Best Practices Organizations White Paper
BEST PRACTICES ORGANIZATIONS
WHITE PAPER

Prepared by the

Insurance Marketplace Standards Working Group
of the Life Insurance and Annuities (A) Committee

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I. Introduction

The Insurance Marketplace Standards Working Group has been given a charge to “conduct an analysis of standards established by best practices organizations to determine what recognition, if any, such best practices organizations should be given in the development of regulatory requirements for life insurance and annuity products.” The working group began by hearing from existing organizations about their mission, governance, and standards. In order to flesh out the issues, the group decided to develop a white paper analyzing the standards regulators should expect to find in a best practices organization. The white paper is intended to summarize the practices of existing best practices organizations and highlight regulatory comments about issues a state may wish to review more closely before making its own decisions about how to utilize the best practices organizations in its regulatory oversight.

Information about the best practices organizations was provided by the best practices organizations themselves or found on their websites. The working group did not edit the submissions; the text reflects the opinion of the organization being described. After a report from each organization on the various topics, regulators respond.

II. Highlights of the Best Practices Organizations Reviewed

A. URAC

URAC (also known as the American Accreditation HealthCare Commission) was founded in 1990 as the Utilization Review Accreditation Commission. URAC is an Internal Revenue Code (IRC) § 501(c)(3) organization that has issued over 2,700 accreditation certificates to more than 500 health, managed care, and workers’ compensation companies. Thirty-four states and the District of Columbia recognize URAC’s accreditation programs and standards through statutes, regulations, agency publications, contracts, etc. In addition, several federal government agencies recognize URAC’s standards and programs—the Office of Personnel Management for purposes of the Federal Employees Health Benefits (FEHB) Program, the Department of Veterans Affairs (VA) for the VA’s health care advice and information services, specifically the telephone care centers and operations in the 22 Veterans Integrated Service Networks; and TRICARE requires the networks that provide medical services to obtain accreditation. URAC expects to receive approval from the Centers for Medicare and Medicaid Services (formerly the Health Care Finance Administration) for “deeming for the Medicare+Choice program.

URAC is a public organization with corporate members that include the NAIC, the United Auto Workers, the National Association of Manufacturers, and the American Medical Association. URAC has about 35 full-time staff and relies on hundreds of volunteers who serve on committees that develop standards, make decisions on accreditation, and provide guidance to the organization. URAC strives to be accountable to regulators and encourages regulators to audit its standards and observe its review process. URAC started operations with only a health utilization management accreditation program. In the intervening years, URAC has added a variety of accreditation and certification programs. At present, URAC offers about 20 accreditation programs, including standards for health maintenance organizations and preferred provider organizations, workers’ compensation organizations and functions, case management, disease management, and health website accreditation. About half of URAC’s programs are similar to those offered by the other national accreditation bodies, but URAC also offers a number of unique accreditation programs. Some states preclude an organization
from doing business unless it has been URAC accredited, but most states that recognize accreditation use URAC accreditation as one alternative method of licensing, registration, or quality assurance.

Regulators can obtain much of the information that URAC finds in an examination. Companies are told this at the beginning of the process. The accreditation standards are carefully developed through an open process that involves participation by representatives of all of the stakeholders interested in our health care system and includes a public comment period. URAC tries to stay on the cutting edge of health care methodology. URAC works for consistency in its review process and conducts an onsite examination of all companies (except for some health web sites) seeking to become accredited. Eighty percent of organizations that apply for accreditation are accredited. There is a certain degree of self-selection at work: many companies that cannot or will not meet the accreditation standards do not even apply or else voluntarily withdraw from the process before being rejected. The fees charged by URAC for accreditation reviews are some of the lowest in the country for firms that offer this type of program. URAC’s fees can range depending on the type of accreditation program involved and the number of sites to be accredited. URAC sees the accreditation process as an opportunity to share best practices with the companies being evaluated. Roughly 50% of URAC’s revenue comes from accreditation fees and the other half comes from grants, educational conferences, and publications fees.

As an illustration of the development of URAC’s accreditation programs, one of the newest programs offers accreditation of health web sites providing medical information. URAC discovered that almost 70% of people who look up medical information on the Internet do not discuss that information with their doctors. As the Internet becomes an increasingly important channel for consumers to receive health information and services, there is a growing need to help consumers determine whether a web site is credible and to educate consumers on the importance of seeking certain standards for credibility. Following up on a report by Consumers Union, URAC has undertaken a consumer education initiative to help close the credibility chasm. This underscores the importance of accuracy and reliability for health web sites. Since launching this accreditation program in December 2001, URAC has accredited more than 40 web sites, including some of the nation’s largest and busiest health web sites such as WebMD, Aetna’s InteliHealth, and MEDLINEplus, run by the National Institutes of Health/National Library of Medicine. No other organization has attempted to develop an accreditation program for health web sites.

Most of URAC’s accreditation reviewers are full-time employees of URAC. Generally, the reviewers are nurses with graduate degrees in health care or health plan management. In addition, URAC uses attorneys and physicians to evaluate some functions and programs. To bring to bear particular skills or expertise, URAC will use consultant or contract reviewers. For example, URAC uses some contract reviewers on the health web site program because of a special need for specialists in information technology and medical privacy and security. URAC ensures that all of its reviewers are free from possible conflicts of interest.

Most accreditations last two years. At the end of that period, the accredited organization may seek to be reaccredited. Health web sites must seek reaccreditation every year. URAC may revoke or suspend accreditation at any point. URAC may also conduct unannounced, random visits for review.
B. National Committee on Quality Assurance (NCQA)

NCQA is a private, not-for-profit organization dedicated to improving the quality of health care nationwide. The organization is governed by a Board of Directors that includes employers, quality experts, policy makers, health plans and health care providers, consumer and labor representatives. NCQA began accrediting health plans in 1991, in response to the need for standardized, objective information about the quality of these organizations. NCQA evaluates health care in three different ways: through accreditation (a rigorous on-site review of key clinical and administrative processes); through Health Plan Employer Data and Information Set (HEDIS®), a tool used to measure performance in key areas like immunization and mammography screening; and through a comprehensive member satisfaction survey. The versatility of these performance measures allows NCQA to produce valuable information products, such as the online Health Plan Report Card and Quality Dividend Calculator, which help consumers and employers select high quality health care. Additionally, organizations that contract with NCQA-Accredited or NCQA-Certified organizations can reduce the amount of delegation oversight required for accreditation.

NCQA is the only accreditation organization to emphasize performance measurement through quantitative analysis of health outcomes among enrollees of health plans. Although participation in NCQA’s accreditation and certification programs is voluntary, more than half the nation’s HMOs currently participate. NCQA’s Managed Care Organization (MCO) accreditation program covers over 200 health plans in the nation and three quarters of all HMO enrollees nationally and almost 90 percent of all health plans measure their performance using HEDIS.

NCQA offers 15 accreditation, certification and recognition products including programs for MCOs; managed behavioral healthcare organizations (MBHO); new health plans (NHP); preferred provider organizations (PPO); disease management organizations (DM); a partnership for human research protection (PHRP); privacy certification for business associates (PCBA); credentials verification organizations (CVO); physician organization certification (POC); utilization management (UM); credentialing (CR) certification, and physician recognition programs for diabetes, heart/stroke and provider organization office management. Additionally, the U.S. Department of Veterans Affairs (VA) has awarded a contract to NCQA to operate an accreditation program to ensure that VA medical centers are complying with VA and other relevant federal regulations designed to protect human subjects of research.

In addition to NCQA’s longstanding relationship with employers and consumer groups in furthering the health care quality agenda, NCQA has established partnerships and collaborative efforts with many state regulators and the federal government “to streamline regulatory oversight and improve quality review.” Currently, regulatory agencies in 26 states recognize NCQA accreditation for compliance purposes, and several more states have Medicaid agencies or state employee programs that demand or prefer health plans that are NCQA-accredited. At the federal level, the Centers for Medicare & Medicaid Services (CMS) deem NCQA Accreditation as meeting a wide array of regulatory requirements for Medicare+Choice plans. Additionally, the federal Office of Personnel Management requires participating health plans to obtain private accreditation through organizations such as NCQA.

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Both state and federal regulators actively participate in the development and ongoing review of NCQA’s programs.

NCQA’s requirements are developed with the input and support of employers, unions, health plans and consumers. For a health plan to become accredited by NCQA, it must meet certain eligibility requirements and submit relevant application documents to NCQA. The review process is rigorous, consisting of both on-and off-site evaluations conducted by teams of physicians and managed care experts. It focuses on quality assessment and improvement processes, utilization review, provider credentialing, and member rights and responsibilities. A national oversight committee of physicians analyzes the team’s findings and assigns an accreditation level based on the plan’s compliance with NCQA’s standards and their performance on HEDIS measures. In order to make sure the program remains continuous, NCQA annually reviews and revises the standards to which it holds MCOs.

In meeting its mission to improve the quality of health care everywhere, NCQA has obtained significant human resources to develop and deploy its accreditation and performance measurement tools. NCQA has over 150 employees and 160 contracting surveyors dedicated to the organization’s wide array of health care quality activities. Committees comprised of volunteers from a cross-section of various interests in the health care sector advise NCQA on standards and measurement development. NCQA’s survey teams consist of highly qualified health care professionals, headed by physicians, who scrutinize processes, policies and performance on accreditation standards.

Accreditation outcomes based on the extensive results compiled in the survey report are published on NCQA’s online health plan report card, found at www.ncqa.org. Survey reports are confidential, but are shared with state regulatory agencies under deeming circumstances or when required by law.

C. Insurance Marketplace Standards Association (IMSA)

IMSA’s mission is to promote ethical standards for individually-sold life insurance, annuity and long term care insurance products. It is an I.R.C. § 501(c)(6) organization created in 1996. The IMSA Board of Directors is comprised of chief executive officers from IMSA qualified companies as well as non-insurance industry directors. IMSA recently revised its bylaws to permit 50% of the board to be comprised of non-insurance industry directors. IMSA qualified companies are broadly diverse, representing life insurance companies of all sizes that distribute products through virtually all distribution channels (e.g., captive agents, independent agents, banks and broker-dealers) in all 50 states and the District of Columbia. IMSA has seven staff members and is based in Chevy Chase, MD. It is funded by annual fees paid by qualified companies. The annual fees range from $4,000 a year for the smallest companies to $125,000 per year, based on premium volume and asset base of the insurer. The IMSA guidelines were updated three years after they were initially developed and are expected to be updated again in 2004. IMSA standards apply to individually-sold life insurance, annuity and long-term care insurance products and also apply to some group products sold individually, such as an I.R.C. § 403(b) teacher’s annuity. Ninety-eight percent of companies eligible for renewal of their initial IMSA qualification in 2001 did so. Most companies that did not renew their initial IMSA qualification in 2001 had either merged or changed lines of business so that they were no longer covered by the IMSA standards.
Each company being evaluated selects its qualified independent assessor from a list of individuals trained by IMSA. A qualified independent assessor reviews a company’s self-assessment to determine whether the company’s policies and procedures comply with IMSA standards. The testing methods are the same ones states use in a market conduct examination. When a company is eligible to review its IMSA qualification, the qualified independent assessor determines whether the company has complied with IMSA standards over the previous three-year period. Promoting best practices through company and independent assessor training is a key philosophy of IMSA. IMSA qualified companies often do periodic self-assessments to measure their compliance throughout the three-year membership period.

D. National Association of Securities Dealers (NASD)

The overall mission of the NASD is to supervise 5,500 brokerage firms. The organization registers member firms, writes rules to govern their behavior, and examines them for compliance with NASD regulations and SEC rules. The NASD’s website includes information on how to become a member. The documentation to be submitted includes a business plan, supervisory personnel and procedures, net capital, description of capital, description of financial controls and the continuing education plan. The NASD encourages the use of its website, which is used to communicate rules changes. The NASD has a comprehensive database that the securities industry can use to search for information. The NASD system has been used as a tool to create uniformity between the state securities regulators, the NASD and the SEC. A broker conducting business must be registered with the NASD and in the states where he will do business, a broker needs a state registration. The arrangement of federal regulation and a self-regulatory organization allows for much of the work to be done without government funds with just a smaller amount of funding for government oversight. It takes advantage of industry expertise and allows for oversight and approval to any changes in the rules.

E. NAIC Accreditation Program

The NAIC’s Financial Regulations Standards Accreditation Program has been designed to review the state insurance departments’ ability to regulate for solvency. NAIC staff is responsible for administering the program, which includes the hiring of experienced professionals to perform the accreditation reviews. The team usually consists of five members, which include one lawyer, retired partners of international public accounting firms, retired regulators, and experienced insurance professionals in the industry. The majority of these professionals are licensed CPAs. The staff reviews team member resumes, performs background checks, and evaluates the conflict of interest forms team members are required to complete to assess their qualifications and independence. Currently, the NAIC utilizes four professionals as team leaders. These team leaders are responsible for ensuring the accreditation reviews are completed timely, and ultimately present a recommendation to the Financial Regulations Standards and Accreditation (F) Committee.

Staff participate in the reviews to ensure consistency from state to state and to monitor the quality of the professionals (team members) utilized; however, the NAIC staff do not participate in the scoring of a state for accreditation purposes. The accreditation team’s responsibility is to provide a recommendation on state accreditation, but the actual decision to accredit a state is made by the F Committee. The first state was accredited in 1990 and currently 49 states and
the District of Columbia are accredited. In addition to the standard accreditation reviews conducted every five years, NAIC staff perform interim annual reviews, which monitor the status of each state’s compliance with the accreditation standards during the period between accreditation reviews. If issues arise from these reviews, the F Committee chair is contacted and the committee has the option to send an accreditation team to the state to investigate the issue further.

III. Standards for “Best Practices Organizations”

A. Mission

URAC’s mission is: “To promote continuous improvement in the quality and efficiency of health care delivery by achieving a common understanding of excellence among purchasers, providers, and patients through the establishment of standards, programs of education and communication, and a process of accreditation.”

NCQA’s mission is to improve the quality of health care delivered to people everywhere. The organization’s vision is to become the most widely trusted source of information driving health care quality improvement. The following statements comprise NCQA’s official core values:

- Our passion is improving health care.
- We stand for accountability in health care.
- We empower our customers through compelling information.
- People are our most valued resource.

IMSA promotes ethical treatment in the marketplace for life insurance, annuity and long-term care insurance products by evaluating member insurers’ abilities to properly sell and service business. Its stated goal is “to promote high ethical standards for individually-sold life insurance, long term care insurance and annuity products.”

The NASD is unique among these organizations in that it possesses actual regulatory oversight duties and responsibilities granted through federal statutes. Oversight of NASD is through the Securities & Exchange Commission. Its stated goal is “to bring integrity and investor confidence to investors.”

The mission of the NAIC accreditation program is to provide a process whereby solvency regulation of multi-state insurance companies can be enhanced and adequately monitored. The accreditation process is designed to determine whether adequate laws are in place, an effective and efficient financial analysis and examination process is utilized, and the state has appropriate organizational and personnel practices.

Regulatory Comment

The mission of “best practices organizations” is generally to promote ethical conduct and adherence to best practices performance standards related to the services furnished in specific marketplaces and to measure adherence to those standards by member entities. Mission statements will vary from organization to organization, but should be consistent with the regulatory goals of the states and the objectives of the NAIC.
B. Organizational Structure and Financing

Best practices organizations generally exist as not-for-profit associations or corporations established under I.R.C. Section 501c(3) or (6). URAC is an I.R.C. Section 501c(3) nonprofit charitable organization. NCQA was incorporated in 1990 as an I.R.C. § 501(c)(3) not-for-profit corporation. IMSA was founded in 1996 and is an I.R.C. Section 501c(6) organization. The NASD is a tax-exempt organization under I.R.C. Section 501c(6). The NAIC is an I.R.C. Section 501c(3) nonprofit corporation.

Funding of best practices organizations is achieved through different means. URAC’s funding is derived from accrediting services, publications and possibly from “stakeholder” dues. NCQA funding is derived from accrediting services, publications, educational activities and grants. IMSA’s operations are funded by annual fees from member companies. The NASD’s funding is through a variety of registration and service fees, regulatory fines and member assessments. Funding for the NAIC’s accreditation program comes from the annual NAIC budget.

Regulatory Comment

The best practices organization must be free from undue influence from the industry or entities that it seeks to accredit or evaluate. While this working group recognizes that industry will likely play a role in financing the best practices organization, the best practices organization must be able to demonstrate that its financing sources do not create a significant potential for undue influence regarding the mission, structure, governance, standards, compliance review, accountability or publicity of the best practices organization. Thus, the ideal financing structure would involve a wide range of funding sources, from membership fees to educational conferences.

C. Governance

Best practices organizations are all governed by elected boards of directors (or governors in the case of NASD) whose varied membership include individuals from member entities with expertise related to the specific services associated with the particular organization.

URAC’s board is made up of 24 members representing the range of stakeholders interested in our health care system. These include those who finance and receive health care, consumers, employers, providers, health care consulting companies, pharmaceutical manufacturers, regulator, organized labor, and workers’ compensation organizations.

NCQA’s current Board of Directors is composed of 16 opinion and thought leaders from across the country drawn from a diverse pool of expertise. The board includes representation from corporations such as General Electric, consumer advocacy groups, labor and trade unions, academia, business coalitions, health plans, and independent consultants. Accredited entities constitute a small minority of representation on the board; consequently NCQA is not governed by the entities it evaluates.

IMSA’s Board of Directors is divided into three groups who are elected to three-year staggered terms. The IMSA Board of Directors is comprised primarily of chief executive officers representing a cross-section of IMSA-qualified companies as well as non-insurance industry directors but IMSA’s Bylaws permit up to 50% of the Board of Directors to be comprised of non-insurance industry directors. Currently, the IMSA Board of Directors has four non-
insurance industry directors: Professor Patricia McCoy (Insurance Law Institute, University of Connecticut Law School), Professor Jerry Rosenbloom (The Wharton School, University of Pennsylvania), David Woods, CEO of the National Association of Insurance and Financial Advisors (NAIFA) and Terri Vaughan (former NAIC President and current Iowa Insurance Commissioner).

The NASD board is comprised of 25 members overwhelmingly representing the financial services industry along with several nonfinancial service industries (e.g. Nabors Industries) and the public sector (e.g. California Public Employees Retirement System and the American Association of Individual Investors).

The NAIC is governed by its membership through the Plenary. The board of directors is the Executive Committee, with membership elected by each zone. The accreditation program is more directly under the purview of the Financial Regulation Standards and Accreditation (F) Committee, which has direct responsibility for the program.

**Regulatory Comment**

The governance of an organization is an important consideration for regulators. The board should not be vulnerable to the undue influence of those it is accrediting. Its membership should reflect the broad spectrum of disciplines, including consumer representation, which will vary based on the mission of the organization. Committees or other structures to act as sounding boards may help the best practices organization understand the public’s concerns.

Note: States should review such documents as the Sarbanes-Oxley Act also.

**D. Standards**

The composition of URAC’s Health Standards Committee reflects the broad concerns of many interested in our health system. The committee meets on a regular basis to discuss changes in the marketplace, consider legal and regulatory developments, and create new accreditation standards or revise existing standards. As appropriate, URAC will add interested parties to the Health Standards Committee, which ensures an objective, inclusive, and dynamic process. Depending on the standards under development, URAC may turn to advisory or ad hoc committees with particular knowledge or expertise to supplement the Health Standards Committee’s efforts. For example, in developing its Case Management Organization Standards, URAC included nationally-known experts in case management, behavioral and mental health, other medical specialties, workers’ compensation, etc. After completing a draft of new or revised standards, URAC holds a “public comment” period (generally 60 days). URAC conducts “beta” tests for new and substantially revised accreditation modules.

Striving for consensus, URAC develops accreditation standards through a committee process that encourages broad-based public input from hundreds of volunteers, representing a wide range of stakeholders. In addition, URAC actively solicits public comment during the standards development process and tests the standards before submitting the standards to the URAC Board of Directors for final approval.

NCQA’s standards development process is comprehensive, consensus-driven, and evidence-based. The NCQA Standards Committee, which includes representatives of purchaser groups,
regulators, consumer groups, and managed care organizations, oversees the development of the accreditation and certification standards. The Standards Committee is aided in its work by the Practicing Physician Advisory Council, the Health Care Practitioner Advisory Council, the Purchaser Advisory Council, the Public Sector Advisory Council and the Consumer Advisory Council, stakeholders who provide broad-based feedback and perspective. Additionally, the Standards Committee reviews recommendations obtained through the sixty-day public comment period.

The Committee approves all new Accreditation and Certification products, all changes to standards and scoring, provides multi-stakeholder advice to NCQA and reviews recommendations from advisory committees and staff, before making recommendations to the NCQA Board of Directors for final decisions.

In formulating new standards or revisions to existing standards, NCQA reviews scientific evidence, trends in health care policy and legislative/regulatory developments. For example, following the publication of the Institute of Medicine’s (IOM’s) Report, Crossing the Quality Chasm, NCQA incorporated many of the IOM recommendations into its programs.

NCQA reviews a plan’s quality-related systems and assesses their compliance with applicable NCQA standards. The systems and programs reviewed include:

- quality management
- utilization management
- credentialing
- member services
- preventive health.

NCQA’s assessment of compliance includes, review of written documentation and records provided by the plan; on-site observations by surveyors; surveyors obtaining information through staff interviews; credentialing file review; appeals and utilization management case review, and analysis of member service systems, including the handling of complaints and appeals, member education and member surveys.

Generally, NCQA’s accreditation and certification standards are revised annually and interim revisions are made as needed.

IMSA requires its member companies to demonstrate compliance with all IMSA standards. IMSA’s standards are embodied within its Principles and Code of Ethical Market Conduct. Compliance with IMSA’s six principles and 20 code provisions is measured through affirmative responses to 24 questions on the IMSA Assessment Questionnaire. For each Question, there are three “Aspects” which must be investigated and, for each Aspect, there are two “Components” that also must be investigated thereby requiring a company to respond affirmatively to 144 questions of compliance. Companies select “indicators” appropriate to the company’s size, organizational structure and distribution systems to demonstrate compliance with IMSA standards. A company must respond affirmatively to each Question on the IMSA Assessment Questionnaire in order to qualify for IMSA membership. IMSA standards are developed through a committee process involving member company representatives and
independent assessors. IMSA standards are updated periodically to reflect changing market conditions and other external factors.

The NASD has developed a list of criteria for evaluating an application to become a registered broker/dealer. The standards are included in Rule 1014, developed by the NASD.

The standards for NAIC accreditation are in three parts: laws and regulations, regulatory practices and procedures, and organizational and personnel practices. The standards for the NAIC program were created originally by the Financial Regulation and Accreditation Committee and are constantly reviewed and updated. New models laws and standards are often proposed to be included as accreditation standards by members of the committee or other regulators. The 13 members of the F Committee ultimately make the decision as to whether to include new standards; however, the committee will first request input from the insurance industry, other interested parties, and regulators through a rigorous public response period. The development of the standards is a continuously evolving process that adapts to the current needs of regulators. The guidelines are developed by the committee but go through the entire NAIC approval structure up to the Plenary. The standards are developed in executive session but are exposed for public comment and adopted in open session. The F Committee reviews any comment letters it receives.

**Regulatory Comment**

The standards by which entities seeking accreditation by a best practices organization are judged will generally form the foundation of the organization’s membership or accreditation requirements. Important aspects of the standards include consistency with regulatory objectives and requirements, types of standards, and method by which the standards are developed.

If a state is considering granting a best practices organization some level of recognition within its regulatory framework, a very important aspect of the standards is whether they are consistent with regulatory objectives and requirements for which recognition is being considered. In some cases, the regulatory requirements may be general and in other cases the requirements may be specific. In any event, the standards used by the organization to establish membership or accreditation should be compared to the regulatory requirements for which recognition is being considered.

With respect to the types of standards, several different approaches are possible. Standards may be “core standards” in that each standard must be met in order to achieve accreditation or membership. It is also possible that standards may be optional or only required to achieve a more specific or “higher” level of accreditation or membership. Standards may also be set such that only a certain number or percentage of the standards must be met in order to achieve accreditation or membership. Standards may vary depending on whether the entity is seeking initial accreditation of membership or seeking to renew accreditation or membership. The minimum standards that must be met to achieve and maintain accreditation or membership should comport with regulatory requirements.

The working group identified a variety of approaches to developing the standards. Standards for several organizations were developed with some mechanism for input from interested parties. One organization indicated that it “works to get input and support of many different constituencies when developing its programs” by managing several advisory councils, populated by different constituencies, to review new standards and evaluate current standards. In one case, standards were developed strictly by the Board of Directors of the organization. It is important to identify the method by which standards are developed. In
addition, regulators should determine how often standards are updated to reflect changes in the marketplace and if the process for updating the standards differs from the process used to develop the initial standards. The method for developing and updating standards should be such that the standards meet regulatory requirements for which recognition is being considered now and in the future.

E. Best Practices Organizations’ Review of Entities for Compliance with Standards

In general, URAC uses its own full-time staff to conduct accreditation reviews, but may use consultant-reviewers with special knowledge or skills or for particular purposes such as medical doctors. URAC “blinds” information about applicants until the application process is complete. Once an applicant submits a completed application form, the assigned accreditation reviewer will conduct a desktop review (DTR) of all of the materials submitted by the applicant. As needed, the reviewer may prepare a request for additional information. This request will include a description of the issue, the standard, and a recommendation to comply with the standard. The reviewer will send the request for additional information to the applicant and schedule a telephone conference to review outstanding issues. This call helps to ensure that the reviewer understands the applicant’s operations and processes and the applicant understands the intent of the standards in question. Once the applicant can demonstrate its documentation meets the intent of all of the accreditation standards, URAC will conduct an onsite review to observe the applicant’s operations and practices, sample documentation and files, interview senior management and other staff, and observe staff performing their duties.

Following the desktop and onsite reviews, and once the reviewer is satisfied that the applicant complies with all of URAC’s standards, the reviewer presents a summary to URAC’s Accreditation Committee. The Accreditation Committee makes recommendations to the Executive Committee, a subset of URAC’s Board of Directors. The Executive Committee has final authority to grant or deny accreditation. URAC grants these levels of accreditation:

*Full Accreditation.* Granted to organizations that demonstrate full compliance in operating processes in accordance with the standards. Full accreditation lasts for two years, at which time the health care organization must go through the accreditation process again.

*Conditional Accreditation.* Granted to organizations that meet most of the standards, but need some improvement before achieving full compliance. URAC requires organizations with Conditional Accreditation to follow a plan to demonstrate full compliance and move to Full Accreditation within six months.

*Provisional Accreditation.* Granted to organizations that have otherwise complied with all standards, but have not been in operation long enough (less than 12 months) to demonstrate full compliance with the standards.

*Corrective Action.* URAC will place an applicant on Corrective Action status if the applicant does not meet the standards in more than one area and requires major changes in staffing or operations (i.e., hiring and training of additional staff) to correct identified problems. An applicant must immediately discontinue the practice(s) to which URAC objected and submit a “corrective action plan.” The reviewer will conduct a follow-up review within a specified period to ensure the applicant is complying with the corrective action plan.
Denial. URAC rarely rejects an application for accreditation. Instead, URAC tries to work with an applicant at the Corrective Action stage to avoid a denial. Other applicants voluntarily decide to drop out and not pursue accreditation either because of an unwillingness or inability to comply with the accreditation standards or some other business decision.

NCQA’s review for compliance with standards consists of four phases.

Eligibility. An organization must meet certain eligibility requirements, including having a process implemented to monitor, evaluate, and improve the quality of care provided to its members; providing access to necessary clinical information for its members; providing or arranging to provide through an organized delivery system to enrolled members defined benefits package, including adult medical and surgical; pediatric medical and surgical; obstetrics; mental health; and preventative health services; and services in a setting that includes ambulatory and inpatient sites. In addition, the organization must be in operation for at least 18 months, must be located within the U.S. or one of its territories; must be in compliance with applicable federal, state, and local laws and regulations, including requirements for licensure; and must operate without discrimination on the basis of sex, race, creed, or national origin.

Application Process. An organization that meets the eligibility requirements begins its process for accreditation by submitting a signed Application for Accreditation Survey, a signed NCQA contract, an application and pre-assessment fee. Application materials are readily available on NCQA's web site at: www.ncqa.org.

Survey Process. An organization and NCQA schedule a mutually agreeable date for the survey after NCQA receives the organization’s completed application materials.

Six months prior to the scheduled survey, NCQA assigns internal staff and a survey team to the review. The size and composition of the survey team varies, depending on the complexity of the organization. At a minimum, a survey team includes one physician surveyor and one administrative surveyor. Surveyors typically have experience in and responsibility for quality management in their own organizations. Many are medical directors and are either senior clinicians or senior administrators. All surveyors complete a surveyor training program. NCQA ensures that surveyors have no direct financial relationship with the organization under review.

Also during this period, NCQA requires the organization to submit critical information about the organization, including an overview of the organization’s size, scope, structure, and operations. During this preassessment process, NCQA and the applicant exchange information, and NCQA staff and surveyors use the disclosures to prepare for the onsite review.

NCQA conducts an on-site survey to evaluate all requested product lines/products against the accreditation standards. A site visit generally spans two to four days.

If NCQA finds that an aspect of an MCO’s operations may adversely affect the health and safety of members, the findings may be considered by NCQA for accreditation purposes, even if NCQA standards do not specifically address such operations.

If NCQA identifies any condition that poses a potential threat to the health or safety of members or patients, the findings may be relayed immediately to the MCO’s chief executive officer; to the vice president, product delivery; and to the president of NCQA. However, even
when an MCO is not provided immediate notice from NCQA of a condition posing a health or safety threat, NCQA may consider and assess the condition in its subsequent decision to determine accreditation. To maintain accreditation, MCOs must undergo a survey at least every 3 years (36 months) against the standards in effect at the time of the survey. Depending upon performance and other circumstances, additional on-site surveys may be necessary.

Upon completing an on-site survey, the survey team conducts a summation conference with individuals selected by the organization. During the conference, the survey team summarizes its preliminary findings regarding the organization’s quality-related systems. The team does not make a determination regarding the organization’s compliance or provide conclusions regarding MCO accreditation status.

In the post-survey phase, surveyors produce a report that is reviewed by staff and submitted to the organization for comment. In arriving at an organization’s final accreditation outcome, NCQA combines the results of the survey against standards with the HEDIS results. NCQA incorporates into the preliminary report any relevant changes and additional information submitted by the organization during the comment period.

The report is then submitted to the Review Oversight Committee (ROC), an independent review committee consisting of physicians external to NCQA. For each survey, NCQA ensures that no ROC member involved in the decision has a conflict of interest. The ROC utilizes NCQA’s scoring guidelines to determine an accreditation outcome.

In the accreditation program, status outcomes include:

- Excellent
- Commendable
- Accredited
- Provisionally Accredited
- Denied

NCQA recalculate each organization’s accreditation status annually, based on its HEDIS results for that year.

IMSA relies upon qualified independent assessors to determine whether companies have complied with IMSA standards in order to qualify for IMSA membership. Qualified independent assessors often work in conjunction with associate assessors who are permitted to provide solely objective support services during the independent assessment process. Qualified independent assessors and associate assessors represent a variety of different practice disciplines including accountants, lawyers, and independent consultants. All qualified independent assessors and associate assessors must meet specific qualification standards, agree to abide by IMSA’s independence standard, continuing education and other requirements and attend IMSA training in order to be approved to perform independent assessment activities on behalf of IMSA.

In order to qualify for IMSA membership, a company must perform a self-assessment of its own policies and procedures to determine whether their policies, procedures and practices are reasonably designed to comply with IMSA standards. Thereafter, the company engages a qualified independent assessor to conduct an independent assessment to determine whether
the company can demonstrate compliance with IMSA standards. A prospective member company seeking IMSA qualification must select an IMSA-approved qualified independent assessor to conduct the independent assessment analysis necessary to attain IMSA membership. The prospective member company then engages and pays the qualified independent assessor to conduct the independent assessment analysis.

The heart of the independent assessment analysis lies in a prospective member company's ability to provide evidence to support the aspects and components necessary to respond affirmatively to each question on IMSA's assessment questionnaire. Each question on the assessment questionnaire encompasses categories of subquestions. IMSA refers to these categories as "aspects" and "components" of each question. The three "aspects" of each question in the assessment questionnaire are as follows: approach, deployment and monitoring.

Each aspect has two components. In order to respond affirmatively to any given question on the assessment questionnaire, a company must be able to demonstrate an affirmative response to all three aspects of the question and their related components. These three aspects and the two components of each aspect, which apply to every question, are:

1. **Approach.**
   - Does the company have in place policies and procedures that address the objective of the question?
   - Is someone (individual or team) responsible for establishing, maintaining, communicating, using, and monitoring these policies and procedures and acting upon the results of such monitoring?

2. **Deployment.**
   - Are these policies and procedures communicated?
   - Does the company consistently use these policies and procedures?

3. **Monitoring.**
   - Does the company routinely monitor the operation of these policies and procedures with a view toward achieving the intended result?
   - Does the company act upon the information received?

The self and independent assessment processes are based on IMSA's *Principles and Code* and evaluates the company’s ability to respond affirmatively to each of the questions in the assessment questionnaire. As part of the self-assessment, the company must demonstrate compliance by gathering sufficient evidence to support its affirmative response to each question. The qualified independent assessor will review and, as appropriate, test the company’s responses and supporting evidence to determine if there is a valid basis for the representations. The testing is based upon the indicators selected by the prospective member company and the evidence used to support the prospective member company's affirmative response to an applicable question.
Qualified independent assessors may evaluate a prospective member company's compliance with IMSA standards using a variety of testing methods. There are five major testing methods:

- Documentation Review;
- Interview/Field Validation;
- Direct Observation;
- Sampling; and
- Surveys.

More detailed information concerning the actual test steps and sampling techniques required for the independent assessment analysis is outlined within the IMSA Independent Assessment Manual which can be found on the general section of IMSA's web site located at www.IMSAethics.org. The independent assessment process is designed to allow the qualified independent assessor to gain reasonable assurance that the prospective member company's policies and procedures comply with the Principles and Code. IMSA qualification is granted for a three-year period and must be renewed by requiring the company to undergo both the self and independent assessment processes every three years thereafter.

The NASD staff conducts a review of the entity seeking membership. The technique used is an interview. In order to evaluate the entity’s ability to comply with NASD rules, the NASD also looks to see if any prior actions have been taken against the entity. If the entity meets the standards, it must be approved.

An independent team of professionals paid by the NAIC conduct the NAIC accreditation reviews. NAIC staff chooses the team after review of the applicants’ credentials. The team reports to the F Committee with a recommendation as to whether the state should be accredited and the final decision on accreditation is made by the members of the committee. The accreditation is for a period of five years. An interim annual review is done by NAIC staff and, if any problems are noted, an on-site review can be scheduled. A state could lose its accredited status if the results of the review warrant it.

**Regulatory Comment**

Organizations will have a method for determining whether the entity seeking accreditation or membership complies with the standards for accreditation or membership. Organizations generally perform a “desk top” review followed up with a more rigorous “on-site” review. The evaluation should include both an assessment of the procedures in place to achieve the standard as well as a review of whether the company is actually following the procedures. In some cases, a best practices organization may test actual outcomes of the procedures under review.

Organizations generally use individual “reviewers” or a “review team” to evaluate whether entities seeking accreditation or membership meet the requisite standards. Reviewers should be required to have appropriate experience and qualifications and to not have a conflict of interest with the entity being evaluated. Reviewers also should be able to demonstrate to regulators that they have adequate training.

Methods for selecting and compensating reviewers vary. In some cases, the reviewers are employees of the best practices organization. In other cases, the reviewers are independent contractors. IMSA permits the reviewer to be selected by the entity being accredited from a list of approved reviewers. The method...
for selecting and compensating reviewers should be such that it does not introduce bias into the evaluation process.

The frequency of review varies by organization. Some organizations require an annual accreditation or membership renewal. Other organizations require renewal every two or three years. The frequency of review should be such that regulatory requirements are satisfied. In addition, the process should be such that the level of scrutiny upon renewal is at least as rigorous as the level of scrutiny of the initial review.

F. Accountability

URAC’s Board of Directors, which represents a wide range of stakeholders, including consumers, providers, purchasers, and regulators (for example, the NAIC has long had a representative on URAC’s Board), exercises authority over the accreditation and other programs. Further, a number of states and several federal agencies explicitly incorporate URAC’s accreditation standards or programs in their regulatory oversight and processes. There are many other states that may not mandate or require URAC accreditation, but have relied on URAC’s standards for developing their own regulatory requirements.

NCQA is accountable primarily to its Board of Directors, which is comprised of representation from diverse constituencies including unions, consumer groups, private non-health related companies, educational institutions and health plans. The Board meets four times a year and plays a key role in setting NCQA’s agenda and defining the scope and content of its various evaluative programs. The board also helps to ensure the successful introduction of new NCQA evaluative programs into the market.

In addition to its Board of Directors, NCQA has demonstrated its transparency and responsiveness to various stakeholders by incorporating several standing advisory committees in its decision making process. One such advisory committee, the Public Sector Advisory Council, is chaired by a senior NAIC staff member and includes several federal and state regulators. Several federal and state regulatory agencies have relied on NCQA standards in developing their own regulatory requirements. NCQA has established strong cooperative relationships with regulators and has provided them with technical expertise to facilitate collaborative initiatives. NCQA’s observer policy allows regulators to attend on-site surveys of health plans, thereby establishing a stronger comfort level for regulators with NCQA processes. NCQA has incorporated into its accreditation programs regulatory requirements, such as complaint and appeal timeframes. NCQA’s Public Sector Advisory Council provides the organization with broad guidance on the regulatory import of accreditation activities.

IMSA is accountable to its Board of Directors and its qualified companies. The IMSA Board of Directors is comprised of life insurance company chief executive officers as well as independent directors representing interests from outside of the life insurance industry. IMSA has approximately 200 member companies representing nearly 65% overall market share for individually-sold life insurance, annuities and long-term care insurance products. These qualified companies are accountable, in turn, to qualified independent assessors who conduct an independent assessment every three years to determine whether a company complies with IMSA standards. Qualified independent assessors are accountable to IMSA to the extent they review a prospective member company’s qualifications for IMSA membership. Any modifications to IMSA standards undergo a thorough review by qualified companies, qualified
independent assessors and the IMSA Board of Directors prior to approval. IMSA standards are reviewed, updated and revised as necessary to reflect changing market conditions.

The NASD is accountable to the SEC for its decisions and procedures.

The NAIC membership has ultimate authority over the Financial Regulation Standards and Accreditation Committee and votes on adoption of all of its standards and procedures. The General Accounting Office (GAO) has also reviewed the NAIC program.

**Regulatory Comment**

As a practical matter, the most compelling arguments for NAIC recognition of best practices organizations are those best practices organizations that engage in activity that closely parallels regulatory functions. To be eligible for regulatory recognition, a measure of accountability from the best practices organizations would be necessary.

1) **Best practices organizations accountability to states.** Periodic audits by the NAIC and/or states would reassure regulators that the best practices organizations continue to operate effectively and objectively. The granting of recognition should be conditioned upon free access to information, including statistical results, manuals, organizational charts, etc., of the best practices organizations. It seems appropriate to take that position until a compelling case to the contrary is demonstrated.

In order to determine accountability to the states, the question of whether a recognized best practices organization should be required to report violation of law by the entities it reviews also arises. On the surface, there are obvious regulatory and enforcement efficiencies gained by such a requirement. A large number of best practices organizations all reporting insurance law violations could have a multiplier effect upon regulators’ current examination activities.

However, several practical considerations may reduce the likelihood that such a state of affairs would ever develop. One is that entities may be reluctant to use the services of a best practices organization if doing so adds to or hastens their exposure to regulatory sanction or legal liability for past conduct. In addition, a violation-reporting obligation may do more than merely reduce the entity’s overall interaction with best practices organizations. It could have the unfortunate result of reducing most sharply the use of best practices organizations by the entities that need it most: those whose current and past regulatory compliance are most problematic. This is exactly the subset of entities who should be encouraged to commission best practice reviews. A violation-reporting obligation seems likely to discourage this beneficial activity.

Regulators should expect that best practices organizations will seek to avoid being put in this position. Further, best practices organizations may be less confident that entities are providing them with information that is as complete and accurate as it would be if the best practices organization had no violation reporting obligation. The experience of the legal profession may be instructive here in that lawyers and courts have long been convinced that clients give their counselors more information if clients are confident that counselors will not disclose sensitive information to others, including courts and regulators. Clients benefit from that arrangement because by giving their counselors more information, their counselors can give the clients better advice. If the same dynamic would operate in the area of best practices consulting and other services to insurance entities, that seems like a powerful reason not to require best practices organizations to report insurance law violations by their clients. We might also note that when entities get better advice or services from best practices organizations as a
result of a freer flow of information, then the public is in a position to benefit from that improvement as well.

The organizations themselves are likely to have additional reasons for wanting to be free of such an obligation. One is that the organizations may be concerned about the performance standard they will be expected to meet in identifying violations and whether they might be held liable for their failure to uncover violations. In addition, characterization of a set of facts as constituting a violation of law can sometimes be more a matter of legal analysis calling for a professional’s judgment about an array of gray circumstances rather than a clear cut identification of black and white instances of compliance and non-compliance.

2) **Accredited entities accountability to best practices organizations**. The length of time between accreditation and re-accreditation of entities varies between current best practices organizations. Some form of monitoring of those entities may be necessary to ensure continued adherence to the principles, standards, etc. of those best practices organizations during that period of accreditation. This form of monitoring could entail targeted or full audits or examinations, status reporting, etc.

3) **Accredited entities accountability to states**. Entities reviewed by a best practices organization should have to share information with insurance regulators about the best practices review, especially the outcome of any adverse report or audit. The laws of many states entitle a regulator to virtually all information the regulated entity possesses or controls that is relevant to the regulator’s duty to enforce the insurance laws. Since the accreditation process may be a substitute for regulatory requirements, accountability is important.

It is fairly clear why entities would not welcome the imposition of a violation reporting duty upon best practices organizations themselves. Regardless, the duty to report any adverse findings should be the responsibility of the regulated entity. Any adverse finding could be presented to the domestic regulator along with a corrective action plan, if necessary. This would give the regulator the option of conducting its own review to ensure compliance with the laws and holding the entity accountable for any violations.

G. **Publication**

URAC frequently revises the information on its web site (www.urac.org) about all accredited organizations and publishes (and distributes for free to state insurance departments and other regulatory agencies) an annual directory (i.e., *URAC’s Directory of Accredited Organizations: 2003 Edition*). In addition, URAC will respond directly to all requests from consumers and regulators regarding details of an accredited company’s status.

After NCQA conducts a survey, it reports to the accredited organization and to the public. Annually, NCQA reviews an organization's HEDIS results, reassesses the accreditation status for each product line, and reports the results to the plan and the public.

On its website, NCQA provides the public, free of charge, with health plan report cards that rate the performance of accredited entities based on five reporting categories. NCQA produces the State of Health Care Quality report, which releases annual aggregate results of health plan performance nationwide on HEDIS clinical outcomes measures.
NCQA survey reports compiled for accreditation purposes are confidential and are between NCQA and the organization. NCQA does not release confidential information prepared during the accreditation process to any third party, except:

- with prior written authorization from the organization
- as otherwise required by law or regulation, including state regulators obligated to review the reports for regulatory deeming of NCQA accreditation, or
- as otherwise provided in the NCQA Policies and Procedures or the Contract.

Additionally, organizations may, at their discretion, release certain components of the final accreditation report to third parties (e.g., purchasers, regulators).

IMSA makes available a list of companies who have qualified for IMSA membership in the general section of IMSA’s website located at www.IMSAethics.org. IMSA also publishes on its website a list of all independent assessors who have met IMSA’s qualification standards and have been approved by IMSA to determine whether a company has attained IMSA standards. IMSA’s website contains information concerning the assessment process leading to IMSA qualification, IMSA’s Principles and Code, IMSA’s Assessment Handbook, IMSA’s Independent Assessment Manual and IMSA’s Board of Directors and officers. IMSA’s website also contains helpful links to other web sites that provide insurance-related information for consumers such as the NAIC’s website. Life insurance companies that have qualified for IMSA membership are permitted to use the IMSA logo in company publications including advertising and sales materials, annual reports and websites so consumers may know that the company is committed to IMSA’s high ethical standards.

The NASD website includes information about state-registered investment adviser firms at www.adviserinfo.sec.gov.

Outcomes of NAIC accreditation are publicly reported and available on the NAIC website. The work papers for the reviews are confidential and are destroyed immediately after the next accreditation review is conducted, which is usually every five years.

**Regulatory Comments**

1. **Access to information by regulators should include appropriate confidentiality safeguards.** Understandably, regulators may more comfortably provide compliance recognition of private accreditation in return for information on accreditation outcomes. In some circumstances, a regulator may find it necessary to review survey or audit reports produced by a best practices organization in its evaluation of an entity’s performance. In order to maintain the incentive for entities to voluntarily pursue private accreditation activities that lead to improvements in performance, regulators should provide appropriate confidentiality safeguards for the information solicited for such review. These safeguards would be consistent with the approach used by many state regulators to protect the confidentiality of sensitive financial information collected by the regulator through a financial audit.

Confidentiality safeguards do not preclude regulators from reviewing survey or audit reports for purposes of ascertaining compliance with state requirements. Moreover, state regulators always retain the discretion to pursue further investigations and make their own findings if and when necessary. Confidentiality safeguards are not anti-consumer, as confidentiality safeguards for other types of audited data are often respected by regulators in order to assure financial stability or market fairness on behalf of
consumers. States that currently require disclosure to regulators of survey reports for health plans to obtain compliance recognition of accreditation have strong protections for the confidentiality of these reports.

Some states may be sufficiently comfortable with private accreditation processes to provide some compliance benefit without direct review of survey reports or other confidential information pertaining to accreditation outcomes. Several states currently recognize accreditation for compliance purposes without soliciting survey reports.

2) Aggregate accreditation outcomes should be publicly reported and available. While specific accreditation reports should be handled confidentially, consumers have a right to know the overall outcome of an accreditation report. A best practices organization should provide at least general performance levels or ratings that designate to consumers the overall outcome of an accreditation report. Preferably, a best practices organization will also provide some specific data on outcomes in a readily reportable format, quantitative or otherwise. Reported data must also be intelligible to consumers. If applicable, best practices organizations should be encouraged to provide “report card” style data to consumers that will facilitate their ability to make wise choices in the insurance marketplace.

Regulators should recognize that reporting formats and technologies evolve with time. Various constituencies, including consumer groups, can help provide best practices organizations with feedback on how to improve reporting strategies and data sets. Best practices organizations should demonstrate to regulators their ability to consider this feedback and incorporate consumer views into the reporting process.

H. Penalties

URAC takes seriously its obligation to help promote the quality of the health care system. In response to consumer, provider, or regulatory complaints or on its own initiative, URAC may review any accredited organization. Depending on its findings, URAC may revoke or suspend accreditation and may also notify the appropriate federal and/or state regulatory or other organizations of its findings.

NCQA closely monitors the compliance of its accredited and certified organizations with NCQA standards, policies and procedures. Failure to remain in compliance may result in suspension or revocation of the accreditation status of the reviewed entity.

NCQA may recommend an immediate suspension of an accreditation status based on the following grounds:

- the organization has been placed in receivership or under rehabilitation and the outcome remains to be seen;

- a component of the organization’s system has been placed in receivership or under rehabilitation;

- NCQA is investigating improprieties in plan operations;

- state, federal or other duly authorized regulatory or judicial action restricts or limits the organization’s operations.

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After a basic investigation of the facts, the following are grounds for recommending a suspension of an accreditation status:

- circumstances or allegations have arisen within the organization that appear to place members at great risk;
- allowing the organization to carry an accreditation status during the Discretionary Review process would damage NCQA’s brand.

Because suspension of an accreditation status is temporary and is designed to allow NCQA to investigate and gather information for decision making, the reconsideration process is not available when an accreditation status has been suspended.

NCQA may recommend revocation of an accreditation status based on the following grounds:

- the organization has been placed in receivership and is being liquidated;
- results of a Discretionary Review confirm that the organization committed fraud during the accreditation survey process;
- the organization has violated NCQA’s Guidelines for Advertising and Marketing, and by doing so, has misrepresented its accreditation status;
- NCQA identifies a significant threat to patient safety or care.

In addition to reasons set forth above, NCQA may revoke an organization’s accreditation status if the organization:

- fails to comply with the Contract (including the requirement for annual reporting of HEDIS data);
- violates NCQA Guidelines for Advertising and Marketing or other published NCQA policies;
- fails to comply with recommendations or does not adequately address deficiencies set forth by NCQA in an accreditation determination;
- fails to comply with a Discretionary Review.

NCQA publicly reports any revocation of accreditation status. Because a revocation is a final action by NCQA, organizations have the opportunity to request a reconsideration of revocation of an accreditation status.

IMSA member companies must demonstrate a commitment to IMSA’s Principles and Code of Ethical Market Conduct. IMSA maintains specific procedures to permit IMSA to take appropriate action in the event a member company fails to abide by IMSA standards. Under these procedures, IMSA may conduct further inquiry regarding the circumstances pertaining to any failure to abide by IMSA standards. If the company does not verify that appropriate corrective action has been implemented, these procedures authorize IMSA to suspend or expel a member company, if warranted.
IMSA member companies undergo an independent assessment every three years to evaluate their compliance with IMSA standards. In the event a prospective member company can not demonstrate its compliance with IMSA’s Principles and Code to the satisfaction of a qualified independent assessor, the company will not qualify to renew its IMSA membership.

The NASD disciplines member firms that fail to comply with its rules. Examinations are generally the result of consumer complaints. The discipline could take the form of expulsion or suspension.

A state that no longer meets the standards of the NAIC accreditation program can lose its accredited status.

**Regulatory comment**

Best practices organizations can play a role in the regulatory environment. As they review the processes of regulated entities, they will be in a position to identify areas that may be potentially non-compliant. Their role at this point should be to report this possibility to the regulated entity and require the development and implementation of a compliance plan. The best practices organization should establish follow-up procedures to ensure that the potential violation has been corrected. At the same time, they should encourage the regulated entity to notify the appropriate regulatory agency thorough a self-reporting mechanism. The regulator should be willing to accept the self-reported non-compliance and cooperatively work with the regulated entity and the best practices organization in correcting the issue while considering an appropriate enforcement action reflecting the self-reported non-compliance. If a best practices organization is retained by a state to examine an entity’s legal compliance, compliance failures must be reported to the state, as these failures may in fact constitute violations of law.

Regulators should consider a tiered approach to penalties, with the self-reported violations being addressed with more lenient penalties. The degree of penalty should increase with the avoidance of self-reporting and the degree of work required by the regulator in the normal examination process. Best practices organizations should not be required to report potential non-compliant issues.

I. **Effectiveness**

IMSA member companies maintain policies and procedures designed to reasonably assure compliance with IMSA standards. Independent assessors review every three years objective evidence presented by the company to support their affirmative responses to a series of questions within IMSA’s Assessment Questionnaire—the tool member companies and independent assessors use to gauge compliance with IMSA standards. Independent assessors employ a variety of different testing methods to conduct their analysis. These testing methods include documentation review, interviews/field validation, direct observation, sampling and surveys.

One key objective of the independent assessment analysis is to determine whether the company’s policies and procedures are operating as intended at the point-of-sale. IMSA member companies are required to maintain a monitoring system to provide reasonable assurance that the company’s sales and marketing practices comply with IMSA’s Principles and Code of Ethical Market Conduct and applicable laws and regulations. Independent assessors perform various testing methods pertaining to the company’s monitoring system to
determine whether the company acts upon the results of information provided by the monitoring system and takes corrective action as appropriate. The monitoring system required by IMSA is designed to foster “continuous improvement” of the company’s IMSA-related policies and procedures. The monitoring system provides information to allow the company to detect isolated instances of non-compliance before they may become widespread and take appropriate corrective action, as warranted, to provide “continuous improvement” of the company’s sales and marketing practices.

The NAIC accreditation program has resulted in an increased budget for many states, with more qualified and larger numbers of examination staff. New laws have been added that enhance the ability of the state regulators to ensure company solvency. The numbers of insurer insolvencies has been reduced dramatically since the accreditation program has been in place.

**Regulatory Comment**

A fundamental requirement to any grant of recognition to a best practices organization by state insurance regulators is that the organization seeking recognition must be able to demonstrate its effectiveness to the satisfaction of state insurance regulators.

To demonstrate effectiveness, a best practices organization must meet two tests. First, the best practices organization must establish performance standards and cause its members or clients to meet those standards. Second, the best practices organization must demonstrate that its standards improve market conduct practices and ethical treatment of consumers. The first test evaluates the processes of the best practices organization while the second test measures performance in the marketplace.

To meet these tests, a best practices organization should provide to the state insurance department:

- A copy of its standards and a description of the nature, scope and timing of the periodic review of its standards;
- Information documenting whether members of the best practices organization meet and/or adhere to the organization’s standards; and
- Documentation of improved market conduct practices and ethical treatment of consumers results from members of the best practices organization meeting and/or adhering to the organization’s standards.

A regulator may use standard auditing and examination techniques to assess whether the best practices organization is effective at causing its clients or members to meet and/or adhere to the organization’s standards. The manner in which effectiveness in improving market conduct performance can be demonstrated will vary depending upon the industry characteristics the best practices organization purports to measure and what type of recognition is sought. However, the state insurance department should evaluate any information provided by the best practices organization in comparison to its own data (e.g., complaints, etc.) and other relevant market information to measure any improvement in market conduct performance.
IV. How Do State Regulators Use the Best Practices Organizations?

A. Delegation of Authority

The ability of an administrative agency to delegate functions to a private entity is limited. The general rule is that an administrative agency may delegate the performance of fact-finding duties to a private entity as long as the insurance department maintains ultimate control over duties or functions that are discretionary or quasi-judicial in nature. Market conduct examinations are fact-finding processes. Accordingly, an insurance department may delegate the performance of certain examination/audit functions to a Best Practices Organization or rely upon a compliance report generated by a BPO as an additional regulatory tool.

This practice is consistent with current financial and market conduct examination policy and procedures. In fact, market conduct examination policies and procedures already permit the consideration of internal audit, compliance and other external reports during the examination process. Internal audit and other compliance reports are already considered as a part of some market conduct examinations. Similarly, financial examination procedures provide that insurance departments may rely upon the annual independent CPA audits, opinions on insurance reserves by qualified actuaries, and annual financial statement analyses as a part of the regulatory tools available to monitor the solvency of insurers.

Most state laws authorize the commissioner to conduct examinations whenever it is deemed necessary and subject the scope of the examination to the commissioner’s discretion. The delegation of the performance of certain examination fact-finding, audit, or investigative functions to, or reliance upon a compliance report generated by, a BPO does not diminish the commissioner's authority to conduct examinations. It is simply an additional regulatory tool that may be used as a part of a state's market analysis or surveillance program. The department must maintain ultimate control over the examination and its quasi-judicial and discretionary functions to avoid any violations of applicable state law.

B. Licensing Standard

The certification or accreditation provided by a best practices organization could serve as a “short cut” to licensing the entity. The fact that a review has already been done will tell regulators that the applicant has met the standards of the organization. To the extent that those are the same standards used to determine an applicant’s qualifications for licensure, the process can be streamlined. To the extent that a state measures an entity’s “quality” before deciding whether to grant a license, accreditation will tell the regulator more about the entity.

C. Market Conduct Examinations

If the standards for accreditation match some or all of those used by a state to conduct market conduct examinations, the process can be streamlined if the regulator feels able to rely on the quality of the examination of those same aspects of the entity’s conduct by the best practices organization. After a determination of the practices that have already been reviewed, the insurance department may decide to conduct a targeted examination of just the aspects that have not been reviewed. It may place reliance on the fact of accreditation itself or review the work papers of the accrediting organization. The continuum of reliance could vary from “none” to total reliance on the work of the accrediting organization for the areas that it measures.
D. Requirement to Use Best Practices Organizations

A state may decide to consider requiring a certification from a best practices organization instead of doing its own review. For example, if the state does not have staff qualified to measure an entity’s quality assurance procedures, it may choose to require that the entity receive a certification prior to licensing. This would be a much stronger reliance than using the certification as a safe harbor. Requiring accreditation might impose a hardship on smaller entities, so regulators should consider a small company exemption.

E. Current Recognition of Best Practices Organizations

The types of recognition currently bestowed on best practices organizations vary from state to state. State insurance departments should evaluate best practices organizations and their entities to determine the appropriate degree of regulatory recognition that may be warranted.

Currently, the types of recognition granted seem to be narrowly focused on the application/licensure process, compliance with a particular regulation or group of regulations, and/or as a requirement to operate within a state in a specialized area. To promote efficiency and apply regulatory recognition concepts in the market conduct context, the state insurance department may provide formal express authority to market conduct analysts and examiners to rely upon the independent review conducted on behalf of a best practices organization to the extent that such reliance is deemed warranted by the commissioner.

There appears to be five overarching types of regulatory recognition granted today:

1. Deemer—Best practices organizations are often given state recognition through a “deemer” clause. If an entity is accredited by a best practices organization, the entity is deemed to have met the state’s regulatory requirements without further proof of compliance.

2. Specific accreditation required under state law—Accreditation by a best practices organization is often part of a list of requirements imposed by state law.

3. Alternative accreditations accepted under state law—Some states require an entity to be accredited by a “nationally recognized accreditation organization,” “independent accreditation organization,” or “external quality review” and subsequently list specific best practices organizations as acceptable alternative accreditors.

4. Accreditations accepted with supplemental requirements—At least one state recognized a best practices organization’s standards as sufficient to meet state regulations provided that the entity also ensures that it is in compliance with any additional state regulations that may not be found in the best practices organization’s standards.

5. Waiver—Regulatory requirements imposed upon an entity are occasionally waived if that entity is accredited by a best practices organization.

Note: The working group has done a study of the types of recognition that currently exist, attached as Appendix A. See also New York Circular Letter 17 (2003) and Texas Bulletin B-0006-04 on the uses of best practices organizations in market conduct examinations, attached as Appendix B.
V. How Could State Regulators Use Best Practices Organizations in the Future?

This is a question that seems to loom large as the question of this paper, and the answer may be simple, or it may difficult. How we use best practices organizations in the future may depend on the issue and/or the desired outcomes.

Section IV describes how best practices organizations are currently being used and the five (5) types of regulatory recognition currently being granted. Future use could be any one or a combination of the components or all, depending on the issue. In addition, a regulator could tailor its market conduct examination of an insurer to those areas not reviewed by the best practice organization during the accreditation process. Or the regulator may be able to narrow the size of a market conduct examination of an accredited insurer by using smaller population samples in the state’s review. Additionally, a regulator may be able to target those insurers that have not been accredited by a best practices organization in scheduling upcoming market conduct examinations.

How best practices organizations are used in the future may depend largely on their performance and their effectiveness in the marketplace. Positive measurable outcomes that demonstrate effectiveness will enable regulators to consider increased recognition and use of these entities. Why duplicate processes and procedures if the desirable outcomes are being met by these entities? As you can see, it is not clear how regulators can and will use best practices organizations in the future, the basic premise becomes how much value do these organizations bring to the regulator and the insurance marketplace; and generally, that is in the eye of the beholder. The elementary result is simply this; states will make these determinations independently based on their desires and needs.

Regulatory recognition of best practices organizations has previously been reviewed by the NAIC. Please refer to the suggestions outlined in the NAIC’s “A Reinforced Commitment: Insurance Regulatory Modernization Action Plan.”

VI. Conclusion

It is the recommendation of the working group that regulators evaluate a best practices organization recognition candidate for its adoption of standards consistent with those set out above and that, if best practices organizations demonstrate adoption of such standards, that they be considered for the types of recognition set forth above as appropriate.

VII. Appendices
Abbreviations for best practices organizations are used throughout this document. URAC is not an acronym, but the organization was formerly known as the Utilization Review Accreditation Commission. NCQA stands for the National Commission on Quality Assurance. JCAHO is the Joint Commission on Accreditation of Healthcare Organizations. IMSA is the Insurance Marketplace Standards Association.

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<tr>
<td>AL</td>
<td>Health Care §§ 27-3A-3 to 27-3A-4 Workers' Compensation Reg. 480-5-5-.06</td>
<td>An entity that has current accreditation and files a certification of accreditation with the department annually is exempt from certifying its compliance with the utilization review statute. Utilization review of medical services provided under workers’ compensation may be performed by insurance carrier, employer/agent, self-insured employer, or group self-insurance fund. There is no requirement to hire an outside utilization review provider.</td>
<td>URAC</td>
</tr>
<tr>
<td>AK</td>
<td>No provision</td>
<td></td>
<td>Any utilization review entity that is accredited by URAC shall be deemed to be qualified.</td>
</tr>
<tr>
<td>AZ</td>
<td>Health Care § 20-2502</td>
<td>If an entity is accredited, it may perform utilization review without certification from the director.</td>
<td>URAC, NCQA or any other nationally recognized accreditation organization recognized by the director.</td>
</tr>
<tr>
<td>AR</td>
<td>Health Care Ins. Reg. 76 s 7, 76 s 11</td>
<td>The health carrier shall assign an independent review organization from the list of approved independent review organizations maintained by the commissioner.</td>
<td>Commissioner may deem an independent review organization certified by URAC as certified to conduct external reviews.</td>
</tr>
<tr>
<td>CA</td>
<td>Health Care Bus. &amp; Prof. § 4999</td>
<td>No business whose primary function is to provide telephone medical advice shall operate unless registered with the Telephone Medical Advice Services Bureau.</td>
<td>An entity that submits proof of accreditation by URAC, NCQA or other named organizations shall be deemed provisionally registered until its application for registration is granted or denied.</td>
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<tr>
<td>DE</td>
<td>Health Care tit. 18 § 69.405B</td>
<td>A managed care organization must have, at least every 3 years, an external quality audit or show that it is accredited.</td>
<td>Nationally recognized private accrediting entity.</td>
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## CURRENT RECOGNITION OF BEST PRACTICES ORGANIZATIONS

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<tr>
<td>DC</td>
<td>Workers’ Compensation Reg. tit 7 DCMR 232</td>
<td>Any medical care or service is required to be subject to utilization review by an accredited organization.</td>
<td>A utilization review organization or individual shall be certified by URAC.</td>
</tr>
<tr>
<td>FL</td>
<td>Health Care § 641.512, Reg. 59A-12.0071, 59A-12.0072</td>
<td>Each health maintenance organization and prepaid health clinic shall apply for accreditation within 1 year and be accredited within 2 years of the organization’s receipt of its certification.</td>
<td>The accreditation organization must have nationally recognized experience in HMO accreditation activities and at least 3 years of experience in reviewing all types of HMOs. Both NCQA and URAC claim recognition.</td>
</tr>
<tr>
<td>GA</td>
<td>Health Care § 120-2-58-.03, Reg. 120-2-80-.07</td>
<td>All managed care entities offering managed care plans are required to have a utilization review program that is certified or deemed compliant by the commissioner.</td>
<td>Each application for certification of renewal must include documentation that the private review agent has received full accreditation by NCQA or URAC.</td>
</tr>
<tr>
<td>HI</td>
<td>Health Care § 432E-11</td>
<td>Each unaccredited managed care plan is required to submit a plan to the commissioner to achieve national accreditation status by January 1, 2005. All unaccredited plans are also required to submit an annual progress report to the commissioner on the status of gaining national accreditation.</td>
<td>The commissioner determines the national accreditation organization that is appropriate for each plan. Both NCQA and URAC claim approval for this purpose.</td>
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<td>No provision</td>
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<tr>
<td>IL</td>
<td>Health Care 215 ILCS 134/85 Reg. tit. 50 § 5420.130</td>
<td>At least every two years, any party conducting a utilization review program in this State must certify compliance with URAC standards or submit evidence of accreditation. An accredited utilization review organization is entitled to a 50% discount on the annual fee for registration with the director.</td>
<td>URAC</td>
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<tr>
<td>NCQA, URAC or JCAHO</td>
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<tr>
<td>IN</td>
<td>Health Care § 27-8-17-14</td>
<td>The department may determine that a utilization review agent satisfies the requirements for registration if the utilization review agent has and maintains accreditation by a utilization review accreditation organization that has been approved by the department for the purposes of this section.</td>
<td>The provision does not specify any nationally recognized accreditation organization that has been approved by the department for this purpose, but URAC claims approval.</td>
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<tr>
<td>IA</td>
<td>Health Care § 514F.4</td>
<td>Except for utilization review performed under contract with the federal government, third-party entities performing utilization review must be accredited. A third party conducting a utilization review is required to provide the commissioner with an annual certification of compliance.</td>
<td>NCQA, URAC or another national accreditation entity recognized and approved by the commissioner. URAC or other nationally accredited entity recognized and approved by the commissioner.</td>
</tr>
<tr>
<td>KS</td>
<td>Health Care § 40-22a06</td>
<td>Certain requirements for certification as a utilization review organization do not apply to URAC-accredited applicants.</td>
<td>URAC</td>
</tr>
<tr>
<td>KY</td>
<td>Health Care §§ 304.17A-600, 304.17A-613</td>
<td>The department shall accept accreditation or certification by a nationally recognized accreditation organization as sufficient documentation that the insurer or private review agent meets the application requirements for registration or renewal.</td>
<td>NCQA, URAC, JCAHO or any other organization identified by the department.</td>
</tr>
<tr>
<td>LA</td>
<td>§ 22:2022D</td>
<td>The commissioner is authorized to issue regulations to implement procedures that assure that participating HMO providers and members have the opportunity for the resolution of their grievances. None have been issued.</td>
<td>Regulations can include accreditation by a nationally recognized accrediting body or entity recognized by the commissioner.</td>
</tr>
<tr>
<td>ME</td>
<td>Health Care Ins. Reg. Ch. 850 § 8</td>
<td>A carrier accredited by a nationally recognized accrediting organization may seek a waiver from certain requirements for becoming a utilization review entity upon approval by the Superintendent. To become certified to conduct utilization review, an applicant shall file proof that accreditation is current or pending. If accreditation is pending, applicant must certify accreditation within 6 months of applying.</td>
<td>The provision does not specify any nationally recognized accreditation organization, but both NCQA and URAC claim approval for this purpose. URAC</td>
</tr>
<tr>
<td>MD</td>
<td>Health Care Ins. § 15-10B-03</td>
<td>The commissioner may consider an applicant as having met a particular certification requirement if the applicant has obtained utilization management accreditation from an approved accrediting organization as determined by the commissioner. This provision was added via an amendment effective October 2003. The Commissioner is drafting regulations to implement it.</td>
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<td>MA</td>
<td>Health Care</td>
<td>A managed care carrier must be accredited to provide health care services. It may apply for deemed accreditation when it is accredited by a national organization and meets other requirements.</td>
<td>JCAHO, NCQA or URAC</td>
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<tr>
<td></td>
<td>Reg. 211 CMR 52.05</td>
<td>Any carrier’s application for accreditation will be reviewed for compliance with certain national standards.</td>
<td>NCQA</td>
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<td>Reg. 211 CMR 52.08</td>
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<td>MI</td>
<td>No provision</td>
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<tr>
<td>MN</td>
<td>Health Care</td>
<td>In awarding a contract for independent external reviews, the commissioner shall take into consideration any national accreditation standards that pertain to an external review entity.</td>
<td>The provision does not specify any nationally recognized accreditation organization.</td>
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<td>§ 62Q.73</td>
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<td>MS</td>
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<td>MO</td>
<td>Health Care</td>
<td>A health carrier may satisfy the regulation’s utilization review program requirements by implementing the most recent utilization review program documents it submitted to meet accreditation requirements and supplementing to meet any additional state requirements.</td>
<td>URAC, NCQA or any similar entity</td>
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<td>Reg. tit. 20 § 400-10.010</td>
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<td>MT</td>
<td>Health Care</td>
<td>If the department finds that the standards of a nationally recognized accrediting organization meet or exceed state standards and that a health carrier has been accredited by a nationally recognized accrediting organization, the department shall approve the health carrier’s quality assurance standards.</td>
<td>The provisions do not specify any nationally recognized accreditation organization.</td>
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<td>§ 33-36-301, Reg. 37-108.505</td>
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<tr>
<td>NE</td>
<td>Health Care</td>
<td>The director may recognize accreditation by nationally recognized private accrediting entities as evidence of meeting some or all of the requirements of the Health Care Professional Credentialing Verification Act.</td>
<td>The provision does not specify any nationally recognized accreditation organization.</td>
</tr>
<tr>
<td></td>
<td>§ 44-7005</td>
<td>An applicant for certification as a utilization review agent shall submit documentation that the applicant has received accreditation by URAC or a similar organization with substantially similar standards.</td>
<td>URAC</td>
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<td>§ 44-5420</td>
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<tr>
<td>NV</td>
<td>Workers’ Compensation § 616.xxx</td>
<td>SB 320, effective June 9, 2003, provides that an external review organization that is accredited by a nationally recognized accrediting body shall be deemed to have satisfied all the conditions for certification.</td>
<td>The provision does not specify any nationally recognized accreditation organization.</td>
</tr>
<tr>
<td></td>
<td>Health Care Reg. 695C.310</td>
<td>The state board of health shall examine the quality of health care services of any health maintenance organization at least once every 3 years.</td>
<td>As part of the examination, the board may consider the examination of an organization conducted by a nationally recognized group that provides accreditation of health care organizations.</td>
</tr>
<tr>
<td></td>
<td>Reg. (uncodified) LCB File No. R127-03</td>
<td>External review organizations must include a list of required information on its application, or indicate that it has been certified or accredited as an external review organization by an accrediting body and provide it certification.</td>
<td>A national recognized external review accrediting body.</td>
</tr>
<tr>
<td>NH</td>
<td>Health Care § 420-E:3</td>
<td>Each medical utilization review entity shall adopt standards established by a nationally recognized accreditation organization as the minimal acceptable standards for licensure, unless the commissioner adopts rules establishing stricter standards.</td>
<td>The provision cites NCQA, URAC or other similar standards acceptable to the commissioner.</td>
</tr>
<tr>
<td></td>
<td>§ 420-J:5-d</td>
<td>The commissioner may determine that accreditation by a nationally recognized private accrediting entity with established and maintained standards that meet or exceed minimum qualifications is sufficient for certification as an independent review organization.</td>
<td>The provision does not specify any nationally recognized accreditation organization.</td>
</tr>
<tr>
<td></td>
<td>§ 420-J:6</td>
<td>Each health carrier that does not contract with a utilization review entity shall establish written procedures that shall conform to nationally recognized standards.</td>
<td>The provision requires that procedures conform to either NCQA or URAC standards.</td>
</tr>
<tr>
<td>NJ</td>
<td>Health Care Reg. 8:38-7.2</td>
<td>If an HMO attains accreditation granted by an external quality review organization within the 12 months prior to the department’s review, the HMO shall be exempted from examination by the department in any area in which the commissioner determines that the external review demonstrated specific compliance with state standards.</td>
<td>The provision does not specify any nationally recognized accreditation organization, but URAC claims approval for this purpose.</td>
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<td>NM</td>
<td>Health Care Reg. tit. 13 §§ 10.13.19 to 10.13.20</td>
<td>A managed health care provider may submit accreditation by a nationally recognized accrediting entity as evidence of compliance with listed requirements for utilization management and quality improvement.</td>
<td>NCQA is cited as an example of an entity recognized and approved by the superintendent for purposes of continuous quality assurance, licensing, credentialing and utilization management.</td>
</tr>
<tr>
<td>NY</td>
<td>Circular Letter No. 17 (2003)</td>
<td>As part of the examination process, examiners routinely ask if companies are members of IMSA. If so, the examiners request and review the documentation gathered to demonstrate compliance with IMSA’s standards. Examiners may consider the IMSA documentation in determining the scope of their own review of the marketing and sales practices of a company. Examiners may also make use of the IMSA documentation in certain other areas, such as consumer complaint handling.</td>
<td>IMSA</td>
</tr>
<tr>
<td>NC</td>
<td>Health Care §58-50-85</td>
<td>The commissioner may determine that accreditation by a nationally recognized private accrediting entity with established and maintained standards for independent review organizations will cause an independent review organization to be deemed to have met, in whole or in part, the requirements for approval.</td>
<td>The provision does not specify any nationally recognized accreditation organization.</td>
</tr>
<tr>
<td>ND</td>
<td>Health Care § 26.1-26.4-04</td>
<td>The commissioner may find that the standards in this section have been met if the utilization review agent has received approval or accreditation by a utilization review accreditation organization.</td>
<td>The provision does not specify any nationally recognized accreditation organization, but URAC claims approval for this purpose.</td>
</tr>
<tr>
<td>OH</td>
<td>Medicaid Reg. 5101:3-26-07</td>
<td>Managed care programs accredited by a quality review organization during the time period under review may be eligible for deemed approval.</td>
<td>The provision does not specify any nationally recognized accreditation organization.</td>
</tr>
<tr>
<td></td>
<td>Health Care § 1751.821</td>
<td>A health-insuring corporation may present evidence of compliance with standards for utilization review by submitting evidence to the director of its accreditation by an independent, private accrediting organization.</td>
<td>Examples of accrediting organizations include JCAHO, NCQA and URAC.</td>
</tr>
<tr>
<td></td>
<td>§ 3901.80</td>
<td>After reviewing the accreditation process used by a national organization to accredit an independent review organization, the director may determine that accreditation by the national organization constitutes accreditation by the director.</td>
<td>The provision does not specify any nationally recognized accreditation organization.</td>
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<tr>
<td>OK</td>
<td>Reg. 310:656-3-2</td>
<td>Accreditation of a managed care plan by a national private accreditation body shall not be construed as exempting a managed care entity from filing an application.</td>
<td>The provision does not specify any nationally recognized accreditation organization.</td>
</tr>
<tr>
<td>OR</td>
<td>Reg. 836-053-1310</td>
<td>In order to gain approval by the director, an independent review organization may submit evidence of accreditation to demonstrate compliance.</td>
<td>The provision does not specify any nationally recognized accreditation organization.</td>
</tr>
<tr>
<td>PA</td>
<td>Health Care § 40-39-1251</td>
<td>A utilization review entity must be certified by the department. The department may adopt a nationally recognized accrediting body’s standards to certify utilization review standards. In lieu of a site visit and inspection, the department may accept accreditation of the applicant by a nationally recognized accrediting body whose standards meet or exceed state requirements. The department may require proof of continuing accreditation by a nationally recognized accrediting body whose standards meet or exceed state requirements.</td>
<td>The provision does not specify any nationally recognized accreditation organization.</td>
</tr>
<tr>
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<td>Reg. tit. 28 § 9.747</td>
<td></td>
<td>The provision does not specify any nationally recognized accreditation organization.</td>
</tr>
<tr>
<td></td>
<td>Reg. tit. 28 §9.748</td>
<td></td>
<td>The provision does not specify any nationally recognized accreditation organization.</td>
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<tr>
<td>RI</td>
<td>Health Care § 23-17.12-8</td>
<td>The department shall waive certain requirements for a utilization review agent that has received, maintains and provides evidence to the department of accreditation.</td>
<td>The department shall accept accreditation by URAC or other organization approved by the superintendent.</td>
</tr>
<tr>
<td>SC</td>
<td>Health Care § 38-33-170</td>
<td>The director may make an examination of the affairs of an HMO as often as is reasonably necessary but not less frequently than once every three years. An independent review organization accredited by a nationally recognized private accrediting entity approved by the director may be deemed to meet the minimum qualification requirements. An independent review organization must notify the director of any material changes in qualifications, including removal or loss of accreditation by a nationally recognized private accrediting entity.</td>
<td>The provision does not specify any nationally recognized accreditation organization, but NCAQ and URAC claim that accreditation may be submitted as evidence of fulfilling quality standards.</td>
</tr>
<tr>
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<td>§ 38-71-2000</td>
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<td>The provision does not specify any nationally recognized accreditation organization.</td>
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<tr>
<td>SD</td>
<td>Health Care §58-17C-64</td>
<td>The director or the secretary of health may require that a utilization review organization seeking registration submit the status of any accreditation designation it holds or has sought.</td>
<td>Any nationally recognized accreditation organization.</td>
</tr>
<tr>
<td>TN</td>
<td>Health Care § 56-6-704</td>
<td>Any utilization review agent that has received accreditation by URAC shall be exempt from the annual $1,000 fee due upon certification filing.</td>
<td>URAC</td>
</tr>
<tr>
<td></td>
<td>§ 56-6-705</td>
<td>The commissioner shall exempt from the minimum standards any utilization review agent with URAC accreditation.</td>
<td>URAC</td>
</tr>
<tr>
<td></td>
<td>Workers' Compensation § 50-6-124</td>
<td>The commissioner shall establish a utilization review system by providers qualified pursuant to law or URAC.</td>
<td>URAC</td>
</tr>
<tr>
<td>TX</td>
<td>Bulletin No. B-0006-04</td>
<td>As part of the examination process, examiners routinely ask if companies are members of a best practices organization. Examiners may consider the documentation in determining the frequency of examinations and the scope of an on-going review of the marketing and sales practices of a company. Examiners may also make use of the documentation required by a best practices organization in certain other areas, such as consumer complaint handling.</td>
<td>Best practices organizations</td>
</tr>
<tr>
<td>UT</td>
<td>Health Care Reg. R590-76-9</td>
<td>A new HMO shall arrange and pay for a review and certification of its quality assurance plan no later than 18 months after receiving a certificate of authority and commencing operation. An existing HMO shall arrange and pay for a review and certification of its quality assurance plan every three years unless required sooner by the certifying entity.</td>
<td>NCQA, JCAHO, URAC, Health Insight or other entities as approved by the commissioner shall conduct reviews.</td>
</tr>
<tr>
<td>VT</td>
<td>Health Care tit. 18 § 9414, Ins. Reg. 10.204(B)</td>
<td>A managed care organization may evaluate the quality of health and medical care provided to members through an independent accreditation organization approved by the division.</td>
<td>The provision does not name any nationally recognized accrediting body, but NCQA and URAC claim approval for this purpose.</td>
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<td>VI</td>
<td>No provision</td>
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<tr>
<td>VA</td>
<td>Health Care Reg. 12 VAC 5-408-100</td>
<td>Under certain conditions, the department shall accept the accreditation of a managed care insurance plan by a nationally recognized accrediting body. A second review by the accrediting body must be scheduled and completed within 15 to 18 months.</td>
<td>The provision does not specify any nationally recognized accrediting body, but NCQA and URAC claim approval for this purpose.</td>
</tr>
<tr>
<td>WA</td>
<td>Health Care § 43.70.235</td>
<td>The department may accept national accreditation or certification by another state as evidence that an organization satisfies requirements to be an independent review organization.</td>
<td>Both NCQA and URAC claim approval for this purpose.</td>
</tr>
<tr>
<td>WV</td>
<td>Health Care § 33-25A-17a Reg. 114-58-8</td>
<td>An HMO that has been in existence for 3 years is required to apply for an examination to be performed by an accreditation review organization. The commissioner shall approve external review organizations eligible to be assigned to conduct external reviews. The commissioner may deem that accreditation by a national organization satisfies the approval standards.</td>
<td>A nationally recognized accreditation review organization approved by the commissioner. Both NCQA and URAC claim commissioner approval. Neither NCQA nor URAC cite commissioner recognition for this purpose.</td>
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<td>No provision</td>
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<td>WY</td>
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This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Every effort has been made to provide correct and accurate summaries to assist the reader in targeting useful information. For further details, the statutes and regulations cited should be consulted. The NAIC attempts to provide current information; however, readers should consult state law for additional adoptions.
Appendix B

Circular Letter No. 17 (2003)—Market Conduct Initiatives

STATE OF NEW YORK
INSURANCE DEPARTMENT

TO: All Licensed Life Insurers and Fraternal Benefit Societies

RE: Market Conduct Initiatives

STATUTORY REFERENCE: Section 309 of the Insurance Law

The Insurance Department is continuing its efforts to promote higher standards in connection with market conduct activities. As part of this process, the Department is reviewing existing standards regarding marketing and sales, underwriting, complaint handling and claims practices.

The Department will be reaching out to the life insurance industry to discuss: the sources of meaningful market conduct data for effective analysis and the means by which to collect such data; the development of a market conduct analysis function; changes and improvements to current market conduct regulatory processes; ongoing and emerging market conduct issues; and the role and effect of “best practice” organizations.

The Department has been reviewing the work performed by “best practice” organizations during the examination process. As part of the current examination process, Insurance Department examiners routinely inquire as to whether companies are members of the Insurance Marketplace Standards Association (IMSA). If a company is a member, the examiners request and review the documentation gathered to demonstrate compliance with IMSA’s standards. Examiners may consider the IMSA documentation in determining the scope of their own review of the marketing and sales practices of a company including such areas as: agent training and licensing; replacements; and advertising. Examiners may also make use of the IMSA documentation in certain other areas such as consumer complaint handling. The Insurance Department looks forward to the opportunity to work with industry on these initiatives.

Very truly yours,

Gregory V. Serio
Superintendent of Insurance
January 29, 2004

TO: All Licensed Life Insurers, Fraternal Benefit Societies, Third Party Administrators, Agents, and any other representatives or entities marketing and/or managing products in the life insurance industry

RE: Market Conduct Initiatives and the Use of Best Practices Organization Documentation during the Examination Process

The Texas Department of Insurance (“the Department”) is continuing its efforts to promote higher standards in connection with market conduct activities of licensed life insurers, fraternal benefit societies, and their agents and representatives. As part of this process, the Department is reviewing existing marketing and sales standards, underwriting guidelines and practices, complaint handling, and claims practices.

The Department will be reaching out to the life insurance industry to obtain its input related to: the sources of meaningful market conduct data for effective analysis and the means by which to collect such data; the development of a market conduct analysis function; potential changes and improvements to current market conduct regulatory processes; ongoing and emerging market conduct issues and trends; and the potential role and effect of "best practice organizations".

The Department recognizes the value of utilizing and reviewing the work performed by best practice organizations within the regulatory framework. The Department also encourages life insurance companies to become members of such organizations in an effort to promote higher market conduct standards and to facilitate the regulatory examination process. As part of the current examination process carried out pursuant to Texas Insurance Code article 1.15, the Department examiners routinely inquire as to whether companies are members of best practice organizations. The Department examiners currently utilize information and data obtained from certain best practices organizations, such as the Insurance Marketplace Standards Association (IMSA), as they examine licensees that are members of such organizations (IMSA is named as an example of an acceptable best practices organization and should not be interpreted as an endorsement). Consideration may be given to the documentation in determining the frequency of examinations; the scope of an ongoing examination, and/or the marketing and sales practices of a company, including such areas as; agent licensing, training, replacements, and advertising. The examiners may also make use of the documentation required by a best practices organization in reviews of other areas such as consumer complaint handling.

If you have additional questions, please call Danny Saenz at 512-305-7258, or e-mail him at <danny.saenz@tdi.state.tx.us>

Sincerely,
Jose Montemayor
Appendix C

Comments of Consumer Advocates on the Best Practices Organization White Paper

These comments are divided into two sections. Section 1 contains principles for recognition of best practices organizations (BPO) in health care developed in 2000 by consumer health care advocates. Section 2 is our comments on the regulator comments and recommendations in the white paper.

1. Consumer Principles for Public Sector Reliance on Private Entity Review and Data Collection for Health Care

In 2000, the Center for Health Care Rights, the Center for Disability and Health, Families USA, the National Health Law Program and the National Partnership for Women & Families endorsed a consensus statement of principles that should be applied when a public entity requires or allows private accreditation as part of licensure or permits private accreditation / data collection to meet public standards. The following is an edited version of the Consumer Principles.

The key issue for consumers is to ensure that public accountability remains and that where private entities are relied upon to meet regulatory standards, those standards are met.

Principle 1: Public regulatory or purchasing entities must retain full authority and enforcement powers regardless of whether they do or do not rely upon private entities information or process. The public entity’s reliance on private information or processes should not diminish its authority to investigate or act in its public capacity. In addition, public entities should specifically have the authority to initiate actions based on the results of private processes relied upon.

Principle 2: The use or reliance of private entity measures and processes must be subject to full and open public comment process. Public entities should actively promote public comment opportunities for private entities on which they rely.

Principle 3: Private entities’ standards and measures should be readily and publicly available at no or nominal cost. The goal is to ensure that there is complete transparency to any processes relied upon by a public entity. Performance measurement should also be publicly available.

Principles 4: The information about the individuals who conduct reviews should be publicly available and include qualifications and a description of any potential conflicts of interest.

Principle 5: When a public entity relies upon private processes or data, it must provide comprehensive and ongoing oversight of the private entity to ensure the completeness and rigor of what is being relied upon. Performance measurement data should be independently audited.

Principle 6: The results of private review processes relied upon by the public entity should be public. The entire findings collected by the private entity must be provided to the public entity and, at a minimum, the public entity should make public the results to the same extent it would have had it collected the information.

Principle 7: Public entities should only rely upon the processes or standards of private entities that can demonstrate their independence from the entities being reviewed. At a minimum, private entities must demonstrate that they are governed by a board that includes consumer representation and has a majority representation of individuals or organizations that are not subject to the review of the private entity.
2. **Comments on Criteria for Recognition in White Paper**

We greatly appreciate the tremendous time and effort put forth by regulators to craft this white paper. The regulators’ efforts serve as an example of a public process for BPOs. Generally, we support the regulatory comments and suggestions with a few exceptions where we believe the recommendations should have gone further to ensure public accountability. We agree with the regulatory comments on Organizational Structure/Financing and Effectiveness. We believe the regulatory comments on the following topics should specify additional requirements.

**Governance:** Accredited entities must comprise, at most, a minority of the BPO’s Board of Directors. It is axiomatic that a BPO whose Board is controlled by accredited entities is susceptible to undue influence by those entities.

**Standards:** Compliance standards must be developed in a public process with opportunity for public involvement.

**Review for Compliance:** Compliance review must include analysis of market outcomes in addition to review of processes and accreditation must be conditioned on successful market outcomes as well as compliance with process standards. If the accreditation period is greater than one year, the BPO should annually review the performance of the insurer. The BPO must have the resolve to deny accreditation to entities who fail to meet the BPO’s standards and the ability and resolve to withdraw accreditation from entities that develop problems during the accreditation period.

**Accountability:** The BPO must be accountable to the public as well as to regulators and must create institutional mechanisms to affect such public accountability. The analogy of the BPO/accredited entity relationship to an attorney/client relationship is inappropriate. A lawyer is the client’s advocate; a BPO should not be an advocate for the accredited entity.

**Publication:** The entire findings collected by the BPO must be provided to the public entity and, at a minimum, the public entity should make public the results to the same extent it would have had it collected the information.
Statement of the Insurance Marketplace Standards Association (IMSA)

NAIC White Paper on Best Practices Organizations

The Insurance Marketplace Standards Association (IMSA) commends the NAIC and its Insurance Marketplace Standards Working Group for developing its White Paper on Best Practices Organizations (the “White Paper”). The White Paper provides a broad range of information that will allow regulators and members of the public to gain a better understanding of best practices organizations to advance ethical market practices and interests of consumers. The White Paper confirms that best practices organizations such as IMSA can play an important role as a tool to advance market conduct analysis techniques.

The NAIC leadership and the Working Group also should be commended for its willingness to review the role best practices organizations may play to promote market conduct regulatory reform and good consumer protection. The NAIC has endorsed a new emphasis upon a “market analysis” approach to market conduct regulation. The findings of this White Paper are consistent with such an approach to the extent that information provided by best practices organizations and their entities will be used by regulators for market analysis purposes to more effectively and efficiently oversee the national insurance marketplace.

To allow the White Paper to provide meaningful improvements in market analysis, it is essential that the NAIC leadership clearly communicates its goals and objectives pertaining to market analysis as well as the need to consider new approaches to market conduct regulation not only to commissioners but also to the “front-line” practitioners who will be performing market analysis techniques. In order for the White Paper to enhance current regulatory efforts, commissioners need to advise and direct their market conduct staff to acknowledge a “new frontier” for market conduct regulation that may require careful evaluation of the efficacy or lack thereof with respect to past examination practices including exclusive reliance upon the NAIC Market Conduct Examiners’ Handbook. In this new environment, best practices organizations such as IMSA can play a very important role. It is only when all practitioners of market conduct regulation – NAIC leadership, commissioners, market conduct analysts and examiners – understand, accept and acknowledge the new “market analysis” paradigm and the important role best practices organizations can play in a new market analysis environment that the enhancements to market conduct regulation contemplated by the White Paper’s key findings will have a discernable, positive impact upon market regulation and advance the interests of insurance consumers and companies.

General:

The White Paper provides regulatory comments on a series of different subject matters to describe the types of best practices organization characteristics that should be considered when determining whether regulatory recognition should be granted. IMSA and its qualified companies manifest these characteristics as part of IMSA’s mission to promote high ethical standards in the life insurance marketplace. A growing number of states have already recognized IMSA’s value in the marketplace and have begun to use IMSA information in their market conduct analysis and examination techniques. We anticipate that an increasing number of states will use IMSA information in their market analysis as a result of publication of the White Paper.

Authority to Rely Upon Best Practice Organization Information:

The White Paper correctly identifies the importance of providing formal express authority to market conduct analysts and examiners “to rely upon the independent review conducted on behalf of a best
practices organization to the extent that such reliance is deemed warranted by the commissioner.” By providing such authority, regulators will be permitted to follow the guidance found within the White Paper to make practical use of best practices organization information to enhance current market conduct analysis and examination techniques. To provide this authority, states may wish to consider the following sample statutory language:

This Act grants authority to market conduct analysts and examiners acting under the direction of the Commissioner to consider and, if warranted, rely upon information generated through a regulated entity’s qualification in a life insurance best practices organization to carry out market conduct oversight, including but not limited to refining the nature and scope of a market conduct examination. The qualified entity shall make available to the state the best practices organization’s standards. This provision will not diminish the Commissioner’s authority to conduct examinations but rather will promote more efficient market analysis and examinations of regulated entities on behalf of the consumers of this state.

Education:

The information outlined within the White Paper will have greater value if it is reviewed by fully informed readers. To achieve this result, regulators should be encouraged, if not required, to enhance their understanding of best practices organization standards on a regular basis through continuing education activities. The NAIC should work in conjunction with best practices organizations to provide educational opportunities for regulators to learn more about the specific elements of a best practices organization’s standards and assessment process in order to permit regulators to make informed judgments concerning the appropriate use of best practices information.

IMSA’s Independent Assessment Manual:

Prior to final publication of the White Paper, IMSA completed a comprehensive review of its independent assessment standards which led to issuance of the IMSA Independent Assessment Manual which is available via IMSA’s website (www.IMSAethics.org). The Manual was designed to promote uniformity and consistency with respect to independent assessment activities. The Manual outlines qualifications for all personnel who conduct independent assessment activities on behalf of IMSA. The Manual also includes clear independence standards to avoid conflicts of interest that may impair a Qualified Independent Assessor’s objectivity and judgment.

The Manual also contains specific testing guidance pertaining to a variety of subject matters to be used by all Qualified Independent Assessors when evaluating whether a company has complied with IMSA standards. The Manual also introduces the required use of a Supplemental Report, which can serve as a summary of the key findings of the independent assessment review. Regulators are encouraged to become familiar with these independent assessment standards and report forms to facilitate their utilization of IMSA information.

Mitigation of Fines and Penalties:

Sound public policy and market conduct regulatory reform suggest that insurers that attain qualification in a best practices organization should be acknowledged for their commitment to abide by high ethical standards and maintain a culture of compliance. Insurers that voluntarily maintain a compliance infrastructure designed to detect and remedy market conduct-related issues before they become more
widespread provide a significant benefit to help consumers avoid systemic harm. In this regard, IMSA is encouraged that the White Paper rightfully acknowledges these contributions by considering such actions to possibly mitigate any fines or penalties imposed upon an insurer.

**Best Practices Organizations/Entities:**

The White Paper places little emphasis upon the distinction between best practices organizations and entities that comply with the best practices organizations’ standards when, in fact, the assignment of any regulatory recognition will ultimately attach to the regulated entity. Very few sections within the White Paper acknowledge this important analytical distinction. Therefore, readers are encouraged to consider this distinction when evaluating the scope of possible regulatory recognition for market analysis purposes.

**Disclosure of Self-Evaluative Information:**

When considering the extent to which recognition of a best practices organization and its entities may be warranted, regulators should recognize that company policies and procedures may differ with respect to disclosure of self-evaluative information. It is axiomatic that any grant of regulatory recognition must be premised upon a demonstration of compliance with the best practices organization’s standards. Yet, in the current litigation environment, confidentiality of self-evaluative or self-audit documentation remains paramount. In this regard, IMSA encourages jurisdictions to enact appropriate statutory self-critical or self-evaluative privilege legislation to promote self-evaluative activities. Absent such protections, regulators should recognize that companies reserve the right to assert applicable confidentiality safeguards including but not limited to attorney-client privilege, work product doctrine, trade secret or other protections. In these instances, regulators are encouraged to avoid extrapolating a particular company’s practice to arrive at judgments that may impugn other companies that have attained qualification under the best practices organizations standards simply because a company elects to rightfully assert its applicable legal privileges or other protections.