- The MCAS data set is intended to be used for supervisory examinations, and it is, appropriately, limited. Wider availability of MCAS data will be without context and can distort consumer assessments by over-focusing on insurance supervisory elements only (such as complaint handling) rather than other, equally important considerations of an insurance company. It is questionable as to whether MCAS data is even truly useful for a consumer in establishing benchmarks or making comparisons.

- Use of a limited data set, outside its intended context, will lead to litigation which will be complex and time-consuming, reducing resources more constructively directed toward regulatory compliance. While transparency with regulators is vital, expanding MCAS data offered to the general public will provide unnecessary incentives to litigators, potentially subjecting insurers to costly and unmeritorious litigation.

- MCAS data collection is just the start of a regulator’s interaction with an insurer, and it is not conclusive in the same way one might treat, for example, complaint ratios.

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3 NAIC amicus curiae brief submitted in the case of State ex rel. The Plain Dealer v. Ohio Department of Insurance. 687 N.E. 2d 661 (Ohio 1997). NAIC in its White Paper notes that, although the court ruled for The Plain Dealer on other grounds, “the Ohio court seemed to accept the NAIC’s reasoning.” NAIC has since incorporated its conclusions in its administrative and interpretive materials.
Concerns regarding Insurance Supervisors

Widening access to MCAS data under a collection method other than that of an examination will usurp the authority of insurance supervisors and undermine their ability to regulate consistently, comprehensively, and effectively. Among these concerns are:

- If faced with a challenge to wider public availability, identifying materially identical, confidential information as being something else has the potential to be counterproductive.
- Widening public availability will lead to over-enforcement. Consumers will consider only the personal costs and benefits of MCAS data. Insurance supervisors, by contrast, must consider the impact of MCAS data to the public at large within their comprehensive assessment of insurer vitality and overall regulatory compliance.
- A consumer may be less sensitive than an insurance supervisor to the economic and social consequences of MCAS data, diminishing the legislatively-derived authority of the insurance supervisor to balance private and public concerns by identifying appropriate levels of review and enforcement on a company-specific basis.

***

Thank you again for the opportunity to submit comments on this important matter. Please let me know if you have any questions or need additional information.

Sincerely,

[Signature]

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From: Mitchell, Martin [mailto:mmitchell@ahip.org]
Sent: Friday, July 25, 2014 9:22 AM
To: Ewing, Ginny M.
Cc: Mitchell, Martin
Subject: AHIP Comments on 2014 MISTF Charges Regarding Wider Accessibility of NAIC Market Regulation Data

VIA E:MAIL

Market Information Systems (D) Task Force
National Association of Insurance Commissioners (NAIC)

C/O Ms. Ginny Ewing
Sr. Manager, Information Systems
Market Information Systems (D) Task Force Staff Support

Re: 2014 MISTF Charges Regarding Wider Accessibility of NAIC Market Regulation Data

July 25, 2014

Dear Ms. Ewing:

I write in response to the NAIC Market Information Systems (D) Task Force (the Task Force) notice soliciting comments addressing the following 2014 Task Force charges, on behalf of AHIP and its member plans. Our comments are in reference to these charges:

- Develop a plan for making more widely available the public data collected in the NAIC Market Information Systems.
- Evaluate all data currently collected in the NAIC Market Information Systems and considered confidential to determine what, if any, can be made more widely available.

As we understand these charges, as requested by NAIC funded consumer representatives, that the Market Regulation and Consumer Affairs (D) Committee direct the NAIC to provide the public with broader access to market regulation information held by the NAIC to assist consumers in evaluating insurance carriers and their products before purchasing coverage. As the NAIC is not a regulatory agency, this data, held by the NAIC (and best exemplified by the Market Conduct Annual Statement data) has been provided by insurance carriers pursuant to state law for the purpose of facilitating state focused market analysis and regulation. The data has not been provided to the NAIC for the general purpose of consumer education or for the specific purpose of assisting consumers in the evaluation or purchase of insurance products.

AHIP and its members are committed to furthering consumer insurance education; our own health literacy efforts and those of our members date back more than ten years are evidence of that. Our experience has shown that merely providing consumers with data does not necessarily equate to providing consumers with actionable information to assist them in the evaluation and purchase of insurance coverage, and merely providing consumers with data is no substitute for educating consumers about health insurance issues so that they can use data.

This conclusion is illustrated in the consumer issues seen in the health insurance marketplace, and where the Market Analysis Procedures Working Group (MAP) is today struggling with issues surrounding modernizing health insurance marketplace analysis and market conduct regulation. Having concluded that the current tools, and by inference the current data set, is inadequate to regulate the health insurance marketplace in light of the passage of the Affordable Care Act, MAP is conducting a fundamental reassessment of its health insurance protocols and processes.

If the tools and data are inadequate for the regulatory purposes for which they were originally designed, we question how consumers can benefit from this data. Even if the health insurance marketplace regulatory protocols and processes for the
post-ACA marketplace were adequate for market regulation purposes, we still ask if the data held by the NAIC could really provide actionable information for consumers. Thus we recommend that the Task Force, and perhaps the D Committee, should first determine whether or not the data held is appropriate for public use by consumers before it launches into a project to determine how to release the data.

AHIP's health plan members are not yet subject to the Market Conduct Annual Statement (MCAS) process, which may be a key driver behind these charges. However, we join others in asking whether the NAIC has the legal authority to publically release any market regulation data supplied by carriers pursuant to specific state law, controlled by state law, and provided to the NAIC pursuant to written agreements with state regulators.
July 16, 2014

VIA EMAIL

Commissioner Mike Kreidler (WA), Chair
NAIC Market Information Systems (D) Task Force

Ms. Ginny Ewing
Sr. Manager, Information Systems

NAIC Central Office
1100 Walnut, Suite 1500
Kansas City, MO 64106-2197

RE: Request for Comments on Public Access to Data Collected in the NAIC Market Information Systems

Dear Commissioner Kreidler and Ms. Ewing:

The American Insurance Association (AIA) writes in response to the call for comments on the 2014 Market Information Systems (D) Task Force charges to (1) develop a plan for making more widely available the public data collected in the NAIC Market Information Systems and (2) evaluate all data currently collected in the NAIC Market Information Systems and considered confidential to determine what, if any, can be made more widely available. AIA represents approximately 300 major U.S. insurance companies that provide all lines of property-casualty insurance to U.S. consumers and businesses, writing nearly $117 billion annually in premiums. Our membership includes U.S. insurers that write insurance only within the U.S., U.S. insurers that write insurance inside and outside the U.S., and the U.S. subsidiaries of multi-national insurers. Thank you for this opportunity.

AIA’s concerns lie with the second of the two charges – “evaluate all data currently collected in the NAIC Market Information Systems and considered confidential to determine what, if any, can be made more widely available.” We believe this is not necessarily a difficult undertaking. States have varying laws with regard to the confidentiality of information collected via market analysis. As this charge contemplates treatment of data from ALL states that is contained within the Market Information Systems, it would follow that unless ALL states’ laws allow for the public release of data, the NAIC should not be considering allowing for public access through a centralized portal. To contemplate otherwise would be a costly and complicated exercise for the organization. Consider the time and monitoring necessary to ensure that each state’s specific confidentiality laws were being adhered to for each individual piece of data currently collected.
The data collected through the Market Conduct Annual Statement (MCAS) often comes up in discussions of what should be made public. This is a perfect example of data that the NAIC is not in a position to arbitrarily open up to public access. Setting aside arguments about inevitable misinterpretation of raw data were it to be made publicly available without accompanying analysis and context and the original intent of MCAS, which was only as a tool for regulators to determine whether further analysis of a company may be necessary, there are states that provide specific confidentiality protections for MCAS data in their statutes. Washington provides that “[a]ll data and documents … obtained by or disclosed to the commissioner … or obtained by the NAIC as a result of any of the provisions of [the Washington Market Conduct Oversight Law (under which MCAS is collected)], to the extent the documents are in the possession of the commissioner or the NAIC, shall be confidential by law” (Wash. Rev. Code § 48.37.080). Louisiana states that “market conduct annual statement information … shall be given confidential treatment” and may be shared with the NAIC if the NAIC “agrees to maintain the confidentiality of [the information] which [is] confidential under the laws of [Louisiana]” (La. Rev. Stat. Ann. § 22:1984). These are just two examples of many state statutes protecting the confidentiality of MCAS data, but it should not require more than one to end any discussion about making MCAS data universally available through the NAIC Market Information Systems.

Because of the variation in state confidentiality laws pertaining to the various data captured in the Market Information Systems, AIA suggests that any confidential information currently contained therein and collected and stored there in the future remain inaccessible to the public through any NAIC interface.

* * * * *

Again, AIA appreciates the opportunity to comment on the 2014 Task Force charges related to public data access and looks forward to continuing to collaborate with the Task Force going forward.

Respectfully submitted,

Lisa Brown
Sr. Counsel & Director, Compliance Resources

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Hello Ginny:

You requested comments for the 2014 Task Force charges. The District of Columbia’s suggestions follow:

The Market Information Systems (D) Task Force (MISTF) requests suggestions to address the following 2014 Task Force charges:

- Develop a plan for making more widely available the public data collected in the NAIC Market Information Systems.

**DISB Reply:**

*Develop report templates that can be accessed and used by consumers to enter the name of an insurance company and extract relevant (but not necessarily all) data from the Complaint Data System CDS, Market Analysis Review System (MARS) and the Market Conduct Annual Statement (MCAS).*

Evaluate all data currently collected in the NAIC Market Information Systems and considered confidential to determine what, if any, can be made more widely available.

**DISB Reply:**

*Continue legal review by NAIC staff to determine what information can be disclosed. Another approach would be to develop the template suggested above listing all information that might be useful to consumers, then ask NAIC staff to determine if those data points can be disclosed to the public. This approach would limit the data that NAIC staff would be required to review.*

During the Spring National Meeting, the following suggestions were made to the Task Force:

1. Use another means besides a state’s market conduct authority to gather Market Conduct Annual Statement (MCAS) data so that the data may be made public.

   **DISB Reply:**
   
   *Any approach that expands the volume of meaningful information that can be made publicly available is useful.*

2. Develop metrics for MCAS data that will assist consumers in making decisions about their insurance and insurance company.

   **DISB Reply:**
   
   *This is consistent with DISB’s reply to the first bullet above. By establishing metrics, presumable meaning data points that would be useful for a consumer to consider in evaluating an insurance company, the work required by NAIC staff to evaluate whether that information can be legally disclosed will be reduced, hopefully allowing a quicker availability of the information to consumers.*
3. Determine the best method to present data so that the results reflect the marketplace, such as by group code instead of individual company code.

DISB Reply:

The NAIC consumer representatives could assist in reviewing the types of data that is being considered for presentation in a consumer reporting format. They might be useful in evaluating both proposed information and presentation formats and ultimately the may wish to make a final determination or suggest focus groups be formed to assist in evaluating the information and presentation format.

Lee Backus, Director
Compliance Analysis Division
Department of Insurance, Securities and Banking
202-442-7812
July 25, 2014

Commissioner Mike Kreidler (WA), Chair  
Market Information Systems (D) Task Force  
National Association of Insurance Commissioners  
1100 Walnut, Suite 1500  
Kansas City, MO 64106-2197  
Attn: Ginny Ewing  
VIA EMAIL to gewing@naic.org  

Re: Charges Related to Making Market Information Systems Data Widely Available

Dear Commissioner Kreidler:

The following comments are submitted on behalf of the member companies of the National Association of Mutual Insurance Companies (NAMIC). NAMIC is the largest property/casualty insurance trade association in the country, serving regional and local mutual insurance companies on main streets across America as well as many of the country’s largest national insurers. 1,400 member companies serve more than 135 million auto, home and business policyholders, and write more than $196 billion in annual premiums. The following comments are submitted in response to the request for comments offering suggestions to address the Task Force’s following charges:

- Develop a plan for making more widely available the public data collected in the NAIC Market Information Systems.
- Evaluate all data currently collected in the NAIC Market Information Systems and considered confidential to determine what, if any, can be made more widely available.

Further, these comments are responsive to the following suggestions cited in the request for comments, described as having been made at the Spring NAIC National meeting:

1. Use another means besides a state’s market conduct authority to gather Market Conduct Annual Statement (MCAS) data so that the data may be made public.
2. Develop metrics for MCAS data that will assist consumers in making decisions about their insurance and insurance company.
3. Determine the best method to present data so that the results reflect the marketplace, such as by group code instead of individual company code.
As an initial matter, we would observe that the charges as written are not objectionable. If information is public then we do not see a problem with making it widely available. However, it is not clear what the fundamental objectives of the charges are. In other words, we are not aware of what sort of problem is meant to be solved or what sort of benefit is to be gained by pursuing either charge, and we would urge the Task Force to consider and identify such in order to guide its work. Doing so would provide guidance to interested parties on what sort of suggestions to offer to achieve the charges’ goals.

Meanwhile, we do have significant concerns about the suggestions provided and cited in the request for comment, as discussed below.

In our view, the first suggestion, to use another means besides a state’s market conduct authority to gather MCAS data so that the data may be made public, is based on a fundamental misunderstanding about the function of MCAS and the data provided. As you know, MCAS is a regulatory tool designed to provide regulators with a means of conducting market analysis in an efficient and comprehensive manner. The nature of MCAS data is such that it simply should not be made public, regardless of what means are used to collect it. Consequently, it would be misguided to pursue using other means besides market conduct authority to gather the data so that it can be made public.

The second cited suggestion, to develop metrics for MCAS data that will assist consumers in making decisions about their insurance and insurance company, suffers from being based on the same flawed misconception as the first. MCAS information was never intended to be used by consumers in the manner suggested. An MCAS filing represents the start of a conversation between a company and the regulator rather than a finalized report that is appropriate for public consumption. In our view, MCAS data is inherently subject to misinterpretation by parties other than the regulator and should never be made public.

We also note as a general matter that where the first two suggestions anticipate publicizing information that is not currently public information they both exceed the scope of the charges.

To the extent that the third suggestion relates only to the other two we would refer to the comments above. Generally, however, we have no objection to public information being provided at the group level.

From prior proceedings we understood that the cited charges were at least partially being addressed with the addition of a link to the existing NAIC Consumer Information System web page that would bring the user to an interactive map of the United States where the user could click on an individual state to link to individual state’s insurance department sites where enforcement actions or completed market conduct exams are listed. In our
view this is an appropriate means of making public market regulation information more accessible.

We appreciate the opportunity to provide these comments and we look forward to continued interaction with the Task Force as it works on market regulation information issues.

Sincerely,

Paul Tetrault, JD, CPCU, ARM, AIM
State & Policy Affairs Counsel
(978) 969-1046
ptetrault@namic.org

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MARKET INFORMATION SYSTEMS (D) TASK FORCE

2015 Proposed Charges

The mission of the Market Information Systems (D) Task Force is to provide business expertise regarding the desired functionality of the NAIC Market Information Systems and to prioritize regulatory requests for the development and enhancements of the NAIC Market Information Systems.

Ongoing Support of NAIC Programs, Products or Services:

1. Complete implementation of the State Survey Project Action Plan, which includes making changes to the market systems to be consistent with the strategic direction set forth by the Market Regulation and Consumer Affairs (D) Committee. Once completed, monitor state data entry to the NAIC Market Information Systems in order to evaluate the impact of the system enhancements. The Market Information Systems include: 1) Complaint Database System (CDS); 2) Electronic Forums; 3) Examination Tracking System (ETS); 4) Market Analysis Prioritization Tool (MAPT); 5) Market Analysis Review System (MARS); 6) Market Conduct Annual Statement (MCAS); 7) Market Initiatives Tracking System (MITS); 8) Regulatory Information Retrieval System (RIRS); and 9) Special Activities Database (SAD) (in conjunction with the Antifraud (D) Task Force).—Essential

2. Appoint a Regulatory Information Retrieval System (D) Subgroup to review the coding structure for the NAIC Regulatory Information Retrieval System (RIRS) and provide recommended changes to the coding structure.—Important

3. Appoint a Market Information Systems Research and Development (D) Working Group to review and prioritize submitted Uniform System Enhancement Request (USER) forms to ensure an efficient use of available NAIC staffing and resources.—Essential

4. Develop a plan for making public data collected in the NAIC Market Information Systems more meaningful and widely available.—Important

5. Evaluate all data currently collected in the NAIC Market Information Systems and considered confidential to determine what, if any, can be made more widely available.—Important

6. Analyze the data in the NAIC Market Information Systems. If needed, recommend methods to ensure better data quality.—Important

7. Determine how to effectively provide state users query access to NAIC Market Information Systems data.—Important