MCM

Best Practices of Conducting Market Conduct Examinations

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Preface

This is the initial version of the IRES *MCM Best Practices of Conducting Market Conduct Examinations* textbook. This textbook was developed, published, and edited by the Insurance Regulatory Examiners Society. It is another example of the fulfillment of the "purpose" of IRES ... "to promote fair, cost effective, and efficient insurance regulation by ensuring professionalism and integrity among the individuals who serve state and federal insurance regulatory bodies".

These chapters are authored by knowledgeable regulators and examiners with years of hands-on experience. These authors wrote as examination and insurance professionals, not as professional authors; so their writing styles may vary. But, these stylistic differences in many ways add to the presentation.

One of the challenges the authors and editors of this textbook faced is the wide range of terminology used to refer to some similar concepts. We used the most standardized terminology while recognizing that actual usage may differ from state to state. For example, Examiner-in-Charge (EIC) can be thought of generally as the same position as Senior Examiner or Lead Examiner in other states. Commissioner is the term we normally used to represent the person in charge of the Insurance Department. This person might be called Director or Superintendent in other states. We used company as the generic term to include all forms of organizations that are subject to a market conduct examination. As to the forms used by various states to explain alleged violations, the authors have used an assortment of terms, including Criticisms, Critiques, Crits, Exceptions and Comment Forms, but all really refer to the same reporting instrument.

The textbook focuses on general knowledge of the market conduct examination process; a supplement that addresses job skills is also available. This textbook will be used in MCM classes, which apply the knowledge gained from these chapters to Case Studies (also prepared by the MCM textbook authors). Every effort has been made to provide the most current information; nevertheless, readers may want to contact the appropriate state insurance department or IRES for updates.

Some of the material in this textbook is, by its nature, similar to material contained in the NAIC's *Market Regulation Handbook*. In any instance where conflicting information is perceived by the reader, the handbook should be considered to be the definitive source.

Users of this textbook will include new and experienced regulators and market conduct examiners as well as insurance company personnel and attorneys seeking to better understand the market conduct examination process. Both examiners/regulators and company personnel/attorneys will use this textbook as part of their preparation for the MCM certification program.

Thank you to everyone who has been involved in this process.

IRES Market Conduct Certification Plus (MCM) Textbook Committee

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Acknowledgments

This textbook is the result of thousands of hours of effort by a large number of persons in, or connected with, the market conduct examination process. The Board of Directors of the Insurance Regulatory Examiners Society (IRES) first authorized this project in 2003. A sub-committee was formed, and a curriculum outline was created and approved. Volunteer authors were selected and recruited for each chapter based on their expertise and experience in the subject matter. Initial drafts of each chapter were reviewed by other experts in the field. Once the content was approved, each chapter went through a series of grammatical and consistency edits. Through a Request for Proposal (RFP) process, IRES hired Human Dynamics to edit this textbook for style and substance consistency. IRES appreciates the professional efforts of Human Dynamics's Paul Heacock, George Phillips, Bob Dinkins, and Karen Gustin.

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We believe you will find this textbook accurate, informative, and useful. We were privileged to work with such a dedicated group of individuals.

Douglas A. Freeman, CIE, JD, IRES President, 2006-2007
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Chapter 1
- Introduction to Market Regulation

Educational Objective

Understand the history and purpose of market conduct examinations conducted by state insurance departments. Understand how market conduct fits into the larger picture of market analysis. Be able to determine which regulatory tool is appropriate (and when a market conduct examination is the right choice) to address problems uncovered through the market analysis process.

History of Insurance Laws

The first insurance company as we know it today was as a result of the great fire in London in 1666. In 1752, Benjamin Franklin and other prominent Philadelphia citizens formed the first United States fire insurance company, the Philadelphia Contributionship for the Insuring of Houses from Loss by Fire.[1] Insurance companies were chartered at the state level and many early charters included limits on how the insurers could transact business.[2] Some of the earliest forms of insurance regulation were related to the premium taxes imposed by the states on out-of-state insurers and grew out of the registration and reporting requirements imposed for the purpose of determining insurers‘ tax liabilities. Although statutes dealing with insurance had been enacted by the states as early as the beginning of the 19th century, the history of modern insurance regulation began shortly before the Civil War when several states established bodies to supervise insurance operations within their borders.[3]

The New Hampshire Board of Insurance Commissioners was established in 1851. Massachusetts followed shortly thereafter, and New York instituted its board in 1859. Insurance regulators‘ responsibilities grew in scope and complexity as the industry evolved.[4]

One member of the Massachusetts board was Elizur Wright (1804-1885), who is often called the father of insurance regulation. He was an abolitionist who used his energies toward the elimination of unsavory practices in the insurance industry. He was an ardent proponent of federal regulation of insurance and viewed the state insurance department as a step toward a national insurance bureau.[5] Mr. Wright was the first to establish life insurance in America on a strong foundation. His reports on that subject, made during his long term as Insurance Commissioner for Massachusetts, have formed a sort of Constitution by which the policies of all life insurance companies are still guided.[6]

In 1868, the case of *Paul v. Virginia* focused on the preeminence of the right of the states or federal government to regulate insurance. The U.S. Constitution gives the federal government the right to regulate interstate commerce, and the issue in *Paul v. Virginia* was whether the sale of insurance is interstate commerce. Samuel Paul, a native of Virginia who represented New York insurance companies in his home state, challenged Virginia's right to regulate insurance by selling policies without obtaining a state license. Virginia denied Paul a license because his insurer would not comply with its demand for a security deposit. Likewise, a license for the insurer was denied on the same grounds. Paul continued to sell insurance without a license and was arrested and fined. The case was carried to the U.S. Supreme Court, where the court decided in 1869 that the sale of insurance was not commerce and, therefore, could not be interstate commerce. Thus, the sale of insurance was not subject to federal control. This decision stood for 75 years during which the insurance industry was regulated by the individual states.[7]

Another test of the authority of the federal government to regulate insurance was made in 1942, when the U.S. Attorney General filed a brief under the Sherman Act against the South-Eastern Underwriters Association (SEUA), a cooperative rating bureau, alleging that the bureau constituted a combination in restraint of trade. The Supreme Court's decision of the SEUA case in 1944 reversed its decision of *Paul v. Virginia* by stating that the sale of insurance *is* interstate commerce and, as such, is subject to regulation by the federal government. This decision still stands today.[8]

While the SEUA case was being decided and appealed, the insurance industry viewed with considerable alarm the prospect that the court might overturn *Paul v. Virginia.* This would have especially affected the property & casualty field, where concerted ratemaking through bureaus was the rule rather than the exception. Since it was clear that pooling loss information to generate standard industry rates constituted a form of price-fixing that would be illegal per se under the Sherman Act, the industry moved to obtain an exemption from the Sherman Act and other federal antitrust laws.

The insurance industry arranged to have bills introduced into Congress that would have exempted it from the federal antitrust laws, but these bills were all defeated. Finally, the National Association of Insurance Commissioners (NAIC) drafted a law: *Public Law 15*, or the *McCarran-Ferguson Act*, which became law on March 9, 1945. In the McCarran-Ferguson Act, Congress reaffirmed the right of the federal government to regulate insurance, but it agreed that it would not exercise this right as long as the industry was adequately regulated by the states as this appeared to be in the public's best interest. The law explicitly grants to the states the power to regulate the insurance business; however, this exemption from federal law was not complete as the Act provided that the Sherman Act would continue to apply to boycott, coercion, and intimidation.[9]

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Following enactment of Public Law 15, the states attempted to correct any known inadequacies, such as passing rating laws, defining fair trade practices, and extending licensing and solvency requirements.

Purpose of Market Regulation

One of the arguments for state regulation of insurance is the ability to protect consumers. State regulators can monitor local economy, trends, and social needs. State insurance departments provide extensive services in company and producer licensing, financial review, product and rate filing review, market conduct, enforcement, and consumer services.[10]

The two original goals of insurance regulation were insurer solvency and policyholder equity. These goals were articulated by Professor Spencer L. Kimball, a world-renowned scholar on insurance law and regulation, who referred to them as the principles of *solidity* and *aequum et bonum, est lex legume.* (What is good and equal is the law of laws.) These are still the dominant purposes associated with regulation; however, new issues of availability and affordability have recently emerged. Some believe that regulatory programs should be designed to guarantee the availability of insurance to all who want it and provide it at affordable rates.[11]

While financial regulation addresses insurer solvency, market regulation reviews the conduct and practices of insurers to protect consumers. Market conduct examinations include a review of the company operations and methods of conducting business to assure that the company is complying with state laws and regulations as well as their filed products and rates.

Structure of Market Regulation

There is little disagreement in principle on the need for some form of government control of insurance business; however, there is disagreement over the form that this control should take.[12]

Current

Headquartered in Kansas City, Missouri, the National Association of Insurance Commissioners (NAIC) is a voluntary organization of the chief insurance regulatory officials of the 50 states, the District of Columbia, and five U.S. territories. Formed in 1871 as the National Convention of Insurance Commissioners, it is the oldest association of state officials. In 1936 the organization changed its name to the National Association of Insurance Commissioners.

The mission of the NAIC is to assist state insurance regulators, individually and collectively, in serving the public interest and achieving fundamental

insurance regulatory goals in a responsive, efficient, and cost effective manner, consistent with the wishes of its members in the following manner:

Protect the public interest;

Promote competitive markets;

Facilitate the fair and equitable treatment of insurance consumers;

Promote the reliability, solvency and financial solidity of insurance institutions; and

Support and improve state regulation of insurance.[13]

Through NAIC membership, individual jurisdictions work with each other and pool ideas and resources to assist in insurance regulation. NAIC members produce white papers, model laws, regulations, and guidelines; however, each state implements its own laws and means of regulating the insurance market.

Insurance is presently regulated by the states through the three basic branches of state government: Legislative, Judicial, and Executive.[14]

State Legislatures set broad policy for the regulation of insurance. The Legislatures establish and oversee state insurance departments, regularly review and revise state insurance statutes, and approve regulatory budgets. State insurance departments issue regulations, or rules, which interpret, but do not exceed, the scope of the statutes passed by legislatures. Bulletins issued by state insurance departments express a Department‘s interpretation of, or position on, existing law, including rules, regulations, and statutes, but they do not have the force of law.[15]

The Judicial branch exercises control over the insurance industry through the courts by:

- Rendering decisions on the meaning of policy terms; and
- Ruling on the constitutionality of the state insurance laws and the actions of those administering the laws.[16]

The insurance commissioners represent the Executive branch. In most states the Governor appoints the Commissioner, but in 11 other states the Commissioner is an elected position. The Commissioner:

- Administers the business of insurance in a state; and
- Determines compliance with insurance law.[17]

Although often criticized as inefficient, inadequate, and inconsistent, the states currently remain as the main regulators of the insurance industry.

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Future

The prospect of federal regulation of the insurance industry has been contemplated since the SEUA case in 1944. Although the McCarran-Ferguson Act left regulation in the hands of the states, it did so with the implied or understood (although not directly expressed) condition that the federal government would not regulate insurance as long as the states were doing a good job. It has been noted that the principal supporters of federal regulation include the U.S. Department of Justice, some members of Congress, banks, and many large insurers.[18]

Bills to repeal or otherwise modify McCarran-Ferguson have been introduced in virtually every session of Congress since 1977. More recent attempts to modify McCarran-Ferguson have gone to the heart of the system of state regulation. The Gramm-Leach-Bliley Act, enacted in November 1999, expanded the ability of national banks to engage in the insurance business. Given that national banks are already regulated by a federal agency (the Office of the Comptroller of the Currency), it is not surprising that they would prefer a federal system of insurance regulation. In addition, large insurers have become more vocal in their criticism of state regulation. Both the banks and the insurers contend that it is inefficient and unnecessarily costly to comply with individual state laws.[19]

In 2001 several proposals for a system of federal charters were initiated by segments of the insurance industry. The American Bankers Insurance Association (which represents banks entering the insurance industry), the American Council of Life Insurers, and the American Insurance Association all developed legislation to create a dual system of regulation that advocates federally chartered insurance companies under the supervision of the Secretary of the Treasury.[20]

In April 2006 the National Association of Professional Insurance Agents (PIA) urged lawmakers on Capitol Hill to kill the Sununu-Johnson legislation that calls for a measure of federal regulation of insurance and gives insurers the choice to be licensed and supervised at the federal level. There is also opposition from states and other trade groups. Under this legislation there would be no loss of state premium-tax revenue as insurers would continue paying premium taxes to individual states and contributing, under most circumstances, to state guaranty funds that are used to pay claims in the event of insolvent insurance companies. Many of the large life and property & casualty companies support the notion. This legislation as proposed would not apply to health insurance since that line of business is regulated separately under a combination of state and federal oversight.

According to 2006-2007 NAIC President and Alabama Insurance Commissioner Walter Bell (as quoted in the magazine Reactions), an interstate commission that allows states to develop uniform product standards is a better way to improve insurance regulation in the United States than the

optional federal charter. Twenty six states, or 40% of the market, must approve the interstate insurance regulation compact model. When Alaska became the 26th state, an Interstate Commission was created that provides the states with the ability to collectively use their expertise to develop uniform national product standards. The interstate compact model will allow insurers to launch new products in multiple states more quickly and efficiently by establishing a central point of filing for insurance products. Under the system, companies can post a product filing in one state, and it will be automatically approved by all cooperating states. The Commission held its first meeting in Washington, D.C. on June 13, 2006, and took the first critical steps toward making the compact fully operational in early 2007, thereby streamlining state oversight of insurance products. So far, the compact includes only the life, annuities, disability income, and long-term care markets, but similar models may be considered for other lines of business.

The supporters of state regulation include the NAIC, some insurance agents and their associations, and a large number of insurance companies. The controversy between those advocating state regulation and those calling for federal control will no doubt continue. The eventual result may well be a dual system of regulation, but even in this event, the debate regarding which system is superior will probably continue.[21]

Vehicles for Market Regulation

It is common to distinguish between two broad, but interrelated, areas of insurance regulation: solvency regulation and market regulation. A primary focus of insurance regulation is insurer solvency, and it has been argued that this should be the primary function of regulation. Interest in insurer solvency is concerned with the early detection of potential insolvencies and the prevention of the detrimental effects on consumers when insolvencies occur.[22]

A second major focus of insurance regulation is the fair treatment of consumers. An insurer could be financially sound, yet engage in practices that are detrimental to the public – such as incorrect or untimely claims payment, discrimination in underwriting and rating, inaccurate advertising, and failure to relay in policy forms the mandated benefits to be provided.

Financial Examinations

State insurance departments conduct financial analyses and on-site financial examinations to protect consumers from financially unstable insurance companies. Many insurance departments are required by law to examine their domestic insurers once every certain number of years. Insurers are also required to submit annual and quarterly financial reports. These filings are also submitted to the NAIC and make up the largest financial database of over 5,000 insurance companies.[23]

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If financial analysis and review indicate an insurer is in financial distress, the insurance department may petition the courts for receivership or liquidation. In the event of insolvency, many lines of insurance are covered in the states by guaranty associations. These associates are created by law, and member companies pay an assessment. Once a company is declared insolvent, the guaranty association is activated to provide benefits for insureds and claimants.[24]

Market Conduct Examinations

NAIC records indicate the first state to conduct a market conduct examination was Illinois in 1969, with Missouri following suit in 1972. In a study funded by the NAIC and conducted by McKinsey and Company in 1974, one of the recommendations was to develop and conduct more frequent examinations of how insurers conduct business in hopes of protecting consumers as well as identifying practices that could lead to financial concerns in the future.[25] The study identified a specific need for a new type of examination, a formalized market conduct examination. As stated in the McKinsey Report, —T[]he purpose of market surveillance is to protect policyholders and claimants against unfair market practices. Although some states have been dealing with selected types of market conduct problems for many years, few have developed a comprehensive, organized system for dealing with all of them."[26]

The 1979 Government Accounting Office (GAO) report entitled —Issues and Needed Improvements in State Regulation of the Insurance Business" criticized states for not developing a system to uniformly track consumer complaints and exchange information about them with other regulators and the public. The GAO concluded that complaints were an important means of identifying market conduct issues. In response to this criticism, the NAIC members formed working groups and task forces to determined ways to achieve these goals. In 1991, the NAIC Complaint Database System (CDS) became available.[27]

Market regulation attempts to ensure fair and reasonable insurance prices, products, and trade practices in order to protect consumers. Specifically, market conduct examinations are designed to review how insurance companies conduct business with consumers for the purpose of protecting the public. The focus is on general business practices in underwriting, policy forms, rating, claims, marketing and sales, producer licensing, and complaint handling. These areas are checked for compliance with state statutes, regulations, orders, and interpretations.

Market conduct examinations can occur on a routine basis, but they are also triggered by complaints against an insurer or by other market analysis benchmarks. A comprehensive examination reviews producer licensing issues, complaints, types of products sold by the company and producers, producer sales practices, proper rating, claims handling, and other market-related aspects of an insurer's operation. Compliance with the state's

insurance statutes, regulations, rules, orders, and interpretations is also evaluated. Targeted market conduct examinations may focus on one or two issues, such as complaints or claims, or on a specific line of business.

When violations are found, the Department makes recommendations to improve the company's operations and to bring the company into compliance with state law. In addition, a company may be subject to civil penalties or license suspension or revocation.

Much has transpired during the ensuing 25 plus years since the first GAO report.[28] In fact, the GAO has since conducted another review of the states' progress in the market conduct area. On September 30, 2003, the GAO released its study entitled —Insurance Regulation: Common Standards and Improved Coordination Needed to Strengthen Market Regulation". This study once again focused on the need for states to develop a reliable and effective market regulation process. This time it also concluded that the states needed to focus attention on using technological resources currently available to them and to better monitor the behavior of the companies in the marketplace.[29]

Types of Market Conduct Examinations

Market conduct examinations can be conducted on all entities regulated by the state insurance departments. Regardless of the type of examination, all market conduct examinations should be performed in accordance with the procedures and guidelines as outlined in the *NAIC Market Regulation Handbook*. Chapter 10 of the *Market Regulation Handbook* details the various types of examinations and when they are generally used by the states.[30]

Market Analysis

Market analysis, as it relates to insurance market surveillance, is a relatively new term. In reality, regulators have conducted some form of market analysis for years. The current market analysis process is being developed through the NAIC by documenting and standardizing the methods that regulators use to determine whether there are issues of concern in the marketplace. For instance, consumer complaints have long been considered by market regulators when determining what companies or lines of business need attention. By documenting how different regulators use complaint information and creating a standardized system of recording complaint information, the market analysis method becomes formalized. It is important to note that market analysis is not just the evaluation of complaints. In fact, you will see in this chapter how market analysis is really much, much more.

As stated previously in this chapter, the states took the criticisms of the McKinsey Report and original GAO study under advisement and embraced the idea of market conduct examinations. The 2003 GAO report, —Insurance Regulation:

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Common Standards and Improved Coordination Needed to Strengthen Market Regulation", concluded that although most states conducted some form of market analysis, it was inconsistent, lacked standardization, and was not formalized. They found that states were not routinely utilizing all the tools available to them to analyze the market place and determine which insurers required further scrutiny. This GAO report can be seen as the genesis of the formalization of the Market Analysis program.[31]

What Is Market Analysis

While volumes can be written about what market analysis is and what it is supposed to do, the following definition sums up the meaning of market analysis:

> The concept of *market analysis* is the use of data and information already available to a state to understand the marketplace behavior of insurers.

There currently exists a large amount of data that is reported by companies to the states; for example, the Annual Statements, interrogatories, schedules to the Annual Statements, changes in Statutory Page 14 and 15 [State Pages] information, the computation of IRIS ratios by the states and NAIC, and special data calls from the states. There is also additional information collected by each state, such as its consumer complaint indices, information pertaining to filings, examination history and results, data calls, and other readily available data and information. There are also numerous trade journals, association information, litigation reports, research papers, newsletters, web pages, etc. that also provide additional information.

This volume of information can be overwhelming. In a state that is committed to monitoring its marketplace and wants to perform its regulatory functions efficiently and effectively, one can easily be confused as to what information is helpful and what is sensory overload. Market analysis provides a cohesive approach to the use of all of this data and information. This data and information, if used correctly and uniformly, can assist a state in identifying possible predictors of potential problems, thus allowing it to use its resources better, and develop a more detailed understanding of its marketplace. This integrated approach to the use of all currently available data and information assists a state in developing a type of risk-based approach to its regulatory responsibilities.

It is important to remember that there is no one predictor that can always indicate the need for an examination or any other regulatory response. Emerging issues are not always quantifiable. Market changes – such as the expanding use of credit reports, various manipulations of underwriting criteria, or the increasing use of genetic testing in underwriting life policies – often raise new consumer protection and regulatory concerns. Issues such as these are not always reducible to a number in an Annual Statement or

question on an Information Systems Questionnaire (ISQ). Analysts and examiners need to incorporate the information gleaned from Annual Statements, for example, with information obtained from the rates and forms section within the Department and with the results of their own analyses in order to fully understand the marketplace, whether a specific line of business or the specific practices of an insurer.

The functions of market analysis should be viewed as part of an integrated process. Market analysis is more than just monitoring a company for potential consumer harm issues. If a state is going to rely upon competition to assist in regulating its marketplace, that state has to know:

- Who – which companies are writing
- *What* – the types of coverage, the use of endorsements
- *When* – are certain companies writing more or less when the market is hard or soft?
- *Where* – are all markets being adequately served?
- *Why* – is a company suddenly writing a new line of business it has little expertise in?
- *How* – the various producer distribution methods, Internet sales, etc.

There is a caveat – not everything is quantifiable. Data elements do not answer all questions. Sometimes it seems obvious that a company needs an examination, based upon regulatory experience and/or company past practices. Furthermore, not every issue is complained about, nor does everyone know to complain. One cannot rely solely upon complaints to obtain a realistic picture of the marketplace. Analysis should not be viewed as variable x + variable y = z, with the resulting action an examination, interrogatories, or a meeting.

Emerging issues are not quantifiable; available data and information tell only so much. They are merely tools, guides, and triggers directing the examiner to do more —thinking". As states develop better analysis techniques and gain a better understanding of their marketplace, new reasons will emerge to justify the required regulatory action. The type of examination, whether comprehensive or targeted, will be driven by pre-examination work, so that the right regulatory response is selected not only as a means of conducting an efficient and effective examination but, more importantly, also as a means of adequately addressing the problem and instituting corrective measures as soon as possible.

States not only need to monitor the collection of data but also need to develop analytical techniques to best utilize the data and possibly refine what they currently have and what they think is needed. Market analysis leads to two eventualities:

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- Better selection of companies in need of regulatory attention
- Better monitoring of the marketplace.

Market analysis is not a substitute for an examination. The process is intended to allow a state to develop a ‗thumbnail' sketch of its major companies and to better understand those companies writing business in that state. It is a process that can help better select companies that need regulatory attention and determine the best method of addressing the documented areas of concern whether it be through an examination or some other less costly and resource draining method of regulatory response. A list of other regulatory responses is presented later in this chapter. Better analysis assists a state in selecting the ‗right' response to a problem.

States will continue to conduct examinations. There are some errors or violations – such as rating errors or improper underwriting practices, rate overcharges, and claims underpayments – that can be found only through the review of actual files. There is no schedule in the Annual Statement for these errors, nor are there many companies that voluntarily report these types of violations. Better analysis leads to a better reason for being there when an examination is warranted.

Ways to Use Market Analysis

When a company is experiencing difficulties, either financially or in the marketplace, its management may try unproven or precarious measures to keep it ‗afloat'. There are many ways they may choose to react. One historic Property & Casualty (P&C) method is to shift away from ―short tail" lines of business in which it is too hard for the company to compete. The company may not have the economies of scale or the technical expertise to successfully maintain those lines of business. The subsequent shift to new lines of business is often made so that the insurer can put off losses and obtain investment income from the premiums for the short term. Of course, in the long run the losses may mount, and the company may also be left with less expertise in the more complex ―long tail" lines. This method of evasion is a delay of failure at best. This is just one example of the reasons that analysts review the change of management on a Level 1 Market Analysis review and the IRIS ratios showing premium volume changes or writings in a new line of business. It is the integration of information and data that provides the analyst/examiner with an accurate picture of an insurer's business.

A similar Life & Health example can be drawn from the behavior of several large life companies in the 1980s as they competed with the ―buy term and invest the rest" philosophy of the mutual fund sales force. The results of some of these companies' practices were replacements, churning, ‗vanishing premiums', and life products being sold as ‗retirement', ‗investment', or ‗tax free' programs. The promises made by some of the sales force and companies have proven themselves to be unsubstantiated. Some very large, well-respected insurers have seen their images severely tarnished, their

ratings deteriorate, and their solvency re-evaluated while having to make restitution to consumers during the course of litigation.

Detractors of market conduct examinations often allege that examinations are too technical or nitpicky or that data calls and interrogatories are too repetitive and cumbersome. However, carelessness in the use of policy forms, vagueness about licensing, confusion as to which rate plan applies, and the inconsistent application of effective dates are all indicators of poor management and poor controls over the products and processes of the company. Questionable advertising materials and lack of experience in a line of business can also be precursors to future problems. Poor management leads to consumer dissatisfaction, which leads to an increase in consumer complaints, which can then trigger the need for some sort of regulatory response by examination or some other action dictated by the performance of the company.

All of these problems serve as striking examples of the value of complaint trending and complaint analysis. It has been stated that some life insurers —… were more solvent than Sweden". While a financial examination may not take issue with these companies, the market conduct examination, by reviewing all relevant data, discerns the extent of suspected problems. This is an example of why an analyst should review past examinations, regulatory actions, and unusual policy filings.

One of the early mandates for state regulators was to do —..a better job of early detection of problem companies."[32] The integration of market analysis into market conduct allows a state to do just that. The systematic review of complaint databases, financial data, information from other states, and other data and information allows a state to make a more informed judgment of the business practices of companies doing business within its borders.

Market Analysis Tools

Market conduct examiners and market analysts have many tools at their disposal to help identify when a company should be considered for different levels of regulatory review. Additional tools help ensure that an examination, at whatever level, is objective and efficiently performed.

NAIC Market Analysis Checklist and the Core Competencies

Prior to 2006, the NAIC developed a market analysis checklist that provided guidelines for formalized market analyses and requirements for a successful state analysis program for Market Analysis Chiefs (MACs) from each state. During the 2006 Summer NAIC National Meeting, the Market Analysis Priorities Working Group recommended that the Checklist be phased out since it duplicated much of the information found in the Core Competencies developed initially by Uniformity (D) Working Group and expanded by the

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Market Regulation Handbook (D) Working Group. (In 2007, the Uniformity (D) Working Group and the Market Regulation Handbook (D) Working Group were combined into one group, the Market Regulation Handbook (D) Working Group.) The Core Competencies are included as an Appendix in the *Market Regulation Handbook*.

The Market Analysis Handbook and the Market Regulation Handbook

As a part of formalizing the market analysis process, NAIC members created the *Market Analysis Handbook*. The handbook was intended to provide states with guidance for improving their ability to select companies for examinations and to monitor the marketplace. Some areas initially developed for the handbook included discussion of the use of complaint data in analysis; a discussion of the Market Conduct Annual Statement; a review of basic analytical tools available through the NAIC's I-SITE, such as complaint data, Annual Statement data, state pages, and IRIS scores; information about the role of the Market Analysis Working Group (MAWG) and direction to the states for developing a baseline approach for analysis using the information provided. In 2006, in keeping with the idea of a uniform approach to market regulation, the NAIC combined the *Market Analysis Handbook* and the *Market Conduct Examiners Handbook* and released the *Market Regulation Handbook*, a combination of both prior handbooks.

Complaint Trending

Complaint trending is currently one of the most prevalent techniques used to identify marketplace problems. Complaint trending has its problems, however, because notification of a problem is almost always after the fact. Nonetheless, trending can be useful. In particular, a state's review of its complaints, confirmed or unconfirmed, written or oral, on a quarterly or monthly basis, can provide real-time information regarding any developing problem area. While states may define complaints differently, each state's data should be consistent internally and should serve as a significant indicator of potential problems with a company. The total number and frequency of complaints can be used as a basic indicator of compliance issues, yet there may also be individual complaints that, because of their nature, raise serious questions about an insurer's conduct. The continuum of regulatory responses, outlined in greater depth in *the Market Regulation Handbook*, provides guidance or suggestions for addressing these emerging issues without the necessity of calling an examination. In addition, a state can use the continuum to assist in developing a more proactive approach to its marketplace rather than waiting for a specific number of complaints to be lodged before taking any type of action. The options available under the continuum can also assist all of the states in moving from a piecemeal approach to an approach that focuses on marketplace behavior. Handling complaints —as they come in the door" does not normally get to the cause of the problem.

States need to learn to —mine" their complaints for more information. While almost all states create some type of complaint index, there needs to be more analysis in addition to the raw numbers. The NAIC's Complaints Database System (CDS) makes it possible to analyze complaint trends at the state, regional, and national levels. The value of CDS will be enhanced only as all states move to full participation and standard coding protocols are adopted. A complaint tracking system should be able to total complaints by type, reason, and company so that an index can easily be established for each company. Another key to this effort involves checking the accuracy of coding protocols to verify that insurers are reporting data on complaints correctly. Miscategorization of complaints might result in the failure to identify trends correctly.

The Complaint Handling and Reporting Standards Subgroup of the Consumer Protection (D) Working Group has been working on improvements to complaint coding, standardization of coding practices and education for regulators to assure more uniformity in complaint coding and analysis. Uniform standards applicable to all companies in all states results in an accurate exchange of information, systematic analysis of that information, accurate use of complaint information in the states' regulatory functions, and useful complaint information becoming available to the public.

Complaint Ratios and Indices

The disclosure of aggregate complaint data varies by state, but most states publish aggregate data in some format via an annual report or consumer brochure or on the Department's website. While not all states affirmatively disseminate aggregate complaint information, many states now publish complaint ratios or indices.

The complaint ratio is designed to compare a company's number of complaints to business written. It is a ratio of the company's number of complaints divided by its premium written. A complaint index compares the complaint ratio for a company to the complaint ratio for all companies selling that line of business. The complaint index facilitates comparison between companies and takes into consideration a company's premium volume.[33] For example, a company with a complaint index of 1.00 has an index equal to the average of all companies. In other words, the number of complaints filed against the company was equal to what was expected based on the total number of complaints received by all companies and the company's market share. If a company has a complaint index of .70, its index is lower than the average of all companies (1.00). Fewer complaints were filed against the company than expected based on the total number of complaints received for that line of business and the company's share of the market. A company with a complaint index of 2.35 has an index 135% greater than the average of all companies. In other words, more complaints were filed against the company than expected based on the total number of complaints received for that line of business and the company's share of the market.

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Because complaint ratios and indices can have an impact on a Department's decision to undertake some form of regulatory action, whether an examination or other continuum option, and because complaints greatly influence the general public's perception of a company, it is very important that complaint ratios and indices be based on reliable data. Internal quality control measures to ensure data integrity should be implemented. Routine audits or studies should be conducted to determine that proper codes are used and are being used consistently. States should also review their codes to determine if new or amended codes need to be proposed to address evolving market issues. However, states must be cognizant of the fact that any proposed change to the internal code structure will impact reporting to the NAIC's CDS. Accordingly, all proposed changes should be coordinated through the NAIC.

The complaint index should be adequately footnoted to clearly specify how it was calculated. While it would be more beneficial and accurate to have complaint ratios based upon the number of policies in force instead of premium volume, most ratios are based upon premium volume because the number of policies in force is not readily available.

Complaint Tracking

It is important for insurance departments to establish a database to track key elements of the complaint process. The analysis of complaint data can identify potential company or industry trends or concerns including non-complying general business practices or acts that may adversely affect consumers. For instance, a large influx of complaints relating to premiums may indicate a lack of affordable coverage in a specific geographic area or a rate increase by carriers within a specific area. The trends identified from analysis of the database can be used to trigger a referral to the market conduct or enforcement area.

When establishing an internal complaint tracking system, it is imperative that states adopt the uniform data standards used for the NAIC's Complaints Database System (CDS). The CDS was established to facilitate uniform data standardization, complaint analysis, and the sharing of complaint data by multiple states. The CDS provides a central repository for complaint information in a standardized format that is electronically retrievable. A variety of standard reports are available. The computerized data collection system provides states with a resource for in-depth analysis of complaint information. Data can be analyzed by geographical area, by line of business, by company, or by any other standardized data element. The CDS provides the states with a technological tool to enhance their ability to regulate the industry and assist the consumer.

The CDS provides a uniform complaint recording form with data fields that identify and categorize:

- The complainant

- The entity against which the complaint is filed
- The type of coverage
- The reason for the complaint
- The final disposition of the complaint.

CDS enables a state to obtain access to more detailed information than that available only through internal departmental databases. CDS provides many reports to regulators including:

- CDS Index Report
- CDS Summary Closed Complaint Counts by State
- CDS Summary Closed Complaint Counts by Code
- CDS Summary Closed Complaint Trend Report
- CDS Closed Complaint Filing Status.

Level 1 Analysis

Starting in 2004, regulators and the NAIC created and implemented Level 1 Analysis, a standardized method for market analysis. Regulators first review baseline information about all insurers in the state selling a particular line of insurance to determine which carriers may need review. The Level 1 analysis is a series of standardized questions about the company‘s management, complaints, market share, product mix, administrative actions, and financial reports. Responses are determined by reviewing information available through I-SITE. At the end of the review, the analyst makes a recommendation for next steps. In 2005, Level 1 reviews were automated allowing authorized Department personnel to view information on Level 1 reviews conducted by other states.

Level 2 Analysis

At the conclusion of a Level 1 analysis, an analyst may determine that the company requires no further review or that more in-depth analysis is warranted. Level 2 Analysis is the next step in the analysis process. It is designed to look beyond the statistics and summary reports used in Level 1. Level 2 Analysis requires analysts to look at other information available within the Department – including individual consumer complaints, enforcement actions, examination reports, and rate, rule, and form filings – as well as from outside sources – such as the company‘s website, the media, and government agencies.

The Level 2 Analysis Guide includes both core and optional areas of review. The core areas of review are recommended for any Level 2 Analysis, while optional areas of review are discretionary and may not always be necessary. Factors such as the line of business, areas of concern identified during earlier

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phases of analysis, and the statutes and rules/regulations of the jurisdiction performing the analysis should be considered.[34]

The Level 2 Analysis Guide is an Appendix to the *Market Regulation Handbook* and contains detailed information about areas of review as well as guidance on issues to consider and suggested resources for each area of review. It is recommended that the reader consult the Handbook for an in-depth review of the Level 2 Analysis process.

There is an on-going discussion at the NAIC about the possibility of automating the Level 2 Analysis, and such automation is anticipated shortly. Unlike the Level 1 Analysis, Level 2 Analysis does not lend itself to complete automation since there is too much subjective reasoning involved and each review may be quite different from the next depending on the company, areas of concern, and tools used in conducting the review. There are, however, basic components required for a Level 2 Analysis that can be documented – such as the line of business being reviewed, the areas reviewed, a contact person for the jurisdiction that completed the analysis, the proposed action to be taken, and a comments section. Until a specific automation process is developed, analysts can enter this information into the Market Initiative Tracking System (MITS) in I-SITE.

In addition to the Level 2 Analysis Guide, Chapter 3 of the *Market Regulation Handbook* provides detailed information on basic analytical tools used to review a carrier‘s performance in the market place and identify areas requiring further review. The reader should familiarize himself with these tools to gain a better understanding of the analysis process and how such tools can be used to target areas of review in the event that a market conduct examination is warranted.

The Market Conduct Annual Statement (MCAS)

The Market Conduct Annual Statement (MCAS) pilot project began in 2000. The goal of the project was to provide a uniform system of collecting market related information for the participating states. The MCAS provides regulators with information not otherwise available for their market analysis initiatives for private passenger automobile, homeowner, life, and annuity products. It promotes uniform analysis by applying consistent measurements and comparisons between companies, thereby allowing all companies to be compared on an equal basis. The NAIC‘s web page contains a detailed explanation of the type of information requested in the MCAS.

In 2004 the MCAS became a permanent project. To limit the impact on insurers, a decision was made to gradually add new participating states. This also enabled states to obtain the necessary resources to handle the MCAS data. In time, it is hoped that all jurisdictions will use the MCAS and that more data and lines of business will be considered.

To assist participating companies in gaining a better understanding of their position in the marketplace, each company is provided with a "report card" from each state where it filed the MCAS. The report card includes information about the company's ratios in relation to average industry ratios and enables the company to use this information in identifying areas where opportunities may exist for the company to take action to improve its performance.

As with other market analysis tools, if a company falls outside the norm, it does not mean a market conduct examination will automatically be initiated for the company. Conversely, participation in the MCAS is no guarantee that a market conduct examination will not occur.

Communication of Market Analysis with Other Divisions and Other States

While all insurance departments tend to be organized differently, all of them perform a similar set of market regulation functions:

- Consumer assistance review
- Producer licensing review
- Rate and form review
- Market conduct examinations
- Investigations
- Enforcement.

All of these functions, as well as the myriad of financial regulatory functions, generate useful information about marketplace concerns. An effective market analysis program must include procedures for regular, routine sharing of information among the various sections or divisions within the Department as well as with other states.

Monthly staff meetings are one way to ensure that pertinent information is shared with the correct person. E-mail messages are convenient, but they frequently do not allow for the open exchange of ideas, questions, and comments.

An Example of Specific Market Analysis Techniques

Claim Handling Review

An insurance company files a significant amount of

Defense Costs	Claims Incurred	Direct Premium

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information in its Financial Annual Statement. That information can be utilized to make some general assessments about a company's claim payment activity. For instance, the level of funds reported as claims defense costs might provide clues about changes in a company's claims payment practices. Consider the following information about ABC Insurance Company's claims defense costs:

Year 1	696,541	2,553,987	6,127,544
Year 2	701,442	3,599,612	6,543,339
Year 3	1,314,980	3,210,923	5,762,128

Year 4	4,459,973	8,238,002	12,092,481
Year 5	5,213,382	7,219,091	12,345,353

Notice the dramatic increase in defense costs beginning in Year 3. Some of the increase can be attributed to the increase in premium volume during Year 4 and Year 5. Most companies experience fairly constant ratios of defense costs to claims incurred and direct premiums. A dramatic shift in one of those ratios could be telling about a change in the company's philosophy regarding claims payment. An experienced market analyst would see this shift in a company's data and consider other available information to determine whether or not a closer look at the company should be completed.

The Market Analysis (D) Working Group (MAWG)

The Market Analysis (D) Working Group (MAWG) identifies and reviews insurance companies that exhibit, or may exhibit, characteristics indicating a current or potential market regulatory issue that may impact multiple jurisdictions. The Working Group determines whether regulatory action is being taken and supports collaborative actions in addressing identified problems.

MAWG consists of representatives from 16 states. It is charged with the responsibility to:

- Provide policy oversight and direction of the Collaborative Actions Designees (CADs), collaborative analysis, and collaborative regulatory interventions
- Facilitate interstate communication and coordinate collaborative state regulatory actions
- Recommend appropriate corrective actions and common solutions to multi-state problems
- Facilitate the use of a broader continuum of regulatory responses.

MAWG members are required to attend the quarterly NAIC national meetings and participate on regular and special conference calls throughout the year. The Working Group meetings at the NAIC national meetings are generally open to all state regulators, but the Working Group calls are for MAWG members only. MAWG does conduct conference calls with department Collaborative Action Designees (CADs) to apprise them of ongoing MAWG initiatives.

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The Continuum of Regulatory Responses

A state has a broad continuum of regulatory responses available when determining the appropriate response to an identified issue or concern. This continuum includes such initiatives as:

- Office-based information gathering
- Interviews with the company
- Correspondence
- Policy and procedure reviews
- Interrogatories
- Desk audits
- On-site audits
- Investigations
- Enforcement actions
- Company self-audits
- Voluntary compliance programs.

The NAIC Market Initiative Tracking System (MITS) is a database that became available in I-SITE in 2006 and is used to track significant market regulation continuum responses that are tracked in neither the Exam Tracking System (ETS) nor the Regulatory Information Retrieval System (RIRS). A review of the initiatives related to a company contained in MITS may provide the analyst with useful information about the company.

For a detailed discussion of the continuum of regulatory response, please refer to Chapter 2 of the NAIC's *Market Regulation Handbook*.

The NAIC's Uniformity Initiatives

As previously discussed, formalized market analysis and uniform approaches to market regulation are relatively new areas of development for regulators and the NAIC. Through the various market regulation working groups of the D Committee, the NAIC continues to enhance uniform standards for market regulatory functions. In recent years Core Competencies were adopted in areas of civil investigations, complaint handling, the continuum of regulatory response, and the roles of the Market Analysis Chief (MAC), Collaborative Action Designee (CAD), and contract examiners. Other competencies will be developed as members identify need. Going forward, the NAIC will continue to establish methods to evaluate and monitor how states implement the Core Competencies to create a more standardized program of market regulation. The Market Analysis Priorities (D) Working Group continues to advance the use of electronic

automation for market analysis functions and monitors the states‘ full participation and accurate submission of data in all of the NAIC‘s Market Information Systems, including the Complaints Database System (CDS), Examination Tracking System (ETS), Regulatory Information Retrieval System (RIRS), Market Analysis Review System (MARS), Market Initiatives Tracking System (MITS), and Special Activities Database (SAD).

Conclusions

The purpose of market conduct examinations is:

- To ensure the equitable treatment of consumers
- To validate compliance with the statutes and rules/regulations
- To monitor the insurance marketplace actively.

How can we accomplish these —missions” today? First, the mindset needs to shift from that of market conduct examinations to market regulation as a much more global view of the function. Remember: It is not just about complaints anymore or the knee-jerk response to conduct an examination whenever a problem is identified in the market place. Market analysis formalizes and standardizes what some states have been doing for years. States have relied upon established criteria for selecting companies to examine and for determining whether some other form of regulatory response is warranted. In the past these results were not necessarily formalized or shared with other states, nor was the process uniformly applied. New strategies in market regulation include sharing results, sharing thought processes for selecting or not selecting companies, sharing examination results, producing a written record, and coordinating actions among the states.

The function of market conduct is going to continue to change. There will be a greater synthesis of the analysis function with the on-site examination function. There will be a —folding-in” of examination results with analysis results. An examination is often times the best means for obtaining —live” results that can then be compared to, and integrated into, the analysis information, both at the individual state level and among regulators from all jurisdictions.

Because market regulation is changing rapidly, it is important that regulators and industry representatives maintain up-to-date information on these initiatives. The current version of the *Market Regulation Handbook* and the information on market regulation posted on the NAIC website (www.naic.org) provide the most up-to-date and accurate information for interested parties and regulators.

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Endnotes

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[31] Insurance Regulation: Common Standards and Improved Coordination Needed to Strengthen Market Regulation. No. GAO-03-433, September 30, 2003.

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Chapter 2
- Anatomy of a Market Conduct Examination

Educational Objective

Be able to identify the sequential components and processes of a "typical" market conduct examination.

Pre-examination Planning

Once a determination is made that a company is an appropriate candidate for an examination, there are several steps to initiate before the specific examination preparation work begins. Some of those steps are described below.

Role of Market Analysis

As defined by the NAIC, a Market Analysis program is a system of collection and analysis of data and other information.[1] This enables a regulator to identify important market conduct problems as early as possible and to eliminate or limit harm to consumers. Making use of market analysis data on complaint trending, market conduct examination history, investigation and enforcement history, producer information, rates and forms information, and financial information can help determine if an insurer is an appropriate candidate for an examination. Once a company is chosen for an examination, an examiner may use the data gathered and analyzed during Market Analysis to help prioritize and coordinate examination activities.

Pre-examination Handbook

The coordinator's pre-examination handbook provides necessary information and instructions to the company's examination coordinator as preparation for the examination:

- General instructions
- Scope of the examination
- Start date
- Data call samples and detailed instructions for sampling
- Requirements for office space and supplies (including modem requirements)
- Location of on-site examination
- Travel information
- Estimated examination time and costs

- Billing procedures
- Instructions for communicating with the company.

The handbook should be sent to the company at least 30 days before the commencement of the on-site examination.

Multi-state Collaboration

All jurisdictions do their own examinations, but cooperation among jurisdictions is important to avoid duplication of effort and make use of information already developed. A multi-state examination designates the lead state to name the Examiner-in-Charge (EIC), utilizes an agreed-on set of standards, and often produces a single joint report. As pointed out in the NAIC Market Regulation Handbook, a multi-state examination can provide a baseline that could allow other jurisdictions to reduce the scope and duration of their subsequent examinations. At least 60 days before the commencement of an examination, each state should enter the examination into the Examination Tracking System (ETS), which is administered by the NAIC. When a new examination is in the planning stages, a review of the ETS system provides information as to whether another state is currently conducting an examination on the same company, has recently completed one, or is about to commence a new one. If the last is true, it may be possible to collaborate with the other jurisdiction in a joint examination.

Before the Examination

The goal of the examination planning process is to identify the areas to be reviewed during an examination, minimize the time spent on-site, and maximize the contribution of personnel resources for each examination. To ensure an effective and efficient examination, 16 steps comprising a standard planning process are usually followed as described below.

I. Preparation and Analysis of Information

Once an examination has been authorized, the various sections within the Department should be notified of the examination and requested to provide pertinent information. Analyzing and compiling internal Department information – along with any information from outside sources – helps define and prioritize issues for an examination. These sources include:

- Internal complaint analysis
- Previous examination findings
- Market Conduct Annual Statements
- Financial analysis
- Rate and form review

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- Market share analysis
- Producer licensing
- Information from outside sources.

For the financial analysis portion, it is of particular importance to review a company's Annual Statement with focus on the Statutory Page – Exhibit of Premiums & Losses when determining what areas to review in a company. The Statutory page provides the lines of business the company is involved in, direct premiums written and earned, direct losses paid/incurred/unpaid, etc. By reviewing this document, a better feel can be developed concerning the company's operations.

The following NAIC databases add specific information:

- RIRS – Regulatory Information Retrieval System tracks adjudicated regulatory actions on companies, agencies, and agents by origin, reason, and disposition.
- CDS – Complaints Database System stores closed consumer complaint information for a period of ten years. This information can be retrieved by state name, types of coverage, complaint reasons and dispositions, and complaint trends and counts.
- SAD – Special Activities Database tracks investigative or suspicious activities by entity and can be accessed only by regulators.
- PDB – Producer Database contains licensing information and status for producers as well as disciplinary history and administrative actions.

II. Examination Scope

Areas for Review

Once information sources have been evaluated for relative significance, the examination scope can be defined. Emphasis should be on the insurer's general business practices. A number of specific market conduct areas may be reviewed in an examination. Some of the primary ones include the following:

- Management/company operations
- Complaint handling
- Marketing and sales
- Producer licensing
- Policyholder service
- Underwriting and rating
- Claims handling.

Populations of Files for Sampling

After the scope of the examination has been established, the populations of files for each line of coverage and area of review are requested. The populations must be accurately and specifically defined by categories such as, but not limited to, line of coverage or type of claim, examination period, state, individual company within a group, premium size (so that the samples that will be selected from these populations will be relevant), etc.

Tests to be Performed

Once data is received from the company, the examiner should check the accuracy and completeness of the information provided. The *NAIC Market Regulation Handbook* suggests the following:

- Control Totals – The company should provide the total value of key fields, and once the data has been converted to a computer program, the totals of those fields should be calculated to ensure there was complete data conversion. Any discrepancies should be addressed with the company and corrected.
- Data Quality Analysis – Once the data is converted to a computer system, a brief review of the data should be performed to ensure that each field contains the correct data and makes sense.[2]

Sampling Integrity Issues

As noted in the NAIC Market Regulation Handbook, a sample —should be a microcosm of the population or field from which it is drawn".[3] It is important that the sample represents all components being analyzed. To preserve the integrity of the samples selected, certain NAIC-outlined standards should be followed:

- Pre-selection – The company subject to examination should not be allowed to pre-select the file samples because such a sampling could be intended to produce a certain biased result. Similarly, an examiner should not be allowed to pre-select the samples, as such selection may be based on his personal needs or comfort level. Computer-based sampling – such as ACL or Excel random sampling – is the preferable method for developing a sample list.
- A sample size that produces a minimum statistical confidence level of 95% should be selected in order to show a result as valid.
- A 10% tolerance level is recommended for all procedures except for claims, where 7% is recommended. Some states' prompt pay claims statutes impose a 5% tolerance level.
- Assumption of results beyond the field of files from which the sample is selected is not acceptable. A sample can be

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representative only of the population from which it is drawn. For example, assumptions about standard fire policies should not be drawn from a population of homeowner policies, since these two policy types are not homogeneous.

III. Discussion with Supervisor

Once a list of proposed lines of coverage and specific areas are selected and prioritized, the EIC or Lead Examiner should review the proposed approach with his supervisor. As a result of this discussion, additional areas for examination may be introduced and other areas re-prioritized or eliminated.

IV. Analysis of Information for Pre-examination Memoranda

When the areas designated for the examination have been chosen and prioritized, the EIC or Lead Examiner next analyzes all the information provided by other personnel, internal Department reports, NAIC databases, and other external information. The goal of this review is to fine-tune the scope of the examination by drafting details in a pre-examination memorandum that will be distributed internally to appropriate Department personnel.

V. Additions or Changes to Scope of Examination

The analysis noted above may have brought to light information that would suggest additions or deletions to the proposed scope of the examination. This is the point at which those changes should be incorporated into the plan so that they can be included in the pre-examination memoranda and in the subsequent call letter to the company.

VI. Assessment of Functional Priorities

Areas of Review

The EIC must identify the areas of review that should be completed on-site and those areas that can be completed in-office (i.e., desk audit). Certain areas lend themselves to a desk audit. Producer licensing, for example, can be completed at the Department office using the sample list with producer names and the producer registry provided by the company in conjunction with the NAIC Producer Database.

Time and Personnel Requirements

After establishing an estimated time for completion of the on-site documentation review, that timeline should be compared against the specific areas to be analyzed. If one or more sections are significantly larger or more complicated, the timeline may need to be adjusted or more examiners added for that area without modifying the timeline for the rest of the on-site review. If one or more areas require expertise over and above

that of the selected examination team, an examiner with the required special expertise may have to be added for those specific areas of review.

Off-site vs. On-site

Just as the on-site examination requires specific allocation of resources, timelines, and budget and expense considerations, off-site examination activities require attention to the same considerations. Once areas to be examined off-site are identified, the EIC or Lead Examiner must determine how many examiners (employee, contractual, or both) are needed to complete the assignment. An estimated date for completion must be determined, costs estimated, and billing procedures established for the off-site portion of the work.

VII. Draft Pre-examination Memoranda

When the planning process is completed, the EIC or Lead Examiner drafts a memorandum providing the major lines of business to be examined, standards for review, a time estimate for the on-site examination, and the participating examiners and their specific designated review areas for the examination. The coordinator and examination site address are noted, and travel arrangements and billing procedures are outlined.

VIII. Draft Notification Letter and Appointment Order

The company to be examined is notified of the upcoming examination by letter. This letter generally explains the examination process, identifies the EIC or lead examiner, and contains the statutory authority for the examination. The announcement of the examination should be sent no later than 60 days before the estimated start date for the on-site review. However, less time may be provided in those instances where an examination must be called quickly in order to respond to issues that require a more expeditious review.

The pre-examination handbook (described above) may be enclosed with the letter announcing the examination. If it is not included with the announcement, it should be sent no later than 30 days before the estimated start date of the on-site portion of the examination.

IX. Meeting with the Supervisor and Chief Market Conduct Examiner

When the pre-examination memoranda and the notification letter have been completed, the EIC or Lead Examiner meets with his supervisor and possibly the Chief Market Conduct Examiner to discuss the final examination plan objectives and details. Barring any unexpected information or event, changes to the plan at this point should be minimal or non-existent.

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X. Budget

Billing procedures and expense parameters for the specific examination should be determined in light of the completed plan and timeline. A decision should be made as to whether the examination can be efficiently completed with company personnel alone or if the additional expense of a company contractual employee is warranted. There are situations where the proposed examination could be effectively completed using only contractual employees hired by the company, thus conserving use of company personnel for other required work.

XI. Data Call

The pre-examination handbook sent to the examination coordinator with the examination notification letter provides detailed instructions for the data requests. The EIC actually requests the data. As suggested by the NAIC, states should use the published uniform data requests or inform the company that they will be supplying alternative data requests. Typical data requests are made for policy types by policy number, effective date, issue date, producer, and premium size; or for claims, type of loss, claim number, date received, and so forth. A specific deadline for receipt of the information should be included with the request. Once the data is received, it needs to be validated.

XII. Pre-examination Conference

Prior to the commencement of an examination, a meeting with the company's examination coordinator and other key company personnel is held to outline the expectations for the examination. This includes:

- A discussion of procedures for handling questions presented by the examiners and the subsequent company responses
- An introduction of the examiners participating in the examination with identification of the specific areas each will be reviewing
- An estimate of time for the on-site examination
- An outline of the timeframe for steps following the on-site examination (initial report, company response, discussion of differences, appeal procedures, and final report/order publication).

XIII. Identifying Team Members, Roles, Timelines

Identifying the right people to be used in the correct roles is essential when building a team. Building a team requires focusing not only on the skills of the individuals involved but also on their personalities. For instance, many times an examination team works together in tight working spaces with few conveniences. In a worst-case scenario, the team

members could be working in an adversarial environment between company personnel and themselves.

Therefore, it is critical to build a team with certain skills. The EIC or Lead Examiner needs to have good communication skills (both written and verbal). He/she needs to have analytical skills and an in-depth understanding of the insurance business under review. Knowledge of software systems and the ability to adapt to various company systems is also required. The EIC or Lead Examiner makes the decisions as to which examiner will complete the reviews. Thus, the EIC or Lead Examiner needs to have leadership abilities to recognize which examiner is good at a certain task and to use the examiner accordingly.

When selecting the examination team, it is important to look for those individuals who will complement the examination process. For instance, if the examination is targeted for claims review, look for an examiner who has a claims background and who is adept at learning new computer systems. It is a good and hopefully obvious idea that the examiner‘s background be in the line of business that is to be reviewed (i.e., Life & Health, Property & Casualty, etc).

Timelines in an examination are very important. The EIC or Lead Examiner should always have a timeline in mind. However, it is not always beneficial to share this with a company. At the beginning of an examination, the EIC or Lead Examiner should estimate the approximate time that it will take to complete the examination based on the amount of business, number of examiners, and number of items to be reviewed. Depending on the circumstances, this timeline usually fluctuates to some degree throughout the examination based upon findings, company responses, and, many times, circumstances that are completely out of an examiner‘s control, such as a company‘s unwillingness to provide information to the examiner or the company‘s very slow response in producing information. Some Departments have addressed this matter by issuing fines based on slow response, threatening to move the examination to the Department, or just playing the waiting game with the company under review. The appropriate procedure depends on the particular circumstance.

XIV. Resource Sharing and Work Submission Procedures

An EIC or Lead Examiner needs to be proactive prior to, and during, an examination in order to gather information about a company. A wealth of data can be obtained from an insurance department. The Department‘s Consumer Services section can provide information about a company‘s complaints for the current year and several prior years. The Licensing Section can produce a listing of current producers and agencies. In addition, sharing data about problem producers is beneficial. If the examination was called due to fraudulent and/or unethical practices, the

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Investigation Section may likely be involved. It is sometimes helpful to check with the Financial Section of the Department. This is where slow claims payers should be reported. The NAIC can provide listings of examinations and fines that have been levied from various state insurance departments.

XV. Problem Resolution Procedures

In order to reduce company fears and anxieties, it is usually best at the start of the examination to state the purpose. A true market conduct examination is one in which an examiner finds the facts and documents those facts. An examiner is not expected to be the company‘s best friend or its worst enemy but rather to determine if any violations of the law are occurring; and if so, to state that in a report that is filed with the Department. It should be explained to the company that once the report is submitted, the company has a certain number of days to respond before final issuance.

In most cases, if the examination team is forthright, a company is more willing to cooperate with the process and agree to disagree in a professional manner. When a problem does arise during an examination, it is usually best to try to reach an agreement. It may be simply an agreement to disagree with one another. When that is the case, neither will be satisfied, but the company and the examiner can continue to move forward with the examination. This tends to eliminate a possible standoff.

For those situations in which agreements are not possible, it is very important that the examiner document the findings. Once a report has been submitted to the Department and a few months pass (or, possibly, a subsequent examination occurs), it is somewhat difficult to remember the facts of a case. If the Department has this information well documented, the details are on record.

The Examination Team

XVI. Standards of Professionalism

It is always important to represent the profession well. Not only is it important to the current examiners and the current examination, it is also important to all fellow examiners that are in the insurance industry. This is a topic that should need little explanation, but unfortunately, different standards, and a variety of meanings, of professionalism do exist.

One‘s degree of professionalism sets the tone for how the examination develops. A professional manner lets the company know that examiners mean business and that they expect respect from the company by respecting the company itself. It gives the company confidence that what is presented is reliable and that the examination is being run competently.

But, what exactly does ‗professionalism‘ mean? It is the examination team's actions. It is not only being competent about the insurance business but also being competent about the interaction with others. Sometimes this means reasonable compromise. For instance, a company whose business attire is suit and tie expects the same from the examiners. However, if a company has business casual as the dress code, speak with the coordinator and inform him/her that the examiners will follow the company dress code.

Besides what the examiners wear, it is important that the examiners respect the company environment. Be courteous by asking where to park, what the company hours are, where the break rooms are located, whether drinks can be taken to the desk, etc. It never hurts to be polite.

Developing a healthy working relationship with the coordinator prior to arriving at the examination site is very beneficial and allows the coordinator the ability to approach the examiners when questions arise during an examination. It is important to take the time to be approachable on the little items so that when big items develop during the examination, both sides will feel comfortable in discussing the situation. Following the saying that ―You can catch more flies with honey than vinegar" seems appropriate in a market conduct examination situation.

IRES Code of Ethics

IRES developed a code of professional conduct and ethics for members who use the designations of the Society. It is the responsibility of the member to ―assume an obligation of self-discipline above and beyond the requirements of laws and regulations". The code contains five articles, which include:

Article I – Responsibilities

In carrying out their responsibilities as professionals, members should exercise sensitive professional and moral judgments in all their activities. Members have a continuing responsibility to cooperate with each other and other regulatory societies to improve the art of regulation of the insurance industry within the framework of regulatory laws and regulations. The collective effort of all members is required to maintain and enhance the traditions of the regulatory profession.

Article II – The Public Interest

Members should accept the obligation to act in a way that will serve the public interest, honor the public trust, and demonstrate commitment to excellence in the performance of their regulatory duties.

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Article III – Integrity

To maintain and broaden public confidence, members should perform all regulatory responsibilities with the highest sense of integrity. Integrity is an element of character fundamental to professional recognition. It is the quality from which the public trust derives and the benchmark against which a member must ultimately test all decisions. Integrity requires a member to be, among other things, honest and candid within the constraints of statutory confidentiality. Service and public trust should not be subordinated to personal gain and advantage. Integrity can accommodate the inadvertent error and the honest difference of opinion; it cannot accommodate deceit and subordination of principle. Integrity also requires a member to observe the principles of objectivity and independence and due care.

Article IV – Objectivity and Independence

A member should maintain objectivity and be free of conflicts of interest in fact and in appearance in discharging regulatory responsibilities. Objectivity is a state of mind, a quality that lends value to a member‘s performance. The principle of objectivity imposes the obligation to be impartial, intellectually honest, and free of conflict of interest. Independence precludes relationships that may appear to impair a member‘s objectivity in the performance of regulatory duties.

Article V – Due Care

Members should observe the profession‘s statutory, technical, legal, and ethical standards promulgated by their regulatory authorities, strive continually to improve competence and the quality of their services, and discharge professional responsibility to the best of their ability. The quest of excellence is the essence of due care. Due care requires members to discharge their regulatory responsibilities with competence and diligence.

Potential Conflicts of Interest

A conflict of interest occurs if the examiner has ever been employed by the company being examined or if the examiner has the potential to have financial gain from the company. Normally, a Department asks the examiner for any possible conflicts of interest. However, if this has not occurred and an assignment has been made where there is a conflict, it is the examiner‘s responsibility to report the conflict.

The Need for Professional Development

Professional development is one of those necessary requirements to maintain excellence in the insurance field. As with all occupations, the world is changing; so in order to maintain one‘s excellence, one must

continue to learn. It is an IRES requirement that continuing education be pursued in order to maintain a designation.

The Role of the Examiner-in-Charge (EIC) or Lead Examiner

The role of the EIC is based upon each of the items described below. During an examination the EIC establishes timelines, organizes work, assigns examiners to tasks, resolves issues that develop, and coordinates with the insurer so that the examination progresses at an adequate rate.

Establishing Timelines

A key role for the EIC is the establishment of timelines for the examination. These timelines are important not only to monitor examination progress but also to schedule other examinations. Usually a Department estimates the amount of time required to complete an examination. It is up to the EIC to meet the time constraints or else give the reasons as to why the timeline dates could not be met.

An EIC establishes the timeline by looking at the lines of business to be reviewed and the amount of business in each. He/she estimates the number of policies that will be reviewed and the amount of time required to review them. The whole process of developing a timeline is estimation at best, and a good deal depends upon the findings, whether additional samples are required, and the company‘s ability to return requested information and respond to criticisms in a timely manner.

The EIC considers the number of people on the examination team and their experience in reviewing the material and makes assignments with a specific timeline in mind. If it becomes evident that the timeline needs to be adjusted, it is the EIC‘s responsibility to inform the Department of the circumstances. Depending on the company‘s attitude, an EIC may want to share the expected timeframes once an examination is under way; however, this can be a double-edged sword when companies are uncooperative. In such instances, companies have sometimes taken a waiting game stance. Therefore, sharing the timeline with a company, in that situation, may not be in an examiner‘s best interest.

Organizing Work

Once timelines are established, the EIC organizes the work. The EIC determines what is to be reviewed first and then prioritizes other areas of the examination. For a full market conduct examination, many times EICs look at complaints first in order to get a feel for any possible patterns of violations that the company may be making. After complaints, the examiners usually review:

- Marketing/advertising along with forms/policies

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- Underwriting guidelines
- New business and rating/underwriting
- Non-renewals/cancellations/rejected policies
- Claims manuals and paid/denied claims.

These are the basic areas of review during a complete market conduct examination. Besides full examinations, targeted examinations are also performed. Targeted examinations are limited in scope and many times require looking at just one line of business or one function of the business (e.g., denied claims).

The EIC considers all of these factors and then determines who on his team has the skills needed to perform the job at hand. The EIC organizes the work so that he/she knows which people will be assigned to each task and then, based upon the amount of business and possible questions/criticisms, he/she constructs a timeline and determines what will be reviewed after each completed section.

Assigning Tasks

As mentioned above, once the work is organized, the assignments are made. The EIC chooses the examiner who is most capable of doing each task. Also to be considered are the expertise of the examiner, his/her ability to become familiar with company software systems, and his/her ability to document information for Department use at a later date, if needed.

Resolving Issues

The EIC is responsible for resolving issues whenever possible. Sometimes that requires calling the Department to get additional information while other times it requires talking to the coordinator in hopes of resolving the issue. During an examination, a wide array of issues can develop. An EIC may be faced with a matter involving the examination staff or company personnel regarding an issue that determines a company‘s ability to do business. Whatever the situation, it is always best to remember that an examiner is there to find the facts. Opinions and judgments are to be left to the Department after the report is written.

Coordinating with the Insurer and the Insurance Department

One of the roles of the EIC is to coordinate the examination with the insurer and with the Department. Usually in the pre-examination packet, the insurer is requested to designate an individual to act as the coordinator for an examination. In the ideal situation, the EIC and coordinator work together to speed the examination process along.

Usually, companies request that the EIC submit all requests/criticisms to the coordinator so that the individual can keep track of the documents and get the

items back to the EIC in a timely manner. It is best to keep the coordinator informed of the progress of the examination and what problems are found. Many times, the coordinator has the ability to get the appropriate company people involved with the examiners to clarify situations that arise and limit misunderstandings between the examination team and the company.

The EIC is also responsible for keeping the Department informed of the examination‘s progress. The progress reports provide the Department with helpful information about the company being examined and also provide the Department with necessary information for the resourcing of further examinations.

Writing the Examination Report

The EIC is responsible for writing the examination report and for having it submitted to the Department in a timely manner according to Department guidelines. The EIC may allow other examiners to write portions of the report, but he is ultimately responsible for submitting an accurate assessment of the company being examined.

The Importance of Workpapers, Organization of Documents, and Confidentiality

Each of these areas is very important for proper execution of an examination. Once an examination has been completed and the examiners have delivered the information to the Department, all that the Department has to base its findings on are the report, workpapers, and documents. Therefore, it is important to maintain this information for the legal staff to review, if necessary.

Workpapers are the documents the examiners maintain to prove that the information was reviewed and are the basis for the findings. Workpapers are confidential documents that contain information about a company‘s insureds and many times the insured‘s personal information. These papers could contain a company‘s underwriting practices, claims practices, marketing, and other information that is vital to the company‘s existence. Thus, it is always necessary to treat workpapers as confidential and proprietary documents.

Documents must be organized prior to being shipped to an insurance department. Examiners must remember that they will not be the ones reviewing this information several months later and trying to determine what someone else did. All paperwork submitted to the Department should be treated as though it is to be presented to a legal staff that may use the information in court.

While most Examination Reports do not wind up in litigation, one never really knows which ones will and which ones will not, so be prepared for anything. For instance, criticisms that are contained in the report must be labeled and

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documented. Many times this entails copying a complete file or at least the pertinent information relating to the alleged violation of law.

Issuing Critique/Comment Forms

What Is Included

At the top of the Critique (Criticism) / Comment form, the name of the company that is being criticized should appear along with the date, claim number/policy number, name (optional), critique/comment form number, and examiner name (See Attachment 1 at the end of this chapter for sample critique/comment forms).

In the body of the text, the examiner needs to explain the alleged violation of law (See Chapter 7 – Addressing Violations of Law – for more details). He/she needs to make reference to the items and then state the language from the statute/regulation that is allegedly violated. The actual statute/regulation code should also be referenced in the form. In the next section, space should be given for the company to respond to the examiners' comments. Thereafter, a designated area should be on the form for the individual responding to sign, date, and give his/her title. Also, at the bottom of the form the statement —agree" or —disagree" should appear with an area in which the responder can check to indicate the company's agreement or disagreement individually with each item contained in the Criticism. States often require that the company provide them with a list of designated, authorized personnel who are qualified to respond to the questions/criticism that arise.

When submitting the form to the coordinator for company response, the appropriate documents should also be attached for review. It is vital to keep a log of items that have been submitted. Be sure to include the log number on the actual critique/comment form. This helps the company and examiners to maintain a list of inquiries that are returned as well as those that remain outstanding (See Chapter 12 – Workpapers and Confidentiality – for more details).

Timeframe for Company Response

Many states have specific timeframes for company responses mandated in their statutes and/or regulations. This required timeframe for company response should be included in the critique/comment form that is submitted to the company.

How to Handle a Company Request for More Time to Respond

Examiners sometimes grant extension requests if the company has followed proper protocol in requesting the extra time. The company should not wait until the last day to ask for more time. Instead, the EIC should encourage the

company at the beginning of the examination to speak with the EIC immediately if a problem arises during an examination.

If a company that requests an extension seems to be conscientious about doing a good job and has responded in a timely fashion on most inquiries, the EIC should allow the extension, depending upon the situation. It is best to tell the company that this is not something that will be granted in a routine fashion and that information is expected to be returned in the timeframes specified.

Several states have statutes and/or regulations that specify the required amount of time given for critique/comment forms. The timeframes allowed are from as few as 5 working days to as many as 15 calendar days.

If a company requests more time, ask the company to state in writing when it expects to complete and return the documentation/criticism response. This helps document the specific instances in which the company did not provide the information in a timely fashion.

What to Expect from the Company in Response to Examiner Criticisms

The examiner should expect the company to provide a well detailed, organized explanation as to what has occurred in a particular file or circumstance. The form should be checked as to the decision to either agree or disagree with the examiner‘s statement. The Critique/Comment Form should include the date and the respondent‘s signature and job title.

In many instances, something is not filled out correctly. If this happens, notify the coordinator. For those instances in which the company does not want to agree completely (check marked as agree or disagree on the Critique/Comment form), the company can state –ni part” (on the Critique/Comment form) and give an explanation of the company position.

Writing the Examination Report

The Examination Report as a Professional Document

The Examination Report is viewed as a direct reflection of the Department. In most states the Examination Report ultimately becomes a public document and is relied upon by its citizens to be an unbiased discussion of a company‘s marketing practices. Although the average consumer may look to a report as a discussion, it should be understood by the examiner that the Examination Report is a professional document reflective not only of the expertise of the individual examiners who write the report but also of the examiners‘ colleagues, the Department, the NAIC, and IRES. Therefore, it is very important that a qualified examiner possess excellent writing skills.

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Main Elements to be Included in an Examination Report

Report by Test vs. Report by Exception

A "report by exception" lists only those findings that were found to be in non-compliance with the statutes and regulations of the state. During an examination, the examiner reviews many areas, but unless something was found that was a violation, it is not mentioned in a report by exception. Since the inception of market conduct examinations, the report by exception is the accepted method of completing an Examination Report.

In a "report by test", all findings are listed. Each test applied during the examination is stated, and the results, both good and bad, are reported. If something is not mentioned in the report, it was not reviewed.

Report by Exception vs. Report by Standards

A report by exception lists only those items that are found to be in violation whereas a report by standards lists all items reviewed.

Construction, Organization, Cohesiveness of the Report

The Proper Use of Grammar

Grammar is important in all functions of an examination. Good grammar is required for written requests of documentation, criticisms, and by all means the report itself. Take time to prepare a well-written document that is free of misspelled words, punctuation errors, and poor sentence structure. The technique is a reflection of the EIC, the examination team, the Department, and the insurance profession. Take time to be a professional.

Technical Writing vs. Everyday Writing

Technical writing is a specific kind of writing. Some universities and colleges actually have classes specifically designed to teach the functionality of technical writing. What is different about it from everyday writing? Technical writing is very specific. For Examination Reports, it is factual, precise, and structured. It does not meander with thoughts and describe stories, but rather it is a detailed document specific to describing the business activities of a company. It is critical that an examiner's opinion is never in the document; only facts are required.

Adequate Proof of a Finding

The essence of why a market conduct examination is performed is to acquire documentation that substantiates findings that show a company's business practices. These findings and the gathering of the data are essential for the final stages of closing a report. When examiners have

gathered what they think is enough documentation, they should check again, and then gather some more. What seems like overkill to an examiner many times is taken to be insufficient by a legal department looking to pursue the matter in court. Make sure that everything is copied and document all findings. (See Chapter 12 – Workpapers and Confidentiality – for more specific details.)

Putting Together a Valid Exhibit that Reconciles with the Report

This step of the examination is vital. Once the report is written and submitted to the Department, the examiner is no longer involved on a daily basis. It is up to the closer of the Department to review the documentation and determine the report‘s substantiation and final disposition in the company. The examination findings must be able to flow from the examiner to the legal department to the courts (if needed) without losing meaning.

What approach do some states advocate to put together a valid exhibit? First, gather all the information that is relevant to the particular finding and make copies. With the copies, attach the critique (criticism) form that contains the examiners‘ comments to the company. That form should also contain the company‘s response. Attach the form along with any other documentation that the company may have submitted to the examination team. Once the information is together, this is considered an Exhibit for the particular item referenced in the report. This Exhibit is given a number once the final report is completed.

When the final Examination Report is completed, the examiner prints another copy that is referred to as the Exhibit Report. This report is different from the Examination Report as the Exhibit Report contains reference numbers to all the documents that were gathered to form Exhibits. For each referenced criticism in the report, there is a corresponding Exhibit. The EIC goes through the Exhibit Report and numbers each of the referenced criticisms. Next, the EIC numbers the Exhibits to match those of the Exhibit Report. When completed, the Exhibits are numbered and presented in the same order as the Exhibit/Examination Report.

Findings Presented in a Cogent Manner

Insurance departments usually require that a report be written in a certain format. That format includes certain sections (e.g., underwriting, claims, complaints, etc) that require specific wording in some instances. When an examiner finds an alleged violation that is to be included in the report, the examiner needs to be blunt and factual in stating the violation. Usually the examiner documents the error and the company response if applicable and then lists the violation of statute or regulation at the end. Included somewhere within the section are the means to identify the file or

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individual insured. In presenting this information, the examiner should logically build the case so that a court of law could understand the progression of the file to the point of the violation.

Fact Finding vs. Opinion

The examination team and the EIC / Lead Examiner are responsible for reporting facts. An Examination Report is to be factual, and neither the examination team nor any one examiner should offer opinions. In order for a report to be successful in a court of law, it must contain facts. Anything less will be considered of no value and will be omitted.

Writing Proper Statutory and Regulatory Citations and Case Cites

Insurance is unique in that each state has its own statutes and regulations that apply. An example for Missouri that applies in a citation is: Section 374.205.2 (2), RSMo. for a statute. When describing a regulation it is: 20 CSR 300-2.200 (2).

In most all states, when a citation begins with the wording —section", one knows that it refers to a statute. For regulations, it can vary. Many times, examiners designate the difference by stating —Regulation".

Ensuring that the Report Focuses on Issues that Relate Directly to Genuine Consumer Protection

A market conduct examination is designed to focus on the business practices of a company and to relate how those business practices are affecting the consumers of the state. While it is important to report all discrepancies, the focus of the report should be written so that the consumer focus is maintained.

A Sample Examination Report

Although the industry is moving toward uniformity, states still use differing reports. The ability to develop a uniform report approach has been discussed for many years. It seems as though no particular form is used widely although several comparable versions between states are being used. The following is an attempt to develop some uniformity. For the purpose of this example, a comprehensive examination is used instead of a target examination. For target examinations, the same language is used as in the comprehensive examination, but only those examination areas reviewed are reported.

Every state has at least two items in its report that are very much the same: Cover Page and the title of the Table of Contents. From there on, the items change in name but not necessarily in content.

Cover Page

Somewhere on the Cover Page, the following are listed:

- State of (state that ordered the review)
- Department
- Company Name
- Company Address
- NAIC Company Code
- Examination Date
- Examination Number.

Many times these are in a different order, but for the most part this is what is contained in a Cover Page.

Table of Contents

Next is the Table of Contents. Below is an example of the Table of Contents for a market conduct report. This format is used uniformly by states that perform market conduct examinations.

- Salutation
- Foreword
- Scope of Examination
- Executive Summary
- Examination Findings
- Forms
  - Marketing
  - Licensing
- Rating/Underwriting
  - New Issues
  - Cancellations/Rejections/Non-renewals
- Claim Practices
  - Paid Claims
  - Denied Claims
- Complaints.

Submission

The Salutation, Foreword, Scope of Examination, and Executive Summary are included among the various state reports, but the placement of the content in these categories varies from state to state.

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- The **Salutation** is the acknowledgement to the directors, superintendents, or commissioners of those involved in the report and with the instructions given for reviewing the company examined.
- The **Foreword** is a statement that the report is by exception. It goes on to explain what this means. It also explains what test method is used and that all tests applied during the examination are reported.
- **Scope of the Examination** cites the statutory authority, time period covered by the examination, examination purpose, tolerance criterion, and areas to be reviewed in the examination.
- **Executive Summary** highlights the principal areas of concern found in the report; the detail is contained in the body of the report.
- **Examination Findings** comprises the basic body of the report. It contains sampling sizes, percentage of errors, and those items of violation and includes documentation pertaining to particular references of regulations or statutes. The sections include forms, marketing and sales, producer licensing, rating of policies, underwriting including new issues, rescinded policies, cancelled/non-renewed, claims paid and denied, and complaints.
- **Submission** gives recognition to the company for its cooperation and lists the examiners involved in the examination.

Although the body of the report might seem to be uniform for all states, it in fact often is not. For example,

- Similar information may be documented in different formats.
- Sections of similar content may be laid out differently under differing headings.
- Some states list only the item found, possible company response, statute/regulation violated, and the reference number of the violation. Other states cite these and then under another heading list recommendations.

Because insurance is regulated by 50 states, the requirements of the Department in each of those 50 states are sometimes different. Examiners have to adapt their reports to the needs of the Department they represent. It is not unusual that two reports completed on the same company by examiners of two state insurance departments would be different when viewed side by side. The EIC must tailor the report to fit the situation (depending upon the state and other factors as well). Some of the factors can include: kind of examination (Life & Health, Property & Casualty, Title, etc), type of examination (target vs. comprehensive), lines of business reviewed, findings found, etc.

What is important to remember is that the report is factual and does not contain examiner opinion. The report should be designed to list the items found in violation, the company response, and reference to the citation in violation. Documentation of the violations through exhibits is critical with the Exhibit Report.

Exit Conference

EIC Explains the Closing Process

When an on-site examination has been completed and the examination team has written, documented, and made exhibits of the report, there is nothing left for the examiners to do but to leave the company. Before their departure, it is often the practice of a Department to request that its examiners have an —Exit" meeting with company officials to explain the closing process and items found in the report. Note that this is not a requirement made by all Departments; therefore, this meeting may occur, or it may not.

At the designated time and day, the EIC and his/her team meets with interested parties of the company. Usual protocol is for the EIC to go through the alleged findings verbally with the company. If there has been open communication between the examination staff and the company during the examination, the meetings go rather quickly, and there is little additional discussion. Once the findings are reviewed, it is normal practice for the EIC to discuss with the company officials what to expect next.

During the discussion, it is reported that the report and documents will be submitted to the Department and that the Department, in turn, will send the report to the company under official letterhead (usually within 30 days). The company will then be responsible to respond to the Department within so many days (usually 30). When the company‘s submission is received, the Department reviews it and issues a closing order that may or may not involve a forfeiture request and additional requirements to permit the company to continue doing business in that state.

It is then up to the company either to accept the decision or to take further action through administrative hearings, etc.

After the Examination

Issuing a Post-examination Questionnaire

A post-examination questionnaire is designed to give an insurance department feedback about the examination process and the examination team. It gives the company that was examined an opportunity to voice any concerns or praise regarding the examination staff that had been on-site.

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When to Provide the Questionnaire

Once the examination staff has left the company and the report has been submitted, the Department sends a questionnaire to the company.

To Whom to Present the Questionnaire

In most instances, the Department sends the questionnaire to the coordinator of the examination. This person is usually the individual who has had the most contact with the examination team throughout the process.

Analyzing and Addressing Company Responses

This can be tricky based upon the situation of the company examined. A company may overly commend (or berate) an examination team as it seeks to benefit from such a response while withholding honest feedback. More often, however, the company does try to be fair and make an honest assessment. In these situations, the company recognizes the importance of maintaining quality work and quality people in the examination field.

The Chief Examiner or Audit Manager should review each of the company responses and weigh the facts. If issues arose during an examination, a discussion with the EIC is instrumental in obtaining both sides of the situation. If several companies report the same issue in their responses, the Chief Examiner may need to address a business practice with the examination staff. The circumstances factor in as well, and eventually the Chief Examiner (or Audit Manager) makes a judgment call.

The Examiner's Role in the Closing Process

The EIC or examiner‘s role in the closing process is to provide assistance in answering any additional questions that the Department staff may have in determining the outcome of the report. Sometimes this entails being in meetings between the Department and company staff, helping with the documentation that was gathered, and giving insight as to the attitude and overall good will of the company.

Department Differences in the Closing Process

States differ in the number of days to respond to a company and in the company‘s response as well, but overall the process is pretty much the same in most states. When a Department closes the report, a closing letter is usually written to the company. Any forfeiture or fine amount is stated, as are the required company corrections. If a re-examination of the company is warranted, that may be stated in the closing letter as well. It is up to the company to pay the fines, make the corrections, and be in compliance with that state‘s laws and regulations.

Enforcement

The Department is responsible for seeing that its state's laws and regulations are being followed by companies doing business in that state. Likewise, the company is responsible for making sure that it is following the laws of the state in which it is doing business. To determine if a company is following these laws, a state sends a market conduct team to do an examination.

When examinations are completed and problems are found, in many instances, a state sends an examination team in to conduct a target examination on just the area found to be a problem. There are also times that several years pass before a routine market conduct examination is called. Overall, these examination teams are doing work to ensure that the laws of a state are being followed. Having an authority figure helps to keep insurance companies honest in their endeavors of making a profit and providing service for the products they sell.

Appeals

If an insurance company does not agree with the Examination Report findings, the company can file an appeal with the Department. The appeals process varies by Department, but usually a hearing is set in which a committee/Commissioner/Director hears the evidence and then makes a ruling.

Being Prepared to Present Documents and Testimony at Administrative Hearings (& How to Give a Deposition)

Any company being examined could eventually go to an administrative hearing. It is important that an EIC or examiner reviewing a company remembers this and documents the findings so that they can be easily presented in a logical format if a hearing were to take place. Earlier in this chapter, documentation and the Exhibit Report were discussed. The Exhibit Report, criticism sheets, and exhibits are the key elements when a hearing is involved. Chapter 12 discusses confidentiality and workpapers in more detail.

If a deposition takes place, it is important to answer just the question asked and no more. An attorney is present to advise whether a question should or should not be addressed. Depositions can last several hours and promote stressful situations. They are made much less stressful by adequate preparation during the examination and by having the documents together in easily found exhibits. When the examination staff is involved, it is usually the EIC who is called in to give a deposition. This is true for hearings as well.

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Attachment 1
- Criticism Examples

Exhibit 1 (a) – CRITICISM

MISSOURI DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS, AND PROFESSIONAL REGISTRATION (DIFP)

INSURANCE MARKET REGULATION DIVISION

Exam Number: ????-??-???

Company: NAME OF Insurance Company
NAIC Co. # ?????

CRITICISM #

EIC Initials: ***???***

Subject:

Examiner:
On-site #:
e-mail:

Item:

Date Submitted: August 28, 2006

Name:

Date Returned: _____
(Missouri Examiners to complete Date Returned)

Please provide the Missouri examiners with answers and documentation to each of the following and label each response [*i.e.***, (1)(a), (1)(b), (2)(a), (2)(b), (3)***, etc.***]: *If you do not agree with the examiners' comments, attach all relevant documentation that you believe substantiates your response.***

(1)

COMPANY RESPONSE ***(attach additional sheets, if necessary, and provide records and documentation)*:**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

AUTHORIZED COMPANY REPRESENTATIVE: _____
(Signature)

DATE SIGNED: _____

COMPANY AGREES WITH CRITICISM: _____
(Signature)

{Please *indicate agreement or disagreement with each part of the pertinent criticism by filling in the above and below lines accordingly [i.e.,* **(1)(a), (1)(b), (2)(a), (2)(b), (3)**, *etc.]*. }

COMPANY DISAGREES WITH CRITICISM: _____
(Signature)

DATE SIGNED: _____

The company shall provide a response within 10 calendar days.

Reference: Section 374.205.2(2), RSMo Cumulative Supp. 1998.

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Bureau Of Market Regulation
Examination Exception

State of Wisconsin
Office Of The Commissioner Of Insurance
P.O. Box 7873
Madison, Wisconsin 53707-7873
(608) 266-3585 - Voice
(608) 264-8115 - Fax

Ref: Sections 601.42, 601.43, and 601.44, Wis. Stat.

INSTRUCTIONS: Please provide a written response to the question(s) or comment(s) listed below. The respondent should sign and return the entire form to the examination team within 48 hours of receipt

Exception No:

Examinee	Area/Subject

If X'd, provide a copy of the entire file ☐ or paper clipped items ☐ with response.

Prepared:	Reviewed:

Company Response:

Date	Company Respondent

OCI 26-104 (R 10/2004)

Endnotes

[1] National Association of Insurance Commissioners, *Market Regulation Handbook, Volume I* (NAIC, 2301 McGee Street, Suite 800, Kansas City, MO 64108-2662), July 2007, pp. 2 – 3.

[2] Ibid., p. 128.

[3] Ibid., p. 178.

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Chapter 3
- Company Communication Techniques

Educational Objective

Understand how to communicate with a company under examination and how to get information from a company without excessive conflict.

Introduction

Key elements in conducting a successful market conduct examination include the examination team's communication techniques. Examiners should always approach insurance company personnel in a professional, pleasant, and non-judgmental manner. Even in the case of a targeted examination for a suspected serious violation of a state's insurance laws, the attitude of the examiners goes a long way in establishing the company's willingness to cooperate during the examination. See Chapter 12 (*Scheduling, Coordinating and Communicating*) of the NAIC *Market Regulation Handbook* for more detailed information.[1]

First Steps in Communicating with a Company

Insurance Department Communication

It is common for insurance departments to send the company being examined a —pre-examination packet" that includes:

- An examination call letter
- A detailed listing of information required for the examination
- A request for work space, including any Internet and telephone requirements
- A request for access to the company's primary computers and the number of PCs/terminals required by the examiners
- Printer and copier requirements
- A request for the office supplies the examiners will need.

Except for rare target examinations needing to be done immediately, this pre-examination packet is usually mailed to the company at least 60 days prior to the examination start date. The Department also names in the call letter the company and/or examiner(s) it has selected to perform the examination.

Examiner Communication

After the company has had time to review the pre-examination packet and route it to the company person who will coordinate the examination, it is a good idea for the Examiner-in-Charge (EIC) to contact the company coordinator to introduce him/herself and offer to answer any questions the coordinator may have about the pending examination and the information requested. This can prevent downtime when the examiners arrive at the company, because the EIC can:

- Confirm the start date for the company coordinator (the company is required to work out any objections it has to the start date stated in the call letter with the Department).
- Determine that the company has a clear understanding of all data requests and will include all required data in the format requested.
- Determine if policy and/or claim files will be available in hardcopy or electronic format and stress the need to review the entire file. If companies are allowed to —pre-select" documents from files, needed information may not be provided.
- Request that data files be sent to the examiners as soon as produced so that samples can be chosen and the company can have at least some of the policy and/or claims files available when the examiners arrive.
- Confirm that workspace to be provided is adequate and that all equipment and supplies requested will be available when the examiners arrive.

Communications after Examiners Arrive at a Company

Informal Meeting

If a pre-planning meeting has not been held with the company prior to the examination, the examination team should request an informal meeting with all company personnel who will have an active part in the examination. This meeting should be held on the first or second day the examiners are in the company. At this meeting, the examiners should discuss with the company:

- The order in which the examination will be conducted (i.e., policies first, claims next, etc.)
- Any additional data or information required that was not shown in the Department‘s list
- How the company should provide and/or format responses to examination requests

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- If applicable, the purpose of comment forms (sometimes referred to as criticisms or —its"). At this time, the examiners should ask the company to confirm, in writing, the names of the company personnel who have been authorized to respond to formal requests and comment forms.
- Time requirements for responses to examination requests and comment forms.

Requests for Additional Information or Data

An examination moves more smoothly if the company is given formal requests for additional information or data. These formal requests should include the following:

- Consecutive request numbers
- Date of the request
- Required response date
- Clear and concise description of the information or data required.

Comment Forms

When examiners question whether certain files, statements, coding, etc., conflict with state insurance statutes, regulations, bulletins, and/or filed company rules and procedures, comment forms (criticisms or —its") should be provided to the company. These forms should include the following:

- Consecutive comment form numbers
- Date of comment form
- Required response date
- Specific reference to the laws, rules, or procedures being cited
- When preferred by the state, a direct quote of the laws, rules or procedures being cited
- A clear and concise explanation of why the files, statements, coding, etc., are being questioned
- Numbers, names, and effective dates of any policies or claims being questioned
- A space for the company's response
- A space for the responding person to sign his name and show his job title
- A space for the response date

- A conspicuous quote of any statute or regulation the state may have that calls for a fine when a company does not respond by the required response date.

Communications with Company Personnel

There are times during an examination when examiners need to ask questions of company personnel in specific areas to clarify something found in a file. For instance, examiners may need to ask for a legend or dictionary of company codes used on computer files, etc. Although some companies, as well as some examiners, prefer to have all examiner questions directed to the company coordinator, it is best, if possible, to talk directly with the person who handles that particular item for the company and have the coordinator present, if necessary. This eliminates any confusion or misunderstanding that may be generated when information is passed to or from examiners through other people.

There are also times when company personnel need clarification on items requested by the examiners. Often times, a question concerns formatting of data requested before or during the examination, the potential that the company programmers may not be able to provide certain data, etc. This is a particularly important time for the examiners to ask to speak directly to the company personnel involved as this is a common area for confusion or misunderstanding that may be generated when information is passed to or from examiners through other people. Examiners should remember that a company‘s examination coordinator may or may not have in-depth knowledge of the line or lines of business under examination, even if that person is the company‘s compliance officer. This person does not necessarily need to know how to underwrite and/or rate a policy of insurance in order to see that the company complies with state laws when writing policies. The company coordinator may refer the examiner to other people who do have in-depth knowledge of a subject. It is vital for examiners to be aware of, and have the proper documentation of, the company authorized personnel who are officially speaking and responding for the company in regard to the market conduct examination and who does not have that authority.

For purposes of examination cohesiveness and examiner training, it is a good idea for all of the examination team to be present during discussions of potential or actual examination problems. This is true whether or not the discussion includes company personnel. The sharing of ideas among examiners can be the fastest way to solve problems or to develop alternative approaches when the team is faced with new or unusual situations. Examiners frequently have varied backgrounds and may more readily share unique experience and insights with others during these meetings. Nevertheless, the size of the examination team may make all-inclusive meetings costly and non-productive, and holding such meetings should be considered accordingly.

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Avoiding Communication Conflicts

There is that rare occasion when examiners go into a company, and either before or after they arrive, the company terminates an employee or employees who worked in an area under examination. If this happens, without regard to whether the person(s) was in management or in an entry-level job, an examiner should never take part in discussions about that person(s) with other company personnel.

For example, a company terminates a vice president because he was found to be committing claim check fraud. Examiners may be asked to review the claims for which these checks were written and/or interview other company personnel about the actions the company has taken or will take in an effort to recoup its money or prevent this from happening again. In a situation such as this, it is never appropriate for an examiner to make any derogatory remarks about the terminated person (e.g., how could they have been so stupid as to think they would not be caught?) or express any personal opinions about what actions they think the company should have taken regarding other company personnel. This is unprofessional behavior that could reflect badly on the examiner, the employer of the examiner, and/or the Department that called the examination.

It would also be unprofessional behavior to ask questions of a personal nature about the terminated person. This includes questions about exactly what happened, how it was discovered, the person‘s family, past employers, personal habits, etc. Since it is not humanly possible for everyone to like everyone else, there will occasionally be times during an examination when friction develops between an examiner and a company person. Examiners should keep in mind that allowing a situation such as this to get out of hand is counter-productive to the examination process since it may affect the company‘s willingness to continue to cooperate with the examination team. It is recommended that the EIC make his supervisor aware of the situation immediately if something of this nature occurs. If necessary, the Supervisor and/or the EIC may need to make the Department aware of the friction and its cause.

It is a good idea for the examiner or examiners involved to document the occurrence in as unbiased a manner as possible and forward it to the team‘s supervisor. This lets the company know that the situation will be looked into and allows the examination team to move on with the examination. There is never a justifiable occasion for harsh words or less than professional behavior on the part of an examiner. Even if the conflict involves something personal about an examiner, unprofessional behavior only compounds the problem and reflects badly on the examination team.

Communication "Manners"

Last, but certainly not least, good professional communication skills also call for examiners to use good manners. Including words such as —yep" or —ya", slang expressions, or failing to say things as simple as —thank you" or —you're welcome" could have the effect of having the company think an examiner lacks social skills. This not only reflects poorly on the examiner, but may also leave a negative image with the company for whom the coordinator works.

When the examination is over and the examiners are preparing to leave the examination site, it is also a good practice for the examiners to thank the company people directly involved in the examination for their help and the help of their staffs. This leaves a good impression of the examiners, the company for whom they work, and the Department they are representing. Remember, anything an examiner does or does not do may affect how a company views market conduct examiners in general and how cooperative the company will be during future market conduct examinations.

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Endnotes

[1] National Association of Insurance Commissioners, *Market Regulation Handbook* (NAIC, 2301McGee Street, Suite 800, Kansas City, MO 64108-2662), July 2007, Volume 1, Chapter 12.

Chapter 4
- Examination Assignments

Educational Objective

Identify the best practices to follow when assigning examiners to a market conduct examination. Consider how assignments are made and how people work together.

Introduction

When scheduling a market regulation activity, the Supervisor should review Market Analyses to determine the appropriate response, scope, and subject matter for the activity. When the most appropriate course of action is a market conduct examination, it is important to give careful consideration to assigning appropriate examination team members to the project.

Staffing constraints, resource limitations, and timing issues may complicate scheduling the ideal team for each job, but the Supervisor should consider the suggestions contained in the following paragraphs.

Assignment by Scope

Thorough market analysis permits the Supervisor to define the scope of the examination. Narrowing the scope of the examination to areas of concern and high consumer impact allows for more efficient use of resources. A narrowed scope permits regulators to focus on areas of genuine concern.

Most examination teams benefit from a written examination plan outlining the reason, purpose, and scope of the examination. A written plan also clarifies time and budget allowances and documents how the examination will be conducted.

Knowing each examiner's past insurance industry experience and examination work experience helps in making appropriate assignments. Interview potential examiners and consider asking them what specific functional areas hold more interest for them; use this in the assignment process where possible. Likewise, consider keeping a journal of examiner assignments that have been handled well. This helps the Examiner-in-Charge (EIC) to know which examiners should be able to readily review specific areas. Considering the scope of the examination when assigning examiners helps to ensure a well-balanced team. The better defined the goals, the better the ability to allocate the resources.

Issues Related to Differences in Examination Team Member Skills

A successful examination results from using a variety of skill sets effectively. Organization and documentation skills, writing and communication skills, computer savvy, critical thinking abilities, and analytical and computational skills are all desirable. However, few individuals possess all of these capabilities; most have specific strengths and experience. Matching the right skill sets with the tasks of the examination plan is key.

Following are a few examples to suggest how skills can be matched to specific tasks and review areas:

- Health claims and prompt payment – Computer skills
- Commercial underwriting and rating – Computational skills
- Claim denials – Analytical skills for contract interpretation
- Report writing – Communication skills
- EIC – Organizational skills and market conduct examination experience.

Make best use of examiners with specific skills to assist in teaching those skills to other examiners. The examination team should be mindful, however, that companies should generally not be charged for training-session time that consists of much more than answering incidental on-the-job questions.

Best Use of Seasoned Examiners

A seasoned or well-trained EIC should be selected. The EIC should ensure the following:

- The examination plan is followed.
- The examination is kept on schedule.
- Proper documentation practices are followed.
- Examiners are supervised.
- Examination issues are handled appropriately.
- The examination plan is modified when deemed necessary.
- A professional written examination report is prepared.

The selection of examiners with experience or training in the particular type of insurance being reviewed – or with the types of issues being examined – is beneficial. Nevertheless, some advocate that an examiner having limited experience in a particular type of insurance or functional area can capably serve as an examination team member because such individuals are more likely to question common business practices that are otherwise taken for granted.

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However, it is important that an experienced team member review any questions expressed by the less experienced examiners. Questions or critique forms provided to insurers during the examination that are simply a result of examiner inexperience could reflect negatively on the entire examination.

Maintaining Consistency in the Examination Process

Keeping consistency within the same examination as well as between different examinations is beneficial. This reduces confusion, increases efficiency, and helps to ensure equal treatment of companies. Additionally, uniform processes and documentation could be important in the event that examination results are challenged in a formal administrative hearing. There is a general desire to maintain a higher level of consistency among states through such endeavors as the NAIC Market Conduct Uniformity Working Group[1] and the development of NAIC Core Competencies[2]. The use of uniform and consistent procedures during the examination process engenders professionalism.

The development of written policies and standardized procedures to be used in carrying out the various examination plans is the first step in maintaining consistency. Training at all levels is also helpful.

Consistent use of examination coordinator handbooks[3], along with pre-examination meetings, helps the company know what to expect during the examination.

During the examination the EIC can provide examiners with directions that allow for a more consistent process. Specific directions should be provided to examiners about the following:

- Work times and work place rules to be observed during the examination
- Examination workpapers documentation
- Workflow processes involving organization of the examination working space
- Methodology for communication with the company's examination coordinator
- Expectations regarding timing of completion of assignments
- Critique-form strategy and writing methods.

Use of prepared —worksheets" assists with maintaining uniformity. Many states now use electronic worksheets set up in spreadsheet or database programs. In some cases an examiner may have a worksheet he has developed on his own. The EIC should make sure that all of the worksheets used for a particular review are compatible, but care should be taken to ensure that new, better ideas are not precluded. The worksheets should collect the same information and in the same

format, thereby allowing for the combining of data if more than one individual is working on a particular segment.

Regardless of whether seasoned examiners are used, the EIC should review all critique forms before providing them to the company. This helps maintain consistency, keeps the EIC better informed of the progress of the examination, and allows the EIC to maintain communication among the examination team members.

Maximizing Efficiency and Effectiveness of the Examination Process

Keeping the examination on track with the pre-determined work plan and budgeted time allowance is key to maximizing efficiency.

Occasionally, during the course of an examination, examiners may uncover unanticipated issues. If those unanticipated issues call for additional time and work outside the plan, the EIC should consult with his/her supervisor to determine if adjustments to the work plan are desired. When adjustments are made, that information, along with the reasons, should be communicated to the company as well.

Assigning an EIC or Lead Examiner with good judgment skills can help keep the examination team on track and assist in avoiding such pitfalls as:

- Spending too much time on issues that are no longer relevant

  For example, a company may no longer administer specific types of policies for which problematic transactions occurred, and there is no policyholder remediation necessary because of the past problems. Spending too many resources on the past problems may be a pointless endeavor.

- Dwelling on minutia

  Translating rules and regulations too literally can sometimes lead to interpretations that have no real benefit to anyone. For example, if a requirement indicates that form numbers are to be printed on the right-hand bottom of each policy form and they are accidentally printed on the left-hand, has anyone been harmed? Document and move on.

- Over-documenting or over-examining a specific problem
- Reviewing and developing issues outside the work plan without prior approval of the EIC or his/her supervisor
- Basing an examination focus on an incorrect interpretation of a statute, regulation, or bulletin or even on an obsolete one

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- Spending too much time on attempting to prove a point when the company is in disagreement with the examiner‘s interpretation of an issue

  Examiners can avoid confrontation between themselves and coordinators for the company by referring such disagreements to the EIC.

- Going off task

  It is important to keep the examination on task to keep the examination on schedule. Keeping on task helps maintain a professional attitude and also helps prevent the circulation of negative anecdotes about such things as examiners that spend time reading the paper on the job or spend time browsing the Internet.

Using those same good judgment skills helps to identify times when an examination is impeded because of a lack of cooperation from the company being examined. It is important to communicate to the company examination coordinator about delays caused by such things as lack of cooperation, late responses to questions, provision of incorrect materials, faulty documentation, or insufficient access. When lack of company cooperation severely impacts the ability of examiners to keep the examination on schedule, the EIC and his/her supervisor should consider addressing the matter in writing with the company. In some instances, the coordinator may be the problem. In those rare instances, it may be necessary to have a meeting with the coordinator‘s supervisor. If there is a meeting, the EIC should write a confidential memorandum to file outlining the problems and describing the content of the meeting and what the company will do to resolve the problem.

Other Considerations

- Scheduling team members whose personalities match well may be a consideration, but it is not an over-riding factor. Expect all examiners to work together as a team and in a professional manner. Occasional rotation of team members when starting a new examination can be beneficial to the team performance as well as to the individuals involved.
- Avoid using an examiner who has previously worked for the company being reviewed, or has family members that are employed by the company.
- Attempt to maintain a balance of fairness when giving travel assignments.
- Consider making reasonable accommodations as necessary. For example, if an individual cannot comfortably travel because of a temporary medical condition, it may be possible to assign that individual to desk examinations or scheduled examinations that do not involve travel.

Endnotes

[1] National Association of Insurance Commissioners, *Market Regulation Handbook, Vol* I (July 2006), p.85.

[2] Ibid., p. 5.

[3] Ibid., p. 154.

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Chapter 5
- Core Examination Procedures

Educational Objective

Identify best practices that can be used successfully and uniformly in conducting market conduct examinations.

Development and Use of Effective Examination Plans

The foundation for the conduct of any examination is the work plan (also called a planning memorandum or project plan). The examination work plan outlines the specific details of how an examination will be conducted. To create an examination work plan, the following fundamental facts must be determined:

- Will the examination be of a group of insurers or a single insurer?
- Will the examination be a single-state or a multi-state examination?
- What lines of business (e.g., auto, homeowners, health, life, annuities, title, etc.) will be reviewed?
- What functional areas (e.g., claims, underwriting) within each line will be included – will this be a targeted or comprehensive examination?
- How long will the examination take?

Once the above items are determined, it is necessary to identify each step required to achieve the examination objectives.

A work plan outlines in specific detail how an examination will be conducted, who will be responsible for which tasks, when and in what order each task will be accomplished, and the dependencies that exist among the tasks. Work plans may include some or all of the following elements:

- A short description of the project's objective
- A list of personnel participating in the project noting areas of expertise for each person
- A list of all equipment and facilities to be used in the project
- A breakdown of the project into specific tasks, including indications of which tasks are dependent upon the completion of other tasks
- A schedule indicating when each task will be started and when it will be completed along with who will perform the task
- A time and cost budget.

The best way to build a work plan to meet the needs of a particular examination is to modify a comprehensive template supplied by the Department for the type of examination being conducted. However, if that is not possible because the Department has not created such a template or due to the unique circumstances of the examination, the following steps may be followed to create a practical work plan:

1. Gather Pre-existing Baseline Documents

   Review the scope of the examination to ensure an understanding of the purpose of the examination. The scope may not be complete, but it needs to contain sufficient data in order to allow a draft work plan to be built.

   Baseline documents include copies of some or all the following, as well as other material that may be appropriate. Some of these documents may be reviewed prior to going on-site.

   - Certificate of Authority – to verify that the company is licensed in the state and that it has authority to write the lines of business it is selling.
   - Annual Statements, including state pages, for the most recent past two or three years – to show lines of business sold, claim volumes, and recent changes in product mix.
   - Recent examinations by other jurisdictions and the most recent examination by the state to note prior concerns – to verify that prior concerns have been addressed by the company. This should include both financial and market conduct examination reports.
   - Computer listings of agents, brokers, and/or producers appointed by the company to market products.
   - Department complaint ratios and company complaint logs.
   - Grievance logs.
   - Recent Market Analysis findings to help define the scope of the examination and prioritize the work to be done.
   - Any preliminary data pulls relevant to company actions during the examination period to help determine relative sizes of samples needed. This data can in turn help determine resources needed for different parts of the examination.

2. Create a Work Breakdown Structure

   Determine the large segments of work that must be completed in order for the entire project to be completed. At this point, it does not matter how the segments are defined as long as all the necessary work is identified by the end of the process. For instance, one traditional way to break down the work is according to the phases to be examined.

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Break down the work in a structure that is consistent with the project and makes sense for the examination team. This initial high-level breakdown of work is called level one. The point of the Work Breakdown Structure is to capture all work elements. Sequencing is not important at this time.

Once the initial breakdown is complete, determine whether any of the pieces require work effort that exceeds the estimating threshold. (The estimating threshold is usually 80 hours of effort, but it can be defined to be larger or smaller depending on the size of the project.) For medium to large projects, more than likely, most of the level-one work exceeds the estimating threshold. Look at the level-one work items whose time requirements exceed the estimating threshold and break them down further into specific activities required for completion. It may also be necessary to further break down work whose time requirements are already less than the threshold. These smaller tasks form level two of the Work Breakdown Structure.

Estimate the work required for the level-two tasks to determine if tasks still require more time to complete than the estimating threshold permits. If so, they need to be broken down further. Continue to break down each task as above until all of the work is represented as granularly as necessary, with no activities having an estimated time requirement larger than the threshold. This process results in level three, four, five, etc. It is a rare case, indeed, that requires more than five levels.

3. When the work plan is complete, review it and provide a specific estimate of effort required to complete each of the detailed activities. (The detailed activities are those at the lowest chosen level of breakdown.)

Focus on Deliverables, Then Activities

Sometimes people have a hard time getting a work plan started because they are not sure what to make a priority, and they are uncertain about how to break down the work. Although there are many ways that the work plan can be started, ultimately the focus should be on deliverables.

Deliverables consist of criticisms, findings, and confidential memorandums or management reports describing circumstances where company practices deviate from applicable state or federal laws, regulations, bulletins, and, perhaps, the company‘s own policies and procedures. Of course, the primary deliverable is the examination report itself.

Assume that the top level is the overall project (level 0); in the next level (level one), the actual deliverables to be produced by the project can be listed. For each deliverable, list the activities that are required to produce it. The work plan is ultimately made up of activities, but they need to be developed in the context of completing deliverables.

There are a number of options for structuring the work plan at level one:

- Placing the major project deliverables directly at level one; then breaking the deliverables into smaller components on the next level, if necessary.
- Describing the areas that will be involved, such as Sales, Marketing, IT, etc. In this case, the next level describes the deliverables that each area will produce.
- Looking at the life cycle for the examination. For instance: analysis, design, construction, testing. If this is the most logical way to look at level one, then level two should describe the deliverables produced in each life-cycle stage.

Level one can start with deliverables or another way of logically grouping major sections of the examination. However, if another way is chosen to organize the thinking initially, transition immediately from there to deliverables, and then move to the activities necessary to build the deliverables.

For example, one could start by reviewing policy forms and filings for compliance if it is determined that the company needs more time to compile additional records related to complaints and grievances. Similarly, review of complaints and grievances may provide insights to underwriting and claims which might go unnoticed if reviewed later in the examination. Target examinations, focused on narrow objectives, require less planning effort.

As each section is completed, the examination team may communicate additional requests and/or criticisms or findings to the company. Such criticisms or findings form the core of the team‘s final report to the Department.

Time and Cost Budgeting

Create a time and cost budget for each examination. Many insurance departments have established templates that are used to format and document the budget. The budget should be part of the examination workpapers. Document deviations from the expected budget carefully to explain factors that may extend (or shorten) the life of an examination. Sometimes an examination is delayed until after a new Annual Statement is published. If the new Annual Statement reveals that one of the lines of business to be audited was discontinued or sold, less time may be needed to complete the examination. Other factors may delay the completion of tasks. Unexpected delays in obtaining documentation or a discovery of ~~b~~ad data” may frustrate timely completion of essential analysis.

The examination work plan forms the basis for the time and cost budget. It sets forth the area of the examination in terms of the lines of business along with functional areas, such as underwriting and claims, to be examined. The work plan varies depending on whether an examination is of a group entity or

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an individual company or companies, whether the examination is targeted or comprehensive, and whether it is a single-state or multi-state examination.

After the basic information has been determined, each step used in performing the examination should be identified in order and documented in the examination work plan. Items for consideration include the scope of the examination, the sampling method, the size of the sample(s), and other steps necessary to meet the examination objectives.

To create the budget, assign the number of hours estimated to complete each task in the work plan. Multiply the hours by the hourly rate of the examiner assigned to perform the tasks. Factors to consider in compiling a budget include some or all of the following. Each section below may have several sub-parts.

- Time needed for planning and administration
  - Pre-examination review of company and Department records
  - Preparation of initial and subsequent requests
  - Coordination meetings with the company and/or Department
  - Review of Handbook and compliance procedures
  - Preparation of periodic reports
- Time needed for examination procedures
  - Review of company history, organization, licensing, and operations
  - Sales and marketing review
  - Underwriting and rating review
  - Claims review (by line of business)
  - Complaints, grievances, and appeals
  - Preparation of criticisms / notices of findings of variations from applicable statutes, regulations, and Departmental bulletins
  - Report writing.

How to Focus the Examination

Communication with the Examiners and the Company

It is vital that the examiners establish routine and productive communications with the company. If the company does not initially assign an examination coordinator, the Examiner-in-Charge (EIC) should request one.

A company‘s examination coordinator(s) should:

- Be located in the same facility as the examiners

- Have a complete working knowledge of the company being examined
- Have the authority to make decisions on behalf of the company
- Identify persons in the company, in addition to the coordinator, authorized to respond to requests and criticisms
- Establish a line of communication between the examination team and upper management of the company
- Have a back-up.

The EIC should establish a weekly (or bi-weekly) meeting with the coordinator and other necessary company personnel. At the meeting the EIC should discuss:

- The time and cost budget (some states may choose not to reveal detailed cost information)
- The current status of the examination
- The next steps of the examination
- The status of outstanding requests and criticisms
- Miscellaneous housekeeping items.

Since the examiners‘ presence represents a cost to the company, the EIC should strive to keep the company coordinator informed of the status of the staff (who may be exiting or joining the examination) and ensure that the company resources are used properly.

The examiners should discuss and share findings regularly. Regular exchange of impressions and objective findings may alert team members to important factors and practices. For instance, an examiner looking at disability income claims may find evidence of a common practice not readily evident in processing life claims. Sharing results may lead to more consistent findings and may help to isolate truly unique mistakes.

Regularly published status reports that indicate progress against the plan and highlight the activities and deliverables leading up to the next status report are important to keep ongoing focus on the examination.

Customization and Use of Examination Worksheets

Each examination is unique in its own right. Although an examination may begin with a basic plan and a set of standardized worksheet templates, these items need to be customized based on the needs of the examination and the data available from the company. Document formats should be changed to create the best possible work flow. Such change can be minimized by asking the company to provide data in columns following the same order as a standard —template”. Small details, such as insisting that

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dates be formatted for Microsoft Excel or Dbase, can facilitate computation of date ranges. Additionally, the actual data should be modified in order to accurately accommodate the most easily obtained and efficiently processed information that meets the examination objectives.

Depending on the accuracy of data provided by the company, additional columns may be added to document variances found during the course of the examination. For instance, some companies may record the date of receipt of a claim as the date the claim is received in its claim processing center but may not record the date the claim was received by a Third Party Administrator for re-pricing. Depending on applicable state law, the earlier date received by the re-pricing entity may govern compliance with prompt payment or timely response laws. It is helpful to document the frequency of necessary corrections to data, particularly when large samples are involved.

Review of Internal Data

Licensing, Rate Filings, Form Filings, Appointments, Annual Statements, RIRS, Complaint History, Legal Actions

Internal Departmental data is important in determining if it is necessary to perform an examination as well as focusing the efforts of the examination team once an examination is called. Complaints from policyholders are another source for identifying areas to be examined. Other factors include large fluctuations or changes in lines of business or significant changes in management. These ideas and concepts are discussed in greater detail in other chapters of this textbook.

Using Software Analysis Tools

There are many different software analysis tools available to assist in conducting an examination. The most popular tools used in the industry to date are ACL and Microsoft Excel (PUP Ad-in). ACL and Excel can generally sort for any type of testing need. They can sort according to timely payment of claims (e.g., 0-30, 31-60, 61-90, over 90 days), rejected zip codes on underwriting, etc. Additionally, Microsoft Access can be used to develop a database of information with sorting capabilities. However, the Access program tends to be more complicated and time consuming. Therefore, when the same processing can be accomplished, ACL and Excel are the programs of choice.

Note that larger file sizes cannot be managed by pre-Office-2007 versions of Excel, since Excel worksheets are limited to 65,536 lines and a default of 256 columns in these versions. Excel 2007 does ease the limitation considerably; however, it does not totally address it as the number of rows is limited to 1,048,576 and the number columns to 16,384. While both ACL and Excel can be used to select random samples, ACL is more flexible when larger file sizes occur,

as is common when auditing larger companies or HMOs that process tens of thousands of claims per month. In Excel, arrays in worksheets are limited by available random access memory, by the total number of array formulas, and by the "entire column" rule.

See http://support.microsoft.com/kb/166342 for more information.

Also, ACL can use more than three columns of data as the sort key for a file, thereby allowing more sophisticated sampling techniques. ACL's biggest drawback is that it is more complex and requires a longer learning curve to become (and to remain) proficient in its use. It may be more effective to have one or two people do all of the preliminary sampling using ACL for examinations involving larger databases.

Learning the Rudiments of the Carrier's Data Systems

Insurance companies use different hardware and software applications to perform a variety of functions. Currently, companies are moving toward "paperless" systems for the operational areas, such as underwriting and claims. Consequently, fewer and fewer hardcopy files are available for examination.

When coordinating the examination with company personnel during the pre-examination stage, it is important that examiners determine the format in which the company's records are maintained. If the records are maintained in an electronic format, time should be allotted by both the examiners and the company for a tutorial of the systems necessary to retrieve and review files that are part of the examination. This should also include access of any paper documents which may be archived as scanned images. A clear understanding of how to access such documents is becoming more important as companies continue to move away from expensive maintenance of hard copy documentation. Federal requirements for electronic filing of claims further solidify this trend.

Some systems are Microsoft compatible. However, more often than not, the data systems are home grown or have been cobbled together over the years and are difficult to use. Many companies use older DOS-based systems written in a variety of languages. More challenges arise as the result of mergers when a company emerges using many different systems simultaneously. There may be many computer programs in use by companies and little data sharing among the programs. In these cases numerous "screens" may need to be viewed in order to obtain the information needed to complete the audit of a particular area.

Generally at the time of the initial examination coordination, it is necessary for the examination coordinator to contact the Information Technology (IT) staff and other supporting personnel to have step-by-step processes created for the examiners to use during the review of company information and data files. It may also be helpful to have a joint meeting involving the examiners, the coordinator,

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IT staff, and representatives from other departments to ensure that all involved share a common understanding of what data is needed. When completing this process, it is important that all —screens", as well as the commands used to maneuver within the system, are printed out. It is critical that the examiners also have dictionaries of all relevant codes used by the company to document its actions. For instance, denial/pend codes need to be clearly understood. This enables examiners to verify whether the company's decisions are supported by appropriate documentation. Understanding these processing codes is essential to effective analysis of data and selection of samples relevant to the examination. Companies often use multiple codes to describe similar actions, and it is important to be aware of all the variations.

Examination Techniques vs. Investigative Techniques

Examination techniques involve reviewing and analyzing data readily available within the content of the policy, underwriting, and claims files/records as well as in the company's policies and procedures manuals.

Investigative techniques are often used during examinations to explore issues that are not apparent by a review of the files and/or company policies or procedures manuals. Investigative techniques are used in situations that involve work flow crossing departmental lines or when documentation of a transaction is maintained in different areas of the company (e.g., when all the documentation or handling of a process is broken down into several parts, and each piece of documentation is maintained separately without a central file). Investigative techniques are also used to develop more detailed information regarding suspected incidents of wrong doing. For example, medical records related to underwriting or claim decisions may be archived in a different location than other parts of the file. The company may also vary its file retention guidelines by documentation type.

As health care providers begin keeping more records electronically, the need to access records retained only on paper will give way to the need to review electronic records. Regardless of the medium, companies must be able to reconstruct records supporting their business decisions.

Areas of Examination Emphasis Based on Known Concerns about the Company

When an examination is called on the basis of a concern regarding a company's business practice(s), emphasis should be placed on the examination of the known area(s) of concern. The work plan should include various ways to validate or discredit the concerns regarding the company. The examination team will more than likely want to employ some investigative techniques such as conducting interviews using open-ended questions, sending out consumer

surveys, etc. The time allotted for the examination must be sufficient to ensure that the concerns regarding the company are resolved in one way or another before the examination is concluded. If the areas of concern were developed from complaint ratios, the examiners should examine the complete complaint, grievance, and/or appeals files, including all documentation related to the circumstances giving rise to the complaint, grievance, and/or appeal. This review should disclose the degree of validity of the complaints, etc. It may also identify business practices that contributed to the problems found. Not all complaints, or all company disclaimers of liability, are justified.

When and How to Make Use of "Statements under Oath"

A statement under oath is a formal statement in the presence of, and recorded by, a court reporter who provides an official transcript of the entire proceeding. The decision to utilize a statement under oath instead of less formal techniques, such as recorded statements or informal statements, depends upon the individual circumstances as well as the policies and procedures of the companies involved.

As a general rule if there are potential violations that may lead to a hearing or prosecution, detailed documentation of what any individual states is very important, and a statement under oath should be used. Additionally, if there appear to be serious misrepresentations or conflicts between statements and/or information obtained from the company/agency personnel, the statement under oath is a much stronger method of obtaining details of the event(s) in question.

The decision to obtain such statements causes a more confrontational and adversarial environment. Cooperation by the company subsequent to obtaining such statements is likely to be impaired if not impossible. Therefore, the decision to exercise this method of documentation may require approval of the Audit Manager or Chief Examiner. Carefully documenting conflicting responses and securing copies of related evidence may suffice. Statements under oath should be used sparingly and cautiously; they are best obtained after the on-site portion of the examination is complete.

Making Use of Alternative Examination and Investigation Techniques

The collection and analysis of information from companies in various forms can be used in place of, or as a supplement to, an on-site examination. Following is a brief summary of some of the alternative examination and investigative techniques available. Note that a more detailed treatment of these and other techniques can be found in Chapter 2 (*Continuum of Regulatory Responses*) of the NAIC's *Market Regulation Handbook*.[1]

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Data Calls

Data calls are used to collect some basic information regarding a company's business that is maintained in an electronic format. Data calls can also be used to establish a baseline of information captured by companies for a particular line of business or in relation to a newly enacted statute or regulation. This method yields results only as good as the data provided allows. Not only must the general integrity of the data be tested, but some actual file copies must also be reviewed to confirm that the data provided accurately reflects the company‘s practices. Comparing date stamps, dates of letters, and explanations of benefits with dates shown on the data calls, for example, may be helpful.

Written Inquiries

Written inquiries are used to collect narratives regarding policies, procedures, and actual company practices. Inquiries should be written in a manner that requires the company to provide detailed information that substantiates actual company practices rather than established policies and procedure standards. Inquiries or requests should clearly identify data and documentation needed for review. Often, each state has requirements for timely response to inquiries or requests. The EIC usually decides whether to grant extensions, but the flexibility to grant extensions decreases as the examination‘s term shortens.

Desk Audits

Desk audits are generally small-scaled examinations during which the company provides data and files to an examiner working off-site. Examiners are initially limited to the data and/or file copies provided. Communicating over long distances may be challenging, and obtaining additional information may be difficult. The success of such efforts depends on the complexity of the problems being reviewed as well as the amount and accuracy of data. Verification of data is essential. Again, comparing date-stamps, dates of letters, and explanations of benefits with dates shown on the data calls, for example, may be helpful.

Survey of Policyholders

Policyholder surveys are used to gather information directly from a company‘s policyholders. These surveys are generally used to determine:

- The policyholders' understanding of the product(s) they purchased
- The consequences of various actions policyholders take regarding the product(s) they purchased
- Any disclosures that may have been made to policyholders by the company and/or sales personnel.

Make surveys brief and fairly simplistic in order to encourage policyholders to respond. Return-mail envelopes with pre-paid postage improve response rates dramatically. Direct the responses to an address other than that of the company being audited. To the extent possible, send surveys early in the examination process. Another use of surveys is to verify that the company complied with requests to mail additional settlements or information to policyholders and/or claimants.

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Endnotes

[1] National Association of Insurance Commissioners, *Market Regulation Handbook* (NAIC, 2301 McGee Street, Suite 800, Kansas City, MO 64108-2662), July 2007, Volume 1, Chapter 2.

Chapter 6
- Questions of Fact

Educational Objective

> Identify the best practices in solving problems when questions of fact arise in the examination process.

What Are Facts, Anyway?

This seems like a simple question. The answer depends on many issues. A fact, to most of us, might be strongly influenced by our belief systems, and something we believe is a fact may be considered false or merely an opinion by others.

—Facts" may be defined in many ways. For the sake of simplicity, this chapter presents several such definitions and highlights the role of market conduct examiners in the resolution of questions of fact. Facts are not opinions, nor are they matters of ethics. They simply are what they are.

Some Definitions

Since this chapter depends on a clear understanding of what facts consist of, it is important to look at a few definitions. A contemporary definition may be found on the Internet from —Wikipedia, the free Encyclopedia" (http://en.wikipedia.org/wiki/Fact).

This source defines —Fact" as follows:

> —Generally, a **fact** is something that is the case, something that actually exists, or something that can be verified according to an established standard of evaluation… There is a range of other uses, depending on the context. People are interested in facts because of their relation to truth."[1]

Most of us have an intuitive understanding of —facts" along these lines.

<u>Webster's Ninth New Collegiate Dictionary © 1983</u> (an older source) defines —Fact" in several ways, including:

- —a thing done"
- —the quality of being actual"
- —a piece of information presented as having objective reality"
- The phrase —in fact" may be interpreted as —in truth".[2]

Webster's also defines under this section a —fact finder" as:

> —one who tries to determine the realities of a case, situation, or relationship; esp.: an impartial examiner designated by a government agency to appraise the facts underlying a particular matter."[3]

The latter part of this related definition in Webster's could be used to describe the general role of the market conduct examiner. The market conduct examiner should be: —an impartial examiner designated by a government agency [such as by a state insurance department] to appraise the facts underlying a particular matter [the business of insurance]".

These definitions help point out the range of belief related to the basic question of defining what facts are and how we differentiate between a fact and conjecture or opinion. How can this be done by impartial examiners designated by a government agency to appraise the facts found during the course of a market conduct examination?

Separation of Facts from Fiction and Opinions

A good place to start is to consider examples of facts considered in the course of a market conduct examination. As market conduct examiners, we must determine facts under many circumstances. Some are clearer than others. Yet we are really only able to offer our conclusions and findings based on a review of many bits and pieces of information. Therefore, if many facts we face day-to-day are really best guesses, how can we: —...appraise the facts underlying a particular matter"?

The "Simple" Date Issue

Some information in file documents, such as the date an approval letter was written, may be considered factual (or true). However, that date may or may not be the same as the date a claim was paid. Similarly, the date a check was issued – the check date – may not be the same as the date the check was mailed. Since companies may or may not mail a check on the date it was issued, the examiner must determine the company's practices and use that additional information when compiling information about the company's practices.

It may be wise to discuss this issue with the company and establish a clear understanding about such matters. Thus, an agreement may be made to consider how to establish certain —facts" when such —facts" cannot be readily proven. Sometimes, it is agreed that the check date itself is the date paid, and sometimes using the next business day as the date paid is acceptable. The agreed-on date rule should be used unless subsequent findings raise questions about the validity of the manner in which date information is accepted. Therefore, even something as innocuous as a date paid cannot always be readily accepted as factual when it appears on the documentation

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provided. Such information is key when conducting a limited examination of prompt-pay compliance or when documenting other time-study issues.

Documentation – Policy Forms and Advertising

State law and regulations may mandate that advertising, applications, policy contracts, and amendments conform to certain minimum standards. Some standards involve content, including confirmation that:

- Mandatory provisions are included for various lines of business.
- The document is not misleading or confusing.
- An application does not ask questions not allowed by law.
- Disclosures are clear concerning celebrity endorsements.
- Undue prominence is not given to benefits in comparison to limitations (small print).
- Illustrations are given to applicants.

One type of task in a market conduct examination is to review such forms and records, including audio and video tapes, to confirm compliance with applicable laws and regulations. The task involves documenting variances from statutes and regulations and, when they occur, reporting them with a high degree of confidence as factual deviations. Exhibits consisting of copies of non-compliant documents usually settle such issues. It is not uncommon that, upon receipt of a criticism pointing out non-compliant language, a company finds a revised form that was overlooked earlier. Such new forms should include documentation as to when the prior form was discontinued and use of the new form commenced. Each element of additional information may be a reportable fact and should be carefully recorded.

However, some documents may be written in Spanish, French, or another language (other than English) to serve a special client base. In such cases, the company should supply an accurate translation of each such document. It is prudent to review such translations very carefully to verify that the translations are accurate.

If a member of the examination team is bilingual, this may be easy to do. If a bilingual team member is not on-site, another staff employee may help. Another source might be a foreign language department at a local college or university. Non-compliant language is reportable, regardless of the language in which it is non-compliant.

A good place to start such a review is to compare the English version of a document with its foreign-language counterpart. To narrow areas of concern, it may be possible to spot obvious differences such as areas where one version is markedly longer or shorter than its counterpart. The –look” of the foreign language version should mimic the English version as closely as

possible. This preliminary review may lead to a quicker resolution of a potential concern. Admittedly, this may be easier with some languages than others.

Nonetheless, reporting facts concerning non-compliant language in policy forms and advertising is usually straightforward. The required language is present or it is not present. Likewise, prohibited language can be photocopied and highlighted or otherwise clearly described.

Illustrations, advertising, and policies should also be clear and organized so that they communicate clearly without giving undue prominence to benefits at the expense of limitations or exclusions. A company‘s practice of describing benefits in larger print on the front of an illustration or in a prominent manner while disclosing exclusions or limitations in smaller print several pages back in the document can be used to document the company‘s use of undue prominence in describing a policy. Variances like this can document methods used to mislead potential customers.

Celebrity endorsements of products are used by companies to enhance advertising. Most states require that such ads include notification that the celebrity was paid to make the supportive statements. The market conduct examiners should retain any non-compliant tapes as exhibits for the final report when they discover errors in such ads.

Opinions as Facts

An attending physician‘s conclusion that an insured is totally disabled cannot be considered more than that physician‘s opinion as to the extent of disability. Further, it may be reasonable for a company to conclude that an insured may be disabled from his own occupation, but not from any occupation for which he is qualified by age, education, or experience.

The attending physician‘s opinion regarding a diagnosis, the extent and duration of disability, a repair shop‘s estimate of the cost to repair a vehicle, or a medical examiner‘s report indicating what caused a person to die are not facts per se. Rather, they constitute what amounts to a professional‘s best expert opinion. A physician‘s expert opinion may be considered as a fact when a judge or jury makes a legal finding of fact. Ultimately, while such a finding is binding by law, the result might be simply that which is believed to be the case by that particular judge or jury.

The physician‘s or expert‘s opinion is a fact. The company‘s conclusion relative to those opinions is a fact.

Hearsay

Sometimes, market conduct examiners are unexpectedly exposed to additional information while on-site. While this may not happen often, it is important to know how to evaluate and respond to such serendipitous events.

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For instance, while returning to their assigned work area from an on-site cafeteria, two market conduct examiners might overhear two company employees talking on the other side of a partition. The examiners hear allegations of embezzlement. Should such information trigger additional investigation as though it is true?

The simple answer, of course, is that any such comments overheard were, at best, hearsay. Perhaps a prudent course of action would be to report this event to the Examiner-in-Charge (EIC). Then, the EIC can discuss the potential problem and its possible impact with the Supervisor. Ordinarily, such information is outside the scope of a market conduct examination and should be investigated, if at all, by a financial examination team or another entity. Some states combine financial and market conduct examinations. In such cases, it may be appropriate to be sensitive to clues which support or discount a potential risk to the insurer‘s financial solvency. While these events are rare, market conduct examiners must guard against allowing hearsay information from clouding their objective and impartial appraisal of a company‘s practices.

Impact on Reporting Findings

Even though market conduct examiners are not ―finders of fact” in the same legal context as is a judge or a jury, examiners are charged with the duty to report objectively what they find in the course of examining an insurer‘s records. They report on what documents reveal and how such information compares to the statutes and regulations relevant to various transactions found in the course of an insurer‘s interaction with its insureds, providers of services, other carriers, and regulators. As such, they are ―fact finders”.

Such findings may be the product solely of the company‘s response to formal requests for information or data. Findings may also flow from additional information obtained in the course of a market conduct examination due in part to how the examination is conducted and to how various tasks are assigned.

For instance, a comprehensive market conduct examination may involve auditing activities in the following order (other sequences may be used). The order of review does not necessarily correspond with the order these items appear in the Report, which was discussed in Chapter 2 of this textbook. Rather, certain areas are generally reviewed first to get an overall picture of the company‘s operations, but this sequence could vary from state to state.

1. Market Analysis
2. Sales and Underwriting
    - Certificate of Authority
    - Advertising / Marketing

3. Policy Forms and Filings
4. Policy Issue Procedures and Practices
5. Cancellations and Rejections
6. Contracts with Third Party Administrators (TPAs)
7. Minutes of Board of Directors
8. Producer Licensing
9. Underwriting and Rating
10. Complaints and Grievances
11. Claims Administration (by Line of Business)
    - Payment Time Studies
    - Accuracy
    - Closed Without Payment
    - Claim Practices
12. Non-Forfeiture Provisions and Practices
13. Other Areas such as Credit Certificates of Deposit and Unclaimed Funds
14. Examination Report Preparation.[4]

Assignment of specific examination tasks by the EIC may facilitate the discovery of violations. For instance, one person may be assigned to review producer licensing while another is looking at life insurance and annuity policy forms, and a third is looking at health insurance policy forms. If all finish their tasks at the same time, the results of any questionable or recent producer appointments may be shared and reviewed before the underwriting review is started. It may then be more effective to note discrepancies in producer licensing related to lines of business. Similarly, if the examiner who reviews life insurance and annuity underwriting also looks at complaints and claims for those lines, that examiner will become more intimately familiar with the insurance company‘s practices.

Such an approach may not be possible in all cases because of staff limitations. However, if such an approach is followed and meticulous records are kept, it may be possible to find areas of concern that might otherwise go unnoticed.

In the course of auditing producer records to verify that those selling insurance are licensed to do so for a particular line, a market conduct examiner may find, for example, that several producers became licensed on

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June 1 of the calendar year being audited. If, in the course of reviewing underwriting or claim files, the examiner discovers policies being applied for and issued before that date, with commissions being paid to one such producer, the examiner may report this in the form of a criticism of the company's business practices.

Here is an example of an irregularity found while comparing complaint records to claims records: While reviewing complaints, appeals, or grievances for an HMO, an examiner runs across a formal grievance that seems unfamiliar. A quick review of the examiner's worksheet of grievances shows that the grievance just found is not on the company's Grievance Log and has not been previously audited by the examination team. If this "newly discovered" grievance was promptly and correctly handled, the examiner might report only the fact that the insurer's Grievance Log was incomplete. If other grievances were not logged, a more serious violation may have occurred. If the grievance was mishandled, additional findings might be reported in a criticism.

Separation of Facts from Fiction and Opinions – Impact on Decisions

It is imperative at this point to draw a distinction between what market conduct examiners do with regard to facts and traditional legal concepts.

First of all, examiners are not "Finders of Fact", as that term encompasses duties and responsibilities not inherent in the role of a market conduct examiner. A "Finder of Fact" is usually understood to possess *jurisdictional* authority as exercised by a duly appointed or elected *judge* or by a legally convened *jury*. The responsibilities assigned to a judge and jury include drawing conclusions about circumstances and evidence. Such conclusions include, for example, determining whether a plaintiff should prevail or whether a defendant is guilty or not.

The examiner's role is to be a "factfinder" and to report, objectively, the realities of a case, including relevant data. It is also appropriate to determine whether or not the information discovered violates certain laws and/or regulations. While doing this, examiners must be mindful that they are not allowed to draw conclusions in the same way that a judge or jury may draw conclusions. They must stop a step or two short of drawing conclusions related to possible motives for deviations from applicable statutes and regulations. The facts reported speak for themselves. One or two criticisms of a given nature will not be deemed harmful, per se, and might simply represent the finding of isolated errors. However, when all the findings are considered as a whole, patterns of conduct usually rise to the surface.

The report of the findings may lead to further actions or sanctions such as Cure Orders, Cease and Desist Orders, Stipulations, Fines, or other penalties. Those decisions are not within the scope of the responsibilities of the market conduct

examiner. Those decisions are usually made by the Commissioner, Director, or Superintendent.

Documentation of Facts – in General

Market conduct examiners are asked to examine a variety of documents to ascertain whether or not a company complied with state statutes and regulations and/or federal laws and regulations. For simplification, this chapter primarily covers state requirements. Examiners also – at times – evaluate whether a company complied with its own written policies and procedures.

To complete this task an examiner must review, or examine, a variety of documents to determine what, when, how, where, and, sometimes, *if* a given event happened.

First, determine which documents are relevant to examination during a given assignment. Depending on the assignment, these documents may include some of the following:

- Claim form(s)
- Database information
- Bills from providers of services
- Independent examinations of persons or property insured
- Medical records, including those from:
  - Medical care providers (MDs, DOs, DCs, DPs, DDSs, DMDs, DPs, ODs, PsyDs, PhDs, Medical Examiners, etc.)
  - Hospitals
  - Radiologists
  - Independent laboratories
  - Ambulance services
  - Treatment centers
  - Nursing facilities
  - Veterans' treatment facilities
- Company documents
  - Board of Directors (including committee and subcommittee) minutes
  - Litigation files
  - Examination Reports from other state insurance departments
  - Policy contracts, including schedules of benefits, applications for coverage, and any riders issued

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  - Current ownership and beneficiary records
  - Policies and procedures relevant to the situation being audited
- Correspondence
- Official reports from law enforcement agencies
- Payment vouchers or explanations of benefits
- Job descriptions (for disability claims)
- Company computer records concerning prior claims, histories of applications of deductibles, out-of-pocket expenses, premium records, etc.

Second, examine the condition of each document relevant to a given situation carefully. Are the records original paper, photocopies, imaged paper, or electronically stored? If in an electronic format, are the records archival only? Faxed documents are considered copies.

Original paper documents are usually the "best" source of evidence with regard to the content of the document. Original documents on a company's or provider's letterhead have characteristics not found in other formats. Such may include colored ink, logos, a "footer" with information about the entity from which the document was produced, and other readily recognizable features. Fonts may differ between the pre-printed letterhead and the text of the document. Corrections, if any, are usually apparent, though in today's environment of word processors with spell-check and grammar-check software, it is increasingly rare to see evidence of white-out.

Photocopies are generally monochrome – black print on white paper. Imaged copies are becoming more common, and may be in color, but are usually scanned in black & white. Those documents are usually reviewed via access to a company's document image database. Most photocopies may be accepted as if they were originals unless they exhibit characteristics which point to having been altered or redacted in some manner. Official documents, such as certified death certificates with raised seals, may "scan" so well that it is possible to read part or all of the seal. Other seals simply disappear when scanned.

Most readers will recognize those characteristics that raise doubt:

- Text that does not "line-up" with the rest of the document
- Blacked out text
- Pages that look different from other pages in the series of pages; for instance, lack of a footer on one page or other physical inconsistencies
- Faint lines surrounding all or a part of a section of text – Was something pasted over the original text?
- Irregular appearing text – Was white-out used, followed by an attempt to change letters?

- Variation in font or font size.

Third, examine the content of these documents. Does the document reflect primarily "factual" information, such as might be found on a bill for services, or does the document reflect opinions or conclusions based upon specific facts? Is the content consistent with other file information? If the content contains "…information presented as having objective reality", the examiner can, and should, treat that information as reasonably factual.

Some of the facts gleaned from file documents might be those from a hospital or physician bill. The illness(es) or injury(ies) suffered (ICD-9 codes), when treatment began, length of hospital confinement, treatments provided (CPT or hospital billing codes), address of the insured, employer name, birth date, and a host of other clear-cut elements needed to "put the file together" can be learned from the bill.

Other documents, such as claim forms and correspondence from physicians, may summarize a litany of information reflected in several records of objective findings (blood pressure, results of laboratory tests, examinations of physical limitations, emotional state, etc.) As a result of a variety of relevant information, an attending physician may conclude that an insured has incurred a given illness that necessitates a particular course of treatment. Or, the physician may conclude that an insured is totally disabled.

Fourth, if applicable, examine the date stamps on the documents. While this might be considered under content, date stamps are important in determining when events occurred; they may take several forms. Some states mandate that certain documents bear a legible date stamp.

Original documents may have a traditional date stamp affixed by machine or by hand. This is usually in ink that differs markedly from that found elsewhere on the original and may or may not include a time stamp. Scanned documents may have a record/document number, which includes a Julian date, at the top or along one side. It is necessary to obtain the record format for such numbers to allow them to be readily converted to the examiner's preferred method of recording.

Other documents are dated on receipt by having the receipt date literally drilled through the paper. Normally, this is done in batches and poses no problem. No problem, that is, unless the drill inadvertently obliterates information on the paper, or if the document is subsequently scanned and the "drilled date" becomes illegible.

Photocopies may be date stamped in the same manner as originals, and faxed copies may contain a date line at the top or bottom showing when the document was sent to the recipient. This date can usually be relied upon as the date the document was received by the recipient company.

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The date stamp simply documents the date a particular document is received by the company being audited. Problems occur when a document is not physically date stamped. Some companies attempt to document the date received by reference to a received date on a separate database. The EIC must decide whether, or under what circumstances, to accept such dates. Key to this is whether the separate database adequately identifies the document itself and whether the alleged receipt date —makes sense".

It may be necessary to ask an insurer for copies of its written procedures for handling incoming mail, incoming electronic claims and other communications, and outgoing mail. Such procedures should be dated and authorship by responsible company staff documented.

> For example, a database asserts receipt of a claim form on January 2 of a given year. However, the claim form itself was signed by the insured and the health care provider on November 20 of the prior year. Is that January 2 receipt date credible? Would it be credible if the claim form was signed on December 22 of the prior year? Some documents bear multiple receipt dates, and care must be taken to observe the context of that document in the work flow as a transaction is processed. Multiple dates, if widely separated, may reflect the fact that a document was sent back and forth between parties.

Another reason for multiple dates is that a document might be received by the mail room on Tuesday and by a claims or underwriting department on Friday. Usually, the mail department receipt date is the one that counts when measuring response times. However, other earlier dates may apply.

Multiple date stamps may include a:

- Date stamp from a third-party vendor or TPA (Third Party Administrator)
- Date stamp from a PPO re-pricing company
- Date stamp from the insurance company's mail room
- Date stamp from the operating department
- Date record in a computer system for an —imaged file" document.

Given a choice, many insurers prefer to count the date they received the re-priced claim from their TPA, rather than the date the TPA received the claim from the claimant, as the original receipt date. Since the TPA is an agent of the insurer, however, initial receipt by the TPA should normally be the controlling date.

More claims, particularly medical claims, are now required to be filed electronically. Most jurisdictions accept the electronic claims receipt date as found in the archival data captured by a company as valid.

Fifth, determine, to the extent possible and reasonable, if any details are missing. This is not as hard as it may appear at first blush.

- Content of documents in a file may mention other correspondence that appears to be related to the matter at hand. Is that other correspondence in the file? Was it requested?
- Correspondence from a physician to an insurance company may mention referral to a specialist, and the specialist's records are not in the file.
- Missing documents may be identified by inconsistent content. For instance, if the majority of contested disability claim files contain a formal evaluation of the ability of an insured to perform various components of his job, why don't all such files processed during the same time period contain the same evaluations?
- A dental claim may state that a crown is not covered because certain requirements were not met (fracture, excessive caries, etc.) However, a copy of the related dental X-ray is not in the file.
- A life insurance claim is denied because the insured died of a pre-existing illness within two years of the insured's effective date of coverage. No records of medical care for the last illness are in the file.
- The insured mentions that he was previously allowed benefits for a similar claim, and he does not understand why his current claim is being denied. It would be necessary to review the prior claim(s) to determine why the earlier claims were allowed.

Concealment of Records

Board of Directors meeting minutes, as well as minutes of committees and subcommittees of boards, may offer critical information about company operations and inter-relationships with other companies, litigation, internal operations, and overall philosophy. These sources may help market conduct examiners focus on specific areas for possible violations of statutes and regulations.

From time to time, some companies resist disclosure of these documents for one or more reasons, including, but not limited to their concern that:

- The minutes could become part of a report or workpapers that may be "discoverable" in the future.
- Records may contain legal opinions protected by attorney-client privilege.
- Some parts of the minutes are not relevant to the business of insurance.
- Some of the documents contain "sensitive" content.

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Excessive reluctance to provide records should be a red flag for the market conduct examiners. Most board deliberations are of little concern to a market conduct examination. From time to time, however, these documents identify additional complaints, grievances, deviations from normal company practices, and many other issues. In short, details found in these documents may enhance the market conduct examiners‘ efforts to discover all the facts relevant to multiple areas of examination of a company‘s practices.

If a company refuses to supply these records as the result of a usual request, the market conduct examiners have a variety of tools to consider using to achieve access to the board minutes.

First, the company must be assured that the records will be kept confidential. This can be done in several ways. Some states have laws establishing that documents obtained in the course of an examination —…shall be given confidential treatment and are not subject to subpoena and may not be made public by the Director or any other person…” (Section 375.204.4., RSMo.) subject to certain other legal requirements. Other states may have similar protections through statutes.

Portions of minutes involving attorney-client privilege may be reviewed by the Department‘s general counsel, in some cases, to help protect confidentiality concerns. However, without such a review, it is impossible to confirm that the privilege applies.

Records may, of course, be subpoenaed. Or the EIC might work with the Department‘s general counsel to draft an affidavit for all board members to sign (and have notarized) confirming that the redacted documents contain no information related to the business of insurance.

In extreme cases failure to provide records needed for an examination could lead to temporary suspension of an insurer‘s Certificate of Authority to conduct the business of insurance. Such a step should be considered only as a last resort and only in the event of a total breakdown of communications between the market conduct examiners and the company.

Database Concerns – Electronic Records

A key aspect, not only of auditing records but also of determining if and when to call a market conduct examination, is accuracy of insurance company data. This data is analyzed carefully to determine (in part) whether to call for an examination. Market analysis is covered in Chapter 1 – Introduction to Market Regulation.

Care must be exercised in review of data provided by the company. Information kept in an insurer‘s computer files related to identity of insureds, policy numbers, effective dates, and other base data is usually so reliable that it is desirable to ask for this information in a format that can be imported into the worksheets used

to review different kinds of records. However, some data is not all that reliable, for several reasons.

The main problem is communication. Market conduct examiners always know what they mean when they ask for a list of data elements from which to select a sample for review. By the time the request is forwarded to the company staff person who actually selects the data requested, it is not uncommon to find that some of the information just does not fit. A request for a date paid may be interpreted and reported by the company as the date approved for payment by a claim examiner. That is fine, if the claim payment is issued and mailed the same day. However, most companies do not mail claim payments on the same day that a claim is approved by a claim examiner. The claim may need further approval by a supervisor or manager before a check is created. The norm seems to be that the payment and Explanation of Benefits, if any, is mailed on the next business day following "approval". Even that is not to be assumed. Some companies mail payments only once a week. Some companies may even mail payments less frequently.

Insurers do not always capture all the information desired, so it is necessary to look at underlying documents to verify the company's actions. Use of third parties to handle functions, including marketing, underwriting, and claims, complicates matters more. If insureds or covered providers are required to send claims or other requests to a Third Party Administrator (TPA) instead of directly to the insurance company, the TPA acts as an agent for the insurer. Receipt by the TPA of the related mail, claim, or application is usually deemed as receipt by the company. That is the date the clock starts for time-study analyses. Few insurance companies seem to capture that earlier date in lieu of the date the documentation is received by the home office department charged with the relevant area of responsibility.

Many companies keep records of incoming customer service phone calls, e-mail, internal consultations, utilization review contacts, and general notes on company databases or logs instead of a paper log. Such records may contain abbreviations and internal company "jargon" that could be difficult to interpret without assistance from the company. Careful scrutiny of these records might help locate documents that were inadvertently omitted when a file was assembled for review.

Form Letters

Years ago, insurance companies used form letters to communicate a variety of decisions to insureds. They were easy to spot. Pre-printed check-off letters or single topic letters were in vogue for many years and continued to be widely used until word processors appeared. Today, form letters are more sophisticated and allow company staff to select a wide range of pre-approved text – resulting in a more personalized communication.

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Many insurance company administration systems allow companies to generate letters that communicate decisions clearly and in a very cost-effective manner. They work well so long as the keystrokes entered are correct and the responses are appropriate. However, mistakes happen and applications are denied, or claims are adjusted inappropriately. Another concern is that some letters so generated are just too vague.

Regardless of whether letters to insureds, attorneys, beneficiaries, or insurance departments are form letters or individually composed, the company has a duty to communicate clearly and accurately how it has handled matters with its insureds. The correspondence should be factually accurate about policy benefits, coverages, policy language, etc. Such letters should be completely accurate when quoting matters such as information received from third parties when such information impacts actions taken.

Adverse actions on claims or underwriting based on medical information should communicate all the relevant information received. Companies should be very careful about selectively quoting information, particularly when the insured may not have a copy of the complete text of what was provided.

Imaged Files

Some companies have eliminated almost all paper records and keep all transactions either in computer data files or as carefully indexed, scanned images of paper documents received (and sent). In these cases, sample selection proceeds as usual, but all records are reviewed while sitting at a computer terminal. When related documents are indeed carefully indexed so that everything related to an application or claim or policy service request can be found, the examiner may be able to efficiently and quickly audit all the facts related to transactions without touching a piece of paper.

Few negatives accompany such an environment. Cross-referencing to related files can be accomplished by either electronic flags or additional copies of scanned documents. Quality of originals obviously affects the quality of the scanned image. The usual test involves the ability to reproduce a printed image that is as clear as the original. There are risks associated with any system that substitutes an image for an original, but safeguards exist to discourage a company from —doctoring" a document. It is simply too easy to obtain, for instance, an original from the source.

Statutes – Regulations – Federal Laws

Each state has many statutes, regulations, and bulletins issued to insurers documenting requirements for doing business therein. Most states have passed laws relating to unfair trade practices which prohibit boycott, coercion, or intimidation that causes or may cause restraint of trade or a monopoly in the

business of insurance. The various states appear to have jurisdiction over such business practices.

Thus, if a market conduct examiner discovers evidence that an insurer has established a process whereby applications for insurance are —sifted" by a broker to a limited number of carriers, it is proper to report such findings as violations of the state's unfair trade practices laws.

Most states have laws similar to Section 376.383.9., RSMo. (Missouri law), which states that:

> —Denial of a claim shall be communicated to the claimant and shall include the specific reason why the claim was denied."

The company would be ill-advised to issue a denial which states only that the claim is not covered because:

> —This service is not a covered expense. Refer to your policy for definitions, exclusions, and limitations."

Some companies have defended such vague denials as necessary to comply with HIPAA regulations banning disclosure of confidential medical information. HIPAA rules apply to private communications between insurers and insureds as well as to communications with third parties. Failure to provide reasons for a claim denial as related to specific policy limitations and exclusions falls outside the limitations imposed by HIPAA. Specifically, when an insurer is writing to its insured about policy benefits, there can be no publication of its decision, or of the facts supporting this decision, to a third party. There is a notable exception under HIPAA that allows disclosure of confidential medical information to regulators for legitimate audits of insurance company operations. Federal law 45 CFR § 164.512(a)(1) states:

> A covered entity may use or disclose protected health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.[5]

These disclosures occur after the fact and do not constitute a concurrent publication of restricted information at the time a decision is sent to an insured.

It is generally not reasonable to expect an insured to read through all of a policy's provisions and deduce why a claim is being denied when the reason for the denial is not clearly identified. Therefore, it is generally acceptable for an insurer to communicate facts related to its decisions directly to its insureds.

Determination of Who Pays

The facts of a given claim determine who pays what for insured losses. In the case of managed health care plans that include PPO or HMO arrangements, the

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entire cost of covered services might be paid by the health care plan after the insured pays a specific co-payment. In the case of other insured plans, an insured may be responsible for a deductible and coinsurance until a specific out-of-pocket limit is reached. Property-casualty claims are typically subject to a specified deductible and policy limits that are the responsibility of the insured or another third party.

Policy contracts identify certain non-covered risks under Limitations or Exclusions sections. However, market conduct examiners should be aware of hidden exclusions – exclusions that might be listed as exceptions to an otherwise covered benefit. For example, a dental plan covers a limited amount for tissue regeneration, except when such is necessary following extraction of a tooth, even if the extraction itself is covered. It is easy to see how an insured would be confused by such a convoluted benefit design.

Uninsured losses may be covered by the insured alone. Such losses may also be covered by someone who intentionally or negligently caused the loss. When a third party is liable for a portion of a loss, an insurer may have a right of recovery with few limitations. Each state has different laws and regulations determining what expenses may be recovered by the primary carrier. It may be necessary to review several documents to ascertain whether a company correctly exercised a right of recovery.

Endnotes

[1] http://en.wikipedia.org/wiki/Fact © 2007, September 24, 2007.

[2] Webster‘s Ninth New Collegiate Dictionary © 1983, p. 444

[3] Ibid.

[4] National Association of Insurance Commissioners, Market Regulation Handbook (NAIC, 2301McGee Street, Suite 800, Kansas City, MO 64108-2662), July, 2006, Volume 1, pp. 1-3, 5, 6, 8, 11, 13-17, 20, 22, 25-31, 35-38, 40-42, 46-49, 60-62, 64, 65, 70, 75, 85, 87, 110, 111, 119, 122, 133, 141, 142, 148, 170, 189, 198, 243, 245, 253, 258, 262, 263, 276, 283.

[5] 45 CFR § 164.512(a)(1)

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Chapter 7
- Addressing Violations of Law and Regulations

Educational Objective

Describe the process for reviewing compliance with statutes and regulations and identify the best course of action when an examination reveals practices that are violations of either or both.

Process for Reviewing Compliance

The goal and purpose of this chapter is to outline and explain how to address various violations of law and regulations during a market conduct examination. As a prerequisite, one should be aware of the various types of violations that may occur during an audit and how to distinguish an alleged violation of a law or regulation from other types of errors.

Three Tests

When reviewing records for compliance, an examiner should perform three tests.

- First, test to see if a violation of law or regulation has taken place.
- Second, test to see if a violation of company procedures, rate or form filings, or insurance policies occurred.
- Lastly, use professional skepticism (i.e., the —smell test") in instances when the facts do not seem to add up to some logical conclusion.

Violation of Law or Regulation Test

A violation can take several forms: a company may have violated a state statute, or a company may not have complied with a specific regulation. While technically not a violation, a company‘s failure to follow a Department bulletin completely or correctly should be cited as well. Another possibility is that a court in the pertinent jurisdiction may have recently ruled on a case similar to the fact pattern at issue in a review.

Violation of Company Procedures, Rate or Form Filings, or Insurance Policies Test

A violation of company procedures, rate or form filings, or insurance policies is not the same as a violation of law, but all should be cited. While a company may not have violated a specific insurance law, it does have a contractual duty to provide the services that it promised to perform when issuing an insurance policy. Furthermore, even if a company did provide a

contracted service (according to a policy provision or rate or form filing) and did follow the state's insurance laws, the company can still be criticized for not following its own filings or written procedures on how to handle a claim, underwrite a file, etc. If a rate or form filing was approved by the Department incorrectly, the examiner should inform the EIC, who should then handle the matter in an internal Department Management Report.

"Smell Test"

Even if a company has followed the law and all of its procedures and has complied with its rate and form filings and insurance policy provisions, the possibility exists that a situation may still be suspicious due to the specific nature of the circumstances. An examiner should not go on a "witch hunt" or attempt to "throw the kitchen sink" at a company. However, an examiner's instincts should be followed in those instances when something just does not add up or make sense (i.e., it fails the "smell test").

Best Course of Action

An examiner should address each of the above three types of violations in a specific manner, as outlined below. At times, the examiner can address the various types of violations simultaneously. What is important to keep in mind while reviewing the relevant files is that the standards and procedures for these three types of violations differ from each other, and the best course of action for each may vary, depending on the situation.

Documenting Violations of Laws and Regulations

For instance, in order to allege a violation of a law or regulation, an examiner must have specific proof and documentation of an error. This first requires obtaining the pertinent facts and a list of relevant state statutes, regulations, Department bulletins, and case law for each line of business under examination. Other chapters of this textbook cover how to obtain the pertinent facts and sample data for review. Presented here is how to acquire the relevant pool of insurance law within which to test the company under review.

Nobody should expect an examiner to know all the insurance laws of all the states off the top of his head. Yet, it is prudent for an examiner to research, summarize, and organize the basic insurance laws into a format that an examiner can easily access.

While state employee examiners, contract examiners, and independent examiners may have several assignments pending for various projects or clients simultaneously, it is usually true that an examiner is working on one examination at one time for one state (or several states, if it is a multi-state

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examination). Therefore, it is reasonable for the examiner to follow some version of the best courses of action indicated below.

Compiling Statutes, Regulations, Bulletins, and Case Law

Whether compiling state statutes, regulations, Department bulletins, or case law, the examiner should get a listing of all pertinent laws associated with the lines of business (individual and/or group life, accident and health, property & casualty, annuities, managed care insurance, etc.) for the market conduct examination in effect for the jurisdiction (i.e., state) and time period of the records under review.

Fortunately, for those examiners who travel to the insurer's site to perform examinations, the Internet has simplified the task of obtaining these listings of laws. The NAIC has a link to all state insurance departments, which in turn have links to state insurance statutes, regulations, and Department bulletins in most instances. Be careful, though, to use the law in effect during the time period under review. Some Internet sources contain only the current law and not the laws in effect years ago. Even though the chances of a law being changed are small, it does occur more often than one may realize, and an oversight in this area will not reflect well on the final work product.

Obtaining an accurate list and interpretation of pertinent case law is a little bit more difficult. It is recommended that the examiner work through the EIC either to research the matter or to contact appropriate Department legal counsel in order to retrieve the correct case briefs, rulings, and Department legal interpretations of court rulings in effect for the jurisdiction during the time period of the examination.

Recording Data and Legal Research on Excel Spreadsheets

After obtaining this pool of insurance laws, regulations, Department bulletins, and case law relevant to the lines of business and jurisdiction under review, the examiner should develop – under EIC supervision – Excel spreadsheets or similar types of worksheet to serve as a checklist and record of the examiner‘s work. The format and content of these spreadsheets vary a great deal. Basically, they should contain the company listing of the data from the sample or census of the line of business under review along with pertinent supporting data, dates, amounts, etc., that the examiner – under EIC supervision – has selected through computer programs like ACL. The examiner usually adds more columns to the spreadsheet to note important dates, company actions taken or not taken, and formulas to count the number of calendar and/or work days taken to acknowledge, investigate, and/or pay or deny a claim, underwrite a file, reply to complaints, file advertising, calculate any interest due, etc.

In addition, many examiners – with EIC approval – add columns to these worksheets with notes and legal citations summarizing their research about the pertinent state laws for the line of business under review. These checklists are handy, quick references to remind the examiners what to look for during the review and to record their work appropriately.

Documenting Violations of Company Procedures and/or Policies

At this point, one should have completed the research on the pertinent laws, obtained the supporting data to be reviewed, and organized the information in a spreadsheet in order to begin the market conduct review.

Other chapters of this textbook discuss how to collect company data and sample in a statistically valid and fair manner. In addition, examiners may need other supplementary material in order to continue with the review. This includes selecting insurance policies from the state being examined and all other relevant jurisdictions to review for legal compliance, gathering rate and form filings from the state being examined and each relevant Department, and obtaining other materials pertinent to the line of business and jurisdiction(s) under examination. By working through the EIC, appropriate market conduct and legal staff in each Department office can assist the state employee, independent or contract examiner, etc., with the collection of this material.

Gathering Company Insurance Policies from the State Being Examined and from All Other Relevant Jurisdictions

When an examiner selects or is provided with insurance policies from the state being examined and from all other relevant jurisdictions to review for legal compliance, it is important to note and verify the following:

- First, obtain a list of all the company insurance policies. While it may be helpful to have the template for all versions of these policies, for legal compliance, the examiner really needs the actual policy forms, amendments, riders, etc., for the specific file(s) in the sample under review. Many policies look similar but have important differences. Templates are not detailed enough to check for legal compliance when auditing specific files. A company should be able to reconstruct the actual, complete policy.
- Further, some companies market policies in other languages to serve particular markets. Do not assume that the foreign language version of an insurance policy, application, or marketing piece is exactly the same as the English version. If a member of the examination team is not fluent in the other language, it is helpful to have policies, applications, and marketing materials translated by a competent person. Often, it is not necessary to have the entire document translated, but sections concerning eligibility, benefits, limitations, and exclusions should be scrutinized carefully. Foreign

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language applications should also be translated to assure that the questions asked comply with each state‘s laws and regulations.

Obtaining Rate and Form Filings from the State being Examined and from All Other Relevant Jurisdictions

Likewise, an examiner needs to gather – or be provided with – rate and form filings from the state being examined and from each relevant Department for the lines of business under review. Some insurance departments may have this information on-line, but again, be careful to use the appropriate version when auditing files from years ago. Obtaining an accurate list of forms and filings and the Department form approval sheets is vital for a thorough compliance review.

Documenting “Smell Test" Concerns

An examiner‘s instincts and experience are important tools for reviewing files for compliance, as explained more fully later in this chapter. However, documenting one‘s instincts and experience requires a carefully and accurately drawn distinction between one‘s personal concerns and the facts. The examiner should document concerns in an internal Department management report for possible legislative and NAIC model law consideration and tracking or reference to other regulatory authorities (other states or federal government entities) with jurisdiction in those other areas.

Performing the Compliance Review

Now the examiner is ready to review the material for legal compliance and apply the three tests described above.

Testing for Violations of the Law

In order to test for violations of the law, remember the following basics:

- Statutes supersede regulations, which, in turn, supersede Department bulletins. All are subject to interpretation by courts and administrative hearings in the pertinent jurisdiction. If a specific law applies, use that law instead of a general law if a conflict exists. In many instances, a statute authorizes the issuance of regulations. Sometimes an examiner needs to cite both the statute and the regulation. The Department issues bulletins to clarify regulations even further, but a company not adhering to a Department bulletin is technically not a violation. However, it should still be noted in a market conduct examination report. Court rulings and administrative hearings apply to specific cases, but the ruling may have broader implications to similarly situated circumstances. The examiner should work through the EIC to inform and/or consult with Department legal counsel to clarify the

interpretation of a law in effect during the time period of the records under review.

- Laws are not necessarily clear or specific. One may think that "time studies" laws are straightforward. Yet, many "prompt pay laws" are not as clear as one may think. Moreover, some laws – particularly in the health insurance arena – are subject to some interpretation. Yet, examiners are fact finders, not courts of law. The role of an examiner is to record the facts, inform the Department via the EIC, and not act as a judge, jury, or attorney.

So, how does one lay out the facts in a way that demonstrates an alleged violation of law? While there is no one way to proceed with this task, the following recommendations may be helpful, especially with the more complicated laws:

- Follow the wording in the law.

  Whether an examiner likes, understands, agrees with, or disagrees with the law does not matter. Follow the wording in the law.

- Do not paraphrase. When in doubt, quote the law, word for word.

  State Legislatures pass laws for specific reasons, and insurance departments issue regulations for specific reasons as well. Each word and/or punctuation mark may be in the text of the law for a particular purpose. It is not the examiner‘s right or prerogative to paraphrase statutes, regulations, bulletins, or case law. When in doubt about the meaning or phraseology of a law, quote the law, word for word. <u>It is also a good idea to consult with the EIC about asking Department legal counsel for assistance</u>.

- Break down complex laws into their component parts.

  In more complex statutes and regulations, outline and break down the elements of the law into component parts. This facilitates the task of ascertaining whether or not each element of the law has been met.

- Outline the gathered facts to follow the component parts of the law.

  Especially with more complicated fact patterns – such as, but not limited to, disability claims – outline the facts in a way that mirrors the component elements of the law, as described above.

- Lay out the facts in a manner that leads the reader to see that the component parts of the law were not followed.

  Try to lay out the facts in a manner that matches the component elements of the law. When following this technique, an examiner is not drawing conclusions. Rather, the examiner is reporting the facts and demonstrating how the facts violate the component parts of the law.

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- Do not draw any conclusions. Just lay out the facts.

  Again, the examiner is a fact finder, not an attorney, judge, or jury. Examiners just report the facts in allegation documents via the EIC in order to inform the Department. Describe what the company actually did in response to the facts presented and explain how the action(s) did not comply with the applicable statute(s) or regulation(s).

- Document the alleged violations and submit to the company for response.

  Insurance departments submit criticisms to the company in varying formats. Regardless of what the documents are called – "Criticisms", "Critiques", "Comment Forms", or whatever – present the alleged violations in a format that asks for the company to review and comment on the specific instance or instances at hand.

Testing for Violations of Company Procedures, Rate and Form Filings, and Insurance Policy Provisions

In order to test for a violation of a company procedure, rate or form filing, or insurance policy provision, the following steps are suggested:

- Obtain access to the company's procedure manuals, either in hard copy or on-line, as well as rate and form filings and Department approval forms. Also, as described above, acquire the pertinent and specific company insurance policies (including policy forms, riders, amendments, etc.) that the company issued to the individuals and/or groups under review.
- Confirm with company personnel that the company procedures were the ones in place during the time period of the files in the audit.
- Examine the documents in the file to make sure that the company followed its procedures, rate and form filings, and insurance policy provisions.
- Note any difference among company procedures, rate and form filings, and promises made in insurance policies.
  - A company procedure is an internal procedure that company employees should follow for various lines of business.
  - A company rate or form filing denotes a process by which the company handles certain rates or forms, subject to certain Department requirements (information filing only, file and use, etc.)
  - A company insurance policy, which is issued to an individual or group, is a contractual agreement to provide services in exchange for a fee.

  - A violation of a company procedure is one matter. A violation of a company insurance policy is a contractual, legal concern. A company not properly or timely filing a document is a different matter. Please note, however, that if a rate or form filing was incorrectly approved by the Department – and the company followed that filing based on that prior Department approval – the examiner should inform the EIC of this fact and let the EIC handle the matter through an internal Department management report, rather than citing the company.
- Document any discrepancies and submit the allegations to the company for response.

"Smell" Testing

The following recommendations should be kept in mind when applying the —smell" test:

- The examiner is a fact finder, not a —itch hunter" or —kitchen sink thrower", nor is an examiner going on a —fishing expedition" looking for inappropriate company actions.
- The examiner should listen to his instincts and not let something go just because there are no laws, company procedures, rate or form filings, or insurance policies violated.
- The examiner should consider whether there is any potential consumer harm possible.
- The examiner – with EIC approval – should thoroughly research if there are any federal (i.e., fraud) or other state laws, NAIC Model Laws, or other guidelines available concerning the particular topic or line of business under review.
- The examiner – under EIC guidance – should express concerns in an internal Department management report for possible legislative and NAIC model law consideration and tracking or reference to other regulatory authorities (other states or federal government entities) with jurisdiction in those other areas.

Examiner Allegation Documents and Company Responses

Once the examiner drafts – under EIC guidance – his Criticisms (or whatever the particular Department calls the allegation documents), he should attach documentation that illustrates the alleged violation of law, company procedure, rate or form filing, or insurance policy. The examiner should include documentation of the specific and relevant pages from the file, company procedure, rate or form filing, insurance policy, or any other material that substantiates the violation alleged in the Criticism.

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Chapter 12 deals with confidentiality and workpapers and the whole issue of chain of custody. The examiner should follow the guidelines in that chapter when preparing these documents and take measures to comply with state and federal Health Insurance Portability and Accountability Act (HIPAA), privacy, and other legal and confidentiality requirements.

For items that may not pass the —smell" test, the examiner – under EIC supervision – should submit Formal Requests (or whatever the particular Department calls them) to ensure that the Department has all the documents and clarifications necessary for the examiner to include in his internal management report to the Department.

Soliciting Insurer Response Regarding the Resolution of the Violations

Most Departments have laws regarding the necessity for companies under review to cooperate with market conduct examinations and regulators in order to promote timely, efficient, and effective audits. Most insurance departments also offer the company an opportunity to comment on the criticisms that the examiners submit. These company responses then become part of the exhibits and supporting material in the Market Conduct Examination Report.

Handling Documentation of Insurer Responses in Examination Reports

Whether the Department allows the company to respond to each individual criticism or just to the entire market conduct report as a whole, the examiner should review the company responses completely, inform the EIC, and log the responses to keep track of how long it takes the company to answer the examiner‘s inquiries. This documentation is important to substantiate the substance, length, and content of a market conduct examination.

It is recommended that, based on the company‘s response, the examiner compile some sort of internal memorandum to the EIC and the Department explaining why an alleged violation should be kept or dropped from the market conduct report.

It is not recommended that the examiner get into a debate with the company about whether an item should be kept or dropped from a report. It is the examiner‘s responsibility to document the facts and cite any alleged violations by informing the Department via the EIC. Engaging in a back and forth debate with company personnel serves no purpose. So long as the company has provided all of the requested material necessary to conduct the review, the examiner should focus on reporting the facts and documenting alleged violations and errors. The EIC should clarify any discrepancies with the company coordinator while on-site.

Conclusion

In summary, addressing violations of law, regulations, and court cases can be a difficult matter if the examiner does not remember his role as a fact finder. Even if examiners are trained as attorneys, it is not their role to be an advocate for either side. Rather, the market conduct examiner‘s role is to document the facts to the Department via the EIC, provide a level playing field for the company, and provide consumer protection – all within the purview and scope of the state laws pertaining to the lines of business under review.

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Chapter 8
- Technology in the Examination Process

Educational Objective

Describe the types of technology that enable more efficient market conduct examinations.

Introduction

As the scrutiny of market regulation increases, the pressures to make the examination process more effective and efficient also increase. The controlled use of technology provides a means to overcome such pressures.

Benefits and Drawbacks of Technology in the Examination Process

The introduction of technology into the examination process can provide many benefits, such as increasing efficiency, improving results, and allowing the examiners to focus on the examination rather than the process. Implementing technology in the examination process solely for the sake of technology is not sufficient reason to do so. Introduction and use of technology should have clear goals. Gains in efficiency may not be realized immediately. However, with time, the examiners will become more familiar with the technology, and the efficiencies associated with the use of these tools will be realized.

The use of technology also brings with it some potential drawbacks – such as increased chances of drawing incorrect conclusions based on data presented, misuse of the technology, and decreased efficiency and effectiveness – when technology-challenged examiners are members of the examination team.

Benefits of Technology

One of the most important benefits of the use of technology in the examination process is an increase in the efficiency and effectiveness of the examination.

Increases in efficiency can be achieved by using technology to automate routine tasks so that they may be accomplished more quickly and easily. For example, the selection of sample populations to be reviewed, standard analysis of data, and the creation of reports are just a few routine items that can be automated.

Technology can also be used to improve the effectiveness of an examination by allowing an examiner to focus on the examination itself rather than on the process. This gives the examiner more time to concentrate on analyzing the data and conducting a more thorough review of the items being examined. This is a far more effective use of an examiner's time. For example, through the use of an audit tool such as ACL, an examiner can analyze underwriting data for all policies issued by the company during the examination period rather than just for a portion of the population or a specific field. This expanded analysis can provide the examiner with the ability to identify potential problems and focus resources on those areas which appear problematic. The use of technology to identify issues helps an examiner target potential problem areas, thus allowing the examiner to pinpoint the nature and extent of any issues more quickly. This increases the chances that systematic issues affecting a large number of policyholders will be found, which results in a more effective examination.

Other benefits include the consistent application of procedures and techniques in reviewing and analyzing the information provided. For example, the use of an audit management tool such as TeamMate[1] can help ensure that examiners follow the same set of procedures and consistently review necessary information for each examination.

Audit management tools can also lead to a better-documented examination file when features such as scanning and automatic indexing are utilized. A well-documented examination file makes it easier for the examiners, the Examiner-in-Charge (EIC), and the Chief Market Conduct Examiner to locate and share workpapers.

Improved efficiency and effectiveness through the use of technology can also lead to a reduction in the overall cost of an examination. Examiners are able to process more work in a shorter period of time, which can reduce the length and cost of an examination.

Drawbacks of Technology

There are some potential drawbacks to the use of technology in the examination process. Being aware of these drawbacks helps to minimize the negative impacts associated with them.

Perhaps the most important drawback to be aware of relates to the use of tools for analyzing data that are provided in connection with the examination. When using analysis tools such as ACL, the chance of drawing incorrect conclusions based on data presented is increased. Incorrect conclusions could be the result of the EIC or examiner not understanding data and the proper way to analyze it. It could also be the result of the company providing incorrect or bad data. The best way to minimize the risks of drawing a bad conclusion is for the EIC to clearly communicate with the examination team and the company exactly what data is required. It is absolutely necessary that

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the company clearly understands what data is requested and that the examiners understand the company's definition of the data elements provided. In addition, the EIC needs to communicate clearly to the examiner(s) analyzing the data the exact nature of the analysis to be performed. It is important to remember that analysis of the data using tools such as ACL is not a substitute for auditing the actual files or source documents (where source documents exist). Failure of the EIC or the examiner to confirm via a sample of the source document(s) that the proper information has been provided could also result in a bad conclusion.

There is also a chance that there will be a decrease in the efficiency and effectiveness of an examination when an incorrect tool is used or when technology-challenged examiners are members of the examination team. A technology-challenged examiner is an examiner who is resistant to technology or who is not technologically savvy. However, proper training and encouragement can help reduce any negative impact on the efficiency and effectiveness of an examination when faced with technologically-challenged examiners. Dealing with technology-resistant examiners is covered in more detail later in this chapter.

Tools & Their Uses

Many different tools can be used during the examination process. Whether managing workpapers, analyzing data, conducting research about the company being examined, documenting and summarizing examination findings, or preparing reports, finding the right tool and using it in the most efficient, effective manner is a challenge for any examiner.

Managing the Examination and the Workpapers

The main objectives of an audit management tool are to:

- Organize workpapers
- Guide examiners by detailing the examination requirements
- Provide for the documentation of the examination findings
- Allow for the summarization of the findings.

There are a variety of tools that can be used to manage the workpapers of an examination, ranging from common off-the-shelf software packages, such as the programs contained in the Microsoft Office Suite, to specialized software programs such as TeamMate. Since TeamMate is the NAIC-endorsed audit management tool, the following discussion focuses on managing the examination and its workpapers electronically through the use of TeamMate.

Managing the Examination

Examination management is a universal process used across all business sectors for all types of examinations or audits. TeamMate was designed for use across all business sectors for all types of audits, and one of its features provides the ability to tailor the software to meet the needs of insurance regulatory examinations.

In managing an examination, TeamMate provides the EIC with some very valuable features that are aimed at increasing the efficiency and effectiveness of an examination. While it is beyond the scope of this text to provide an in-depth review of the program and its functions, following is an overview of some of the features available to assist the EIC in managing the examination:

- Detailed information on the exact work to be completed during the examination, such as specific procedure steps, required workpapers, related statutory and administrative code references, and instruction on how to complete each procedure.
- The ability to assign specific work to specific examiners.
- Electronic sign-offs, allowing the examiner to indicate when the work is ready for the EIC to review and allowing the EIC to indicate his approval of the work done.
- Summaries of the amount of work in progress, completed, and reviewed.
- The ability to prepare time and resource budgets, including the ability to track and monitor the actual time and resources required to complete the examination.
- The capability that allows multiple examiners to work on the project file simultaneously either in a network environment or on a stand-alone basis through a replication process.
- The ability to track issues associated with the examination.
- The ability to instantly generate reports summarizing the examination status and findings at any point in time during the examination process.
- The ability to instantly generate Examination Reports using the Department‘s standard report template.

Managing the Workpapers

TeamMate is also designed to automate the workpaper process, which leads to an increase in the efficiency and productivity of the audit process. Following are some general features available to assist the EIC in managing the examination workpapers:

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- The ability to create and include standard procedures and to associate specific workpapers with the procedure steps.
- The ability to add any document type to the TeamMate project file. The only requirement is that the computer must have the program necessary to read the file type in order to open and work with the file.
- An imaging software program that allows the examiner to add scanned documents directly into the project file. These documents are automatically indexed to the appropriate procedure step.
- The ability to incorporate all standard examination procedure steps and workpapers into a TeamMate Library and TeamStore. The TeamMate Library is a template project file that is used when creating a new examination project file. TeamStore is a repository that includes standard procedures and associated workpapers that can be incorporated into an existing project file.

Analyzing Data

There are three main types of tools that can be used to analyze data provided in conjunction with an examination. They are specialized auditing software, database programs, and spreadsheet programs.

Specialized Auditing Software

There are several specialized auditing software packages that can be used to analyze the data provided in conjunction with an examination. ACL is the NAIC-endorsed tool for data analysis. The following discussion focuses on the features of ACL; however, other auditing software packages contain similar features and can be used to analyze examination data in a similar fashion.

ACL is a powerful audit tool that has the ability to analyze data regardless of the type of system from which the company produced the examination data. An examiner can use a desktop computer and ACL to analyze data provided in a variety of formats including those compatible with Dbase, Excel, and Microsoft Access, such as flat fixed length files, tab delimited text files, and comma separated formats. ACL can also analyze data downloaded directly from mainframe or legacy systems. Regardless of the format in which the company provides the examination data, an examiner needs only ACL to analyze it. For example, if the company provides the file in a format compatible with Dbase, the examiner does not need to have Dbase software loaded on his computer to analyze the data. ACL is able to read the data without it.

Although it is beyond the scope of this text to provide detailed information on the features and functions of any single software package, following is

a list of some of the more common ACL functions that can be used during the examination process:

- Age – Produces aged summaries of data.
- Calculate – Calculates the value of an expression that may result in a character, numeric, date, or logical value being displayed.
- Classify – Counts the number of records relating to each unique value of a character field and displays the total number of records for each unique value.
- Count – Counts the number of records contained in any one file.
- Duplicate – Locates and displays duplicate records in a file based on one or more fields.
- Export – Exports the data into a number of different formats that can be used during the examination process. The export formats include Dbase, delimited, Excel, Lotus, Microsoft Word, and WordPerfect.
- Extract – Selects records based on user-defined criteria from a file and places them into another file within ACL.
- Gaps – Reports whether sequentially numbered fields in a file contain gaps in the sequence.
- If – Runs a test only IF a certain condition is met.
- Index – Creates a file that allows direct access to the records in a logical order rather than the physical order provided by the company.
- Join – Combines fields from two different files and places the results into a third file.
- Merge – Combines two files with identical record structures into a third file.
- Profile – Provides summary statistics – such as total value, absolute value, minimum value, and maximum value – on one or more numeric fields contained in the file.
- Random – Generates random numbers.
- Report – Creates and formats reports of the data or summaries of the data, including graphic representations of the data.
- Sample – Creates record or monetary unit samples from a population within the file. The samples may be periodic-interval or random samples.
- Size – Determines an appropriate sampling size.

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- Sort – Sorts the file into ascending or descending order based on specified fields within the data.
- Statistics – Calculates and displays descriptive statistics on one or more number or date fields.
- Stratify – Counts the number of records falling into specified intervals or key fields; totals one or more numeric fields for each stratum.
- Summarize – Generates a record count and numeric field value totals for each distinct value of key character fields.
- Total – Totals the value of fields in the data file.
- Verify – Checks for data validity in the file based on one or more fields.

See Attachment 1 for a comparison of analysis functions among the various tools.

Using a combination of the functions listed above, an examiner is able to test the data provided by the company to make sure that it is valid and contains the requested population. An examiner may also run various tests on the data to isolate specific subsets of the population, perform attribute testing on the entire population, or match records from two different files.

Certain tests for each type of data received are performed for each and every examination. Additional efficiencies in the examination process can be gained by using ACL when scripts or small batch programs are written to allow the examiner to run a group of routine or standard tests in a single pass of the data rather than running the tests individually. This saves the examiner time and ensures that all standard tests of the data are run.

Database Programs

Database programs such as Dbase and Microsoft Access provide the examiner with many of the same capabilities as ACL. For example, an examiner can analyze data using the following functions typically found in database programs:

- Calculate
- Classify
- Count
- Export
- Extract
- If

- Join
- Merge
- Report
- Sample
- Sort
- Gather statistics
- Stratify
- Summarize
- Total

See Attachment 1 for a comparison of analysis functions available in the various tools.

Performing some of the above functions may not be as easy using a database program as when using ACL. Depending on the analysis to be performed, it may take more than one step to accomplish the task at hand using a database program. In some instances, the ability to do many of the analysis tasks listed above requires the examiner to have advanced computer skills.

Another drawback to using database programs over ACL is that they are not as flexible as ACL in accepting multiple data formats from the company. The scope of acceptable formats for database programs is much less extensive than ACL's. While it is possible to use database programs to do much of the data analysis, the examiner should be aware that the company or the examiner may have to convert the data from its original format into a format compatible with the database program. Data conversion introduces the risk of data corruption and the inability to use the data as originally provided.

Spreadsheet Programs

An examiner may use spreadsheet programs such as Microsoft Excel to analyze examination data. However, this is the least powerful analysis tool available to the examiner. With a spreadsheet program, an examiner can use the follow functions to analyze data:

- Calculate
- Classify
- Count
- Export
- Extract

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- If
- Merge
- Report
- Sample
- Sort
- Gather Statistics
- Total

See Attachment 1 for a comparison of analysis functions among the various tools.

As with a database program, accomplishing some of the above functions using a spreadsheet program may not be as easy as when using specialized audit programs. Again, it may take more than one step to accomplish the task at hand, and in some instances, data analysis may require the examiner to have advanced computer skills.

Spreadsheets offer the least flexibility regarding acceptable formats. As with database programs, data conversion may be required. This introduces the risk of data corruption as well as the inability to use the data as originally provided.

Conducting Research

It may be necessary for the EIC or an examiner to conduct research about the company‘s activities during the examination process. Activities that might need to be researched include consumer complaints against the company, regulatory actions against the company, examination activity, and information about the company‘s financial position from the company‘s Financial Annual Statement. Much of the research may be done by an examiner using electronic systems available from within the insurance department systems and/or through the NAIC‘s I-SITE system.

Various systems within an insurance department may be available to assist in conducting research about a company. Internal insurance department systems may include systems that track consumer complaints, regulatory actions, and/or financial information about the companies that do business in the Department‘s state. It is beyond the scope of this text to detail the systems used by individual state insurance departments as these systems will vary by Department. Examiners should consult with the insurance department to determine what information is available via internal systems.

Regardless of the internal systems used by a state insurance department, the systems may very well provide an examiner the ability to gather and assemble the background information on a company quickly and electronically. Having the information in electronic format allows an examiner

to quickly analyze the data using such tools as ACL and/or spreadsheet and database programs. In addition, having the data electronically allows the examiner to easily include the information in the workpapers when an electronic work paper management program, such as TeamMate, is used to document the examination of the company.

I-SITE is the NAIC's web-based application that houses the various NAIC applications. Using I-SITE regulators access and download information required during the examination process to conduct background research about the company. The following table summarizes the type of information available via I-SITE that examiners may use to conduct research on a specific company. More detailed descriptions of the information available through these systems is located elsewhere in this text.

Area	NAIC System
Consumer Complaints	Complaints Database System (CDS)
Regulatory Actions	Regulatory Information Retrieval System (RIRS)
Market & Financial Examinations	Examination Tracking System (ETS)
Financial Information	I-SITE & via QuickLink

As with internal insurance department systems, gathering and analyzing the necessary background information via I-SITE helps reduce the amount of time required to gather the information and allows the examiner to collect it in an electronic format. Again, having the data in an electronic format makes it easier to analyze and allows for easy storage of the information in electronic work paper management programs such as TeamMate.

Although most of the examination is performed on extracted data, there exists, from time to time, the need to view live company data and its flow through the company's systems. Accordingly, read-only access to the company's primary systems also provides an important research tool.

Documenting and Summarizing Examination Findings

Documenting the examination findings is an essential part of any examination. Without the proper documentation to support each and every examination finding, it is likely that the company would prevail if it challenged an Examination Report. Technology can assist examiners in documenting and summarizing the findings of an examination. Word processing, imaging, spreadsheet, database, and audit management programs are some of the more common tools used to document and summarize examination findings.

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Word Processing Programs

Word processing programs, such as WordPerfect or Microsoft Word, can be used to document the examination findings. Examiners can record their findings in files using word processing programs. While these programs can be used to document the findings, information within a single document or multiple documents may not be easily summarized. It is also difficult to automatically pull the information from a word processing document for use in the Examination Report. For these reasons, it may be best to limit the use of word processing programs in the documentation phase of the examination.

Imaging Programs

Scanning software and hardware can be a very cost-effective and efficient method of collecting and retaining documentation to support the examination findings. Use of scanning technology enables the examiner to include in the electronic examination workpapers copies of documents provided by the company that directly support an examination finding. When used in conjunction with an audit management tool, such as TeamMate, scanned documents can be easily located and viewed throughout the examination process. In addition, the volume of physical documentation associated with an examination is greatly reduced, thus reducing the costs associated with the storage of the workpapers.

Scanning technology is not an appropriate tool to use to summarize the examination findings since the information within each scanned document cannot be easily summarized or incorporated into reports.

Spreadsheet Programs

Spreadsheet programs, such as Microsoft Excel, can be useful tools in both the documentation and summarization of examination findings. Spreadsheets may be used to record the various items selected during the review of a sample population. Once the sample population is reviewed, the examiner can use filters and other tools in the spreadsheet to identify potential issues and to summarize trends associated with the sample reviewed. In addition, information contained in spreadsheets can be merged with, linked to, or copied into the word processing program used to compile Examination Reports.

Database Programs

Database programs, such as Dbase or Microsoft Access, can be useful tools in documenting and summarizing the findings of the examination in much the same fashion as spreadsheet programs. As with spreadsheet programs, the information contained in the database can be merged with or linked to the word processing program used to compile examination Reports.

Audit Management Programs

One of the main features of audit management programs, such as TeamMate, is their ability to document and summarize the findings of the examination. Audit management programs can be used separately or in conjunction with other software programs to perform this very import aspect of an examination.

Audit management programs include specified areas in which the examiner can record his findings. These programs also provide the examiner with the ability to generate reports based on the information entered into the areas dedicated to recording the examination findings. The automatic report generation feature allows the examiner or EIC to quickly assemble the examination findings into a single document.

In addition, audit management programs allow the examiner to add documentation to the audit file to support the findings. The types of documents added could include Word documents, databases files, spreadsheet files, Internet files, and scanned documents, just to name a few.

Preparing Reports

Sometimes one of the more challenging tasks during the examination process is preparing the various reports required throughout the examination process. Whether it is an interim status report, a report on the preliminary findings of the examination, the first draft of the actual report, or the final report, many of the tools noted above can be used to help make the preparation of reports more efficient.

In addition to being used for the basic preparation of examination documentation, some of the more advanced features of word processing programs can be used to help make the preparation of the reports more efficient. Features such as mail merge, search and replace, and dialogue boxes can help the examiner prepare a report more quickly. For example:

- The mail merge function can be used to merge data from spreadsheets, other word processing documents, and databases into a pre-defined report.
- The search and replace function can be used to quickly locate a specific term or phrase within a document and replace it with another.
- The inclusion of dialogue boxes in report templates allows the examiner to enter repetitive information, such as the name of the company, only once and have it inserted in all of the necessary places throughout the document.

Spreadsheet programs can help in the preparation of reports. For example, the examiner can copy and paste or link to numeric data contained in a spreadsheet

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so that the information appears in the report. Copying and pasting or linking to the information, rather than re-keying it, helps to reduce typographical errors and saves time. The examiner can also use the graphing features of spreadsheets to create graphical representations of the data and place them in the report instead of, or in addition to, the underlying data.

Software used primarily to prepare presentations, such as Microsoft PowerPoint, can also be helpful in preparing reports. As with spreadsheet software programs, presentation programs often contain features that allow the user to create basic graphs and organizational charts. An examiner can use presentation software to create a graph or organizational chart and then copy and paste it into the report.

Using the Right Tool

While there are many choices, an examiner may be limited in his choice of tools based on those purchased and supported by the examiner‘s employer. Regardless of which tools an examiner has to choose from, the process of selecting the right tool to use is the same.

The first step in identifying the right tool to use is to review the goals and objectives of the examination. It is important to know what needs to be done before deciding how to go about doing it. After reviewing the goals and objectives of the examination, the EIC should:

- Identify what information needs to be collected to achieve the goals and objectives of the examination
- Determine the sources of information and the best method to collect the information
- Obtain the required information from the company
- Understand what information has been provided and what possibilities and limitations are present
- Develop an analysis plan of action including selecting the best tool or tools to process, analyze, and store the information.

Failure to identify and use the correct tool to accomplish the tasks at hand results in a reduction in the efficiency and effectiveness of an examination. When the wrong tools are used, incorrect conclusions may be drawn and the work may have to be redone using the correct tool. Either way, the efficiency and effectiveness of the examination is diminished.

Dealing with Technologically Resistant Examiners and Companies

The use of technology is quickly becoming a necessity in the examination process. However, there are still examiners and companies that have not yet embraced its use. From time to time an EIC may encounter examiners and/or companies that are resistant to technology.

Dealing with Technologically Resistant Examiners

An EIC is responsible for completing an examination in cooperation with the examination team in the most efficient and effective manner possible. In order to do this, an EIC must help examiners who are resistant to the use of technology. Helping technologically resistant examiners with the technology allows the examiner to concentrate on the work and not on the process. It also results in more efficient and effective examinations now and in the future.

There are many reasons why an examiner may be resistant to technology. It could be a fear of change or a lack of skills. Quite often, it is not a result of a lack of ability to work with the technology. No matter the reason for the resistance, there are many ways in which an EIC can help the examiner with the technology.

The following is a list of tips to help an EIC in dealing with technologically resistant examiners:

- Be patient and supportive.
- Explain to the examiner the benefits of using technology to complete the task at hand.
- Recognize that everyone learns at a different pace and that what works for one examiner may not work as well for another.
- Explain to the examiner, step by step, how to complete the task at hand without doing it yourself.
- Avoid using technical terms, and when it is necessary to use a technical term, explain the term.
- Avoid using the examiner's computer.
- Walk the examiner through the task, step by step, and have him perform the steps while you watch. Be sure to give the examiner ample time to perform a step before moving on to the next step.
- Be prepared to repeat yourself and demonstrate how to do something multiple times.
- Make yourself available to answer an examiner's questions as they arise.

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- Enlist the help of other team members who are more technologically savvy.
- Encourage the examiner to seek and complete additional training to acquire the required skills.
- If all else fails, speak to the Chief Market Conduct Examiner or the examiner‘s supervisor (if the examiner is a contract employee) about the individual‘s need for training.

Dealing with Technologically Resistant Companies

Almost all insurance companies, both small and large, utilize technology in their day-to-day business operations. Some insurers have embraced technology and are leading the way in developing and implementing technology in their business operations. However, not all insurers are Fortune 500 companies with large information technology budgets or resources. In addition, some insurers may be resistant to using technology to enhance their operations, which can cause issues in the examination process.

Many small and medium-sized insurers may appear to be technologically resistant when in fact it is the lack of the budget and/or resources to handle large requests for electronic information that makes them appear resistant. Some insurers, usually smaller companies, may in fact be resistant to technology, as they have been able to successfully manage the business without embracing it. Regardless of the reasons, an EIC eventually runs across a company that is resistant to providing the information required in an electronic format.

The following is a list of tips to help an EIC in dealing with technologically resistant companies and with those companies that may have limited resources:

- Engage the company in a conversation; do not just demand the information in an electronic format.
- Explain the reasons why you need information in an electronic format and the benefits to the company if the information is received in the requested format.
- Be flexible and try to look at it from the company‘s point of view.
- When possible, seek alternative acceptable formats, electronic or otherwise, and be willing to accept the information in a non-electronic format, if necessary, or where it makes more sense.
- Give the company as much lead time as possible to produce the information in the requested electronic format.
- Involve the company's IT people in your discussions with the coordinator and/or the business people involved with the examination.

- Recognize that the time, effort, and expense required to prepare the information electronically may outweigh the benefits of receiving it electronically.

Training Options

Having properly trained examiners on the examination team helps realize the many benefits of using technology in the examination process. Training is also one of the best ways for an EIC to deal with technology-resistant examiners or those who are less technologically savvy.

One of the many benefits of living in such a technologically oriented society is that there are a variety of options available for individuals seeking technology training, including classroom courses, self-study options, and networking options.

Classroom Courses

Classroom courses in technology are offered by many different entities and provide interactive instruction on the use of software programs. These courses often provide hands-on experience throughout the course. Classroom courses are very good learning tools for individuals who need a more structured learning environment and whose style of learning is better suited to a classroom setting.

Another advantage of classroom training is that it provides the examiner the opportunity to interact with other users of the software. Such interaction may be a valuable learning tool. However, classroom courses generally have a predefined agenda that must be accomplished by the end of the course. Accordingly, the pace at which the material is covered is predetermined, based on the skill set to be taught and the length of the course. This pace may or may not suit the educational needs of the examiner.

Classroom courses in technology are offered by educational institutions, other governmental entities, employers, the National Association of Insurance Commissioners (NAIC), private training vendors, professional educational associations, and some software vendors.

Educational Institutions & Other Governmental Entities

Many educational institutions, such as local technical or community colleges, offer courses on generic software packages that are offered for sale to the general public, such as those manufactured by Microsoft. Similar courses, such as local city recreation and leisure programs or school-district continuing education programs, are offered by governmental entities.

Many of these courses are offered in the evenings or on weekends and are usually very reasonably priced. The courses vary in length and may last only a few days or an entire school semester. While the longer courses may not be

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appropriate for examiners who travel extensively, in those cases where an examiner can attend, longer courses provide the examiner more time to absorb the presented material.

Courses offered by these institutions range from introductory courses covering the basic functions of the software to more advanced courses covering advanced features of the software. While the course work is not geared specifically to the examination process, it does provide the examiner the opportunity to master basic to advanced skills that can then be applied on the job.

Employers

The examiner‘s employer may offer training in the technology, both hardware and software, that the examiner is expected to use. The training may be of a general nature or tailored to the specific skill sets needed for examination work. This training is usually free to the examiner, and the course length is typically only a few days.

Courses are generally offered at the employer‘s home office. Employer-sponsored training can be scheduled to coincide with a pre-scheduled visit to the home office in order to minimize the amount of time the examiner has to be away from the job site. This type of training provides the examiner the opportunity to interact with other users of the technology who may be using it in the same manner and for the same purpose as the examiner. Employer-sponsored training may be the only training that teaches the examiner how to use proprietary employer software and the hardware.

National Association of Insurance Commissioners

The National Association of Insurance Commissioners (NAIC) offers classroom courses on both NAIC endorsed programs (ACL and TeamMate) and NAIC-owned applications such as RIRS, I-SITE, CDS and ETS. Outside of any training offered by an individual Department on these systems, the NAIC is the only source of training on the various NAIC applications.

The classroom training offered by the NAIC is usually at the NAIC‘s headquarters in Kansas City, MO. It generally lasts only a few days and may include regulators from all around the country. The NAIC offerings range from introductory courses to more advanced classes. The course work is usually geared specifically toward insurance regulation and the examination process although its primary focus may not be on market conduct examinations.

Arrangements may be made to have an NAIC State Trainer visit the Department to conduct courses on any of the NAIC endorsed products or NAIC applications. This training opportunity offers all the same benefits of employer-sponsored training and provides training that an examiner may be unable to get through another option.

Private Training Vendors

There are many private training vendors who offer training on both general and specialized software packages. The courses can be conducted at the vendor's place of business or another location, such as an insurance department's office. Many vendors offer general sessions ranging from introductory to advanced levels on generic software programs. It may also be possible to work with the vendor to have an „in-house' course tailored to address the skill sets required in the examination process. Courses offered through private training vendors usually last only a few days and tend to be more expensive than some of the other available options.

Professional Educational Associations

There are several professional educational associations – such as Insurance Regulatory Examiners Society (IRES), Society of Financial Examiners (SOFE), Institute of Internal Auditors (IIA), and the Association of Insurance Compliance Professions (AICP) – that offer general or specialized training sessions in software products commonly used in the audit or examination process. These training sessions are generally short in duration, lasting from just a few hours to a few days. Often the sessions are held in conjunction with an annual meeting or seminar. This gives the examiner an opportunity to increase his technological skills during a time when he would be away from the job to attend the seminar anyway.

Software Vendors

Some software vendors of the specialized programs used in the examination process, such as ACL and TeamMate, offer classroom training on a periodic basis throughout the country through a professional educational association or via individual insurance departments. These programs are generally a few days in length and may provide instruction on introductory to advanced features of the software program.

When offered on a periodic basis at various locations throughout the country by a software vendor, the classes are open to all individuals interested in learning how to use the software and may not be geared toward insurance regulatory examinations. If the software vendor conducts the training at the invitation of a professional education association, it may be possible to have the training tailored to address the skill sets required for the examination process, depending on the composition of the class. Most software vendors are willing to provide specialized training geared toward the examination process if they are conducting a session sponsored by an insurance department solely for the benefit of examiners.

While the cost of these training sessions is typically on the high side, usually the trainer is an employee of the software vendor and an expert in the use of

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the software. The benefits of having an expert instructor may outweigh the extra costs associated with attending this type of training.

Self-Study Options

Self-study can be a very effective training option and may be a more viable option for examiners who travel extensively, as it does not require that an examiner be available for instruction at a preset date and time. Self-study courses allow examiners to progress through the required material at their own pace whenever and wherever it is convenient. Through self-study, an examiner is able to learn new skills or refresh existing skills. This allows the examiner to spend more time on those areas where additional instruction is needed and move quickly through or even skip over those areas where he is already proficient. Generally speaking, self-study courses are not geared specifically for the insurance regulatory examination process as they are designed to meet the needs of a broad range of users.

While self-study offers considerable flexibility, it also requires discipline, self-motivation, commitment, and good time-management skills. It may not be the best option for an examiner who needs a highly structured learning environment. Depending on the type of self-study, an examiner may also be required to have the proper equipment, such as a PC or laptop (including the required software and peripheral hardware) and a television set with video or DVD player, and access to the Internet and/or an e-mail address.

Options for self-study include on-line, video, and textbook training.

On-line Training

A variety of vendors offer on-line training courses for generic software packages. Software vendors of the specialized programs used in the examination process, such as TeamMate, may offer on-line training courses also. Unless offered by the NAIC, on-line training courses for specialized auditing software packages are usually geared toward audiences of internal auditors. No matter the audience, an on-line course generally provides detailed instruction on the use of the software itself. This instruction provides the examiner the opportunity to master basic to advanced skills that can be applied on the job.

Some on-line courses have a specific time frame during which the work must be completed; however, this window varies from vendor to vendor. For example, some vendors may require the examiner to log onto the Internet at specified dates and times over a period of two weeks. Other vendors may allow three to six months to complete the course and not require the examiner to log on at specified times.

The cost of these types of courses ranges from free to several hundreds of dollars. For example, some software vendors, such as Price Waterhouse Coopers, offer on-line courses free to licensed users of

TeamMate via its user community. ACL provides on-line training to those licensed users who upgrade to the premium support package. Others, such as the NAIC or private training vendors, charge for on-line courses, either for an individual course or for a bundle or grouping of courses. It is possible that the examiner's employer has an agreement in place with a specific provider of which he could take advantage at little or no cost to the examiner.

Video-Based Training

Examiners may also self-study by taking video-based training courses. A video-based training course is one where the examiner receives the instruction via a video tape or DVD. As with on-line courses, a variety of vendors offer courses on generic software packages. The cost of these types of programs varies greatly depending on the vendor and the amount of material covered. Video-based training may also be available to the examiner free of charge through the Department or a local library.

It may also be possible to obtain video-based training courses for specialized software packages used in the examination process. However, it is likely that these training courses have to be obtained directly from the vendor and may be far more expensive than video-based training for generic software programs.

Textbooks

The third self-study option involves textbooks. As with the other forms of self-study, a variety of textbooks that provide instruction on generic software packages are available. In addition, specialized software vendors may sell textbooks that enable an examiner to self-study. While textbooks for generic software programs are generally very inexpensive, textbooks for the specialized software programs are more expensive, as the demand for this type of textbook is not as great. The examiner may also be able to borrow textbooks for either type of software free of charge through the Department or a local library.

Textbooks provide the same advantages as the other forms of self-study; however, they may not be the best form of self-study for less technologically savvy examiners or for technologically resistant examiners. Unlike the other forms of self-study, textbooks do not require that the examiner have any special equipment. Nevertheless, in order to practice the information presented in the textbook, the examiner should have a PC or laptop equipped with the appropriate software available while studying.

Networking Options

Networking with co-workers and peers is a valuable source of technology training. Networking is not a substitute for more formal training; however, it

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can be especially helpful when it comes to learning how to complete a specific task or solving a problem.

Asking for help from co-workers or members of the examination team can be an important source of immediate information. These individuals bring to the table their own sets of skills and experiences. In addition, co-workers and examination team members are readily available and are familiar with the examination process.

An examiner may also network with co-workers and peers via bulletin boards or user communities established by the NAIC or software vendors.

- A bulletin board is a World Wide Web-based facility that allows people to post messages and share information.
- A user community is a web-based facility that provides members of the community access to information and aids relating to a software program, such as technical documents, frequently asked questions (FAQs), training material, users and reference guides, newsletters, on-line training, the ability to contact the vendor‘s help desk, and a discussion forum or bulletin board.

NAIC

The NAIC recently launched a pilot bulletin board program available to insurance department employee-users of TeamMate. This pilot program provides a bulletin board dedicated to TeamMate. Regulators can post questions, answers, and comments and exchange ideas regarding TeamMate with fellow regulators. The bulletin board is limited to regulators only. Contract examiners are not allowed on the site at this time. Information on how to join the TeamMate Bulletin Board may be found on the StateNet portion of the NAIC‘s website.

Software Vendors

Many software vendors offer assistance and the ability to network with other users on-line. Both ACL and Price Waterhouse Coopers offer user communities to licensed users of their products. The amount and type of information available on these sites varies. However, both are an excellent source of information about their respective software product.

ACL refers to its user community as the Support Center, and it is available via its website at www.acl.com. Depending on the level of support purchased, members of the Support Center can access ACL‘s newsletter, user forums, software releases, help desk, on-line learning, and a database of best practices, troubleshooting tips, predefined scripts to be used with ACL, and information on how to optimize the use of ACL technology.

Price Waterhouse Coopers maintains a user community for the TeamMate suite of products. Registered TeamMate users can access the TeamMate

Users Community on the Web via the Help function inside TeamMate or directly at www.teammate.pwcglobal.com. The TeamMate User Community provides users support and the ability to share best practices and experiences with other TeamMate users. The user community provides access to news and events, the TeamMate help desk, discussion forums, on-line training, technical support documents, user manuals, frequently asked questions, and sample audit programs and libraries.

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Technology Attachment 1 – Common ACL, Database & Spreadsheet Functions

Function	ACL	Database Programs	Spreadsheet Programs
Age	●		
Calculation	●	●	●
Classify	●	●	●
Counts	●	●	●
Duplicates	●		
Export	●	●	●
Extract	●	●	●
Gaps	●		
IF	●	●	●
Index	●		
Join	●	●	
Merge	●	●	●
Profile	●		
Random	●		
Report	●	●	●
Sample	●	●	●
Size	●		
Sort	●	●	●
Statistics	●	●	●
Stratify	●	●	
Summarize	●	●	
Total	●	●	●
Verify	●		

Endnotes

[1] TeamMate was developed at the PricewaterhouseCoopers World Research and Technology Centre in Menlo Park, California. TeamMate was designed to be used across a wide range of business sections for all types of audits including: compliance, contract, controls, efficiency and regulatory reviews, financial, government, IT, investigations, procedural, and security. TeamMate automates the entire workpaper process including, preparation, review, report generation, and global issue tracking. TeamMate is now owned by CCH, a Wolters Kluwer business. For more information contact CCH or see: http://tax.cchgroup.com/TeamMate/default

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Chapter 9
- Effective Communication within the Insurance Department

Educational Objective

Identify the various sources of information within the Department that can assist market conduct examiners in selecting companies for examination and in performing the examination.

Introduction

Effective market regulation relies on access to accurate and timely information regarding the insurance marketplace and the regulated entities. As indicated in other chapters, a wealth of information is available from external sources; however, even more information is available from within the various work units of the Department. Unfortunately, much information and many sources of information within the Department are often overlooked.

The purpose of this chapter is to identify the types of information commonly available within each work unit within an insurance department that may be of value to those in other work units, particularly to those conducting market conduct examinations. The types of information described here may not be all-inclusive or reflect data maintained by the work units in each jurisdiction. The organizational structure of each state‘s Department or agency varies, but with this understanding, the following types of information are identified as a starting point to help regulators to be aware of the types of essential information they are surrounded with in their work place each day.

Knowing what information exists and where to find it is the first step. However, regulators are often overwhelmed with the –nformation overload” environment that has become the norm. To assist regulators with information management, this chapter includes suggestions for how best to share the information that is available in each work unit and how to make certain that such information is available when needed. This chapter also includes concepts that may assist an examiner in identifying communications techniques for sharing information that work best within the Department.

The Importance of Communication within the Department

Communication within the Department is crucial in creating a focus for any examination called. The information available, and its importance to an examination, varies from company to company. Therefore, it is critical that all

available Department resources be tapped to ensure that the appropriate priority is given to the determination of which companies are to be examined and what specific areas, if any, need to be emphasized during the course of the examination.

Information Gathered Prior to Establishing an Examination Schedule

Prior to establishing an examination schedule, market analysis information should be reviewed in conjunction with licensing information and consumer complaints for the companies and their producers. Additionally, any information available from the Public Information Officer and/or the Commissioner/Director should be evaluated. All of this information helps determine which examination best serves in addressing the concerns and protection needs of the state‘s insurance consumers. All work units within the Department should have input into the process for selecting companies for examination. The types of information available are described more fully in the following text.

Information Sources Once a Company Is Selected for Examination

Once a company is selected for examination, examiners can tap into many resources within the Department to gather knowledge of the company and its business practices prior to beginning examination fieldwork. The first areas from which to gather information are often the consumer complaints, rates and forms, and market conduct sections of the Department. The review of the rates and forms and market conduct information generally directs any further review of internal information regarding the company. These, too, are addressed more fully in the following text.

Types of Information Available from Each Work Unit

The information available from each work unit within the Department is vast. Following is a brief summary of the information available and the purpose it serves in the examination process. While the sharing of information among work units is important in all operations of the Department, special emphasis is given here to that which is important for successful market conduct examinations.

Consumer Complaints

Consumer complaints have long been the basis on which examinations are called. Contrary to popular belief, the volume of complaints is not necessarily the deciding factor in calling an examination. The evaluation of complaint ***trends*** is more important than the actual number of complaints filed. Complaint trends should be evaluated by company, type, and seriousness. If a company conducts multiple lines of business, the complaints should be broken down and evaluated by each separate line of business. Each line of business is generally handled by a specific automated system and is

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governed by separate policies and procedures. What is a problem with respect to one line might not be a problem throughout the company – or it might – in which case the examiner is able to focus more readily on the source of the problem. Additionally, since the type of coverage involved can affect the complaints received, the trends should also be reviewed on the basis of the coverage type involved.

Since most large companies employ multiple administrative offices, it is important to evaluate whether trends exist on a local, regional, or national level. If the complaints appear to stem from one office, there may be an issue with the training or processes in that office. If the complaints seem to be localized to several states or a special geographical area, there may be an issue with the policies implemented by the management of that specific region. If the complaints appear to be nationwide, there may be an issue with the company‘s overall business practices, corporate philosophy, or ethical standards.

Complaints and complaint trends should not be evaluated independently. Rather, they should always be assessed in conjunction with the ―culture of compliance” within the company as well as the level of cooperation of the company and its employees.

Gross numbers are not always the determining factor. Sometimes, in reviewing complaints, there may not be an identifiable trend or high volume of similar complaints, but the impact on the consumer is so great the situation must be addressed for the good of the public.

Complaint trends must be reviewed in context with the line or lines of business in which the company specializes. Some lines of business generate very few complaints with the Department, while others generate high numbers of complaints. Automobile and health insurance often generate more complaints per policy or per premium dollar than commercial property and casualty insurance or life insurance.

Finally, certain findings may create ―red flags” for referral to other units within the Department. The most classic example of this is where a complaint trend of slow payments of claims is noted. This may very well be indicative of a cash flow problem within the company and should be brought to the attention of the Department's financial examiners.

For market conduct purposes, examiners may wish to review the following information from the complaints or consumer services section:

- Listings of complaints by coverage type and category (e.g., claims handling, rating, etc.) submitted to the Department by consumers
- Final disposition of complaints
- Complaint ratios by industry grouping or line of coverage

- Complaint trend reports
- Complaint information from the NAIC Complaints Database System (CDS).

Rates and Forms

The rates and forms section can provide examiners with a history of rate increases/decreases. Significant changes in rates or benefits may relate to complaint trends and/or provide insight into the company‘s approach to the marketplace. Additionally, a review of the rates and forms information on file with the Department can help in the evaluation of the company‘s overall compliance effort.

The following is a suggested list of the type of information that may be available to assist the market conduct examiner:

- Current and historical rate and form filings and any summary reports showing the frequency of requests for rate increases and amounts associated with rate increases requested by the company.
- Recent changes in benefits reflected in changes in policy forms filed.

Market Conduct

A review of prior market conduct examinations can help examiners narrow the focus for the examination. A review of prior violations and the resolutions implemented by the company can be quickly evaluated and either eliminated from the examination process or identified as a continuing concern for the company. This review can also help the examiner get a feel for the company‘s culture for compliance.

A comparison of the complaint trends from the prior examination period should be made to determine if there has been any improvement since the prior examinations. This comparison can help in determining the company‘s continuing compliance efforts.

Instead of re-inventing the wheel for the new examination, the examiner can use a review of prior examination documentation of the company‘s internal compliance structure – along with its operating systems and processes – as the starting point for the new examination; this could even lead to a self-audit. Sources include:

- Prior examination reports
- Any prior stipulated agreements or agency orders requiring compliance with prior examination findings
- Other states‘ examination reports
- Enforcement actions reported to the NAIC (RIRS)

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- Information from the NAIC Exam Tracking System (ETS) showing other states that have recently performed examinations of the company
- NAIC Market Regulation Reports for the company.

Investigations

Investigations can give examiners information regarding the company and its business philosophies and practices.

Close attention should be paid to any investigation into a company‘s producers. Often an investigation against a producer is a reflection of a company‘s operations and can reveal a problem on the company level as well as the producer level. The number and type of producer investigations can be an indication of:

- The level of oversight the company exercises with its producers
- Company marketing practices
- Agents‘ licensing and appointment problems.

Special consideration should be given to any investigation into allegations of fraud or marketing complaints against a company. If an investigation validates the allegations, it can be an indication of serious compliance concerns within a company‘s operations. Many times complaints regarding marketing of life insurance and annuities are filed against the insurance producer rather than the company. In many states this means that the investigations unit, rather than the complaints or consumer services section, may be responsible for investigating the complaint. Likewise, the investigation section may be charged with resolving and investigating allegations of internal fraud, whistleblower complaints, or specific allegations against an insurer. Therefore, information regarding these types of activities involving the insurer may be maintained in the investigations section rather than in the consumer complaints section. Examples are:

- Summaries of complaints or complaint trends regarding agents appointed by the company
- Findings from any recent investigations of the company‘s activities.

Market Analysis

Market analysis provides information regarding the insurance marketplace and data showing the company‘s compliance with key regulatory requirements. Where a company falls within the market standards can be an indication of its overall compliance. More detailed information regarding market analysis is provided in another chapter. As market analysis functions mature within each Department, the market analysis data is becoming the primary source of information for selection of companies for examination. An

effective Market Analysis section regularly gathers much of the information identified in this chapter from all sections of the Department. Some of the information that may be available from the Market Analysis section includes:

- Complaint ratios
- Complaint trend reports
- Market Conduct Annual Statements
- NAIC database reports, including ETS, RIRS, and MITS
- Level 1 and level 2 reviews for the company
- Any other information compiled by market analysts regarding the market practices of the company
- Analysis of rate and form filings
- Market share and premium information.

Executive

A valuable resource in setting priorities for calling examinations is the Commissioner and executive staff. The Commissioner is aware of key concerns that have been expressed by stakeholders, such as legislators, the governor and staff, other department heads, etc. These concerns should be considered in determining the market conduct section's priorities.

The following is a suggested list of the type of information that should be compiled:

- Media coverage on company issues/problems
- Complaints to legislators from constituents
- Areas of specific interest to the Commissioner
- Concerns expressed to the Commissioner by constituents and other stakeholders in the Department.

Financial Examinations

A review of completed financial examinations can provide examiners with solvency and financial compliance information. The examination results should be evaluated for any links between complaints and financial or solvency issues. The information should also be reviewed for connections between common examination processes and expectations related to the company‘s cooperation.

The following are types of information that may be available from the financial section:

- Reports of financial examinations

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- Audited Annual Statements

Financial Analysis

Examiners should use the details from the financial analysis section to assess solvency and financial compliance information. Additionally, the analysis should provide detailed financial background for the company.

The following is a suggested list of the type of information that should be compiled:

- IRIS ratios
- Lists of companies with known solvency issues.

Public Information Officer

Information obtained from the Public Information Officer can identify public concerns related to the company or a specific line of business. Examiners can also identify issues that overlap those of other states by performing a review of press releases from other states or national journals.

The following is a suggested list of the type of information that should be compiled:

- News articles obtained from various sources, including trade publications, newspapers, and the Internet
- Press releases issued by the Department or by insurance companies.

Producer Licensing

The producer licensing section can provide information regarding the company‘s distribution systems as well as the compliance history of the company and its producers. Information that may be obtained from the licensing section includes:

- Distribution of agent locations throughout the state
- The numbers of agents working for the company and the agency staff‘s years of experience
- Enforcement action against producers
- Common addresses of agents or agencies
- Increases or decreases in the number of agents licensed, appointed, or terminated by the company
- Information regarding agents that have been terminated by the company for cause.

Corporate Licensing

A review of the company licensing records can identify major changes in corporate structure or ownership along with the company‘s affiliations with other entities. Premium tax issues or concerns can also be identified.

The following is a suggested list of the type of information that may be available:

- Audited Annual Statements
- Information regarding corporate structure or ownership
- Authority to write certain lines of business
- Changes in the primary business operations of the company.

Effective Tools for Gathering Information

There are many ways to obtain information from the various working units within the Department. Planning meetings and market and financial analyses are most often used prior to calling an examination. Market conduct examiners may find it helpful to develop surveys and e-mail questionnaires to be sent to the other work units before an examination is called. Throughout the examination process the examiner should be aware of information and resources that may be obtained as needed from all sources in the Department.

Often the most effective way of gathering information for an examination is informal communications among the examination team and the Department staff.

Other Agencies as Sources of Information

In addition to utilizing information available within the Department, examiners can obtain vital information from other entities that have jurisdiction over the subject matter involved. Examples of these entities include the Department of Health and Human Services, Medicaid administrators, Centers for Medicare and Medicaid Services (CMS), the Department of Labor, the Department of Motor Vehicles, and the Governor's office.

Conclusion

The sources of information within the Department are many. The information maintained within each work unit may have greater or lesser importance than those outside the work unit. There is no one simple process to assure that each staff member within an agency has timely access to necessary information. No matter how many meetings, memos, surveys, or e-mails are issued, some key staff members miss out on essential information. The gaps in the

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communications process are best resolved by making certain that those who have information are regularly communicating to others regarding the information that is available or can be obtained. Additionally, individuals who need information must continually identify the sources for the data needed and clearly communicate what they need, when they need it, and in what format it should be provided. The continual exchange of information is key to being able to perform in the most effective and efficient manner possible.

Chapter 10
- *Detection of Fraud*

Educational Objective

Understand the best practices to use when the examination has uncovered suspected fraudulent activity.

Introduction

The primary duty of market conduct examiners in the detection of fraud is to monitor, coordinate, and, when appropriate, refer cases to the proper authority for investigation. Insurance fraud has four primary categories:

1. Insurer fraud
2. Policyholder fraud
3. Claimant fraud
4. Producer fraud.

As part of the financial examination process, the financial examiners conduct a thorough review of the carrier‘s operations to see how it avoids, detects, investigates, and reports insurance fraud. Exhibit G of the NAIC Financial Examiners Handbook provides the financial examiner a detailed checklist related to fraud detection (See Appendix A). Since a market conduct examination is conducted many times by a state that is not the state responsible for the financial examination, the examiner should review the last financial examination to see if there were any irregularities noted in the examination. If there are exceptions noted, the examiners should inquire as to how the issues were resolved.

The insurance regulator often functions as a liaison between insurance carriers and federal, state, local, and international law enforcement. The insurance regulators also coordinate efforts between state and federal regulators regarding the USA Patriot Act's anti-money laundering amendments to the Bank Secrecy Act. The NAIC has made significant efforts through the Antifraud (D) Task Force to assist carriers in the detection of fraudulent activities.

The occurrence of fraud in the insurance industry is a concern for all regulators. Although many states have fraud examiners or investigators that specialize in the detection of fraud, market conduct examiners have an opportunity to work with insurance carriers regarding the coordinated efforts of the insurance carrier, regulator, and law enforcement to identify, report, and avoid fraudulent acts in the insurance marketplace.

Insurance fraud is generally classified as external fraud or internal fraud.

- External fraud refers to fraudulent activities by claimants, policyholders, vendors, providers, or other individuals who are not employees of the insurance company.
- Internal fraud refers to fraudulent activities by insurance company personnel, stockholders, or management.

Many states have adopted the NAIC Insurance Fraud Prevention Model Act regulation. This Act is intended to permit full utilization of the expertise of the Commissioner to investigate and discover fraudulent insurance acts more effectively, halt fraudulent insurance acts, and assist and receive assistance from state, local, and federal law enforcement and regulatory agencies in enforcing laws prohibiting fraudulent insurance acts. The examiner should review his state specific laws and/or regulations related to fraud prevention for specific compliance standards. The examiner may also want to review the model law itself, which can be downloaded from the NAIC Publications Online area of StateNet which can be accessed via I-SITE. In reviewing either the state specific laws and regulations or the model act, the examiner should take special note of how key terms are defined, what is considered to be a fraudulent insurance act, and what type of confidentiality attaches to documents, materials, or other information related to an investigation of a suspected or actual fraudulent act.

Professional Skepticism

Market conduct examiners should employ a healthy amount of professional skepticism throughout their examinations. The term —Professional Skepticism" means to employ an attitude allowing the examiner to doubt what others accept to be true. By using their skill and competence, examiners can ask the proper questions to ensure that what they are told is accurate. For instance, if a company states that it has a Special Investigation Unit (SIU) that oversees the company‘s fraud detection operations, an examiner should request a copy of its policies and procedures manual. If the company cannot provide the SIU‘s policies and procedures manual, the examiner‘s level of skepticism should increase.

If a company consistently fails to provide information and details to support many of its assertions, the examiner should become increasingly concerned about the company. This type of evasive behavior by a company could indicate that there are activities the company does not want an examiner to identify. This behavior could mean that there is fraudulent activity within a company or could just mean that a company is secretive. Regardless of the reason, the examiner‘s level of professional skepticism is appropriate, and questions about a company‘s failure to disclose information should be discussed with the Examiner-in-Charge (EIC) or other appropriate Departmental personnel to see if further investigation is appropriate and, if so, to determine if the insurance department is the most appropriate agency to handle the investigation.

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Reporting Potential Fraud

Since market conduct examiners are not expected to have the expertise to conduct fraud investigations, it is important that examiners know the procedure to notify the appropriate authorities when suspected fraud is uncovered during an examination. Where indicated, it should be explained to the carrier that it is best to notify the appropriate jurisdiction whenever fraudulent activities are suspected. Since many fraudulent acts may involve multiple jurisdictions, it is best to report the suspected fraud to all affected jurisdictions. It should also be noted that, depending on the nature and scope of the suspected or actual fraud, governmental bodies other than the insurance department may also need to be notified.

Red Flags of Potential Fraud

Although estimates vary, it is likely that at least 10% of all insurance claims contain some element of fraud. The following are examples of indicators that suggest a potentially fraudulent activity. A more detailed listing of ―red flags" for casualty insurance, medical causation, premises security, property insurance, and worker's compensation can be found by searching for ―red flags" on Converium Ltd's webpage (http://www.scor-holding-switzerland.ch). As noted above the existence of these indicators is not evidence of fraud; however, market conduct examiners should be aware of them.

As a general guiding principle:

- If the examiner suspects internal fraud, he should inform the appropriate individuals within his Department.
- If the examiner suspects fraudulent external activities that have not been uncovered by the carrier, he should inform his Department and work with the carrier to investigate the activities.

Indicators of Internal Fraud

- Fabricated accounting or financial reports
- Claim payments made to employees of the insurance company
- Claim payments made to post office box addresses
- Agents requiring premium payments to be made in cash directly to the agent
- Policies, contracts, illustrations, or other legal documents appearing to be altered
- Application signatures missing or forged.

Property & Casualty Insurance Fraud Indicators

- Auto or marine craft claims made with a VIN or HIN that does not match the registration or title
- Auto or marine craft claims on rebuilt, previously salvaged, or stolen vehicles
- Title or proof of ownership from out of state or marked as a duplicate title
- Registration numbers appearing to be altered
- Complaints from policyholders indicating that they were asked to sign blank contracts for repair work
- Claims filed by individuals for injury on property when the property owner was not aware of the accident
- Claims filed for loss or damage where the policyholder did not file a police report
- Claim payments made directly to the policyholder without evidence that repairs were completed.

Workers' Compensation Fraud Indicators

- Claims submitted for individuals that are not consistent with the occupations reported by the employer. (For instance, the employer may have reported employment of clerical staff but submits employee claims for injury caused while roofing).

Health Insurance Fraud Indicators

- Claims submitted for procedures that the covered individuals did not receive
- Multiple claims submitted for the same procedures
- Claims submitted by physicians who are not in the proximity of the covered persons.

Life Insurance Fraud Indicators

- Claims submitted shortly after a life insurance policy was issued
- Multiple policies issued on the same life with payments to the same beneficiary
- Claims supported by foreign death certificates
- Claims made after a disaster for individuals who were not in the area of the disaster
- Change of ownership soon after a life insurance policy was issued.

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Market Regulation Handbook

The *NAIC Market Regulation Handbook* has two review standards related to an insurance carrier with antifraud initiatives.

1. A review designed to ensure that the insurance carrier has in place antifraud initiatives that are reasonably calculated to detect, prosecute, and prevent fraudulent insurance acts. Antifraud initiatives may include fraud investigators and an antifraud plan.

   The examiner should:

   - Review the carrier's antifraud initiatives in conjunction with applicable statutory requirements.

     Antifraud initiatives may include fraud investigators and an antifraud plan.

   - Review implementation of the carrier's plan to see how the carrier has staffed the program.
   - Check that procedures are in place to prevent persons convicted of a felony involving dishonesty or breach of trust from participating in the business of insurance.
   - Check that procedures are in place to provide information regarding fraudulent insurance acts to the Commissioner in a manner prescribed by the Commissioner/Director.

2. A review of producer account balances to see if they are in accordance with the producer‘s contract with the insurer. The examiner should inquire to determine if there are:

   - Any producers that have excessive balances with the carrier
   - Any producers with accounts currently exceeding contract limits
   - Any producers that were terminated for mishandling of funds
   - Fraud warning statements on application and claim forms
   - Procedures for the detection and reporting of fraudulent or potentially fraudulent insurance acts to the Commissioner.

Source: *NAIC Market Regulation Handbook*[1]

Conclusion

Although market conduct examiners are not expected to be fraud examiners, they are, nevertheless, expected to recognize when potential fraud exists and to notify the appropriate authorities if fraud is suspected. Since the market conduct examiners may have access to books and records that can aid in the

investigation of fraud, they may be asked by fraud examination personnel to collect evidence to facilitate an investigation. Such evidence collection should be conducted carefully in accordance with the direction of the fraud personnel and considering evidentiary protections, such as the chain of custody discussed in Chapter 12 of this textbook.

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Endnotes

[1] NAIC Market Regulation Handbook (2007).

Chapter 11
- Dealing with Issues that May Not Appear in the Final Report

Educational Objective

Identify the best course of action when an examination reveals practices that are not statutory violations and circumstances where examiners may need to identify and report findings that are not violations of specific insurance laws.

Introduction

In the performance of a market conduct examination, examiners may discover issues that do not rise to the level of being a violation of insurance laws but may be of sufficient significance to merit reporting the findings to the company or the regulatory agency. Additionally, as examiners perform risk-based examinations, there is an expectation that the examiner‘s findings should be reported in order that the state may have a greater understanding of the areas within the company that are at risk due to a lack of internal controls. These types of findings generally fall into three categories:

1. Findings that do not meet a state‘s threshold to be considered a violation
2. Business practices where consumers may be harmed, but the state has no specific laws to prohibit the practice
3. Areas where the examiner finds that a lack of internal controls or procedures may allow for compliance failures.

Historically, market conduct examination reports have included information regarding potential violations of law only. However, examiners may have access to reportable findings or information that may be of value to the state to fully understand the practices of the company examined and to make decisions regarding the need for new insurance laws. Nevertheless, some states declare that if a statute or regulation is not violated, the examination should proceed with no further concentration on the non-violating finding.

Types of Information

The types of information that an examiner may find valuable to report fall into several categories. These are:

Findings that Do Not Meet Standard Threshold or Tolerance Levels[1]

Market Conduct programs generally use procedures developed by the NAIC that allow for tolerance of certain errors because the pattern of errors does not occur with enough frequency within a sample to be considered a reportable error. For instance, the *NAIC Market Regulation Handbook* recommends an error tolerance of not more than 10% for procedures that are not related to claims handling and for actual claim procedures, an error tolerance not more than 7%. The various states may provide more specific guidance in their own examination procedures. This concept is supported by the Unfair Claims Practices Acts and Unfair Trade Practices Acts, as implemented in many states, requiring that the potential violation must be either a willful act or general business practice. In order to determine that a pattern of errors is a general business practice, the examiner must be able to demonstrate that the practice occurs with a certain frequency.

Additionally, some states have adopted procedures or guidelines that allow for tolerance of errors under a certain dollar amount in order to focus on errors that have a greater impact on consumers.

These threshold and tolerance amounts are intended to allow the examiners to focus on errors that have significant impact on consumers and fairly recognize that random errors will occur on occasion with any company. They also provide a framework through which the examiner can determine the general business practices of the company.

Here are two examples of these types of errors:

- In an examination of a homeowners insurer, the examiners discover a single rating error with the application of the factor for protection class. This results in a $2.35 difference in premium on the homeowners annual policy. Because this difference is under the $10.00 threshold, it may be non-reportable in the final examination report.
- In the same examination the examiners find two instances, from a sample of 100 canceled policies, of an improper advance notification of a cancellation. Because the percent of error does not meet the minimum error tolerance level; it may be a non-reportable issue in the examination report.

Harmful Practices that Are Not Prohibited by Law

Insurance statutes that prohibit certain practices are generally implemented to address harmful practices that have occurred and for which a legislative body has determined that the practice should be prohibited. In many cases each state legislature has not anticipated every possible harmful practice that an insurer might devise. Therefore, examiners will continue to find business practices of certain companies that may be harmful or unethical but are not specifically prohibited by a state‘s laws.

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Examples:

- A health carrier has language in its member/insured‘s handbook, policy, or certificate that describes coverage for operations involving obesity. However, during the review of claims, the examiner finds evidence that the company routinely denies claims regarding obesity; e.g., gastric by-pass surgery. Because the state does not have specific laws requiring obesity provisions, the examiner may be prohibited from reporting the issue as a potential violation of a state‘s insurance laws even though the practice may clearly harm consumers.
- A company's claims department pays a $7.50 transfer fee on total losses. The state‘s Department of Motor Vehicles (DMV) fee schedule shows that $9.50 is required. However, if the state has no insurance law that requires transfer fees to be paid by a company on total losses, the practice may not be illegal even though the consumer may be harmed.

Information Gathered Through Risk Analysis

Some states may require that examiners perform examinations involving a risk-based approach to the market conduct examination. For this type of examination, the examiner may review the procedures, processes, and internal controls related to market practices to determine areas where company practices may be at risk for non-compliance. In a risk-based approach the examiner may identify areas of weakness in the management and control of various processes that will likely result in a compliance failure.

Through such a review, the examiners may identify significant areas of concern justifying their reporting of the findings to the regulatory agency. However, the existence of the weakness in controls or absence of procedures may not rise to the level of being a violation.

> For example, an examiner finds that a claims department has no procedures, has performed no audits of its claims files, provides no formal training for claims staff, and has few managers with claims experience. While this scenario might not portray a –reportable" violation, this is certainly information that is important for the insurance department to know as it is a likely indicator that claims for the company will not be processed uniformly or accurately. Additionally, if errors are found by the examiner during the review of claims files, it is important to link the findings from the risk-based review to the claims errors.

Currently, some states request examiners to identify areas where company procedures or practices do not meet industry standards.

Documentation and Reporting

As the examiner finds errors that either do not appear to meet threshold levels or are practices of concern that are not specifically prohibited by a state's insurance law, it is first important to determine whether the errors are random or systemic errors. If the examiner finds several unrelated errors in calculation of claim payments, these may be under the threshold amount and not reportable. However, it is important to audit the company's procedures or software to determine if the error is a systemic error. For instance, if further exploration of the issue reveals that an error was the result of incorrect programming of rates for rating policies or that the company's procedure manual was inconsistent with the rates filed with the Department, such errors may be appropriately included in the examination report. Additionally, if an error rate is near the threshold amount, the examiner may find it valuable to select a more specific sample to determine if a flawed business practice exists. For example:

> If the examiner has determined from a sample of denied health claims that charges for emergency room visits are being incorrectly denied, the examiner may select a sample of emergency room claims to see how all emergency room claims are handled. By doing so, the examiner may find that certain claims are incorrectly denied as a general business practice and that the practice is reportable as a potential violation.

In any event all errors, regardless of threshold amounts, should be documented in the examiner's workpapers. Some states include findings that are not reflective of a general business practice or that are not specifically prohibited in the report of the examination. Other states include in their examination report only findings that appear to be a violation of law. In those states, such "non-reportable" issues may be included in a management letter. A management letter is a communication from the regulatory agency to the company advising the company of the additional findings. The regulatory agency may use this document to advise the company that errors or flawed practices exist. The purpose of a management letter may be to advise the company that its practices may be near a threshold for compliance or may request voluntary compliance for practices that harm consumers but are not illegal. In this manner, the management letter may serve as a warning or early notice to the company that the insurance department may monitor these practices more closely.

Reasons to Report Findings that Are Not Violations

While the findings that are not violations of insurance laws may not be used for administrative action or enforcement, such information may be of value to the state insurance department or commissioner in several ways. Following are examples of how such information may be used.

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Evidence for the Need to Change Insurance Laws

In order for legislators to pass new legislation providing protection for consumers, evidence of the existence and extent of a problem is necessary. For instance, if a legislator intends to introduce legislation restricting an industry practice, such as refusal to issue coverage because of an adverse credit score, evidence of the extent of the practice and the impact on consumers may be necessary to persuade other legislators to understand the issue and to vote for the new legislation.

Understanding the Basis for Complaints

Insurance regulators may see increasing complaints for an insurance company or may even receive inquiries from the local press regarding a company's business practice. By analyzing and reporting business practices that may be generating consumer complaints, the examiner may provide information that allows the Department to respond to interested parties with accurate objective information explaining the basis for the complaints.

Identifying Issues that May Become Violations If Not Addressed

Especially with practices that do not rise to the level of being a violation because the frequency does not exceed the tolerance level, reporting the findings to the Department may allow the Department to advise the company of the concern and request the company to address the issue before it rises to the level of being a violation. For example:

> On review of a sample of issued policies, an examiner finds that 5% of the policies are issued with an incorrect premium charge. The examiner determines that there is not a systemic reason for the errors and that the error is within the tolerance level. However, the examiner may wish to advise the Department that the errors were found and were nearly at the level of being a reportable violation in order that the company may be advised of the marginal practice. By doing so, the company can correct the practice before it rises to the level of becoming a violation.

Identifying Areas Where the System Is Likely to Break Down

Through "risk based" or "risk focused" reviews, examiners will identify areas within the company's operations where procedures or internal controls are inadequate and are indicators of a likely compliance failure. For instance, if through the review of a company's procedures, the examiner finds that the company does not maintain underwriting procedures or guidelines and does not perform any audits of the underwriting function, it is likely that the company's actual underwriting practices will not be uniform. Or, perhaps the examiner may find that the company does not have a process in place for follow-up on recommendations from internal audits. Reporting such findings may identify for the Department areas of risk that may require further

investigation. Such findings may be used to focus on key areas of concern for the remainder of the examination.

Developing Consumer Education

The knowledge of company practices further enables departments of insurance to educate consumers concerning the products and practices that can be encountered in the marketplace.

Reporting Findings that Are Not Violations of Specific Insurance Laws

Including the Findings in the Examination Report

Some states anticipate that the examination report should not limit the findings only to those that are violations of law. While the format of these reports may vary, a common principle of the reports is that they clearly and fairly report those findings that appear to be violations of law and those that are areas of concern or do not meet best practice standards. It is important to recognize that most the examination reports are public information in most states. Therefore, including such findings in the examination report will make the findings public information.

Including the Findings in a Separate Report

Some states prefer that findings that are not violations of law be reported in a separate —confidential memo" or —management letter". While these documents generally provide the information in a format similar to that of the examination report, these documents are generally considered to be a part of the examination workpapers and not public information. If the findings are communicated to the state insurance department in this manner, it is important to recognize that the memo or management letter may not be released to the public.

Whether examiners report their findings within the text of the examination report or in a separate management letter or memorandum, they should report such findings using the same concepts for fair, accurate, and objective reporting addressed elsewhere in this textbook.

Violations Previously Ratified by the Department

Occasionally, the examiner will run across an issue that may constitute a violation of the law; however, the issue had been previously ratified in some fashion by the Department. The most common example would be a policy form approved for use in the state by the Department that contains one or more policy provisions that do not comply with the insurance laws or regulations of that state.

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Addressing the matter directly with the company via a criticism may reflect poorly on, and embarrass, the Department. However, including the finding in the report without notice to the company may result in animosity between the company and the Department during the negotiation phase of the report adoption process. The recommended best practice for handling this type of situation is to contact the Department directly for direction on how to handle the situation.

Approaching the Department first gives the Department options on how to handle the situation. Some insurance departments may want to deal with the issue outside of the examination process; others may want to include the finding in the report along with a notation regarding the erroneous approval; and yet other departments may require that the finding be included in the report without any such notation. Regardless of how the Department decides to handle the situation, the examiner must ultimately proceed based on the direction provided by the Department.

Endnotes

[1] National Association of Insurance Commissioners, *Market Regulation Handbook, Volume I* (NAIC, 2301 McGee Street, Suite 800, Kansas City, MO 64108-2662), July 2007, Sampling Section.

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Chapter 12
- Workpapers and Confidentiality

Educational Objective

> While only a small percentage of examinations end in an adversarial process, the examiner must conduct every examination as if it could be contentious. There are certain portions of the examination papers that are confidential. The purpose of this chapter is to discuss how to assist the Examiner-in-Charge (EIC) in preserving the credibility of the examination work product. The examiner must understand how confidentiality is created and what must be done to preserve it.

Introduction – How to Prevent Table Pounding

There is an old adage in the law about legal presentations:

> When the facts are against you, pound the law;
>
> When the law is against you, pound the facts;
>
> When the law and the facts are both against you, pound the table.

Certainly not every Examination Report results in hearing room drama. Very few companies attempt to deceive or hide their practices. However, if that infrequent situation arises, it is important that workpapers be credible if an examiner is subpoenaed to defend the findings. In some respects, how the examiner maintains the examination documents can be as important as the examination findings themselves. The days of simply placing the examination workpapers and supporting documents in a box and marking it for posterity have long since passed.

Materials subject to review have changed as well. Paper files now often comprise only a small part of the information supplied by the company. Computer printouts are being replaced by diskettes and CDs. On-line services that facilitate coverage applications, claim filings, and electronic signatures contribute to the elimination of hard copy documentation. In some instances, paper documents are imaged and catalogued; the actual paper documents are destroyed. To simplify the discussion below, any item received from outside the Insurance Department, including, but not limited to, company documents, printouts, Compact Disks (CDs), imaged materials, electronic records, underwriting or claim documentation, etc., are collectively referred to as a ~~"file~~".

Examiners report the facts as derived from the files; the facts need no interpretation; they speak for themselves. Likewise, an examiner does not enact

the law; he merely applies relevant statutes to factual situations. How, then, can the company argue about an examiner's report? While pounding the table is an option, pounding a poorly documented report can be a far better defense for the company.

It cannot be stressed enough that the methodology directing what an examiner does is, in many ways, as important as what an examiner finds. Citing a company‘s policy or action as being in violation of law may cost the company a lot of money. Keep in mind that if a company cannot refute what is found, it may be equally effective for a company to discredit how the examiner found the violation or how the examiner documented the evidence of the violation.

While examination procedures and reporting formats are unique to each state, there are common practices that are viable in all formats. The following commentary is aimed at strengthening the credibility of the procedures the examiner uses in producing the Examination Report. These procedures must be instituted on the first day of the examination as most are required to be followed on an ongoing basis. They are not remedial in nature; for example, neither chain of custody nor maintaining confidentiality can be effectively re-established once breached. There is only the original opportunity to establish credibility and protect the examination workpapers properly.

How an examiner handles the workpapers has a significant role in how well the Examination Report withstands close scrutiny. The credibility of the examination findings can hinge on the credibility of the examination procedures. The best way to prevent procedures from coming under question is to be consistent and systematic in the way workpapers are handled.

At the very least:

- Keep all workpapers in a designated location where access is controlled by the examiner.
- Keep files that support the findings secure in the same fashion as the workpapers.
- Once files have been reviewed, consider those portions that are needed to support a finding as confidential and treat them accordingly.
- Always keep unedited copies of all files. If it becomes necessary to —mark up” a set of company files as part of the examination process, keep a second set in its original condition. Be sure to retain attachments, post-it notes, etc. The primary purpose is to re-affirm the origin of any margin notes or comments that a file might contain. This is particularly important if there are questions of biased underwriting or improper claim practices. Follow this procedure for CDs and diskettes as well. In short, never work directly on the copy the company provides.
- Be sure that proprietary information is not exposed to third-party access.

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It is far easier for an examiner to demonstrate credibility if the same procedures are followed each time a file is reviewed or maintained. Following are some of the elements that should be considered during the course of an examination.

Company Responses

There are occasions when the company realizes that the responses given amount to an admission that there have been violations of law or contract. In some instances, the company tries to recant what it has said. Following are some suggestions on how the company can be held to the answers it provided previously.

We Said It, but We Didn't Mean It

During the course of report writing, the examiner may use a company response as a portion of a finding. The situation may arise where the company takes the position that the person who provided the file or the response was not authorized to do so. Now the company's position has changed, and the company challenges the credibility of the findings based upon its new position. While this challenge cannot be prevented, the question becomes: Who has the most credibility in this situation? There is a way that the burden of credibility can be placed on the company's shoulders:

> At the beginning of the examination, request a list from the company of persons authorized to provide responses. The letter from the company should be signed by a senior officer or senior legal counsel of the company. By doing this, the company has already acknowledged that the response given was an authorized response. Let the company explain why an authorized response was incorrect. If a response is received from an unauthorized individual, write a short memo to one of the authorized parties requesting an "authorized" response.

We Meant It Then, but We Found Something Else Later, So Now . . .

When the examiner asks for data, the company normally provides a response. For a variety of reasons, the company may later find additional data relative to that file. If that additional data is important to the report, the company may take the position that providing it is not necessary since the examiner did not ask for any update on the file. Again, the examiner's credibility is challenged - if this data is so important, why didn't the examiner ask for updates? Thus, the onus of pursuing later discoveries of data falls on the examiner.

The possibility of last minute surprises can be reduced by requiring the company to supplement a response automatically if additional data is found subsequent to its initial response. The best time to cover this potential issue is

when the ground rules for the examination are established in a pre-examination meeting or an initial meeting with the company once the examination begins. Obtain a signed acknowledgement from the company stating that in response to any request, any information later discovered by the company will automatically be provided. Again, the burden becomes the company‘s to comply without the constant need by the examiner to ask if anything more has developed on prior topics.

We Have It, but You’re Not Getting It

Occasionally, a company refuses to provide data to the examiner. In some cases the company's representatives claim that the information is not relevant to the examination; in other cases they claim that the data is proprietary and simply refuse to provide it. Nevertheless, in most states there are statutes that state that virtually all aspects of an insurance company‘s conduct are subject to examination. These statutes provide the right for insurance departments to determine what is and is not relevant to an examination. Therefore, if a company refuses to provide data:

> Write a formal request asking for the information. Include a statement asserting that if the company is not going to provide the data, it must provide the specific details as to why it is refusing. If the request continues to be denied, discuss the matter with the Department legal counsel to determine if a subpoena or other legal action should be taken against the company. As near the time of the occurrence as practical, write a narrative of what transpired that led to the refusal; update the narrative as events develop, and sign and date the memo.

Note: This is a prime example of a confidential document created by an examiner. See the next section.

Confidentiality

Identity theft can take many forms. To assist in preventing identity theft, the federal and state governments have enacted laws that prohibit disclosure of certain types of personal information. The examiner is charged with realizing the potential impact to one's identity that comes with the handling of underwriting and claim files. There is no second chance at maintaining confidentiality. Following are some guidelines and recommendations to assist in maintaining appropriate levels of security for the information received.

Why All the Fuss?

Confidentiality can be defined as:

> A principle of information handling that requires measures to ensure that the information is not disclosed to any third party

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and that the information is not used or allowed to be used by a third party in a manner detrimental to the owner of the information.

For several reasons as discussed below, maintaining confidentiality is a critical part of an examiner‘s job. Failure to maintain the appropriate level of confidentiality can result in serious issues for not only the examination but the examiners as well.

There are two categories of confidential information:

1. The first contains data from another party; for example, underwriting files that a company provides to the examiner during the course of an examination. The personal information of the applicant and perhaps even other family members is in the file given to the examiner; however, there is no element of ownership implied for the examiner.

2. The second contains information from the examiner‘s own work product or from fulfilled second-party requests. This second party could be Insurance Department legal counsel or other individuals whose input is used in an examination/evaluation of an insurance company. Such other persons might be the EIC‘s Supervisor, a contact person in an Insurance Department Consumer Services Section or Licensing Department or a representative from another state‘s Insurance Department.

The mere possession of confidential information places a responsibility on the examiner:

- Not to disclose the information to any third party directly
- Not to use the information in an inappropriate or improper manner
- To safeguard the information in a manner consistent with the need to protect it from inadvertent disclosure
- To protect and safeguard information from other states in a manner consistent with that state‘s confidentiality guidelines.

There can be several types of confidential information even in a single claim file. For example, a typical disability claim file could easily contain the following items:

- A policy application showing social security number and personal and family information of the applicant
- Claim data showing current medical issues and past medical history as well as personal data, including other sources of income
- Information provided by an employer outlining job requirements, salary, and other work related details

- Medical records and evaluations, including diagnoses, prognoses, and medications
- The insured's credit card receipt for medical supplies or premium payment
- A voided check from the insured showing account and routing numbers
- Company policies and procedures on claims administration
- Letters and memoranda between the claims department and its legal department on the proposed resolution of a claim. This could include evaluations of claim value for settlement purposes.

In many cases when the insured/claimant (even applicant) provides this information to the company, it is not done with the thought in mind that someone else will have access to it. The company does not write its policies and procedures with the thought of sharing that information with outsiders. Yet, all of this information is available as part of the examination. Keep in mind that much of this information is also provided, as a matter of course, to, for example, the Medical Information Bureau (MIB), a source commonly used by life and health insurers for underwriting information. However, while an examiner may have a statutory right to view the information, there is no right to disclose the information. Possession of confidential information is truly not an element of ownership.

Not all confidential information comes in the form of data. There is a second category of files, containing what is generally referred to as proprietary information that may be entrusted to an examiner. This information includes company policies, procedures, claims handling practices, underwriting guidelines, etc. In essence it is the work product of the company and how it operates its business. Each one of these contains privileged or protected information.

An examiner in possession of confidential information is much like a trustee holding monies in an account. A trustee is very limited in what he can do with those monies. He cannot sell them or use them. He cannot tell any third party how much money is in the account. If he were to leave the money lying out and some disappeared, he would be liable for that part that was missing. If the money's owner writes a check based on what he placed in the account, and the money is now insufficient to cover the check, the trustee must make good on both the check and any subsequent costs as well. The same rationale applies to information in the possession of the examiner. The examiner must treat it as if it were cash belonging to someone else; the information is not his. If a trustee is careless with entrusted money and such action becomes known, chances are he would be hard pressed to be a trustee again. So, too, it is with an examiner who allows confidential information to fall into third-party hands.

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Third-party disclosure can even include people within the company. In some instances, the examiner should not discuss company information with company personnel. For example:

> As a part of the examination, an examiner reviews the minutes of the company's Board of Directors' meeting. The minutes discuss a possible merger with another company. The examiner has questions about how this merger might impact the examination. Discussion with the examination liaison could certainly be inappropriate. If the liaison were not privileged to the information, discussion with him might be considered the release of information that the company does not want to be made public beyond the board room.

Even this type of released information could be considered a breach of confidentiality. An inappropriate discussion could have a detrimental impact on the company; therefore, the examiner must exercise discretion in choosing those with whom he addresses his inquiries or comments. In this case, the proper person to contact is the Secretary or other senior officer of the company.

Inadvertent disclosure can create problems for the examination as well. Consider the following two scenarios:

1. While having lunch in the company cafeteria, an examiner mentions this same potential merger to another examiner and makes an off-hand comment that the home office of the other company is over a thousand miles away. Imagine the shock to the people at the next table learning that they may be losing their jobs shortly. How long would it take for that information to sweep the entire operation, and how would the employees react?

2. Or, consider that an examiner is out to dinner and makes the same comment during the meal. One of the people at the next table is a reporter who recognizes a promising tip when he hears one. In his column the next morning, he prints an article saying that an unnamed local insurance company may be on the verge of being bought out. If the company is identified, how would the company's relationship with the community be impacted?

In either case it might be possible to trace the leak back to the examiner. Clearly, there was no intent to release information, but it happened anyway.

Saying It Is So Doesn't Make It So

In order for data to be considered confidential, there are several conditions that must be met. These conditions fall into three categories:

- The data must be treated differently than non-confidential material.

- The data must be designated as confidential. Data files may also be considered confidential even if not specifically marked as such. In some cases, it is simply —understood" as a general practice. Content of the data files may include confidential information, such as addresses, social security numbers or medical information. In some cases, data is verbally identified as confidential. Even if not stored in a locked room, employees and examiners may need to -badge in" and -badge out" when entering and leaving company premises, and this may be sufficient to add a layer of confidentiality to all information available to the examiners.
- The data must be handled in accordance with state and federal guidelines for confidential data.

Treating confidential data differently is a basic approach for validating the difference. For example:

> If an examiner reviews the already released advertising material of a company, confidentiality need not be considered. The company has made the pieces public and has distributed them to the producers and/or clients. Consequently, the materials can be left on a desktop or in any area that is accessible to third parties.

Claim files, on the other hand, contain confidential information. They should be secured at least to the same level of access that the company provides to the examiner. For example:

> If the company provides files to an examiner and stacks them in an area to which anyone in the company has access, a higher degree of security is not required from the examiner.
>
> If, however, the files are delivered to a locked room, the examiner should not place them in a less secure environment.
>
> If an examiner develops workpapers that are considered confidential from the company, then leaving them on a desktop to which company personnel have access is not appropriate.

Remember, the file owner has a right to confidentiality; however, it is also the owner's responsibility to demonstrate the appropriate level of confidentiality for the file. If the owner does not treat the file as confidential, no one else is required to treat the file as confidential either. If the owner does not take appropriate steps to preserve confidentiality, other parties are not required to consider the file as confidential. Claiming confidentiality after the fact is made more difficult if proper precautions are not taken in advance.

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File, File, Go Away

At some point in every examination the examiner has data that is no longer required. Proper disposal of confidential material is simply another part of dealing with confidential material appropriately. An examiner should never place confidential material of any kind in a wastebasket. This includes documents that the examiner has created that are confidential from the company. Most companies have facilities for the disposal of confidential files. Throwing a file away does not mean it is beyond recovery. Just as money thrown in the trash becomes available to anyone who picks it up, so does data that is discarded as an empty coffee cup. Here, again, is a situation demonstrating that what is not done is at least as important as what is done. Consider this:

> An examiner drafts a memorandum to his supervisor at the Department. This memorandum identifies a serious violation concerning the way claims are paid. It also points out how the violation was discovered and the company documents that are in violation. The examiner works on several drafts over the course of the day and carefully and properly files the final copy. The drafts, however, are tossed into the trash can. If the company were to recover those drafts, it could alter its conduct by eliminating the violating documents from other data or by changing the coding that led to the examiner's discovery. The company could also change the way it records data; it could eliminate forms; it could temporarily change its method of claim handling; etc. In essence, the company could diminish the examiner's ability to show the extent of the violation and that it was a continuing violation. Later, if the examiner learns the manner in which the company became aware of his discovery, he would be estopped from claiming confidentiality. After all, who keeps confidential information in the trash can?

Another example:

> During a privileged discussion with a Department attorney regarding an examination of an insurance company, an examiner asks the attorney for a written opinion on a confidential matter. If the examiner has asked the Department attorney for guidance, the response is considered confidential and should not be left on a desk where it can be found by accident. If the normal procedure is for the company to pick up and leave materials on the desk, then the confidential document is not being treated as confidential.

How to Determine the Required Level of Confidentiality

In determining what should be kept confidential, the first step is to consider the nature of the data. There are levels of confidentiality, and the level is dictated to some degree by the file‘s content. Just as there are different reasons for items to be kept confidential, there are different levels of confidentiality. Using the scenario of the claim file above, different segments of the same file would require different handling procedures. The proper method of handling is a determination that an examiner must make. Just as too little confidentiality can be a problem, too much can be as well. That is, only those segments that warrant confidential treatment should receive confidential treatment. Placing everything in the same category can bring into question the examiner's ability to determine what is truly a confidential file and, therefore, whether any part of the file warrants being considered confidential. Notwithstanding this concern, if the confidential and non-confidential parts of a file cannot be segregated, the entire file should be treated at the higher level of confidentiality.

Below are some elements of the claim referenced above and the level of confidentiality that might be assigned to that particular information.

- HIPAA information – Treat as the company treats the files. Limit discussions to the coordinator and claims management personnel.
- Company documents, such as Board of Directors' minutes – Discuss only with a senior member of management or someone designated by management.

  Note: This specific issue should be handled in the form of a request if the case arises.

- Internal claims procedures – Ask the coordinator who would be familiar with the policies for discussion purposes.
- Underwriting issues concerning company policies – Ask the coordinator for the name of someone who would be familiar with the policies for discussion purposes.

How to Designate 'Confidential'

If an examiner notes a practice that necessitates a confidential memorandum to the file, he should draw upon a set system that establishes how a confidential item is handled. Telling an examiner on-site co-worker is a good practice in that it establishes a witness that the examiner intends for a particular item to be considered confidential. If the item is particularly sensitive, the examiner may want to consider notarizing the memorandum to file and to follow the state and federal confidentiality laws. Stamp or type on the document the word —Confidential” so that it is clear at first glance that the document contains sensitive material and is to be treated accordingly.

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If an examiner possesses confidential papers belonging to the company and realizes that they are confidential, he has met the first criterion that there be a reason to treat the papers differently. The next step: Designate them as confidential. To do so treat the file differently so that it will later be considered to be different. Segmentation from the non-confidential information is essential. If the papers have a low level of sensitivity, it may be proper simply to stamp the items as confidential and keep them in a separate place. Distinguishing by means of a distinctive colored folder not used for any other purpose provides a good starting point. If the individual pages cannot be marked as confidential, mark the folder with language such as —ONFIDENTIAL, FOR EXAMINER USE ONLY". All examiners on-site should store all confidential files in that folder. If the EIC has material that even the other examiners are not to review, that material should be stored in a second, differently colored folder labeled "CONFIDENTIAL, for EIC USE ONLY".

The EIC is responsible for making sure that the appropriate data is placed in the appropriate file. Excessive use of the confidential designation can create problems just as readily as under-use can.

Dealing with Data

There are instances when, as a result of an examination, data or documents must be forwarded or maintained for future regulatory action. The following is meant to assist the examiner in keeping the information secure in the appropriate manner and to ensure that there is no tampering with the files.

The computerization of company data has given the examiner analytic tools that could only be imagined a few years ago. Reviewing data once meant examining mounds of paper. Reviewing more than a handful of individual entries would have amounted to a seemingly lifetime assignment. But, due to the conversion of data into digital formats, one can now literally hold millions of files in the palm of one's hand.

With appropriate programming, one can search for anomalies in the entire database and get far more accurate documentation of a company's operations. The examiner now has the ability to scan information on all insureds with a particular type of policy, or review all claims relating to an individual Current Procedural Terminology (CPT)[1] or ZIP Code, or to see how many policies a company has written on an individual over time. Analysis is no longer limited to a miniscule sample of a large universe, but the examiner must be conscientious about the confidentiality of the data he or she accesses.

The media has reported with increasing frequency about stolen or lost computers containing critical consumer data. The IRS, FBI, credit card companies, and many other entities have acknowledged that computers and/or software containing thousands of personal records have ended up in

the hands of unknown parties. The last thing that an examiner needs is to add his name to the list of persons responsible for releasing confidential company data, such as policies issued or claims handled.

Stop and think for a moment, then ask the following questions:

- At the present time, how much confidential insurance company data resides on your computer?
- How many files on your hard drive contain databases with privileged or confidential information?
- Which files are password protected? Which are not?
- Do you have a password logon on your computer?
- How often do you change the password?
- When you leave a job site for the day or weekend, what do you do to secure the computer and the data on it?
- Have you ever had a virus from the Internet invade your computer?
- Could your data files be uploaded by a hacker?
- Have you ever e-mailed databases without password or encryption protection?
- Have you ever analyzed the security of the servers you use when e-mailing databases?
- Rather than allowing material to remain on your hard-drive, have you thought about transferring the data to a Compact Disk (CD) or a thumb drive; i.e., a USB flash drive?
- What would be the possible negative outcome from a breach of confidentiality of the names, dates of birth, Social Security numbers, addresses, and/or medical histories of thousands of people?
- If you were responsible for a data breach, how could this affect your future employability as a market conduct examiner?

While the ability to —crunch" large numbers of files rapidly has become important to the examiner, there is another —crunch" – this time on the examiner. This —crunch" is an absolute duty to have viable procedures in place to protect the integrity of the data made available to him. The examiner should be aware of what policies and procedures his employer (the Department, firm, or independent contractor) has implemented for data security. The examiner should review how these requirements compare to NAIC guidelines.

Additionally, when starting an examination, the examiner should:

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- Ask the company for its written policies and procedures regarding confidential material.
- Become familiar with the types of information and documents that the company considers ―confidential".
- Be aware of the policies and procedures that are in place at the company regarding the protection of confidential material.

At a minimum, an examiner's own procedures to maintain the confidentiality of the material should be equivalent to, or more restrictive than, those of the company. However, if the confidentiality policies of the Department are more restrictive than the company's standards, then the Department standards should be the examiner's minimum standards.

Remember, not only must these policies and procedures be in place, it is also necessary to abide by them. Data retained in a laptop or on unprotected storage media is like a loaded handgun in a drawer. If there is a danger of someone getting to the handgun, a trigger lock, as well as a separate, secure area for the ammunition, needs to be in place. Similarly, you must have appropriate safeguards in place to protect privileged and confidential information on your computer. In all instances, the burden is on the examiner to have appropriate safety measures in place and to maintain them at all times.

Password Protection and Encrypted Data

In some cases, flash drives come with software installed that allows one to password protect or encrypt the data. Similar software can be added to Compact Disks (CDs).

A password protected file is one that cannot be accessed unless a password is entered. Encrypted data is data that cannot be read by a computer (is illegible) unless a ―key" is provided. Further protection can be provided by separating the data from the computer. This allows tighter control over the data provided that the data is secured in a locked file drawer or other equally limited access storage facility.

Passwords

One brief comment about passwords: There are many passwords that can be easily uncovered only by someone with intimate knowledge of the protector's personal history. For example:

- The initials of a first grade teacher followed by the year you entered first grade
- The name of the character in a favorite movie
- The name of the first person kissed

- Odd names of places visited – such as Walla Walla, Washington, or Phlox, Indiana
- A neighbor‘s dog‘s name.

Use passwords that can be remembered but cannot be linked directly to you or your discernible history. Birth dates of children or a spouse as well as anniversary dates are easy targets and should never be used. Remember, if someone hacks into your computer, he will also have access to all the personal information entered on that computer. While data security does not guarantee an examiner's job security, the failure to protect data adequately could certainly lead to job insecurity. After all, an examiner's future could be at issue following a serious security breach.

If it is necessary to send confidential information via the Internet, or on media such as a diskette or a CD, protect via password or encrypt the data. Do not send the password along with the data. Instead, send the password by separate e-mail or by telephone.

We have all heard the old adage of the futility of shutting the barn doors after the horses are already out. With horses, it is possible to corral them and put them back in the barn. Unfortunately, once confidential information is disclosed, there is no amount of effort that can return those —horses” to the barn. For an examiner, the doors to the barn must be closed and remain closed from the instant that the examiner receives confidential information.

Chain of Custody

Today, confidentiality and chain of custody are important elements of how examination papers are treated both during and subsequent to an examination.

Issues of confidentiality deal with the wrongful, inappropriate, or inadvertent, disclosure of information. The —Chain of Custody” is very different as it addresses the need for maintaining the integrity of the information.

Chain of Custody Defined

Chain of Custody is a trail of document possession that can be used to determine who has had access, possession, or control of data from one point in time to any other point in time. This is accomplished by having set procedures/policies on how documents are passed from one person/entity to another.

Why Is It Important?

In this instance, confidentiality is not a factor. With chain of custody, the issue is whether the data under review was altered or amended without the knowledge or consent of the examiner between the time the company provided it and the time that it was utilized. If there is a question of possibly

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altered information, it is important to determine who had access to the file at any given time. This possession trail facilitates the investigation into the tampering of documents and helps to identify how and when an alteration could have occurred. This potential problem confirms the advisability of maintaining copies of original files in a separate location so that the contents of the original file can be verified. If files are revised, copies of both the revised and the original version should be maintained until it is clear that there are no issues concerning content. As previously stated, there is a need to maintain a clean set of data as received from the company. Then, if the company suggests examiner impropriety in handling the provided information, the original documentation copy to refute the suggestions is readily available. The Chain of Custody also allows identification of the owner of the information and who had the information subsequent to the examiner.

Always work from copies of data files. This enables the examiner to verify whether there has been an alteration to the data used for the examination. Likewise, once a paper file is reviewed, make copies of the relevant documents that substantiate the problem and keep them in a segmented and secure location. Files that do not contain violations can be placed in a less secure place but still subject to due care for any confidentiality.

Summary

In the course of every examination, there is a surprise or two. In most instances, these surprises have little or no impact on the outcome of the examination itself. However, there are those instances when the surprise becomes the crux of the examination findings. In those instances, the examiners may be required to defend the credibility of their findings. The procedures outlined above – if used right from the beginning on every examination – greatly assist in maintaining the integrity and veracity of the work product. In the event of administrative or judicial review, it is better if the spotlight remains on the evidence rather than on the methods and procedures of how it was collected and maintained. Keep the opposition relegated to pounding the table and not the quality of the examination procedures.

Endnotes

[1] The **Current Procedural Terminology** is the list maintained by the American Medical Association to provide unique billing codes for services rendered.

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Chapter 13
- Management of Examination Staff

Educational Objective

The educational objective of this chapter is to identify the best management strategies for an examination staff. As the on-site examination supervisor, the Examiner-in-Charge (EIC) has to deal with numerous challenging issues.

Problematic Examiners: Difficulties with Disciplining / Terminating State Employees

It is important that both independent and state examiners conduct themselves under an expected fundamental code of ethics and that they be advised of their performance expectations. Then, any subsequent warnings, discussions, reassignments, or terminations will be understood to be due to either a failure to perform or a display of unprofessional behavior.

Disciplinary problems are disruptive to the examination process and can arise through behavioral events, attitude, and lack of performance of assigned tasks. It is important to address these disruptive issues quickly in order to maintain a smooth flow in the examination process and for the sake of cohesive teamwork and high morale with all examiners on the job. After identification, the EIC should take the responsibility for dealing with these problems. The EIC should attempt to isolate and address the cause of the adverse behavior and institute remedies for corrective action. All problems should be addressed directly with the pertinent examiner as soon as such issues are identified.

On occasion, problems arise with contractors who carry over discipline problems from one contract or state and team leader to another without correction. State employees are generally subject to performance evaluations. If state employees are placed on probation and successfully pass the probationary period, terminating them is more difficult. It is important for the EIC to document all disciplinary problems (i.e., tardiness or attendance at work, personal phone calls, poor attitude towards the EIC and fellow examiners, etc.). In these cases, the EIC should either issue a verbal warning and discuss these problems with the examiner or begin to document in writing the personnel problems encountered. In addition, the EIC should document the acknowledgement and understanding by the examiner to whom the disciplinary action is directed either by his comments, signature, or other written means to demonstrate awareness of the unacceptable behavior.

Professional Development and Growth

On a positive note, constructive criticism and feedback can lead to professional development and growth. Suggestions for EICs and other supervisory personnel to pursue with examiners include:

- Encourage professional development via professional designations, certifications, and other training and learning opportunities.

  Many states have salary incentives and responsibilities for attaining designations and for the completion of course work. Many states also formally recognize two professional designations developed and awarded by the Insurance Regulatory Examiners Society (IRES) – Accredited Insurance Examiner (AIE) and Certified Insurance Examiner (CIE). The coursework required to obtain these designations can be pursued on an incremental basis. The IRES AIE and CIE designations – as well as various other continuing education programs offered by a wide variety of resources – provide information on current issues in the insurance industry, including ramifications to consumers, and the regulation of insurance.

- Motivate people to grow as examiners.

  As in most professions, insurance regulators and examiners want to learn more about the industry in which they may want a career. As previously mentioned, this can be accomplished in part by taking the IRES course path for designations and by completing subsequent continuing education programs. However, since most of the examination process is learned on the job, it is important for the EIC to create an environment that fosters growth instead of complacency.

  It is important to recognize the individual strengths and weaknesses of each examiner. Some people dislike changes involving new computer applications or new examination procedures. By demonstrating that technological change requires renewed learning for everyone – including those examiners that are technically proficient – the stress of adapting to new technology and software programs may be allayed. There is a similar need to adapt to changes in the *NAIC Market Regulation Handbook* and state laws and regulations and to other audit and examination-related changes. In addition to being able to adapt to change, it is important for the EIC to delegate responsibility to examiners to demonstrate confidence in their abilities. Creating an atmosphere during the examination phase that encourages questions without reprisals is an effective motivational tool towards growth and career development.

- Learn about new industry developments and communicate them to the examination team.

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It is important not only to have a fundamental understanding of all phases of the examination process but also to keep abreast of changes in the industry. The NAIC, IRES, and various state insurance departments publish information concerning trends, news, and other current event information on their websites.

- Train new examiners.

  Most examiners begin by learning on the job. They are assigned certain tasks based on their skills. If they are fortunate to train under an experienced examiner, their growth increases much more quickly and with better comprehension. A trainee with the right attitude and an open mind learns and establishes a basic foundation based on the types of examination exposures and attention and motivation by the EIC. Sometimes, it is possible to have someone within the examination team work with new examiners and those needing training. Such on-site training arrangements depend on the examiner's level of experience and his knowledge of examination procedures, the *NAIC Market Regulation Handbook*, applicable laws and regulations, workpaper and worksheet formula templates, and documentation of items audited. It is particularly important to keep the examination team advised of new statutes, regulations, and official Department bulletins as well as revisions to existing standards for company compliance.

- Review the examiners‘ work.

  All examiners should have a copy of the NAIC‘s *Market Regulation Handbook* which details all audit procedures, provides sample criteria, and presents other examination related information. In addition, it is critical that all examiners involved in an examination be consistent in setting up worksheets (using Excel, Access, Word, etc.) not only so that the EIC can review and extrapolate information in a systematic way but also so that others reviewing the same documentation can find the same information. The EIC should, at the beginning of the examination, assist in formatting spreadsheets and other workpapers so that there is consistency within the examination team. This is especially important if there is more than one examiner auditing samples documented in the same spreadsheet. All examiners should be advised of expectations and responsibilities at the beginning of the examination since their findings and related documentation may well become part of the Examination Report. The EIC is responsible for reviewing all work products whose results are included in the final Examination Report. Deficiencies should be noted and changes addressed so that everyone on the team is aware of the goals and the need for consistency.

Time Budgets

One of the primary mechanisms to establish accountability for the examination process is the time budget. Generally, an EIC or experienced examiners can gauge the time it will take to complete the review of each task included in the examination. Depending upon the sample size, where and how the records are kept (in paper files or electronically), and the completeness of the requested information, time budgets can be organized to promote the efficient completion of assigned tasks as well as the analyses of the results.

The EIC develops a budget to project the estimated time it will take to complete the examination by using tools – such as a Microsoft Excel worksheet – to project hours needed for the examination based on the necessary review phases. This activity can provide preliminary information as to the number of examiners needed and the expected time to complete the examination. Depending upon the reason for the examination, general interrogatories may be sent in advance of the field work to be completed by the company by the time the examiners arrive on-site.

With the input of the examiners who will be involved, all items to be reviewed or audited should be assigned the projected number of hours deemed necessary for completion. Based on past experience, the EIC (with approval from the Audit Manager and/or Chief Market Conduct Examiner) should be able to determine the total number of hours required to complete the examination.

Establishment of Time Controls by Examination Area

It is customary for the EIC to break down the scope of the examination into phases (complaints, producer licensing, underwriting, claims, etc.) and set a limit of total hours allotted for review per phase to establish the overall examination completion target date.

Monitoring Budget to Actual (Hours and Costs)

The EIC can use a software program to track the allotted time per item examined and update the budget on a regular basis in order to monitor the project effectively. The most widely used method involves software such as Microsoft Excel or a database program. On a regular basis the EIC can input the hours per examiner per item audited and compare them to those estimated in the budget. The EIC is thereby able to determine where there may be delays or other problems associated with any phase of the examination and take corrective action. In addition, all expenses and costs (travel, per diem, mileage, etc.) can be input using the same software so that all costs associated with a particular examination can be monitored. Each examiner's timesheet is a good source for hours and salary, and expense billing invoices completed by all team members provide a source for expenses.

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Status Reports to the Department

As frequently as requested, depending upon the directive by the Department, a status report should be submitted describing the progress made on the examination. The report includes:

- Items audited and/or completed
- The time it took to complete an examination phase and whether it was within the allotted time-frame
- Delays in receiving information and documents from the company
- The plan or goals for the following reporting period
- Concerns and exceptions.
- Examination completion date assessment.

  If the date is later than planned, explain why and what is being done to prevent further slippages.

Examinations may still take longer than anticipated, often for the following reasons:

- Company delays in providing accurate and/or complete requested files and information
- Technical problems with access to company systems
- Company inability to find information.
- Failure to manage staff properly or to manage to budget
- Lack of timely response from the insurance department to examiner or company requests

Through the use of time budgets and regular update reports, examiners know the parameters for completion of work assigned. All delays in providing the requested information should be documented and sent to the Department in order to provide a reasonable explanation for the delay in completing the examination.

Strategies for Efficiency and Effectiveness

The EIC should encourage and utilize a variety of techniques to try to ensure effective and efficient examinations.

How to Promote and Ensure Positive Interaction among Examiners from a Variety of Backgrounds and Locations

Everyone has something to contribute. Some examiners have more expertise than others in certain lines of insurance or in underwriting, rating, or claims,

as well as in other technical areas. The sharing of information and on-the-job training can help promote a positive learning environment for all.

Allowing Companies to Divulge Concerns

Companies may complain about the examiners sent by the State – How should the EIC/Department respond?

> Listen to company concerns and address each issue as it arises on its own merit. The EIC is responsible for examiner behavior, and this should be communicated to the company. On issues that surface concerning examiner behavior, it is important to gather all facts surrounding the incidents. It is equally important to include the affected examiner‘s explanation. Serious matters, where a company is complaining about a particular examiner, should be directed to the examination team‘s Audit Manager or to the Department for further investigation and decisions. Advise the company that the matter is being addressed and that action is being taken. It may be that certain examiner personalities conflict with those of company coordinators or that examiners have exhibited similar behavior on previous examinations. The details of any such history should be carefully researched. Regardless, the EIC, Audit Manager, and/or other appropriate Department personnel should resolve the problem. This is not the responsibility of the company.

Problematic Companies

Occasionally, personality conflicts between the EIC and company coordinator arise. In some of these cases, the conflict is due to company personnel wanting to control and dictate the examination flow and findings. Examinations are called for statutory reasons, or they are targeted for reasons such as a company's high complaint ratio. Companies are required to produce all requested documents for review. Cases where there is a known delay in response to comment forms, requests for data, or underwriting and claims files should be documented and become part of the examination findings. In addition, the Department should be informed of any problems with company officials. Copies of correspondence, including request dates, receipt dates, and other evidence to demonstrate problems encountered by the EIC or other examiners should be carefully preserved and documented. It is important to document such concerns as they arise since patterns of behavior by company staff may not be immediately apparent. Perhaps the most important step to take, however, is to discuss problems and differences with the company coordinator before they become insurmountable.

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EIC Responsibilities

Foster Teamwork

- Promote communication, contribution, and cooperation within the examination team.

  Solicit open verbal and written communication from all team members. Recognize contributions; work together towards a common goal.

- Know team members‘ strengths and weaknesses ahead of time with respect to computer skills and specific insurance topic knowledge.

  Understanding examiners' capabilities and limitations can help define each examiner‘s responsibilities. Although giving an examiner the same task each time does not necessarily promote growth, examiners should work on their skills and consistency to strengthen examination fundamentals. At the very least the EIC should diversify responsibilities and offer challenges to promote learning.

  Knowledge of various computer applications and software programs is essential to promote consistency of worksheets, workpapers, and other documentation to efficiently complete the examination. In some cases, an examiner may not be familiar with all software applications. The EIC should provide some instruction explaining the purpose for the program and its use, a tutorial on using the program, and encouragement to experiment with the program even if mistakes are made. Learning a new computer program can be frustrating, so exercise patience. All individuals had to learn the fundamentals of computers and new programs at one point in their careers. Programs are updated regularly, and new features need to be mastered to improve the examination process.

- Accept diversity.

  Solicit different ideas from participants to contribute to an overall examination plan. Remain open-minded to changing formats and different examination audit paths. Encourage team members to discuss impressions and findings regularly. One person may spot a trend early, thereby allowing all to understand the extent of exceptions to required practices.

- Encourage the professional development and growth of the examiner team.

  There are many ways to foster professional development and growth:

  - Recognizing learning situations
  - Bringing to the surface those issues that contribute to team development

  - Communicating ideas and setting goals throughout the examination process
  - Rewarding achievement through recognition and promotion.
- Remain a willing, available mentor for examination team members.

Communicate

- Make sure team members understand what is expected of them during the examination (work hours, company dress codes, and examination responsibilities).

  In order for a team of examiners to function well, it is important for the EIC to set the standards for the examination so that each member is measured according to those standards. Although examination responsibilities may vary according to examiner experience, for on-site examinations other factors, such as working hours and dress, should be dictated by the company‘s standards for work hours and its dress code. At times, the examination team may want to discuss acceptability of working hours that vary from the company‘s usual practice. For instance, it may be more cost-effective for the examination team to work four 10-hour days and then return home each weekend, thereby saving examination expenses. While some companies accept such variations, other companies may not approve of having examiners on-site when company staff is not present to assist with any questions or needs that may arise.

- Provide the examination team information about the company's organization and operations.

  In order for examiners to get a proper perspective of the examination's scope and the review methods to be applied according to their assigned responsibilities, it is important for the EIC to advise the team as to the type of operations the company has and how the review will be organized to document findings. This involves knowing specific physical locations where each function of the company is conducted. For instance, an examination may be located at the company‘s corporate headquarters, but the underwriting and claim functions may be handled elsewhere. This could affect the assignment of responsibilities in cases where a portion of the examination needs to be done at a regional underwriting or claim office. These are areas that should be discussed with the examination team and company coordinator at the pre-examination meeting to determine the most effective and efficient way to conduct the examination and make audit assignments. Some companies may prefer to have all necessary documentation forwarded to their corporate headquarters, while other companies may prefer to have portions of the examination performed at other locations.

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- Assign and discuss responsibilities and work assignments with team members, including time tables for when work needs to be completed, at the start of the examination and as needed during the course of the examination.

  Time budgets are a critical part of planning all aspects of the examination. Based on sample size the EIC should be able to determine the length of time each assigned item should take to complete. Input from the examination team is also critical to the success of creating and adhering to the time budget. The EIC should create a budget based upon the experience of team members, the sample size, and the scope of the examination. Of course, time budgets are estimates, and during the course of examinations there can be unforeseen delays. As mentioned previously, the data sampled may contain —bad" data and cause samples to be re-run, or requested information and documents provided by the company may be delayed or incomplete, etc. Update the time budget as needed with input from the examination team as to whether the completion dates for each assignment, as well as the exit date of the examination, remain realistic.

- Involve the examination team in identifying the need for changes in the examination scope, audit plan, or examination schedule.

  A variety of events may occur and cause the scope of the examination to change. For example:

  - Class action lawsuits
  - An unusually large complaint volume
  - The introduction of new product lines as well as other circumstances.

  It is important for all members of the examination team to be aware of any changes, to express their opinions concerning the impact those changes have on the time-line, and to implement any modifications necessary to complete the examination.

- Keep the examination team posted on examination findings.

  Throughout the examination phases, it is important to share the audit findings with the examination team in order to identify key issues. Often, the same issues occur on other examinations and discussing the findings can provide an element of learning. Further, from time to time, one examiner may find exceptions not noticed by others. While this might result in the need to review certain files again, such a re-audit may give a more complete picture of a company‘s practices and reveal the true extent of deviations from, or compliance with, statutes and regulations.

- Include the examination team in discussions with company representatives and the contact person and in interviews of company representatives, where appropriate.

  It is appropriate to include other members of the examination team in discussions with company representatives. The more exposure team members experience in handling examination discussions, the more learning and growth occurs for examiners who will become EICs in the future. In addition, it is recommended that examiners be included in discussions with company representatives to ensure that there is no misunderstanding between the examiners and company personnel relating to examination issues. In some cases the presence of additional ~~"~~witnesses" to certain discussions may be helpful.

Conclusion

Via constructive criticism, professional development and growth opportunities, time budgets, clear strategies, teamwork, and communication, an EIC can manage an examination staff effectively and efficiently.

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Chapter 14
- Standardized Data Request (SDR)[1]

Educational Objective

This chapter outlines a process to request data from a company in a manner and format that is efficient and effective for market conduct examinations.

The Standardized Data Request (SDR) – What Is It and How Does It Work?

The Standardized Data Request (SDR) is a uniform list of data fields that should be used by an examiner to request electronic data files during an examination of an insurance company. It was originally designed by the NAIC Uniformity Working Group in its charge to make market conduct examinations more uniform from state to state. It has been incorporated into the *Market Regulation Handbook* and, as part of that handbook, is periodically updated and expanded. In its most simplistic format, it tells the insurance company what information the examiner may want to see and the format in which he wants to see it.

During every examination an examiner asks for information to enable the examination team to perform its review. In our current age of technology, insurance companies keep a large majority of their information in some electronic format. With rising storage costs, even paper files are being converted to digital files that can easily be printed or restored when needed but take up less room while being stored. As a result the examiner cannot efficiently and effectively perform his function without asking for and receiving some of that information electronically. The SDR was designed with that efficiency and effectiveness in mind.

History

Standardization and Uniformity

One criticism that was vocalized about state regulation was that examination techniques were duplicative but not uniform from state to state. The Uniformity Working Group's charge was to develop a standardized format that could be used uniformly from state to state. The SDR is built around the knowledge that most companies store essentially the same information electronically and the hope that the information stored is what the examiner wants and needs. This combination of knowledge and hope is why the SDR is sometimes described as a —wish list" of fields that the examiner believes the company maintains and could be asked for during an examination.

Development

In the initial development each state was encouraged to supply the data requests that were currently being used. When these requests were combined, it was determined that there already was some uniformity in place. The states were asking for basically the same information; however, there was some variation in the requested format. Because of this variation, it was decided to use the current format (explained later in this chapter).

Guidelines

As with any tool, it is important to understand the premise upon which it was developed as well as any limitations that may be involved when using the tool. When working with the master SDRs, it is important for the examiner to keep the following in mind:

- In constructing a data request based on a master SDR, include certain standard pieces of information, such as the field name, the field structure format, and a short explanation of what the field should contain. To ensure maximum uniformity in the interpretation by each state and the insurance company, whenever possible, utilize the names and field descriptions contained in the master SDRs.
- The SDR was designed to provide an examiner with information that is normally kept in an electronic format by the insurance company. It is meant to enhance, not replace, the actual review of files. Do not expect or request fields such as underwriter or claims-adjuster notes as a part of the data request.
- The master SDRs are lists of all possible fields, broken down by area of review, that an examiner may require during an examination. Whereas all of the fields contained in an SDR need not be included in a request for data, an SDR may not contain all of the fields necessary for an examination whose scope includes a review of state specific laws or mandates.
- No two examinations are identical. Because situations differ from examination to examination, the examiner has the right to request data fields that are not contained in the master SDRs. When it is necessary to add one or more such fields to the data request, notify the company of the new field(s), explain the reasons the additional information is needed, and provide extra time for the company to produce the data file.
- Companies are not required to capture data electronically for every field contained in the master SDRs. However, they should be able to provide alternative methods for examiners to collect the information if the scope of the examination requires such information to be collected.

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- In constructing a data request for a specific examination, include only those fields from the master SDR that are required for the specific area being reviewed based on the scope and goals of the examination. Including only those fields necessary to validate the data and achieve the examination goals should allow the company to produce the data file more quickly.

  For example, an examiner who is reviewing homeowner claims will pick the fields from the master list that provides the information for a list of homeowner claims processed during the examination period. This smaller, specific list will likely not include underwriting fields since they have nothing to do with claims.

- Decide, prior to developing specific requests, whether the requests will be used for sampling or specific 100% compliance testing. When the main function of the data is to provide an accurate population from which to draw a sample, limit the number of fields included in the request to those required to verify the validity and integrity of the data and to those that the company requires to identify the file for review. Other information can be captured during the actual file review. If the data will be used for 100% compliance testing in addition to pulling a sample, the examiner must also include those fields necessary to perform the compliance testing.

  Claim file testing is a good example of compliance testing where a sample is pulled and other information is captured during the file review. One hundred percent compliance testing is normally used for areas where all of the information needed is captured in the company‘s computer systems. Producer licensing and appointments are good examples of 100% compliance testing.

- The structure of mainframe and database computer files must be considered. Since storage space and the size of computer files are factors that are considered during the development of any computer system, most computer files use codes to minimize the space required. Companies can still provide their information using their coding systems as long as they completely and thoroughly explain the codes.

- Include fields in each request to help determine whether or not the company provides a complete and accurate population of the area in question. This can be the biggest obstacle in a market conduct examination, since there really is no hard and fast way to be sure that the file is accurate. Inclusion of such fields as the NAIC code, state, effective dates, and claim payment dates can help the examiner feel comfortable with the file, and the recently developed Market Conduct Annual Statement can be used to confirm completeness of the data files.

Current Data Requests

SDR Categories

The intent of the SDR is as follows:

> To provide a list of individual fields that an examiner can pick and choose from to make a data request that fits the company and areas under review but still maintain a process of requesting data that is uniform from state to state.

As a result separate master lists, or data requests, can be made for each type of insurance. Then, from that master list data request, sample requests can be developed for the more specific areas – like automobile cancellations or homeowner paid claims. If a state chooses to deviate from the standardized format, it is generally expected that the affected company will be allowed additional time to respond. Standardized Data Requests can be found on the publicly available NAIC website (using the ID and password provided at the front of the *Market Regulation Handbook*) and within I-SITE/StateNet. The major categories are as follows:

- Producer, Commission, and Complaint Data Request
- Property & Casualty Personal Lines Data Request
- Life Insurance Data Request
- Annuity & Deposit Type Contract Funds Data Request
- Property & Casualty Commercial Standard Data Request
- Health Data Request (Including Long Term Care and Medicare Supplement).

To help the examiner get started and to give him an idea of how to use the master list, each SDR contains sample data requests that can be used for a particular area under review. These sample data requests contain descriptions of what kind of information should be included in the file and how the file can be used.

Producer, Commission, and Complaint Data Request

The Producer, Commission, and Complaint Data Request contains the fields that are used to review areas that are common to all types of insurance companies. The master list contains information on advertising, producer licensing, appointments and commissions, and complaints. There are also sample requests for these areas.

Property & Casualty (P&C) Personal Lines Data Request

The Property & Casualty (P&C) Personal Lines Data Request contains the fields that are used to examine the private passenger automobile and

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homeowners lines of business of a typical property & casualty carrier. There are sample requests for claims paid, claims closed without payment, cancellations and non-renewals, new business, surcharges, and subrogations.

Life Insurance Data Request

The Life Insurance Data Request contains the fields that are used for ordinary, group, industrial, and credit life insurance. There are sample requests for new, in-force, and terminated business and for declinations, claims, replacements, policy loans, etc.

Annuity & Deposit Type Contract Funds Data Request

The Annuity and Deposit Type Contract Funds Data Request contains the fields that are used for annuity considerations and deposit type contracts. These fields were separated from the life insurance data request because the terminology is slightly different. The sample requests are similar to those used for life insurance.

Property & Casualty (P&C) Commercial Standard Data Request

The Property & Casualty (P&C) Commercial Standard Data Request contains the fields that are used for all P&C lines of business except private passenger automobile and homeowners. The sample data requests are primarily based on the type of coverage; for example, Workers' Compensation, Business Owners, and Commercial General Liability.

Health Data Request

The Health Data Request contains the fields that are used for a health request. Since the typical health examination revolves around claim payment practices, the emphasis here is also on claims. The terminology from company to company varies greatly for this line of business. Therefore, special attention needs to be given to ensure that the company understands the request. There are other sample requests available that cover the typical areas of an examination – like new business and cancellations. Samples are also given for Medicare and Long Term Care.

Using the SDR

Once an insurance company is selected for an examination, the examiner needs to start making decisions before any data files can be requested. Taking the scope and goals of the examination into consideration, answering the following questions can help determine which SDR should be used and which fields to include in the data call itself:

1. Which line or lines of business are being examined? Which areas are going to be reviewed? Will it be a comprehensive examination that covers all aspects of the company‘s operation, or will it be targeted to one or two specific areas? The examiner needs the data requests that cover these areas.

2. What time period will the examination cover? Will it cover a month, a quarter, a year, or more? Some important factors to consider when determining examination periods are as follows:

   - The ease with which the company can participate
   - The availability of comparable information
   - The number of records to be reviewed.

   Calendar-year or quarter-ending examinations may be easier for the company to accommodate because they match the company‘s fiscal reporting. Calendar-year time periods benefit the examiners by enabling them to use the State Pages from the financial statements to verify the accuracy and completeness testing of the file. For a health claims examination, the number of records is considerably larger than for any other type of examination. Therefore, for this type of examination, periods of a month or a quarter are usually better and more manageable.

3. What standards and tests from the NAIC‘s *Market Regulation Handbook* will be used? Are there any state specific standards or tests that must be used? These standards detail the kind of information that needs to be requested. Automation examples that can be helpful are also provided in the Handbook.

4. What are the applicable rules and statutes? Although the NAIC‘s *Market Regulation Handbook* is very useful and contains a wealth of information, the bottom line is that the examination is normally a test of the company‘s compliance with the specific examining state‘s applicable rules and statutes. To develop a data request, examiners need to know and understand the rules and statutes against which they are testing and to keep their requirements in mind when deciding which fields to request. For example, if a rule states that a notice must be mailed within 15 days of a cancellation's effective date, the data request should ask for the mailed date and the cancellation effective date. Also, consideration needs to be given to whether the examination involves a single state or multiple states. Since states‘ laws can differ, the data request needs to be written to incorporate all of the states but with some common ground in the information requested.

5. For what kind of file is the examiner looking? The data request should be specific to the area of review and to the applicable law. For

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example, if the examiner is reviewing the activities at the point of sale, the data request should be tailored around applications taken, not policies issued. Then all of the sales activities would be reviewed, not just the ones where an actual policy was issued. It would include the issued, declined, and withdrawn policies. This gives a better population for what is being tested.

6. What fields are needed to establish populations? Will the file be used for sampling or 100% census testing? Deciding what to include and what not to include is sometimes the hardest part of designing a data request. The natural inclination is to ask for every field possible because it might open the door to more compliance problems. However, sometimes asking for more information does nothing more than cause confusion and increase the amount of time it takes for the company to produce the data file and for the examiner to analyze the data. The examiner needs to decide up front whether he will be performing a 100% test, which can be used for producer licensing reviews, or pulling a sample, which is normally used in the review of paid claims. This decision then dictates which fields need to be included.

   Census (or 100%) tests need to include the exact information used in the test. For example, the fields needed in the producer licensing test include the producer‘s name, social security number, and licensing date. Then, the supplied information can be directly compared to the Department‘s producer records.

   If a sample is going to be pulled, the examiner needs the fields that define the population. For example, if the examiner is reviewing all paid claims, the request should include the claim number and paid date. However, if the examiner is looking to break the review down into sub-populations – like first-party-paid private passenger automobile claims and third-party-paid private passenger automobile claims – the request also needs to include the claim feature code to enable the examiner to separate the file into the different populations.

   The fields commonly used to determine populations include the policy number, claim number, effective date, state, plan code, feature code, and reason code.

7. Which fields will be nice to have but not completely necessary? When developing a data request, the examiner needs to be flexible. He needs to have a clear understanding of which fields must be provided and which fields would help narrow down the population or review of the file but are not required. For example, having the insured name or a list of riders on a policy is helpful, but the absence of these fields will probably not cause a problem.

8. Will the file be cross-referenced or joined with another file? Some tests require information from a number of different systems or files. To be able to join or cross-reference the files, there needs to be at least one common, unique field in each file. This field is the one used to link the different sets of information together. The examiner needs to plan the test prior to developing the data request so that the necessary fields are included.

9. What steps are necessary to organize the request?

    a. Tailor the request to the specific company and use separate requests for each of the areas under review. The areas under review are usually broken out by the structure of the company‘s computer systems. For example, most life companies have a new business system that maintains information that is not uploaded into the in-force system. A new business data request would be used to capture this information that is specific to new business.

    b. Provide specific instructions or parameters for each file requested. For example, include at the top of each file requested, the state and examination period. This may seem obvious to an examiner, but the computer programmer that receives the request may have no idea which state made the request or the time period under review, especially if the cover letter has been lost. Also, when requesting paid claim data, provide the specific definition of paid claims and whether or not the amounts applied to deductibles are considered under amounts paid.

    c. Understand the layout of the data request and how the format works. The SDR was designed to mimic typical computer file definitions. For each field the request contains an eight-character, or fewer, field name, the expected length of the field, the type – whether it is alphanumeric (contains both letters and numbers) or numeric, and a short description of what the field should contain.

    d. Include a cover letter (see below) that provides instructions relevant to the entire data request and examination in general. Important items to incorporate into the cover letter include the name of the company or companies, the examination period, applicable state or states, format for the data submission, contact person at the Department, due dates for the data files, instructions on how to submit the data files, and, most importantly, a request for a conference call to review the request with the company.

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10. What safeguards can be used to make sure that the information is complete and accurate? Completeness testing for market conduct examinations is not as easy as it is for financial examinations. The examiner normally tries to compare results to the Financial State Pages, but the State Pages are not audited, so the test is spotty at best. Other fields must be placed into the data request to help the examiner feel comfortable that the file is accurate and complete. These fields include the NAIC code, state, and policy effective or inception date. A review of the information in these fields gives the examiner a better comfort level on the accuracy and completeness of the file. However, the best safeguard to make sure that the information is accurate and complete is to maintain constant contact with the systems person making the file.

Have a conference call with the systems and compliance personnel. Review each data request, field by field, so that all parties understand exactly what information is being requested and in what format. If the company cannot provide particular fields, work out an acceptable alternative that is feasible for both the examiners and the company. Follow up, in writing, to confirm any changes to the data request that were agreed to during the conference call. This open communication will produce the best computer files on which the examiner can base the examination.

Format

Cover Letter

In the cover letter include the name of the company, NAIC number, and general parameters for the data files – such as the state, examination period, and acceptable format for sending the files. The following page displays an example of a typical cover letter.

HOMEOWNERS DATA REQUEST FOR:

An Insurance Company NAIC #00000

The examination period will be from **January 1, 2006 through December 31, 2006** and will cover for the state of **(your state)**, all activities described in the following pages. The files will be used on an IBM compatible personal computer, so please provide the information on CD-ROM or via e-mail to the address shown below. If the files are too big to fit individually on the media, please use one of the following backup methods: PKZIP or WINZIP. If sending via e-mail, do not send self-extracting archives or any other -executable" file format.

The files should contain fixed length records using the layouts shown on the following sheets. File format requested, in the order of preference, is dBase, an ASCII flat fixed length, text-delimited file, or Microsoft Access. If the company's field lengths are different from those suggested in the file layouts, please adjust field lengths and include revised layouts with each file. Be sure to include code lists for any fields in which codes are provided.

Please send each file, as it is available. Do not wait until all files are complete.

Send to:
Jane Doe, Data Specialist
Market Regulation Division
A Department of Insurance
100 Main Street
Hometown, STATE 12345
(555) 555-0000 Voice

Once your staff has had the opportunity to review the data request, please contact me to schedule a meeting prior to the preparation of the data files. The purpose of this meeting is to address any questions regarding the information being requested, the file formats, or any other issues relative to the data.

All files are due by Friday, February 16, 2007.

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File Request Explanation

At the top of each file request, explain the purpose of the request and provide instructions addressing what should or should not be included in the file. Repeat the name of the state and the examination period. The following is an example of an explanation that can be given at the top of a cancellations file request:

Cancellations – Homeowners

Please provide a list of all policies in force in **(your state)** and subsequently canceled by your company during the examination period, **January 1, 2006 to December 31, 2006**.

- Include cancellations requested by the insured.
- Exclude cancellations executed by premium finance companies.
- Exclude farmowner policies.
- The reason code field (ReasCode) should provide explanation as to whether the cancellation was initiated at the request of the insured or the company and if it was for nonpayment of premium, cancel, rewrite, cause, etc.

File Layout

Although it is probably easier just to give the company a list of fields, it is better to supply an actual breakdown of what the file is to look like. This helps the company to write the programs to pull the information from its systems, but it also helps the examiner when the file arrives. By providing the company the name of each field, where it starts in the record, how to format it, and an explanation of what the field is, the examiner is likely to receive the file in the format he wants. Moreover, if the examiner has requested this type of file from other companies, any programming or data manipulation that is routinely performed on files can be copied and re-used with little effort. Nevertheless, companies are encouraged to make adjustments, if need be, as long as they provide revised layouts and explanations for the variance. Even if they do make changes, the present format will make it easier for the examiner to follow.

In constructing the body of a data request, include the following items:

1. Field Name – the name of the field being requested.

   Each field must have a unique name. Field names in the master SDRs are limited to eight characters because some computer programs cannot handle field names over eight characters. If it is necessary to

add new fields to the data request, it is recommended that the field name be limited to eight characters.

2. Start Position – the position in a series of characters where the information for that field starts.

   The starting position for the first field is always 1. The starting position for subsequent fields is the prior field‘s starting position plus its length.

3. Length – the length of the field.

   This is important because the information in some fields varies from record to record. For some formats, such as ASCII, the company needs to make the field length standard from record to record so that the examiner can divide the record into its applicable fields. Other formats – like those used by Microsoft Excel or Microsoft Access or characterized by comma delimiters – already divide the fields so that the user knows where each field starts and ends.

4. Type – the format of the data in the field.

   This indicates whether the field is a text field or a numeric field. The two main types are text, or alphanumeric, fields and numeric fields. Alphanumeric fields may contain any type of character (alpha or numeric). They may not however, contain characters that are used to delineate fields within the data file. Numeric fields may contain only numeric characters; i.e., numbers. As a general rule of thumb, it is best to make all fields alphanumeric fields unless the field must be used to do some sort of mathematical calculation. This is particularly important when the field may contain leading zeros, such as policy numbers, zip codes, and/or social security numbers (SSN).

   For example, if a field containing a SSN is formatted as numeric rather than alphanumeric, any leading zeros in the SSN are dropped from the field. If an examiner is trying to compare producer licensing data from the company with the insurance department‘s data using the SSN, improperly formatted fields will cause invalid results. The invalid result comes about because a SSN starting with 007 in the improperly formatted company data becomes a 7 and will not match up with the properly formatted SSN, 007, in the insurance department data.

5. Decimals – the number of places that should be placed to the right of the decimal.

   This applies only to non-date, numeric fields. It is important to specify the number of places after the decimal point to ensure that the company and the examiners are interpreting the data in the same manner.

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For example, some systems report $100 as 100, and others report it as 100.00. Others include decimal places if the amount contains cents and do not contain them if it is a whole dollar amount. Inaccuracies in calculations and reporting appear if this field is incorrectly populated.

6. Description – a short explanation of what the field should contain.

   Since space is limited and this is only a brief description of what the field should contain, the examiner should always verbally review these with company personnel. The description may also provide some additional instructions to the company on how to format the data properly for the field and/or request additional information related to the field. For example, the field description may request that key codes be provided along with the data request or provide information on the types of codes that should be used in the file or on how to format dates.

The most convenient way to present the data call itself is in a table. The following is a typical file layout. Include this note with it:

> Use the following format (If your company's field lengths are different from those suggested in the file layouts, send in revised layouts with the files.):

Field Name	Start	Length	Type	Decimals	Description
CoCode	1	5	A	0	NAIC company code
PolPrefx	6	4	A	0	Policy Prefix (if applicable)
PolNo	10	9	A	0	Policy Number
PolType	19	5	A	0	Type of policy (standard, preferred, etc.)
InsLast	24	25	A	0	Insured last name
InsFirst	49	25	A	0	Insured first name
IncpDt	74	8	N	0	Original policy inception date (CCYYMMDD)
CnDt	82	8	N	0	Cancellation or Nonrenewal effective date (CCYYMMDD)
NotDt	90	8	N	0	Date Cancellation or nonrenewal notice mailed (CCYYMMDD)
AgtCode	98	10	A	0	Agent/Producer company code number
RfndDt	108	8	N	0	Date premium refund mailed (CCYYMMDD)
ReasCode	116	20	A	0	Reason for the cancellation (provide list of reason codes)
EndRec	136	1	A	0	End of record marker. Please place an asterisk in this field to indicate the end of the record. This must be in the same character position for every record in this table.

Conclusion

Use of an SDR will help both the examiners and the company start from the same page literally and figuratively.

Alterations for specific cases can always be made. What is important is to have a common framework from which to start to try to make the market conduct examination process as efficient and effective as possible.

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Endnotes

[1] National Association of Insurance Commissioners, ‗Standardized Data Call Lists – Chapter 13‘, *Market Regulation Handbook, Volume 1*, (2007), Pages 171-176.

Chapter 15
- Actual Data Files[1]

Educational Objective

This chapter offers suggestions on how an examiner can verify that the data received from a company accurately reflects the parameters and scope asked for by the examiners.

Receiving the Requested Files

Even with detailed explanations and instructions, examination data files are rarely received without some small quirk or unexpected issue. A number of reasons come to mind as to why the files might not arrive exactly as requested, but the basic truth is that companies differ from each other, and their computer systems vary as well. Then there are those requests for data that are just not formulated very well.

Even though most market conduct examiners, whether state employees or independent contractors, follow the basic principles outlined in the *NAIC Market Regulation Handbook* during an examination, the formats of the final reports are seldom the same – not better or worse, just different. The same goes for insurance companies‘ computer systems and computer systems personnel. Because of these differences, and the requirement to use the Standardized Data Request (SDR), which is generic for all companies, each company might interpret the requests a little differently. There are, however, a few ways to anticipate, work around, and handle these potential differences.

Transferring the Files

Files can be sent to the examiners in a number of ways: writeable CDs, diskettes, e-mail attachments, and via protected Internet FTP (File Transfer Protocol) sites. Protected FTP sites are the best for security purposes, because passwords are needed for access, but the examiner needs to have high speed Internet access for this to work well. The same is true for e-mail attachments because some files can be too large to download. Some factors to consider:

- Typical file compression programs, like WinZip, can be valuable in reducing the size of files.
- Most e-mail systems have size limitations. In addition, e-mail is not a secure method of transmission.
- Virus protection and e-mail programs block out certain types of files because of their ability to contain executable program code that can

infect a system. In particular, Microsoft Access databases cannot be sent through some e-mail systems. To work around this, the Access file extension, —.mdb", needs to be changed prior to sending the file and changed back once the file is received. A good technique is to rename the file and change the last character to an underscore (e.g. Filename.md_).

- Most insurance companies and insurance departments have access to FTP sites that can be used. Talk to the computer systems personnel for access.

No matter what method is used to receive the data files, the examiner should create copies of each data file and store them on his computer in a folder dedicated to the specific examination. The original files should remain intact and be stored with the examination workpapers. Working with a copy of the file ensures that in the event the working copy of the data file becomes corrupt, it will not be necessary to request a replacement file from the company.

File Formats

Every computer user has a favorite piece of software: Microsoft Excel, Microsoft Access, ACL, etc. Today's software can handle more types of files than its predecessors, so computer files can be sent in basically any format and can still be imported into the examiner's favorite software. There are, however, some idiosyncrasies inherent in some file formats and software, as well, that are worth noting:

- ASCII text format is usable, but it requires attention to details not required with other formats. There are normally no headings, and the examiner must provide the field boundaries of the data to the software. He must also provide the format of the data in each of the fields; i.e., whether the data represents text, numbers, or dates. Records need to be fixed length, and detailed file layouts must be followed.
- ASCII comma-delimited format is better because the field boundaries are provided within the file by some type of character, normally a comma. The important thing to remember with this type of format is that sometimes it cannot be imported accurately because of how the file was originally produced. For example, quotation marks might enclose each field, or commas from the source data might erroneously find their way into the file. Unless the insurance company's computer person carefully reviews the file prior to sending it to the examiner, these data shortcomings may go unnoticed. Since some software assumes that anything within quotation marks is a field full of text, not a number or a date, problems will arise. The examiner may not be aware of such problems until some sort, calculation, or other function fails to work properly.

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- Microsoft Excel and Microsoft Access work well, too, although caution should be used when Microsoft Excel is asked to process data files that contain date fields since sometimes Excel does not accurately show data in fields that are formatted as dates. In addition, earlier versions of Microsoft Excel have a maximum record count of 65,536 records (rows) and a maximum field count (column) of 256 fields per worksheet. While Microsoft Office Excel 2007 alleviates potential issues with these prior limitations, limitations still exist as the maximum record (row) and field (column) counts in Office Excel 2007 are 1,048,576 and 16,384, respectively. As such, Microsoft is not conducive for populations, such as paid health claims, that could easily exceed this record count.
- As mentioned previously, the primary issue with Microsoft Access occurs when the file is being sent through e-mail due to virus concerns, and Access file sizes tend to be large. Otherwise, the program works great. Access tables can easily be linked to ACL. A minor issue to consider is that if the file is very large, the speed at which the program processes can be slow.
- Most mainframe systems can export in the dBase format, and PC software packages can usually import dBase formatted files. Another advantage of dBase files is that the data is already parsed into columns with formats and column headings. There is virtually no time spent ―formatting" the file for the examiner's use. However, when reading dBase files, some software programs have problems with the file if a field or column heading is longer than eight characters. This is why the Standardized Data Request (SDR) limits field names to eight characters. Also, dBase field names must not begin with a number or any character that is not a letter.

File Names

Computer programs recognize the format of a file by the part of the file name that follows the period, the file extension. Occasionally, the extension accidentally gets changed by an inexperienced user. When this happens, programs are unable to process the file. Once discovered, however, the extension can easily be changed to the appropriate one.

Another problem with file names occasionally appears after a file is saved to a hard drive or network drive. When a computer program is trying to open a particular file, it takes a name comprised of the drive, directory, and any sub-directory as the file name. It is rare, but sometimes the program reports an error and says it cannot find the file even though the file is clearly there. Often, the problem is that the complete name, including the drive, directory, sub-directory, and actual file name, is more than 256 characters long. Since these programs were originally developed when the 256-character limit was

important, the limit is still in use today. The fix is simply to move the file to a location where the name is not so long and/or shorten the document name.

Sorting

In the past some states used data requests that instructed the insurance company to put the computer file records in a particular order, such as by policy number or claim number. With the current software used by examiners, it is no longer a problem if the company does not sort the records in the order requested. Any software package can sort the records in any order that the examiners need or want. The wrong sort order is no longer a reason to request that the file be re-run by the company.

Unexplained Codes

The Standardized Data Request (SDR) tries to take into consideration common areas where it is known that internal codes are used by an insurance company to save space in its computer files. It is quite possible for the company also to have other fields of information represented by codes instead of the actual information. If a file is returned with this type of coding, it does not mean that the file is not in the format requested. It just means that the company must supply the examiner with the explanations for the codes. If a large number of codes are possible, the company should supply a computer file listing the code and the explanation for each code. This enables the examiner to cross reference the two files when needed.

Confirming Data File Accuracy

Available Sources

Data file requests for market conduct examinations are different from data file requests for financial examinations in one major way: While financial examinations have accounting records and Financial Annual Statements to which to balance and reconcile, the market conduct examination files do not. Financial examinations almost always correspond to an examination period that was already covered by either a quarterly or year-end Financial Annual Statement. Market conduct examinations usually are calendar year based but not always, and they are normally just for the state performing the examination. At best, there are a few sources that can give the examiner confidence that the market conduct file is complete and accurate. Therefore, the examiner should not expect the information to tie directly number for number. Consideration does need to be given also to the differences that can occur when the examination period is different from the time period of the source used for comparison. Following are some sources and examples:

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Financial Year-End Annual Statements

The State Pages of the year-end Financial Annual Statement can be used for comparison in some instances, but the examiner needs to remember not to expect an exact match or confirmation. State Pages are not normally audited during a financial examination, so their accuracy is not confirmed. Because most companies close their calendar-year books prior to December 31, there might be a slight difference between the numbers in the State Page and the data files that are produced for a market conduct examination that covers through December 31. The examiner could accept the data file amounts as complete and accurate if they are reasonably close to those in the State Page and if this comparison technique is used in combination with other confirmation methods. Otherwise, reconciliation back to a verifiable source should be pursued.

Market Conduct Annual Statement

For the 2009 data year, 29 states will be participating in the NAIC‘s program that requires Property & Casualty and Life & Annuity companies to report specific information on their consumer activities in these states. These filings can be used to determine if the information received for an examination is accurate. In fact, of all of the available sources, the Market Conduct Annual Statement is probably the best available. It includes totals for information that is normally requested during market conduct examinations: claims closed with payment, claims closed without payment, policies in-force, life insurance replacements issued, and policies surrendered, to name a few.

Consumer Complaints

When examiners request a list of consumer complaints from a company, they usually ask that the list include complaints received directly from the consumer and those forwarded from the Department. Those marked as being forwarded from the Department can be confirmed with the Department's Consumer Services Division.

The Department's Form Filings Division

The Department's Form Filings Division can be used to produce a list of the types of policies that were filed. This list should correspond to the policy forms that are represented in the data files provided. Also, other policy information, like territory definitions, can be found in the Form Filings Division and compared to the data files provided.

Market Analysis or Surveillance Information

A number of states have other data calls or reporting requirements that can be used to determine whether the data files provided for an examination are reasonable.

Data Integrity

After the examiner receives the file, imports it into the software program being used, and is confident with the completeness of the file, he needs to look at the details in the file to ensure the accuracy of the data as well.

Examination Parameters

Each data request submitted by an examiner details the examination parameters, but sometimes this does not get communicated accurately to the company's computer personnel. Consequently, the files should first be reviewed for the following general integrity issues:

- Are the relevant dates included in the data within the examination time period?
- Are the claim payment amounts reasonable?
- Was the activity reported only for the state conducting the examination?
- Do the files cover only the lines of business requested?
- Do the files contain information for just the company or companies requested?

Validity Testing

To verify that the examination parameters were followed for the data request, the examiner should run the following validity testing on the data in the files:

Parameter Tests

Using ACL, or whichever software package is available, determine the maximums and minimums for particular fields. This technique works especially well for number fields and date fields. For example, the examiner can assume that the date fields are accurate if the earliest and the latest claim paid dates are close to the beginning and ending dates of the examination period and that the others appear to cover all time frames in between.

Counts

Counting or summing the number of occurrences of particular data elements can give the examiner an indication of whether certain expected information is missing. For example, if during a count of cancellation reasons, there appears to be very few or no cancellations due to non-payment of premium, the examiner should question whether the file is complete since this is normally the number-one reason that a policy is canceled.

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Reasonableness Tests

Of all of the validity tests, this one relies more on the examiner‘s knowledge of the insurance business, rather than on his computer abilities. The examiner should review the information in each field and look for what is missing based on his knowledge of what should be there.

Comparison Testing

This test includes comparing the information in one field with the information in another to determine if the file is accurate. For example, parameter tests can be run separately on the date of loss field and on the claim payment date field to verify that both fields contain dates that are within the examination parameters. Next, the two fields can be compared with each other to ensure that the date of loss is prior to the claim payment date for each record.

Data Cross-referencing

Some validity testing can be performed only by comparing the information from one file to the information in another file or source of information. There are a number of areas where cross-referencing can show that a file that is thought to be accurate actually is not. Since cross-referencing can also uncover compliance issues, this is one area where the examiner should ask numerous questions when discrepancies are found. The following are some examples of cross-referencing:

Producer Licensing

There are three ways to determine if the producer licensing information is accurate and complete:

- Cross-referencing the company‘s producer licensing information to its commission payments
- Cross-referencing the company‘s producer licensing information to the new business information
- Cross-referencing the company‘s producer licensing and commission payment information to the Department's producer licensing and appointment information (where applicable).

Life Insurance Replacements

A company‘s replacement register can be compared to the new business file. A large number of discrepancies can show that either the files are bad or the company has a problem with monitoring its producers' replacement activity.

New Business Activity

New business files can be compared to an in-force business file to determine whether those records listed as new business are included in both files.

Paper Confirmation

After all of the electronic validity tests are performed and the examiner is comfortable that the data files are probably accurate and complete, the final determination is made when the actual paper file review is performed during the examination. This is when the examiner knows for sure that the data file provided is actually accurate because the data can be compared to the information kept in the claim or underwriting file.

It is quite common for an examiner to be on-site, review files, and realize that the data provided weeks before was not accurate and/or complete. Sometimes this cannot be avoided. Once the problem is discovered, the examiner should meet with the company to determine if there is a way to work around the problem or if the file needs to be replaced.

Today many companies no longer have —paper files". Some companies image everything that is sent to them. In these cases —paper confirmation" takes on a whole different look, one of confirmation by computer. However, if the company truly imaged the paper documents, allowing examiner access to the company's image system enables the examiners to verify that the information on the image document was captured correctly on the company's computer system and is accurately reflected in the data provided to the examiners.

Conclusion

By using the above verification methods, examiners can more efficiently and effectively work with companies to reduce the number of file and data technical misunderstandings common to market conduct examinations.

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Endnotes

[1] National Association of Insurance Commissioners, Automated Examinations Tools and Techniques' – Chapter 11, *Market Regulation Handbook, Volume 1*, (2006), Pages 123-130.

Chapter 16
- Examination Management for Company Coordinators

Overview of the Market Conduct Examination Process

In conjunction with their oversight role in regulatory and ethical matters, many insurers draw from their compliance or legal departments to designate the central coordinator for market conduct examinations and inquiries.

After initial notification by a state, the coordinator contacts the affected business units to communicate the scope and present the data requests for the examination. In addition, the coordinator assists in the preparation of any site and accommodation requests and acts as the examiners‘ liaison to the company.

During a market conduct examination, one or several business areas within the company may be affected. The coordinator assembles a team of contacts from these areas to respond to data and file requests as well as to any questions presented by the examiners during their review. Responses to data and file requests and questions are channeled through the coordinator to assure consistency and timeliness. This process works especially well on comprehensive market conduct examinations involving several business units. Rather than dealing directly with multiple business units, the examination team deals directly with one central contact.

Another responsibility of the coordinator is to mediate difficult issues that may arise during the course of an examination. This can help minimize potential misunderstandings and miscommunication.

Upon completion of the examination, the coordinator reviews the report issued by the state and works with the respective department contacts to prepare a response.

Once the report and response is finalized, the coordinator works with the examined areas to assure that any findings or opportunities for improvement are addressed and specific action plans are developed.

There is generally an opportunity to request an administrative review if the company disagrees with any of the examination report findings and cannot seem to come to some sort of agreement with the examining body.

Pre-Examination Phase

Initial Notification

The market conduct examination process typically begins with a letter from the respective regulatory authority. Generally, notification is initially sent to the attention of the company president and is subsequently forwarded to the coordinator. Most states attempt to provide a minimum of 60 days notification before commencing an examination.

The examination letter generally contains the following information:

- Specific statutory authority under which the examination is being undertaken
- The type of examination being conducted
- The anticipated on-site examination start date
- The time frame covered by the examination
- A request for the designation of a corporate contact
- Department and/or examination team contact information
- A checklist of equipment, facilities, and information needed to conduct the examination.

This information typically corresponds to the information set forth in the NAIC guidelines contained within the Market Regulation Handbook. As such, frequently the notification is brief, and most of essential specifics related to the examination are contained within an examination coordinator‘s handbook that accompanies or follows the notification correspondence. The coordinator‘s handbook typically contains the following information:

- An overview of the entire examination process
- Examination fee and expense schedules
- Specific materials, interrogatories, and electronic data requests related to the various operational areas to be reviewed within the scope of the examination
- Recommended file layouts corresponding to electronic data requests
- A due date for the requested information.

Initial Coordination – Contacts and Requested Information

Upon receipt of market conduct examination notification and examination materials, the coordinator should review the documents to determine what type of initial response, if any, needs to be provided to the examining authority and whether there is a due date for such response. States typically require an examined insurer to submit contact information within a specified

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time frame following receipt of the notification. In addition, the state may require that the insurer provide general materials, such as advertising materials and statistical information, relevant to corporate operating results covering the examination time frame.

The coordinator should provide immediate notification to the operational areas that will need to provide information relating to the examination in order to (1) provide the time needed to gather the information needed to comply with examination requests and (2) determine what resources can be dedicated for the examination. The coordinator should also be available to respond to questions from the affected areas that will need to be forwarded to the regulatory agency for clarification.

One good way in which a company can prepare for an examination is to gather representatives of the areas to be examined to review the examination materials. In this forum, all roles, responsibilities, and expectations can be defined. In addition, the coordinator should use this forum to reiterate that all questions to be asked of the examiner need to be directed through the coordinator. The coordinator will then determine the best manner in which to obtain clarification for any questions raised and proceed accordingly. There may be times when the best course of action is for the coordinator to establish a forum of open communication between members of the company examination team and the regulatory examination team in order to assure complete understanding or agreement.

Upon receipt of requested documents and examination materials, the examination coordinator needs to review them to assure that they address the examiners‘ requests and then deliver such documents prior to any established deadline.

Initial Coordination – Facilities and Equipment Needs

Once the examination coordinator has completed the initial analysis and appropriate notifications have been made, the coordinator should commence working on logistical issues regarding the exam. The coordinator must obtain answers to the following questions:

- At what corporate facility or facilities will the examination be conducted?
- What are the physical workspace needs of the examination team?
- What access will the examiners need to corporate information processing systems?
- What are the communication needs of the examination team?
- What equipment needs will the examination team have?

Examination location is largely dependent upon the type of examination and the state conducting the examination. Comprehensive and targeted

examinations generally need to be conducted at a company location which houses the underwriting, servicing, and claim handling functions responsible for the state conducting the examination. There may be times when an examination results in the use of multiple corporate facilities in different states.

The role of the examination coordinator may change depending on the examination location. If the examination is conducted at the coordinator‘s location, the coordinator serves as the primary on-site contact for the duration of the examination process.

For examinations that are conducted at regional facilities and the examination coordinator is not present, he continues to act as the main coordinator. However, in this case it is necessary to utilize the services of one or more on-site coordinators at the examination site. Often, underwriting/service and claims contacts can serve as effective liaisons to the examiners in gathering information. These individuals serve as the on-site contact for addressing only the day-to-day demands that arise during the examination process. It is very important for the coordinator to set parameters early on as to the scope of responsibility of the on-site contacts; this will be discussed in more detail later.

In determining the physical workspace needs of the examination team, the coordinator needs to know the size of the team and if any special accommodations are required. It is preferable to have the examination team physically located together in one area, such as a conference or meeting room. The coordinator can work with company facilities management to locate the appropriate workspace for the examiners. The coordinator needs to emphasize the importance of housing the examiners in an area readily accessible to the company‘s on-site coordinator or contacts.

The coordinator must also determine whether the examination team has any computer equipment needs in connection with the examination. Even if the examination team intends to bring its own computer equipment; the coordinator should inquire as to whether the team has any additional computer equipment needs. Even if the examination teams use their own laptops, it may be beneficial to arrange for at least one corporate computer to be dedicated for use during the examination. Company computers allow the examiners to examine underwriting and claim information stored on the company‘s information systems without having to load additional programs on the examiners‘ computers.

In addition to assessing equipment needs, the coordinator also must assure that the appropriate information system security is granted to the examination team. In order to provide the needed security, the coordinator should obtain any information required by corporate information security policy from each member of the examination team so that proper access can be established. At the time that the coordinator contacts the appropriate area to establish

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system access needs, he needs to be cognizant of the period covered by the initial security access in the event that security access extensions are needed as the examination progresses. The coordinator should provide the examination team with a dedicated direct contact in the event that any computer problems arise during the examination.

The coordinator also needs to make any necessary arrangements for telecommunications equipment to be made available to the examination team. Such equipment needs may differ depending upon the physical location that the examination team occupies.

Examination teams may have specific office equipment and /or supplies requests, and the coordinator must make sure that such requests are fulfilled. For off-site examinations, the coordinator may need to request the assistance of the designated on-site contact person. Any supplies or equipment provided to the examination team is done at company expense.

When dealing with facilities, equipment, and supplies needs, it can be helpful for the coordinator to prepare a checklist, which identifies:

- The specific materials requested by the examination team
- The individual or area responsible for gathering such materials
- The date the individual or area was notified of such request
- The due date for completing any assigned tasks.

Once the coordinator is notified that any requested facilities, equipment, and supplies have been secured, the coordinator should ensure that these items are in accordance with the examination team‘s requests.

On-Site Examination Phase

Entrance Conference

The coordinator can readily convey the cooperative intentions of the company by providing the examination team with adequate facilities and supplies; requested information; and, finally, adequate access to those who can answer policy and procedure questions.

No amount of preparation can completely preclude confusion and glitches with the examination process; however, the expectation is that any issues that do arise should be addressed in a courteous and prompt manner.

An entrance conference gives the corporate personnel involved with the examination and the examination team the opportunity to make any necessary introductions and clarify roles and responsibilities. Such a meeting also allows the examiners to discuss their methodologies and expectations.

Either the examination coordinator or a designated on-site contact should greet the examination team upon its arrival at the examination site. In preparation of the arrival, the coordinator should have secured appropriate ID badges, entry cards, and parking passes or parking spots for the examiners. If those things cannot be secured before the examiners arrive, the coordinator should make sure these items are provided at the earliest possible time following arrival.

After welcoming the examination team, the coordinator should take the examiners to their examination work areas and point out restroom and exit facilities in closest proximity to the working arrangements. The coordinator should also show the examination team where the nearest break facilities are, the location of any cafeteria within the facility, and how to find the work facilities reserved for the examination team.

Upon initial introduction to the examination facilities, the examiners should be asked to review the dedicated work space to assure that it meets their accommodation needs. This may also be a good time to instruct the examiners on how to log on to the appropriate company computer systems and to ask them to attempt to log on for the first time. The initial log on process seems to be one area in which there are invariably problems. It is, therefore, best to anticipate and plan for problems so that they can be resolved as quickly as possible.

The coordinator should also take some time to cover any pertinent issues with the examiners, such as hours of operation, dress codes, and other relevant facts or company work rules that the examiners will need to be aware of. Once the coordinator has assured himself that the examiners‘ equipment is in good working order and that any initial questions have been answered, the examiners should be allowed to unpack and acclimate themselves to their environment.

When the acclimation period is over, the coordinator should proceed with the entrance conference. The timing of the entrance conference is dependent to some extent on the mode of travel used by the examiners and their anticipated arrival time, and this can be carefully coordinated with the examiner-in-charge the week before the examination team‘s arrival.

The entrance conference is usually scheduled to occur shortly after the examination team arrives on site. The coordinator is responsible for scheduling this meeting and assuring all appropriate company staff are in attendance. Whenever possible, the coordinator should plan to physically attend an entrance conference; however, if this is not an option, there are viable alternatives, such as the use of video conferencing or teleconferencing to ensure attendance in one way or another.

In planning for the entrance conference, a good rule of thumb is to plan for approximately a one-hour meeting. The coordinator should solicit information from the examiner-in-charge and company personnel as part of the process

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of preparing for the examination to assure that all relevant topics are discussed during the entrance conference. Entrance conference discussion should include the following items:

- Introduction of the examiners
- Introduction of corporate examination team
- Discussion of the scope of the examination
- Examiners‘ general questions regarding company files, letters, claims, and complaints, or anything else identified in their initial reviews.
- Company examination team‘s questions regarding responses to criticisms, paper flow, and technology gaps.
- The expected timeline for the completion of fieldwork
- Initial system training for the examiners
- Reimbursement issues, if any — Direct deposit, Doing Business As clarifications, frequency of expense reports, expectations regarding reimbursement turn around
- Any other issues brought up by examiners or the team.

Receiving and Responding to Criticisms and Requests for Information

The standard practice for the examiners is to refer to the previously compiled listings and files and review those files based upon criteria in the NAIC Market Regulation Handbook. The common areas of review are:

- Consumer complaints
- Policy rating issues
- Producer licensing
- Advertising
- Underwriting cancellations and nonrenewal of policies
- Claims issues that include timeliness, completeness, and valuation of those claims.

As the examination progresses, the examiners may submit various concerns, questions, or requests for additional information, known as criticisms or —its” to the coordinator. During the entrance conference, parameters should have been established regarding responses to any examiner questions, concerns, or criticisms.

When the examination team delivers an inquiry or criticism, the coordinator and the on-site contact, if there is one, should each receive a copy of the document. The examination coordinator should review inquiries to determine what is needed to provide a response within the time frame allowed by the

examiners. The preparation needs to include sharing the inquiry with the examination team and determining whether the affected area agrees with the criticism or inquiry. If the affected area disagrees with the criticism, it should develop a response that documents the company‘s compliance with the issue highlighted within the criticism or inquiry. It can be helpful for the coordinator to maintain some type of written log documenting any examination inquiries or criticisms received, including any sort of criticism number, the date received by the company, a brief summary of the company‘s response, and the date the response was provided to the examination team.

If the inquiry is a true inquiry, rather than a specific criticism, the coordinator may wish to discuss the issue with the examiner to clarify any confusion or answer any unresolved questions. Once the coordinator is confident in his understanding of the issue, he can assign the inquiry to the appropriate member of the company‘s examination team for a response.

If a market conduct criticism identifies a regulatory violation, the coordinator and the respective operational area should seek to address the criticism quickly, including the preparation of an action plan to completely address the violation. Although a company is only required to agree with a criticism, in the event that a violation has been discovered, a proactive measure for the company to take is to promptly correct any affected policies/claims.

If a company feels that there is a legitimate reason to question a criticism, the coordinator should work with the examination team and corporate legal counsel to prepare a response that (a) clearly articulates the company‘s reason for disagreement and (b) includes documentation for its position on compliance. These responses become very important when responding to the regulatory agency draft report of the examination.

After a response is drafted, the examination coordinator should review the response to assure it addresses the concern(s) raised by the examiner and provide the response within the timeframe designated by the examiners. The coordinator should save copies of responses to all criticisms/inquiries along with any supporting documentation provided to the examination team with the response.

Examination Costs and Expense Reporting

The company is legally required to bear the cost of any market conduct examination performed by a state regulatory authority. The manner in which expenses are to be handled is usually discussed in the initial written examination notification and/or during the entrance conference.

Regulatory bodies differ in their treatment of market conduct examination expenses. Costs generally include travel, lodging, and meal expenses; however, some states do include indirect expenses and other allocated expenses. Some

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states bill a company monthly for the examination costs, while states using contracted examiners seem to prefer a weekly billing process in which the examiners submit their expense reimbursement requests directly to the company. Yet other states may assess companies domiciled in their state annually to cover the cost of all examinations to be done that year on companies domiciled in that state. When this is the case and the domiciliary regulator is doing the examination, the company is not billed for the examination.

Regardless of whether the examination is conducted from the corporate headquarters, or at a regional facility, the coordinator should be the person who is responsible for handling examination reimbursement requests. The coordinator needs to familiarize himself with any internal expense reimbursement processing requirements in order to assure that examination costs are submitted and reimbursed in a timely manner. As the sole point of contact for expense handling, the examination coordinator is usually responsible for tracking all costs associated with the examination.

Exit Conference

Upon conclusion of the on-site portion of the examination, the examiners generally compile the results of their various reviews. Examiners typically review the criticisms, responses, and test results and make an initial determination as to possible areas of concern. This information is usually shared with the company during an exit conference, which may be held on-site or via phone/video conference and which may include other regulatory officials.

Before the exit conference, the examiners may draft a preliminary report of findings. This report may serve to memorialize the various examination test results, findings and concerns. This report may also serve as a draft of the report that will ultimately be issued by the regulator; however, there is no requirement that the examiners produce the draft report before leaving the company.

After preliminary examination findings have been received and before the exit conference, the coordinator should share such findings with the respective operational areas. At this point, no findings should come as a surprise, as the findings should reflect a summary of the inquiries and criticisms addressed by the company throughout the course of the examination. If the coordinator is surprised by a finding or by the findings in general, the coordinator should immediately contact the examiner-in-charge to discuss any disparities.

If there is a situation where disparities exist between the draft report and the criticisms/inquiries encountered during the course of the examination, the coordinator should first follow up with the company‘s examination team to assure that the coordinator did not miss major areas of concern. If the disparity appears to be an error by the examiners, then the coordinator should discuss the disparity with the Examiner-in-charge prior to or at the exit conference. If this is not

possible, attempts should be made to initiate discussions to resolve the disparities as soon as possible after the exit conference.

During the exit conference, the examiner-in-charge usually summarizes the examination findings and confirms that the company is aware of any issues discovered during the examination. The examiner also discusses the remaining process, including any specific procedures that the company needs to be aware of going forward.

The on-site portion of the examination is generally considered complete once the exit conference concludes.

The Reporting Phase

Draft Report and Response

Once the on-site portion of the examination has been completed, the examination team drafts a report that is initially presented to the regulatory agency staff for their review and approval. Once all internal review processes have been completed, a draft report is sent to the company for review.

Examiners may report the results of their findings either by —exception" (focusing only on the areas where the company failed the testing criteria) or by —test" (the examiner reports the results of all tests done). If the company fails any tests, discussions regarding recommendations and action plans are often included within that report section.

The examination coordinator should share the draft report with those members of the company examination team whose areas are affected by the report findings. A discussion, which typically focuses on the areas determined to be in violation of the examining state's laws, should follow. The coordinator then requests that the company areas affected by the findings prepare written responses to those findings. These responses should be consistent with responses previously shared in response to examiner criticisms and inquiries during the on-site examination unless additional information has come to light.

If the examination coordinator discovers areas of concern discussed in the draft report that were not raised during the on-site testing, the coordinator should immediately contact the regulatory contact and inquire why the issue was not previously addressed with the company. This is an opportunity to remove errors from the report that should not be overlooked. If the concern was included within the report due to an oversight, it is better to have the comments removed from the report before providing a formal response. Otherwise, the standard procedure is to leave the concern in the report, and require a company response and if this occurs, the coordinator needs to coordinate the company efforts to address and respond to this issue.

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In preparing a response to the draft report, the examination coordinator assembles all responses received from the affected areas and reduces them to one formal written response. A well organized response:

1. Lists the regulator‘s concern by page and section where it is referenced in the draft report
2. Restates the concern
3. Provides the company‘s response to that concern directly below the concern. If documentation is required, it should be attached to the end of the response.

Once the examination coordinator is satisfied that the response is complete, the response should be shared with the company examination team and the corporate legal area. After incorporating requested revisions, and receiving the full approval, the coordinator should share the company‘s draft response with the appropriate company management involved in the examination process. These individuals may have additional feedback on the nature of the response.

Typically, a response is due thirty days from the date the company receives the draft report. When possible, the company‘s response should be sent electronically and by priority or overnight mail to assure that it can be tracked as received by the regulatory agency. Once the regulatory agency receives the response, the coordinator should file proof of receipt.

Final Report, Administrative Action, and Follow-Up

Once the regulatory agency has received the company‘s response, members of the state‘s staff review the response, contact the company for additional clarification if needed, and make any corrections to the draft report deemed appropriate. The agency then publishes the final report. Unlike the work papers and report drafts, in most cases the final report is a public document. Many regulatory agencies post the examination reports on their web sites. Some states also, upon request, post a copy of the company‘s response to the final examination report along with the report itself.

The coordinator should promptly review the final report to verify whether there are material changes from the draft report. Assuming there are no material differences between reports, the coordinator then begins the process of closing the examination. This process entails:

- Providing a copy of the final report to members of the company‘s examination team, along with the appropriate management involved in the examination process.
- Providing the board of directors with a copy of the final report, along with a brief executive summary of the examination findings, when required to do so. This report should be delivered at the board

meeting, or if it is between meetings, the report should be delivered personally or sent by 1st class mail to each of the directors.

- Collecting affidavits from each board member that affirms they have received and read a copy of the examination report when so required by the examining authority. These affidavits must be provided to the regulatory agency within the specified timeframe.
- Verifying that all examination expenses have been paid.

If there are violations found during the examination, the regulatory agency sends an administrative order that may contain specific monetary sanctions or other stipulations imposed upon the company for the violations. The order also requires corrective action by the company. The administrative order may accompany the examination report, but that is not required.

Once an agreement is reached as to any administrative orders or actions, the examination coordinator should arrange the necessary documentation to show compliance with the administrative action. In addition, the order should be signed and returned to the regulatory agency. This officially closes the examination.

Nevertheless, the work of company personnel in relation to the examination may not be finished, as regulatory agencies may order that certain corrective measures be taken. In that regard, the examination coordinator should:

- Establish a timeline with the affected areas of the company to implement any changes to procedure or system enhancements required as part of the exam.
- Provide any required documentation of changes to the regulatory agency within timeframes established by the order.
- Follow up with affected areas as appropriate to ensure that all problems noted in the final examination report have been properly addressed.

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Chapter 17
- Procedure Review: A Risk-Based Approach to Market Conduct Examination

Educational Objective

Understand the historical needs, mechanics, and advantages of using a Procedure Review approach to enhance the market conduct examination process.

Introduction

The regulation of insurance in the United States currently is under the jurisdiction of the individual states, territories, and the District of Columbia. (For simplicity, all such jurisdictions are hereinafter referred to as _states'.) The pattern is essentially the same across the country. State Legislatures enumerate a series of regulatory duties and responsibilities and vest them in a lead insurance regulatory official, typically titled the Commissioner of Insurance (Director, Superintendent, or Administrator in some states). The Legislatures also structure a series of statutory tools through which a regulator can meet the obligations of his or her office. The principal among these tools is the authority to examine the insurance companies doing business in each jurisdiction.

Over the years, states have made considerable strides in fine-tuning the area of financial examinations, the most substantial occurring in the late 1980s and early 1990s. A major shift in how those kinds of examinations are conducted is currently under way and will be used on all financial examinations by 2010. The new approach has been referenced in a variety of ways and has been called a risk-based review, a top-down review, a management review, a corporate governance review, etc. New skill sets are needed to apply this approach, and the learning curve for both the regulatory and regulated entity sectors has been intense.

Market conduct examinations are historically a more recent innovation even though market conduct concern was one of the founding issues when the NAIC was formed in 1871. The first known market conduct examinations were performed by Illinois starting in 1969 and were followed by Missouri in 1972. In 1974, the NAIC-funded McKinsey report suggested that a new examination format (other than financial) be developed and used. In 1979, the General Accounting Office (GAO) was particularly critical of regulatory failure to analyze complaint data systematically and to use that data in an examination process. The criticism went further and included the exchange of that information and the efficient use of state resources in its market regulation efforts.

It has been said that you have to learn to crawl before you can learn to walk and learn to walk before you can learn to run. These early efforts were the crawling stage, and admittedly mistakes were made. At the time, the information age was not really under way and the necessary information sharing, communication needs, and data gathering capabilities were viewed as futuristic. State laws governing market issues were viewed as too diverse to allow for multi-state or collaborative efforts. As a result the form taken was somewhat vague and provided for an individual state quantitative review. Nevertheless, the states did commence efforts aimed at enhancing the new examination process.

About 1994, some states realized that it was time to learn to walk. The Market Conduct Examiners Handbook at that time really contained little in the way of guidance to a state wishing to conduct a market conduct examination. These states recognized that even though the various state statutes supporting their reviews were diverse, there was sufficient similarity in most cases to allow for general standards or expectations that could be stated as standards and used to move in the direction of uniformity. For many this was a considerable leap. Although states developed relatively uniform market conduct standards, market conduct examinations did not receive the same attention given to financial examinations. The absence of a similar level of oversight for the market conduct examination area of regulation allowed inefficiencies and other issues to develop unchecked. Nevertheless, with the adoption of standards, the market conduct examination process had learned to walk.

The material in this chapter represents a substantial departure from what is viewed as a conventional market conduct examination. Accordingly, the techniques that follow have not been universally accepted to replace or augment those associated with such examinations, are not part of an NAIC-adopted practice, and are not included in the NAIC Market Regulation Handbook. The approaches presented require the increased use of an examiner‘s analytical skills. Procedure Review does not result in a pass or fail, yes or no, or black or white response. Nevertheless, it represents a potential for the acquisition of more information pertinent to a regulated entity‘s operations than does a conventional market conduct examination.

Briefly stated, Procedure Review is the review of the directions provided by a company‘s management in the form of written procedures, directives, processes, strategies, etc. This review reveals how a company manages and controls the various processes it implements to comply with insurance statutes.

Procedure Review is an effective means to determine whether company management in an area or areas under review is proactive or reactive. A proactive process generally results in a minimal level of error or violation. A reactive process has an increased propensity for error and violation.

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Political Change and Resource Allocation

Since the June 2002 meeting of the National Association of Insurance Commissioners (NAIC), market conduct examinations and their continuing role in the regulation of insurance have evoked considerable discussion. Elements in these discussions include:

- Concern with the extent to which market conduct examinations constitute a duplication of effort
- The disproportionate burden on large market share insurers
- The absence of collaborative efforts among states
- The methodologies utilized to select examinees
- Federal interest in the unrepaired flaws in insurance market regulation.

Every state performs financial examinations, but the same is not true of market conduct examinations. The former is the subject of an accreditation process that essentially provides a mandatory structure for financial oversight of the insurance industry. The discussion for a similar structure for market regulation has not seen such a structure arise in part because not all states are equally active in market regulation. Many states would have substantial difficulty developing such a structure due to competing demands on state budgets.

Most states that conduct market conduct examinations do so on a target basis. Routine and comprehensive examinations are becoming rarer. Many states feel that resource allocation is better served through the target examination mechanism. The key for market regulators is how to refine an appropriate regulatory structure that includes all elements needed to avoid past inefficiencies, yet provide effective oversight that comports with the intent of statutory mandates to regulate insurance.

GAO Criticism

On September 30, 2003, the Government Accounting Office (GAO) issued its report —GAO-03-433 Insurance Regulation." This report was critical of states' efforts in the area of market analysis (information gathering to determine issues and identify companies that may need attention) and on-site examinations in market regulation. The report also criticized the progress made by the NAIC in creating more uniformity in the regulation of market conduct. A downloadable copy of that report is available at:

http://www.gao.gov/new.items/d03433.pdf.

Examination Structure - Developing New Tools

The conventional method of examination as described in the *NAIC Market Regulation Handbook*[1] typically reviews the results of an insurance company operation for error or violation of statute and reacts to that result. It is generally quantitative and microscopic in nature. This approach is reasonably effective at identifying violations of state law. It uses sampling methodology to select files for review and then applies standards and tests to determine whether the files reviewed comply with the applied test. This results in considerable duplication when multiple states have similar concerns and conduct separate examinations. The conventional method of examination is truly cumbersome when applied on a multi-state basis unless the subject of the examination is sufficiently narrow and the state laws for the examining states are sufficiently similar. It is, however, not particularly effective at determining causation of file failure. Consider, then, that the principal regulatory interest in this kind of review is not the quantification of violation or error, but rather in corrective action. The conventional market conduct examination utilizes a review of events at the operational level of an insurer.

In an effort to parry the criticism of duplication in regulation, states revisited the role of market analysis. Market analysis existed in states actively engaging in market conduct examinations in one form or another for years; however, it did not possess the refinements that have been developed. In its current configuration, market analysis is being used to determine which of a variety of regulatory responses are appropriate to a particular set of circumstances. As this process is refined, and as the states collaborate in their regulatory efforts, much of the duplication can be expected to dissipate. The challenge is to recognize more effectively and efficiently the indicators that should lead to some form of regulatory interaction.

When a state conducts a review, finds violations or errors, and tells a regulated entity to fix it, a difficult condition may be established. The regulated entity may have no more of an idea of what has caused a violation or error than does the regulator. For that determination a qualitative review is needed, not a quantitative one. The only way to arrive at a qualitative utility is to adopt reviews that look more intensively at the process and controls affecting corporate governance. Like the reviews to which financial examiners are moving, the overall techniques are similar but rely on very different experience bases. The financial examiner reviews corporate governance from the viewpoint of his accounting experience. The market conduct examiner reviews corporate governance from the viewpoint of his underwriting, claims, and/or contract review experience.

The Procedure Review, discussed in this chapter, is a review of management structures and controls of areas impacting market related issues. This approach is very effective at identifying *causes* for violations of statute. The Procedure Review market conduct examination utilizes a review of the processes and controls developed for the operations of an insurer.

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In the 2003 GAO report, the conclusions include the statement: —In addition, existing computerized audit tools could allow regulators to substantially change the way examinations are done by shifting the focus from file review to a review of controls, systems, and processes and possibly by shortening the time needed for the examination."

Enabling Statute

The statute enabling a Procedure Review is found in the examination statutes and in the admissions statute. The language in the examination statutes is generally similar from state to state and provides broad authority to examine matters of regulatory interest to the states.

The provision of interest in the admissions statute is that related to competent management. An enabling statute reads something similar to the following:

> —The Commissioner shall not grant or continue authority to transact insurance in this State as to any insurer or proposed insurer the management of which is found by the Commissioner after investigation or upon reliable information to be incompetent or dishonest or untrustworthy or of unfavorable business repute or so lacking in insurance company managerial experience in operations of the kind proposed in this State as to make such operation, currently or prospectively, hazardous to or contrary to the best interests of, the insurance-buying or investing public of this State, or which the Commissioner has good reason to believe is affiliated directly or indirectly through ownership, control, reinsurance transactions or other business relations with any person or persons of unfavorable business repute or whose business operations are or have been marked, to the injury of insurers, stockholders, policyholders, creditors, or the public, by illegality, or by manipulation of assets or of accounts or of reinsurance or by bad faith."[2]

Review Considerations

An examination that utilizes the Procedure Review method should be based on an understanding of the considerations that contribute to the efficacy of the process. If the considerations and the logic that support the approach are not thoroughly understood, it is not likely that the method can be used effectively.

Management Cycle

The management of a well-run company adopts processes that are similar in structure. An absence or ineffective application of such processes in an insurance company often results in an inconsistent application of the intended

process. Ineffective processes are typically revealed by adverse findings in samples tested during the course of a market conduct examination. The processes include the following components:

- A planning function where direction, policy, objectives, and goals are formulated
- An execution or implementation of the planning function elements
- A measurement function that considers the results of the planning and execution
- A reaction function that utilizes the results of measurement to take corrective action or to modify the process to develop more efficient and effective management of the company‘s operations.

Planning

The planning function is where direction, policy, objectives, and goals are formulated. This function is found in the written policies and procedures of the company. These may also be called processes, strategies, or directives, and are tested for clarity, currency, functionality, and conflict with existing statutes. A proactive process that results in reduced error or violation is one that is clearly stated, up-to-date, fits its intended purpose, and complies with state laws. A reactive process generally results in observable errors and violations that the company cannot avoid because it is not structured to do so. Findings from this review are predictive of areas where an examiner‘s review of a sample will yield criticisms and errors. They also provide the examiner with data that helps identify whether problems found are systemic, intended, unintended, or true error. Finally, review findings aid the planners of the examination in determining what business areas may need further examiner attention.

Implementation

Implementation of the planning function occurs when management-directed policies and procedures are disseminated throughout the company to appropriate and affected persons. Review of this process is useful in determining whether the company is effectively distributing its directives. Testing the implementation of the planning function involves answering many questions including:

- Are the procedures in writing?
- Are the procedures coherent, readable, and on point?
- Are the procedures functional; that is, do they fit their intended purposes?
- Do the procedures comport with statutes and contain state exceptions where applicable?

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- Are the procedures up-to-date?
- Are the procedures readily available to affected persons?
- Are the procedures utilized?
- Are affected persons trained in the use of the procedures?
- If the procedures are computerized, is the documentation for the resultant process adequate and does the process accomplish management's intent?

Measurement

How does the company know that its intended processes are utilized, functioning, and working? The measurement function evaluates the results of planning and implementation. Measurements can be found in internal audits, management reports, supervisory reports, Board meeting minutes, minutes of the Compliance Committee, minutes of the Quality Review Committee, market conduct examination reports, etc. The measurement function is concerned with the quality of information developed to inform the Board of the results and the effectiveness of its directives. Without measurement, management cannot know whether its directions are being implemented effectively. The measurement process must be written, formal, and documented, and must occur with sufficient frequency to function as a reasonable tool. Without the measurement function in place, the process used is passive or reactive, and the company will not have an effective means for knowing that errors or violations are occurring and be in a position to prevent them.

In an actual example of a proactive process, examiners discovered a single error when reviewing the underwriting files of an insurer. When examiners discussed the error with the insurer, they found the company already had detected the potential for that kind of error. The company went on to establish an internal task force to devise a means of preventing such errors in the future. Examiners also found that the company, on a semi-annual basis, reviewed 25 files for each of its underwriters and claims persons. Furthermore, the tests in the company review were more stringent than those applied in the examination process. The company used test results to evaluate its employees and to target areas for additional training. Moreover, the results were applied in a manner that was both accepted and welcomed by company employees. The company designed a highly effective method for providing concrete evaluation of its directives.

Reaction

The reaction function is where a company has the opportunity to insert into the process what it learned through the measurement of its procedures. The process requires a means of utilizing the information arising out of internal audits, management reports, and complaint systems. This is reflected in the

responses to internal audits, management reports, supervisory reports, Board of Directors and Committee minutes, market conduct examinations, and errors detected through the company's complaint system analysis.

This information needs to flow back directly to management so that it can use these findings to modify policies and procedures. The company should also resolve, through documented remediation, any errors that resulted in harm to policyholders and/or the public.

These are things that a company should know about itself. In some cases federal law insists on it. The Sarbanes-Oxley Act (SOX) essentially requires documentation that certain levels of corporate governance are in place and operating.

The Cycle

The cycle of preparing instructions (policies and procedures), disseminating them, testing their results, and making modifications should be a continuous and ongoing cycle. A continuous and ongoing cycle is indicative of proactive management. Of course, not every company is fully proactive or fully reactive. A company can be at both ends of the proactive/reactive spectrum depending on the business area being reviewed. For example, a company with a proactive claims environment may have a reactive underwriting environment.

Policies and Procedures

Policies and procedures are two terms heard with some frequency, but they do not tend to evoke an image of how they might be used in a regulatory application. These terms in fact denote two different things.

Definitions

—Policies" are the high-level general principles by which an entity guides the management of its affairs. It is not critical for the regulator to be concerned with policy statements except to the extent that they represent management's direction to proceed in a particular manner. Policies may be the basis for procedures. Policies are generally too vague to require any regulatory interaction unless they are obviously in conflict with a statute.

—Procedures" are the specific methods or courses of action used to implement a policy or corporate directive. Many companies have processes in place that do not derive from policy and do not really constitute procedures. How a company structures and documents its procedures tells the regulator a considerable amount about the company. Procedures indicate whether a company is proactive or reactive in the management of its operations; whether the corporate compliance activities are a cause for concern; and whether particular areas of concern to the regulator are managed in a way to avoid the need for regulatory interaction.

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Source

Throughout the *NAIC Market Regulation Handbook*, there are suggestions in the review criteria for the various standards to review a particular procedure. Unfortunately, the Handbook is silent concerning what constitutes such a review. A Procedure Review should determine whether the management cycle relating to the procedure at interest adequately considers each of the elements noted in the discussion of the management cycle.

Management analysis of written procedures is a top-down look at how a company operates. It can be thought of as a vertical view of a company's operation. It represents a somewhat different skill set than typically used in the traditional market conduct examination that is more of a "bottom of the ladder" view or horizontal view of a company operation. Both methods are valid and may be used in conjunction with each other. To test the validity of the use of this approach, examinations have been conducted for the last four years utilizing both methods, procedural and traditional including sampling. The examiners have then compared the results of the samples impacted by particular procedures with the management analysis performed relating to that procedure and the findings have been striking.

Testing the Process

Since the examinations conducted during this testing phase have been comprehensive examinations with reasonable levels of sampling, the samples support the notion that the proactive/reactive analysis is a valid tool. The samplings of business areas for companies with proactive tendencies generally yield fairly "clean" results. Where the analysis indicated that there was a passive or reactive process in place or no process in place, the samples revealed considerable human error, systemic error, and certainly more deliberate errors than are seen with proactive management.

Approximately 30 conventional market conduct examinations were completed with a procedure review element during the testing phase of Procedure Review. No attempt was made to develop comparative statistics during the testing phase as the utility of the process discussed in the section on "Review Uses" was not then anticipated. The procedures reviewed were also a variable from examination to examination, thus exacerbating statistical development.

Procedures to Review

The procedures to review vary depending on the lines of business (LOB) written by a company, the reason for examination (target or "baseline", which is defined later in this chapter), and a variety of other considerations. The following is a list of procedures that can be modified as needed:

- Audit [Internal and External] (All LOB)

- Assertions of privilege (All LOB)
- Company records, central recovery, and backup (All LOB)
- Computer security (All LOB)
- Anti-fraud (All LOB)
- Disaster recovery (All LOB)
- MGA oversight and control (All LOB)
- Vendor oversight and control (All LOB)
- Customer and consumer privacy protection (All LOB)
- Production of business (All LOB)
- Complaint handling (All LOB)
- Grievance handling including expedited review (Health)
- Advertising, sales, and marketing (All LOB)
- Suitability disclosure (All LOB)
- Group policy or mass marketing (All LOB)
- Agent-produced advertising (All LOB)
- Producer training (All LOB)
- Out-of-area & out-of-network services (Health)
- Provider selection (Health)
- Replacement [Life, Long Term Care (LTC)]
- Illustration (Life)
- Outline of coverage (Health)
- Network adequacy (Health)
- Producer selection, appointment, and termination (All LOB)
- Producer defalcation (P&C, Health)
- Prevention of use of persons with felony conviction (All LOB)
- Assumption reinsurance (All LOB)
- Premium billing (All LOB)
- Statistical gathering and reporting (All LOB)
- Correspondence routing (All LOB)
- Policy issuance (All LOB)
- Reinstatement (Life, Health)

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- Insured or member requested claim history (P&C, Health)
- Credible coverage (Health)
- Premium determination and quotation (All LOB)
- Policyholder disclosures (All LOB)
- Underwriting and selection (All LOB)
- Rate and form filing (All LOB)
- Termination (All LOB)
- Rescission (All LOB)
- Declination (All LOB)
- Underwriting file documentation (All LOB)
- Underwriter training (All LOB)
- Insured or member enrollment (Life, Health)
- Continuation of benefits (Health)
- Staff training (All LOB)
- HIPAA compliance (Health)
- Adjuster or claim processor training (All LOB)
- Claim handling (All LOB)
- Internal claim audit (All LOB)
- Claim file documentation (All LOB)
- Subrogation and deductible reimbursement (P&C, Health)
- Reserve establishment (All LOB)

Additional Considerations

In addition to the considerations noted above, ethical management, management attitude, and confirmation of management processes are appropriate.

Ethical Management

A critical element in any scheme to develop allocation of examiner resources is ethical management. Ethical management is not a direct standard in the *NAIC Market Regulation Handbook*. It is usually not a direct requirement of the statutes regulating the business of insurance. However, the need for ethical management is strongly implied through the structure of those statutes. For example, a pattern of misrepresentations will raise strong doubts about an insurer‘s ethical base. The standards and tests found in the

Handbook are generally objective indicators that can measure this behavior. Factors such as company attitude and negative, confrontational, or resistive reaction by company management may be more subjective, but no less apparent, to the regulator. Likewise, a company with a reputation for being a —good corporate citizen" typically demonstrates a willingness and structure that is responsive to its customers.

Attitude

Examiners experience a wide range of attitudes on the part of insurer management. Most examiners are instructed to adopt an attitude of being cordial, but firm. Listen to explanations; evaluate on the basis of your knowledge and powers of observation; and act accordingly. The fact that a company may not want to be examined is no excuse for negative, belligerent, or discourteous treatment of examiners. A negative attitude on management's part is a strong hint that the company is not likely to receive a —clean" bill of health on its market conduct examination.

Confirmation

Often a company claims to maintain a process or procedure, but in fact it does not. Therefore, in using this process it is important that the examiner confirm the existence and use of the processes a company purports to maintain. This can be accomplished in several different ways:

- The first is conducting a —walk-through". This exercise provides the examiner with the opportunity to question how the process actually functions. The examiner should have questions prepared so he or she can achieve a thorough understanding of what the company does.
- The next method is the use of interviews of mid-level managers and of persons using the purported procedure. Some companies may use an informal or undocumented process. The efficacy of such processes should also be considered. The challenge with an undocumented process is that it is frequently without measurement, meaning that the company really does not know how that process is working. It also means that there is an increased likelihood of inconsistent application, posing potential unfair discrimination issues.
- The final method is to actually test a sample of files to determine that the process is indeed applied as described.

Review Uses

The use of Procedure Review has a wide range of utility. It can be used as a stand-alone form of examination or it can help to a narrow a focused review of an area of the company's operations.

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Domestic Baseline

The phrase —baseline examination", as used here, contemplates an initial examination of a company conducted by a state. It is expected to provide a —baseline" of information on which to base future regulatory oversight or absence thereof.

The advantage in this instance is that due to the existing and presumably close relationship with the company, the state of domicile is in a better position to look at business areas that other states may have difficulty reviewing. This is true whether the domestic company is a large writer in the domestic state or writes no business at all in the state. The procedures a company utilizes are generally corporate-wide. The domicile state thus may have the ability to look at how the company treats compliance on a scale that is broader than its own immediate interests and to provide other states with information of strong interest to them. This is a meaningful way to address a state's interest in achieving domestic deference.

Typical baseline examinations are conducted on a state‘s domestic insurers. The examinations look at a company‘s total complaint population to determine if there are any detectable patterns that may suggest a need for regulatory interaction. The reviews should not be limited to a single line of business or to a single jurisdiction, but they should consider all jurisdictions in which the company operates. Examiners conducting the baseline examination consider complaints directed at the company, its producers, its vendors, etc. The object is to look for developing patterns anywhere and to determine if the company maintains processes to correct or repair the issues driving the patterns.

In addition, examiners review about 40 written procedures for each company examined, unless the examination is for a group of companies using the same procedures and controls. The process takes approximately nine weeks utilizing three examiners for a single company and a bit more when there are multiple companies subject to the examination. Generally, half of the work can be conducted off-site, resulting in travel-related expense savings. This review also replaces the market conduct work performed as part of a financial examination. The expectation is that this will provide considerable information about each of the state‘s domestic companies, thereby allowing better future allocation of a state‘s regulatory resources. For example, this type of examination may identify companies with reactive or passive management styles and, consequently, allow a state to focus greater attention upon those companies. Data developed in this process should be incorporated into a state‘s market analysis efforts, thus providing a true baseline for future efforts.

It is not unusual to find a company with few, or no, written procedures. Even more commonplace is finding a company that has no way to tell whether its procedures are working since measurements are non-existent. If the company writes a line of business that does not generate consumer complaints, there may

be few other valid indicators of regulatory concern. Maintenance of the data in the baseline, once acquired, is easy to accomplish with minimal effort.

The baseline examination departs substantially from the definition of a conventional market conduct examination. However, in view of recent NAIC discussions, experience in proactive/reactive analysis, and the need for states to accomplish their examinations with minimal resources, states might well consider a baseline examination. Examinations that focus on the company operations and management, proactive vs. reactive analysis of each business area, and a detailed review of patterns that arise from complaint systems provide an insurance commissioner with the necessary data to determine when and where a more limited-scope, targeted examination is appropriate in addition to enhancing data derived from market analysis.

Target Examinations

The analysis completed in the Procedure Review is exceptionally predictive; it lends itself to a more precise application of Department resources. Other indicators used in market analysis may suggest that a specific review of a particular procedure is warranted. This next level of review may be accomplished using Procedure Review as a standalone process or combined with a conventional market conduct examination.

Identification of Causation

When a trade practice or repeat violation of statute is found through market analysis, a conventional examination or complaint review, using a focused application of Procedure Review, is useful in identifying causation. Once the cause of the violation is determined, the regulator is able to develop recommendations to repair the issue or structural remediation with precision.

Market Analysis Supplement

Market Analysis is seeking ways to gather and review data that indicate the need for regulatory interaction. Procedure Review is a valuable tool that provides a means of achieving this goal. However, because the process is relatively new, it will be some time before there is an adequate database upon which states can rely.

Conclusion

The use of Procedure Review has several advantages. These include:

- It can be used on a targeted or routine basis.

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- It requires less time to conduct than does a traditional market conduct examination, and a considerable amount of the work can be conducted off-site.
- The review conducted tends to be corporate-wide rather than state specific, thus increasing the multi-state utility of the process.
- It is readily able to identify causation and potential areas of regulatory slippage.
- It tends to be less confrontational since development of violations is not the primary function.
- It is highly predictive of where violations have occurred or are likely to occur, thus allowing for proactive activity.
- It provides an opportunity for objective regulator/regulated entity dialogue.
- It provides value for the examination costs to the regulated entity.
- It can be used as a stand-alone examination or as a supplement to a conventional examination.
- It is responsive to domestic deference concerns.

Endnotes

[1] National Association of Insurance Commissioners, Market Conduct Regulation Handbook (NAIC, 2301 McGee Street, Suite 800, Kansas City, MO 64108-2662), June XX, 19XX, XXX pp.

[2] Delaware statute 18 Del. C. §508(b).

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Appendix A
- Exhibit G – Consideration of Fraud

In accordance with the Risk-Focused Surveillance Framework, the financial examiner needs to consider fraud risk factors and develop examination procedures in order to adequately obtain reasonable assurance that material misstatements due to fraud are not included in the financial statements. Independent CPAs are required to complete and document consideration of fraud.

The financial examiner should utilize this exhibit in order to adequately document the consideration of fraud for financial condition examinations.

This exhibit includes a detailed checklist of fraud risk factors identified in previously detected fraudulent incidences to assist the examiner in determining applicable fraud risk factors. The Risk Assessment Matrix identifies and evaluates the insurer‘s risk mitigation strategies/controls in place to mitigate fraud risk factors. The risk mitigation strategies/controls should be assessed by determining how well they offset the fraud risk factors identified.

- Each insurance company issuing or underwriting a covered product must have developed and implemented an anti-money-laundering program reasonably designed to prevent the insurance company from being used to facilitate money laundering or the financing of terrorist activities. The insurer does not have to implement a company-wide program, but rather, a program that applies only to the insurer‘s covered products.
- The insurance company must provide training for appropriate persons. Employees with responsibility under the program must be trained in the requirements of the program and money laundering risks generally so that –ed flags” associated with covered products can be identified.

The program must be in writing and be approved by senior management. The written program must be made available to the Department of the Treasury, the Financial Crimes Enforcement Network, or their designee upon request.

Examiner's Checklist

- ✓ Meet with company management to discuss the risk of fraud in the entity and to inquire whether management is aware of any fraudulent activity that has been conducted on or within the company and if the company is compliant with Federal Anti-Money-Laundering requirements.
- ✓ Determine that the company has established antifraud initiatives reasonably calculated to detect, prosecute, and prevent fraudulent insurance acts.
- ✓ Review the fraud initiatives established by the company to advertise, identify, investigate, and report fraudulent acts.

- ✓ Verify that the established fraud program is advertised and promoted to the company's insureds.
- ✓ Verify that the company has established a procedure to report fraudulent insurance acts to the Commissioner in the manner prescribed by the Commissioner.
- ✓ Document the investigation of any potential fraudulent activity noted during the examination period.
- ✓ Verify that necessary information regarding the knowledge or reasonable belief that a fraudulent act has been, will be, or is being committed has been communicated to the Commissioner as required.
- ✓ Review the company's operations, both financial and operative, to identify fraud risk factors.

  The fraud risk factors are categorized according to the three conditions typically present when fraud occurs:

  - Incentives/pressures to commit fraud
  - Opportunities to perpetrate fraud
  - Attitudes/rationalizations that fraud is ethical or acceptable.

Source: Exhibit G, *NAIC Financial Examiners Handbook*[1]

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Endnotes

[1] Exhibit G NAIC Financial Examiners Handbook (2007).

Appendix B
- Acronym Reference Guide

Acronym	Reference
AICP	Association of Insurance Compliance Professionals
AIE	Accredited Insurance Examiner
APS	Attending Physician's Statement
ASCII	American Standard Code for Information Interchange
CAD	Collaborative Actions Designee
CDS	NAIC‘s Complaints Database System
CIE	Certified Insurance Examiner
COBRA	Consolidated Omnibus Budget Reconciliation Act
CPT	Current Procedural Terminology
DOI	Department of Insurance
EIC	Examiner-in-Charge
ERISA	Employee Retirement Income Security Act
ETS	NAIC‘s Examination Tracking System
FAIR	Fair Access to Insurance Requirements Plan
FAQs	Frequently asked questions
FTP	File Transfer Protocol
GAO	Government Accounting Office
GLB	Gramm-Leach-Bliley Act

Acronym	Reference
HHS	The U.S. Health & Human Services Department
HIPAA	The Health Insurance Portability & Accountability Act
HMO	Health Maintenance Organization
IIA	Institute of Internal Auditors
IMSA	Insurance Marketplace Standards Association
IRES	Insurance Regulatory Examiners Society
IRIS	NAIC‘s Insurance Regulatory Information System
I-SITE	NAIC's web-based application that provides regulators access to NAIC applications.
ISQ	Information Systems Questionnaire
JUA	Joint Underwriting Association
MAC	Market Analysis Chief
MAH	Market Analysis Handbook
MCAS	Market Conduct Annual Statement
MITS	NAIC‘s Market Initiative Tracking System
MARS	NAIC‘s Market Analysis Review System
MAWG	Market Analysis Working Group
MCO	Managed Care Organization
MEWA	Multi-employer Welfare Arrangement
NAIC	National Association of Insurance Commissioners
NCCI	National Council on Compensation Insurance

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Acronym	**Reference**
NCOIL	National Conference of Insurance Legislators
NCQA	National Council on Quality Assurance
NIPR	National Insurance Producer Registry
PDB	NAIC‘s - Producer Database
PHI	Protected Health Information
PIC	NAIC's Personalized Information Capture System
PPO	Preferred Provider Organization
RESPA	Real Estate Settlement Procedures Act
RIRS	NAIC‘s Regulatory Information Retrieval System
SAD	NAIC‘s Special Activities Database
SERFF	System for Electronic Rate and Form Filing
SHIIP	Senior Health Insurance Information Program
SOFE	Society of Financial Examiners
SIU	Special Investigation Unit
SDR	Standardized Data Request
TPA	Third Party Administrator
UTPA	Unfair Trade Practices Act
VIN	Vehicle Identification Number

Appendices C, D, and E
- Checklists and References -

Appendices C, D, and E present some additional material that will prove valuable during the course of an examination. Refer to these checklists as you would any other _how to‘ reference when it is important to get off on the right foot and when a cookbook seems to be just what is needed.

Appendix C
- Areas of Review – All Lines of Business[1]

Introduction

This appendix presents some general areas of investigation for all lines of business. It provides checklists and suggestions geared toward Property & Casualty (P&C) market conduct examinations followed by some life insurance checklists, including life replacements. The result is a useful framework for all types of market conduct examinations. Appendix D focuses on health lines, managed care entities, and Health Maintenance Organizations (HMOs). Appendix E details specific types of P&C target examinations.

Regardless of the line of business, there are certain areas of investigation that are common to most general examinations; this appendix addresses them. Common elements of examinations include overall company operations, complaint handling, and producer licensing. In addition to the common elements for reviewing the company‘s market conduct practices, there are common elements for examining specific functions. To get an accurate picture of each company‘s business conduct, examiners must examine for each line of business (LOB) the established and actual practices in marketing and sales, underwriting, rate and forms, policyholder service, and the handling of claims.

How to Proceed with an Examination of Marketing and Sales

A Checklist of Examiner Activities

- ✓ Determine whether the company has made appropriate disclosures in all solicitation and sales materials, including audio, video, and printed media and on Internet sites.
- ✓ Determine whether advertising materials relate to the appropriate policy.
- ✓ Determine whether the company approves and controls producer sales materials and advertising.
- ✓ Determine whether materials falsely project a government agency relationship.
- ✓ Determine whether materials misrepresent HIPAA provisions.

A list of items to be reviewed:

1. A description of the company's marketing plan and/or objectives statement
2. The company's advertising objectives statement

3. The company's producer marketing materials or solicitation kits
4. The company's advertising materials and associated policy forms used during the examination period
5. The company‘s Internet marketing procedures
6. The company's telemarketing scripts
7. The company‘s methods of communication with producers. Are electronic media used to train, inform, and/or communicate with producers?
8. The company‘s procedures and oversight controls pertaining to agent-produced advertising
9. A copy of any buyer's guide in use by the company
10. All producers' training manuals, tapes, etc.
11. A copy of the market selection guide or other underwriting materials provided to producers
12. A copy of all newsletters, bulletins, etc. (written and electronic), sent to producers
13. A copy of all sales-related email sent to producers on a broadcast basis.

Note: A supplemental checklist that can be used for reviewing all advertising materials is available in the appendix of the NAIC‘s *Market Regulation Handbook*.

Characteristics of Advertising Materials

Materials should <u>not</u>:

- Misrepresent policy benefits, advantages, or conditions by failing to disclose limitations, exclusions, or reductions or use terms or expressions that are misleading or ambiguous.
- Make unfair or incomplete comparisons with other policies.
- Make false, deceptive, or misleading statements or representations with respect to any person, company, or organization in the conduct of insurance business.
- Offer unlawful rebates.
- Use terminology that would lead a prospective buyer to believe that he/she is purchasing an investment or savings plan. Problematic terminology may include these terms: Investment, investment plan,

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founder's plan, charter plan, deposit, expansion plan, profit, profits, profit sharing, interest plan, savings, or savings plan.

- Omit material information or use words, phrases, statements, references, or illustrations if such omission or such use has the capacity, tendency, or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, premium payable, or state or federal tax consequences.
- Use terms such as "non-medical" or "nomedical examination required" if issue is not guaranteed unless the terms are accompanied by a further disclosure of equal prominence and juxtaposition that issuance of the policy may depend on the answers to the health questions set forth in the application.
- State that a purchaser of a policy will share in or receive a stated percentage or portion of the earnings on the general account assets of the company.
- State or imply that the policy or combination of policies is an introductory, initial, or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless that is the fact. Enrollment periods may not be described by terms such as "special" or "limited" when the insurer uses successive enrollment periods as its usual method of marketing its policies. This may be determined by reviewing marketing materials over a period of several years.
- State or imply that only a specific number of policies will be sold or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy.
- Offer a policy that utilizes a reduced initial premium rate in a manner that overemphasizes the availability and the amount of the reduced initial premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, all references to the reduced initial premium should be followed by an asterisk or other appropriate symbol that refers the reader to that specific portion of the advertisement that contains the full rate schedule for the policy being advertised.
- Imply licensing beyond limits if an advertisement is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed.
- Exaggerate the fact, suggest, or imply that competing insurers or insurance producers may not be licensed if the advertisement

states that an insurer or insurance producer is licensed in the state where the advertisement appears.

- Create the impression that the insurer, its financial condition or status, the payment of its claims, or the merits, desirability, or advisability of its policy forms or kinds of plans of insurance are recommended or endorsed by any governmental entity. However, where a governmental entity has recommended or endorsed a policy form or plan, that fact may be stated if the entity authorizes its recommendation or endorsement to be used in an advertisement. The company should be able to produce documentation of such recommendations or endorsements.
- State or imply that prospective insureds are or become members of a special class, group, or quasi-group and enjoy special rates, dividends, or underwriting privileges unless that is a fact.
- Contain an assertion, representation, or statement with regard to the risk-based capital levels of any insurer or of any component derived in the calculation.
- Use the existence of the Insurance Guaranty Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance covered by the association.
- Misrepresent the dividends or share of the surplus to be received on any policy.
- Make a false or misleading statement as to the dividends or share of surplus previously paid on a policy.
- Misrepresent any policy as being shares of stock.
- Shall not include projections of past investment experience when illustrating benefits payable under any modified guaranteed life insurance. Hypothetical, assumed interest credits may be used only if it is made clear that such are hypothetical only.
- Refer to an individual policy covering a single specified disease or combination of specified diseases as other than specified disease coverage.

Materials should:

- Clearly disclose the name and address of the insurer.
- If using a trade name, disclose the name of the insurer, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol, or other device or reference if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the insurer or create the impression that a

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company other than the insurer would have any responsibility for the financial obligation under a policy.

- Prominently describe the type of policy being advertised.
- Identify the policy form that is being advertised, where appropriate.
- Indicate that the product being marketed is insurance.
- Comply with applicable statutes, rules, and regulations.
- Cite the source of statistics used.
- Clearly define the scope and extent of a recommendation by any commercial rating system.
- Include testimonials, appraisals, or analyses only if they are genuine, represent the current opinion of the author, and are applicable to a policy advertised and accurately reproduced to avoid misleading or deceiving prospective insureds. Any financial interest by the person making a testimonial in the insurer or related entity must be prominently disclosed.
- State or imply endorsement by a group of individuals, society, association, etc., only if it is a fact; any proprietary relationship or payment for the testimonial must be disclosed.
- When presenting any modified guaranteed life insurance, clearly illustrate that there can be both upward and downward adjustments to non-forfeiture benefits due to the application of the market-value adjustment formula.

Examiner Checklist for Examining Internet Advertising

✓ Review the company‘s and producer‘s Internet sites with the following questions in mind:

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

✓ Run an inquiry in an Internet search engine using the company‘s name.

✓ Review the company‘s home page.

- ✓ Identify all lines of business referenced on the company‘s home page.
- ✓ Research the ability to request more information about a particular product and verify that the information provided is accurate.
- ✓ Review the company‘s procedures related to producers' advertising on the Internet and ensure that the company requires prior approval of the producer pages if the company name is used.
- ✓ Compare all the above with the lines of business approved by your state‘s license or certificate of authority.

Examiner Checklist for Examining Life Insurance Advertising

Introduction

The checklist that follows applies to printed advertisements, internet, audio and video advertisements, and to certain producer training materials that may influence the presentation of other materials or solicitations to sell life insurance products to individuals or to association or group markets.

Checklist

- ✓ Review applicable statutes, rules, regulations, and insurance department bulletins.
- ✓ Determine whether the company approves producer sales materials and advertising and whether advertisements or lead generating calls falsely imply that they were sent by a government agency.
- ✓ Determine whether the advertising and solicitation materials mislead consumers relative to the producer‘s capacity as a life insurance agent. Improper terms may include financial planner, investment advisor, financial consultant, or financial counseling if they imply the producer is primarily engaged in an advisory business in which compensation is unrelated to sales, if such is not the case.
- ✓ Review advertisements to determine that statements concerning benefits are not in larger type than statements concerning limitations or exclusions and that the advertisement as a whole does not give undue prominence to benefits over limitations or exclusions.
- ✓ Determine if analogies between a life insurance policy‘s cash values and savings accounts or other investments and between premium payments and contributions to savings accounts or other investments are complete and accurate.

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- ✓ Determine if the advertisement states or implies in any way that interest charged on a policy loan or the reduction of death benefits by the amount of outstanding policy loans is unfair, inequitable, or in any manner an incorrect or improper practice.
- ✓ Ensure, if non-forfeiture values are shown in any advertisement, that the values are shown either for the entire amount of the basic life policy death benefit or for each $1,000 of initial death benefit.
- ✓ Review the use of the words —free", —no cost", —without cost", —no additional cost", —at any extra cost", or words of similar import. Those words should not be used with respect to any benefit or service being made available with a policy unless true. If there is no charge to the insured, then the identity of the payor must be prominently disclosed. An advertisement may specify the charge for a benefit or a service; it may state that a charge is included in the premium; or it may use other appropriate language.
- ✓ Determine if any advertisement states or implies that, at some point, those future premiums will be paid by application of future or accumulated cash values (vanishing premiums). All conditions affecting such a provision must be clearly stated so as not to mislead applicants.
- ✓ Ensure that the advertisement does not contain a statement or representation that premiums paid for a life insurance policy can be withdrawn under the terms of the policy. Reference may be made to amounts paid into an advance premium fund, from which future premiums are intended to be paid, to the effect that they may be withdrawn under the conditions of the prepayment agreement. Reference may also be made to withdrawal rights under any unconditional premium refund offer.
- ✓ Ensure that advertisements containing testimonials represent actual statements made by the persons represented. Testimonials or commercials featuring spokespeople or celebrities should contain a statement as to whether the person making the testimonial or statement was compensated for his statement(s).
- ✓ Verify that the company's Advertising Log identifies all of the advertising used by the company within your jurisdiction. The log should record when each version of each advertisement was first used, when it was discontinued, and in which markets each advertisement was used.
- ✓ Review the company's marketing and training manuals concerning the use of advertising product by product as well as general advertisements related to the company's identity. Verify that all statistics quoted identify the date and source of such statistics.

Statistics should be relevant and dated recently enough to be relevant to the company's current condition.

- ✓ Ensure that an advertisement does not represent a pure endowment benefit as a "profit" or "return" on the premium paid rather than as a policy benefit for which a specified premium is paid. Such representations are deemed deceptive and misleading and are prohibited.
- ✓ Determine whether advertisements unduly stress the possibility that dependents or others might have to pay for last expenses or other debts unless a policy is purchased.
- ✓ Determine that advertisements related to policies fairly represent the suitability of products for the targeted audience.
- ✓ Determine that the company's procedures and materials relative to all insurance products comply with Right to Free Look requirements.

Documents to be Reviewed (Life Advertising)

- Advertising logs
- Written advertising documents, including print ads
- Producer training materials, even if such are designated not to be distributed to applicants
- Audio advertising tapes / commercials
- Video advertising tapes / commercials
- Original testimonial documents
- Applicable statutes, rules, regulations, and insurance department bulletins
- Company training manuals
- Company advertising manuals.

Examiner Checklist for Examining Health Insurance Advertising

- ✓ Determine that the following information has been disclosed in all solicitation and sales materials:
  - The extent to which premium rates for an individual and dependents are established or adjusted based upon rating characteristics
  - The carrier's right to change premium rates, and the factors, other than claim experience, that affect changes in premium rates

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- The provisions relating to renewability of policies and contracts
- Any provisions relating to any pre-existing condition provision
- All individual health benefit plans offered by the carrier, the prices of the plans, if available, to the eligible person, and the availability of the plans to the individual.

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

✓ Ensure that company advertisements do not misrepresent the process for enrollment/solicitation of individuals eligible through the provisions of HIPAA or otherwise misrepresent the consumer protections mandated by HIPAA and related state laws.

✓ Ensure that the company actively offers all of its available health benefit plans to all small employers and individuals. The company should not engage in marketing practices – such as discriminatory commission levels – that discourage individuals and small employers with less favorable risk characteristics from seeking or obtaining coverage.

✓ Determine whether all outlines of coverage used are authorized by the company. Ensure that the outlines of coverage accurately represent the applicable consumer protections and minimum standards required by HIPAA. The details of these requirements are contained in the NAIC's *Market Regulation Handbook*.

✓ Determine that health policy mandated benefits and benefit limitations are completely and accurately described. Policy benefits should not be given undue prominence over policy limitations and exclusions.

Examiner Checklist for Examining Long Term Care Insurance Advertising

✓ Ensure that the company files all advertisements requested by the Insurance Department.

✓ Ensure that the company annually certifies that the association endorsing the sale of long term care insurance complies with the responsibilities for disclosure, advertising, and compensation arrangements.

How to Proceed with an Examination of Underwriting and Rating

Purpose

The underwriting portion of the examination is designed to provide a view of how the company treats the public and whether that treatment is in

compliance with applicable statutes, rules, and regulations. This is typically determined by testing a sampling of files and applying various tests to the sampled files. The focus is on compliance issues. The areas to be considered in this kind of review include:

A. Rating practices
B. Underwriting practices
C. Use of correct and compliant forms
D. Termination practices
E. Unfair discrimination
F. Use of proper disclosures, buyers‘ guides, and delivery receipts
G. Statistical coding.

Techniques

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

A. Rating manuals and rate cards
B. Rate classifications
C. Rating systems filed with regulators (if required)
D. Payment plans
E. Minimum premiums
F. Policy fees
G. Discounts
H. Company automated rating systems
I. Rating materials provided to producers
J. Underwriting guidelines
K. Applicable policy forms & endorsements
L. Producer compensation agreements, where applicable
M. Statistical reporting requirements
N. Underwriting file contents and structure.

For the purposes of this appendix, —underwriting file” means the file or files containing the new business application, renewal application, rate calculation sheets, billings, binders, credit reports, all underwriting information obtained or developed, policy declaration page, endorsements, cancellation or reinstatement notices, correspondence, and any other documentation supporting selection, classification, rating, or termination of the risk. Be aware that some companies keep portions of the underwriting materials in separate

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files. The examiner must make sure that all of the relevant documentation has been provided for review.

Examiner's Checklist

- ✓ Determine the company‘s policy population (policy count) by line of business. The company‘s Annual Statement should contain this data.
- ✓ Review a random or systematic (as requested by the regulator) selection of business for application of a particular test or apply specific tests to a census population using automated tools. (In the event specific files are chosen for a target review, be certain that the examination results are clearly identified as being from the target selection.)
- ✓ Maintain a list of the various tests to be applied to each file in the sample. This can aid in consistency by assuring that each test is considered for each file in the sample. A worksheet or database may be used to compile data for each file systematically.

If exceptions are noted,

- ✓ Determine whether the exception is caused by such practices as use of faulty automated rating systems or development of improperly or vaguely worded manuals or guidelines.
- ✓ Determine the scope and extent of the problem.

The examiner's responses usually maximize objectivity as he avoids replacing company judgment with his own judgment. Keep in mind that the ultimate –ujdgment” should be that of the statutes under which the examination is being conducted.

Checklist for Examining Rating

- ✓ If rate filing is required, determine whether the company is in compliance with rating systems that have been filed with the regulator. Wide-scale application of incorrect rates by a company may raise financial solvency questions or be indicative of inadequate management oversight. Deviation from established rating plans may also indicate a company is engaged in unfair competitive practices. Inconsistent application of rates can result in unfair discrimination.
- ✓ Obtain information regarding the company‘s policy form numbers or other identification procedures. This allows any references made to such numbers or procedures to be verified without having the particular form attached. The regulator may require the company to attach the actual forms.
- ✓ If policies are issued by an automated system, and the examiner manually calculates the rates, check a variety of different rating factors. Each line of business has some rating factors in common with other

lines of business, and each line also has its own unique factors. Once it is established that the data was entered correctly and that the program is calculating correctly, for remaining policies check only the input data against the information provided to determine that the policies were rated correctly.

- ✓ If rating exceptions are noted, determine the reason – such as the use of improperly or vaguely worded rating manuals.

  Examiners may use audit software to verify correct application of specific rating components. This allows for a more thorough review and can save time during the examination process.

- ✓ Review the rating practices of renewal policies as well as newly issued policies. By reviewing renewal policies, the examiner can verify whether the company is updating rating components – such as property protection class changes. This also allows the examiner to identify any policies in which the initial year premium rates were set at artificially low levels for competitive reasons.
- ✓ Verify in the rating part of the examination that the underwriting files contain sufficient information to support the rates applied to a policy. Inherent in more complex systems is the concern for unfair discrimination.
- ✓ Determine whether file documentation is sufficient to support eligibility decisions.

Checklist for Examining Underwriting Practices

- ✓ Review relevant underwriting information; e.g., the company‘s underwriting guidelines, manuals, underwriting bulletins, declination procedures, agency agreements, correspondence with producers, interoffice memoranda and company minutes. This is to identify any anti-competitive practices.
- ✓ Use this information in determining company compliance with its manuals and guidelines.
- ✓ Confirm that the company underwriters and producers consistently apply the company guidelines for all business selected or rejected.
- ✓ Verify, with the examination team, that the company has correctly classified insured individuals.
- ✓ Underwriting guidelines may vary by geographic areas within the jurisdiction – such as for wind damage in coastal areas of a state. Identify and review data specific to those areas.
- ✓ Some indication of industry underwriting practices may be obtained by a survey of residual markets (FAIR – Fair Access to Insurance Requirements Plan and JUA – Joint Underwriting Association). If such

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programs exist in the state conducting the review, check surplus lines markets and consent-to-rate filings, if applicable.

Sometimes, the examiner verifies in the underwriting examination that properly licensed and appointed producers, if required, are producing the company's business.

Examiners may review situations involving multiple, related companies under common underwriting management. This allows checking for issues involving unfair discrimination between similarly situated policyholders. Restraint of trade issues also may be involved if there are indications of two or more unrelated companies attempting to conspire to monopolize an insurance market.

Checklist for Examining the Use of Correct and Compliant Policy Forms and Endorsements

- ✓ Verify that the company has filed all policy forms and endorsements in use.
- ✓ If applicable, verify consistent and correct use and identification of forms for the insured.
- ✓ Compare the edition dates of forms indicated against those of forms provided.
- ✓ If coverages and riders requested by the applicant are not issued as approved by underwriting, determine why.
- ✓ If a modified policy is issued, determine whether the legal notice of the change, if required by the state, was provided.
- ✓ Review any supplemental applications or underwriting reports, if applicable.

Checklist for Examining Termination Practices

Some states have stringent requirements for declination, cancellation, and non-renewal of policies. The applicable laws may vary greatly between states and between lines of business in a single state.

- ✓ Review those practices in light of the state laws and the company rules, guidelines, and policy provisions. This review may include the notices, if any, sent to mortgage companies, lien holders, additional insureds, and other parties with a legal interest in the continuation of a policy.
- ✓ Verify the accuracy of returned premiums on canceled policies and, in particular, pro rata vs. short-rate return of premiums.
- ✓ Review reinstatement offers and determine the company practice for offering reinstatement. If a high incidence of policy lapse and reinstatement is found, determine whether there is any common factor.

For example, an extraordinarily high percentage of billing notices with very short response times that result in cancellations for non-payment and then immediate reinstatement might indicate a lack of compliance with advance notice requirements in those states that have such laws. Other regulators might view the use of unreasonably short due dates as an unfair business practice under any law prohibiting unfair or deceptive business practices.

For purposes of this appendix, upon receipt of a written nonbinding application or written request for coverage from a producer or an applicant, —declination" means refusal of an insurer to issue a policy. It also includes any refusal of an agent or broker to transmit to an insurer a written nonbinding application or written request for coverage or a refusal even to quote a premium for a risk. An examiner may review the company's declinations if the state has laws governing such underwriting activity. In a state without specific laws on declinations, he may examine declinations under any law prohibiting unfair or deceptive business practices.

States have a variety of notices of declinations. A regulator may require companies to maintain declination files. Any producer with the authority to decline may also be required to maintain declination files. In some states the company is considered responsible for the actions of the producer. In those states, the examiner might find a producer's lack of declination records to be a shortcoming of the company.

The review of declination practices in a particular line of insurance should involve a request for the underwriting file for each policy selected from the random sample of declinations. The sampling should be completed separately for each product line in order to get a fair sampling for each line of business to be reviewed.

Checklist for Examining Statistical Coding

- ✓ Review the company's statistical coding procedures.
- ✓ Ensure that coding on individual policies is current and accurate.
- ✓ Determine to what statistical agencies the company reports its rating/underwriting data and ask about frequency of updates and error correction.
- ✓ Confirm that the company is using the most current codes, classes, territories, town protection classes, zip codes, etc., and note errors without regard to overcharges or undercharges.

Checklist for Examining Tests and Standards

- ✓ Determine the standards based upon the applicable statutes, rules, and regulations.

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- ✓ Determine the tests for compliance. The examiner simply applies the standards and tests provided to him. Because many states have adopted NAIC Model Laws and Model Regulations, the standards and tests can be very similar in different states. Nevertheless, each state has its own version of the Model Laws and Regulations, and some have laws unique to their jurisdiction.
- ✓ Review policy forms, sample policies, and claim and underwriting files, as well as underwriting and rating manuals.
- ✓ Look at the training materials, advertising materials, and the company's published rules and procedures for each function.
- ✓ After determining whether written and established procedures are in compliance, verify that the actual practices and activities are consistent with the stated procedures. This includes calculating rates, return premiums, claim denials, and claim payments to verify accuracy and compliance as well as adherence with the policy provisions and established company procedures. The company must explain any deviations from its established rates, forms, policies, and procedures.

In reviewing the underwriting and rating activities of a company, the examiner is trying to verify that the company's established procedures are in compliance and whether the actual practices and procedures are consistent with written and established procedures. Review usually includes reviewing pricing practices and commission structures for producers to ensure that they are in accordance with statutes and to determine that the company does not permit rebating or inducements in jurisdictions where such practices are illegal.

The examiner determines whether the underwriting practices are improperly discriminatory. He also determines whether the company adheres to the applicable statutes, rules, and regulations of the regulator and to the company guidelines in the selection of risks. All forms and endorsements forming a part of the contract should be listed on the declaration page and, in many jurisdictions, must be filed with the regulator. File documentation must adequately support decisions made, and the company may not engage in collusive or anti-competitive underwriting practices. The examiner reviews cancellation and non-renewal as well as declination notices to verify compliance with any applicable law and policy provisions.

The examiner manually calculates rates to verify that the premium charged is correctly calculated and appropriately applied to the samples. The examiner must verify that the rates in use are consistent with rates filed and approved, according to the requirements of the regulator.

How to Proceed with an Examination of Filings

A review of submitted filings may occur during the examination. Some companies have a separate department that has responsibility for submitting filings. If this is

the case, there are many functions of that department that must also be examined as part of the underwriting examination. Some duplication often occurs in those companies with separate departments. The examiner can minimize the duplication by tracking the activity in a log, like an Excel spreadsheet, and recording it in each part of the examination where it is relevant.

The review generally includes records of rate and form filings. This is done to determine whether the filings were submitted according to the regulator‘s required method. The examiner checks the implementation dates and views a sampling of policies, both new business and renewal business, to verify that the company implemented the filings according to the filed dates.

Filing records are subject to retention requirements according to the applicable laws, rules, and regulations of the state. The examiner determines whether the company has procedures in place to comply with the requirements in the regulator‘s jurisdiction and whether it is correctly following those established procedures.

How to Proceed with an Examination of Forms

Some states require that all policy forms be written according to certain standards for readability. This is gauged by a scoring method such as the Flesch scoring.

Checklist for Examining Forms

- ✓ Verify that the forms are filed or certified with the regulator according to the applicable laws.
- ✓ Review the policy forms in use, reviewing the form numbers and edition dates to determine whether the forms filed or certified are those being used.
- ✓ If appropriate software is available, check the readability of the forms in use, if the regulator requires such verification during an examination.
- ✓ Since most states require fonts of a certain size and type to enhance the readability, review forms actually used to make sure they comply with filed forms.

How to Proceed with an Examination of Policyholder Service

Policyholder service departments vary from company to company. While larger companies may have a full staff to handle policyholder services, smaller companies may include policyholder service as a function of the claim or underwriting department. Some companies do only what is required of them by state statute (e.g., notification of the 1-800 number or policyholder complaint telephone number). In contrast, some actually contact policyholders that have

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had occasion to deal directly with the company – such as when presenting a claim or requesting a policy change. The examiner needs to check with the examination coordinator to determine where the policyholder service function lies within the company. The examiner can then apply the appropriate tests and determine the effectiveness of the unit. A company organizational chart can be very useful for this and for similar issues being reviewed.

The policyholder service portion of the examination is designed to test a company's compliance with laws regarding notice/billing, delays/no response, and premium refund and coverage questions. It also determines the level and adequacy of policyholder service provided by the company.

If the state has a definition of a —complaint", make sure that any —complaint" found during the review is listed on the company's complaint log. This requires examination of correspondence directed to the company to determine whether the complaint is addressed and answered in a timely and responsive manner by the appropriate department. Some states have laws regarding what constitutes a complaint as well as the timeliness of such responses.

Checklist for Examining Policyholder Service

- ✓ Review policy issuance for timeliness.
- ✓ Review renewal premium notices, billings for changes/endorsements, and any other billing notices to determine whether the company gives adequate advance notice of the amount due and the due date. Some states have laws requiring certain time frames for policy issuance, renewal notice, and billing due dates.
- ✓ Even in those states that have no statutory time frames regarding policyholder service practices, the regulator usually has certain standard and possibly published expectations of companies in this regard. Those standards may be based on the NAIC Model Act and/or the NAIC Unfair Trade Practices Act for prohibition of unfair, discriminatory, and deceptive business practices. Many states have adopted some version of that Model Act. The regulator may publish the standards in different ways – such as by issuing bulletins or on a state regulator's website. It might also notify the companies directly.

How to Proceed with an Examination of a Life Company

Introduction

The following applies to underwriting and new issues of life, annuity, and endowment policies to individual, association, or group markets.

Checklist

- ✓ Review applicable statutes, rules, regulations, and insurance department bulletins.
- ✓ Review the company‘s Certificate of Authority to verify that the company is authorized to sell life insurance and annuity contracts.
- ✓ Review the company‘s written processes and procedures for underwriting and issue of life policies.
- ✓ Review all applicable application forms by line of business; i.e., for individual, group, association, credit insurance, etc.
- ✓ Verify whether the insured is also the owner of the policy. If not, verify the owner‘s insurable interest in the life of the insured person. If the owner is not a close relative (parent, child, spouse, sibling), determine if coverage is for a key employee. If not, investigate thoroughly.
- ✓ Determine if a replacement is involved, and if so, verify compliance with appropriate replacement statutes, regulations, and bulletins.
- ✓ Verify overall processing times from the date the application is signed through the date the policy is issued. Does time to issue comply with your jurisdiction‘s statutes and regulations?
- ✓ Verify that any on-line application forms are state-specific and comply with your jurisdiction‘s statutes and regulations.
- ✓ Review all application forms. Are questions clear, specific, and objective? Is sufficient space provided to allow applicants to fully respond to questions? Are all questions used in compliance with state laws and regulations?
- ✓ Verify that the producer is licensed to sell life insurance at the time the application was signed and that the company appointed the producer.
- ✓ Verify that all commissions paid for sale of a policy were issued to producers who were licensed to sell that type of policy.
- ✓ Determine whether applications were submitted with an initial premium payment or if the policy was delivered C.O.D. Some jurisdictions require that companies approve or deny an application within a set time after the application is submitted or require the company to refund the initial premium deposit. Determine that all policies were issued or denied within such statutory time limits.

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- ✓ Review the company's policy issue process. If policies are generated by an on-line computer system, does the company track the date a policy is actually mailed? Is that date different from the date the policy is approved for issue?
- ✓ Determine the policyholder's other coverage with the company by obtaining a complete list of policies, detailing the type(s) of policies, issue dates, termination dates, reason(s) for termination, and names of producers and agencies associated with each sale. Producer and agent identification numbers and addresses should be obtained as well.

Documents to be Reviewed (Life Underwriting and Issue)

- Underwriting and Issue logs
- Underwriting files
- Application forms – both paper forms and forms used on line
- Producer and agent licenses
- Company appointment records for producers and agencies
- Company's Certificate of Authority
- Producer training materials, even if such are designated not to be distributed to applicants
- Applicable statutes, rules, regulations, and insurance department bulletins
- Company training manuals related to suitability
- Company underwriting manuals for each line of business
- Company policy issue manuals.

How to Proceed with an Examination of Life Insurance Claims

Introduction

The following applies to the examination of a company's administration of claims for life insurance, annuities, and endowment policies.

Checklist

- ✓ Review applicable statutes, rules, regulations and insurance department bulletins

- ✓ Select a sample of files to be audited. Depending on the size of a company, this may be all of the life claims processed during a time period, or a random sample of such claims.
- ✓ Review all beneficiary changes from the date of issue to the date of death of the insured person. Are reasons for each such change clearly documented?
- ✓ Review all ownership changes from the date of issue to the date of death of the insured person. Are reasons for each such change clearly documented?
- ✓ Review the entire claim file to determine if the company‘s actions and dates of such may be readily ascertained.
- ✓ Verify calculations of benefits payable, including any adjustments for policy loans, loan interest, premium refunds, and interest payments. Verify that settlement totals are equal to the amount payable, including any portions which might be payable as an annuity.
- ✓ Review all records concerning investigations to determine the cause and manner of death. If the investigation resulted in a claim denial and/or rescission of coverage, verify that any misrepresentations were material to the company‘s acceptance of insurance.
- ✓ If benefits were denied for accidental death, verify that the company‘s investigation documented facts that support this denial.
- ✓ If benefits were adjusted due to a suicide, verify that the company‘s investigation documented facts that support this denial. Does the policy contain exclusions for suicide while sane or insane, or other language?

Documents to be Reviewed for Life Claims

- Advertising logs
- Written advertising documents, including print ads
- Producer training materials, even if such are designated not to be distributed to applicants
- Audio advertising tapes / commercials
- Video advertising tapes / commercials
- Original testimonial documents
- Applicable statutes, rules, regulations, and insurance department bulletins

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- Company training manuals
- Company advertising manuals.

How to Proceed with an Examination of Life Company Replacements

Introduction

Replacement is the exchange of a new policy for one already in force.

Techniques Checklist

- ✓ Review the company's written processes or procedures used for the replacement of life policies.
- ✓ Determine whether errors can be detected and corrected.
- ✓ Review a copy of the company's replacement register.
- ✓ Determine the company's standards for timeliness regarding replacement notices.
- ✓ Review copies of the company's replacement disclosure forms.
- ✓ Determine whether the company advises its producers of its replacement policy.
- ✓ Determine whether the company provides timely notice of replacements to existing insurers.
- ✓ Review the company's time standards for replacement notices. Are these standards sufficient?
- ✓ Examine for effectiveness the company's system of identifying undisclosed replacements. For instance, does the company track repeat sales to policyholders, and if so, are the procedures the same for all ages of policyholders?
- ✓ Determine whether the company has the capacity to produce data required by replacement regulation to assess producer replacement activity.
- ✓ Determine whether the company issues letters to policyholders in a timely manner advising of the effects of loans and other disbursements on policy values.
- ✓ Review policy/underwriting files to verify that the company is retaining required records for required time frames.
- ✓ Examine company procedures for verifying producer compliance with requirements on replacement transactions.

- ✓ Review claims files to determine whether the company provides required credit for suicide and contestability periods on replacements.
- ✓ There may be special requirements for applicants age 60 or over. Refer to statutes, rules, and regulations to determine which requirements apply.
- ✓ Review loan and surrender files to determine whether producers have identified replacement transactions on applications.
- ✓ Review the replacement register and policy/underwriting files to determine whether required disclosure forms are being submitted on replacement transactions.
- ✓ Review the policy/underwriting files to confirm receipt of sales material or required statement. Copies of sales material other than company approved, if permitted, must also be on file.
- ✓ Review replacement disclosure forms for completeness and signatures as required.

Documents to be Reviewed

- Applicable statutes, rules, and regulations
- Replacement register
- Policy/Underwriting file
- Underwriting procedures and manuals
- Rating rules and manuals
- Loan and surrender files
- Agency correspondence file
- Agency bulletins
- Agency procedural manuals
- Claims files
- Agency sales/lapse records
- Company systems manual

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Endnotes

[1] National Association of Insurance Commissioners, *Market Regulation Handbook* (NAIC, 2301 McGee Street, Suite 800, Kansas City, MO 64108-2662), 2006.

Appendix D
- Areas of Review by Line of Business – Health Companies, Managed Care Entities, & Health Maintenance Organizations (HMOs)[1]

Introduction

This appendix presents suggested areas of investigation by line of business (LOB) for a market conduct examination of health companies, managed care entities, and Health Maintenance Organizations (HMOs). It provides checklists and suggestions for the examiner.

Business Areas to Review

A market conduct examination of health insurance operations typically involves a review of one or a combination of any of the following business areas and may apply to all health carriers while others may apply only to health carriers with managed care plans.

Company Operations/Management

This section of a market conduct examination is designed to provide a view of what the company is and how it operates. It does not involve sampling and is more concerned with structure and procedures. In evaluating an insurer‘s operations and management, examiners are concerned with whether the insurer is organized and structured to ensure regulatory compliance. The types of records reviewed may include the insurer‘s Certificate of Authority (C of A), audit plan material, antifraud plans, disaster recovery plans, group trust arrangements, the filing of various mandated reports with the state Insurance Departments, and Board of Directors meeting minutes. If a company is unable to provide data that is subject to market conduct examinations, this is a shortcoming that, although noted in the various sections being reviewed, would most likely be cited under the company operations and management section of the final report.

Advertising and Sales Materials

All states impose regulatory requirements on the advertising and sales materials insurers use to market their products. For regulatory purposes, advertising and sales materials include a variety of items ranging from traditional advertisements via mass media to sales illustrations. The advertising material should be compared to the policy forms they advertise to ensure that the materials accurately represent the terms of the policy forms and comply with applicable state laws. All states have unfair trade practices

acts that prohibit, among other things, misrepresentation and false advertising.

States hold insurers responsible for the content of all advertisements of their policies regardless of who created or used the advertisement. Therefore, a market conduct examination includes a review of the insurer's procedures for reviewing all advertising and sales material, including any allowed to be developed by sales agents/producers. Most insurers now forbid their producers from using any written materials unless the materials have been approved by the home office. Additionally, many states require insurers to file specified advertising materials with the state Insurance Department before those materials are used in the state.

Producers

Because of the technical components involved in insurance products, it is particularly important that the individuals selling insurance understand the contracts they propose to sell. All states require agents/producers to demonstrate a level of proficiency by passing an examination prior to being licensed. The testing shows that they understand the contracts they will be offering to the public and understand the laws under which they will be required to operate.

Checklist for Examining Producers

- ✓ Compare the insurer's records of licensing and appointment of insurance producers (if appointment is required by state law) to the state Insurance Department's records to verify that the records agree. Information related to producer licensing may be obtained from the NAIC Producer Database (PDB) if the state is actively submitting information to the database.
- ✓ Evaluate whether sales producers were properly licensed in the state when the application was completed and whether the producers are soliciting only those insurance products that they are licensed to sell.
- ✓ Review the procedures the insurer follows in terminating its appointment of agents/producers for complete documentation of the reasons for each termination and for verification that the Insurance Department was notified of all terminations.
- ✓ Reconcile company listings of producer terminations with listings of commissions paid to determine whether payouts (renewal commissions) are being made properly to terminated producers.

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Complaints

A comprehensive market conduct examination includes a review of the insurer‘s complaint handling procedures. A random sample of complaints should be selected for review from the company‘s complaint log/register. The NAIC definition of a complaint is:

> —awritten communication primarily expressing a grievance” (meaning an expression of dissatisfaction).

All Insurance Departments offer assistance to consumers in resolving disputes with insurers and insurance agents/producers. Most states require carriers to keep, usually in a required format, a log of consumer complaints received directly from covered persons, attorneys, or providers.

Checklist for Examining Complaints

- ✓ Review the company‘s log and the complaints received by insurance departments to provide insight as to which areas might present problems, especially if there is a pattern to the types of complaints.
- ✓ The required time limits for handling complaints may be dictated by law. Review the insurer‘s written complaint handling procedures for compliance with legal time limits. Also measure the time it takes a company to handle each complaint to assure that the company‘s procedures are followed and that handling is compliant with applicable law.
- ✓ Review the final disposition of the complaints that were directly received by the company and determine whether the company has taken adequate steps to finalize the complaints in compliance with the particular state's statutes, rules, and regulations. Verify that each issue raised in the complaint has been addressed.
- ✓ If the files reviewed for other sections reveal correspondence meeting the definition of a complaint, ensure that these are reflected in the complaint logs maintained by the company.
- ✓ Verify that policyholders are provided with a telephone number and address for consumer inquiries or complaints about their policies. Most states also require that complainants be provided with the address and toll-free phone number of the state insurance department.

Policy Issuance and Renewal Business

A sample of new business policies issued and policies renewed during the period under examination is usually selected for review. Examiners should obtain the following company information sources prior to reviewing the actual

files: underwriting and guideline manuals, classification manuals, and medical underwriting manuals.

Checklist for Examining Policy Issuance

Examination of new business files consists of ensuring that underwriting practices are not unfairly discriminatory and that they are performed in compliance with the insurer‘s guidelines and in accordance with state guidelines. Although not intended to be an all inclusive list, the examiner should proceed as follows for all policies reviewed:

- ✓ Ensure that applications were properly completed, signed, and dated by the applicant for insurance, and that the information in the file supports the underwriter‘s decisions regarding risk classification and premium rating.
- ✓ Ensure that any erasures, corrections, strike-throughs, or other changes on the application were made with the applicant‘s knowledge and consent.
- ✓ If a policy was issued on a basis other than as applied for, ensure that a notice of an adverse underwriting decision was provided to the consumer in accordance with regulatory requirements.
- ✓ In those states where applicable, if replacement coverage was involved, ensure that specific information regarding replacement was made available to the prospective insured. This procedure reduces the opportunity for misrepresentation and other unfair practices and methods of competition in the business of insurance. This notice to applicants must usually be provided in a specific format prescribed by the Commissioner.
- ✓ Evaluate the timeliness of policy issuance after receipt of the application for coverage. Many states require that policies be issued within a specified time after an application is received. If policies are not issued within that time limit, all initial premiums must be refunded.
- ✓ Determine whether all of the policy forms in use are reflected in the filings made with the Insurance Department that list all policy forms in use during the time frame of the examination.
- ✓ Verify that all of the correspondence in the files that was directed to the company was answered in a timely, responsive, and appropriate manner.
- ✓ If reinstatement was involved, verify that reinstatement provisions were applied consistently and in a non-discriminatory manner.
- ✓ Review premium notices for timeliness of mailing.

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Terminations

If applicable, for each type of termination, a sample of canceled, non-renewed, declined, and rescinded policies during the time frame of the examination should be selected for review. Using the sample, the examiner should determine that evidence of creditable coverage was provided in accordance with the requirements of HIPAA and other statutes, rules, and regulations. Certificates of creditable coverage should be issued automatically and upon request and provided free of charge. The following information is required to be included:

- An indication as to whether an individual has at least 18 months of creditable coverage
- For individuals with less than 18 months of creditable coverage, an indication of the dates when coverage began and ended and the date any waiting or affiliation period began
- A contact phone number
- When the certificates are provided upon request, each period of continuous coverage ending within the 24 months prior to the date of the request
- When the certificates are automatically issued, the most recent period of coverage.

Checklist for Examining Cancellations

- ✓ Determine whether a cancellation by the insurer is allowed for the particular type of insurance being reviewed.
- ✓ Review the company‘s cancellation process to make sure it complies with all applicable regulatory requirements. The provision for cancellation usually requires the insurer to give the insured a specified number of days of notice, and this should be reviewed for compliance with policy language and statutory requirements.
- ✓ If an insured requests cancellation, review the correspondence in the file to verify that the request was handled in a timely manner, including return of any unearned premium.

Checklist for Examining Non-Renewals

- ✓ Ensure that non-renewals are processed for allowable reasons only; e.g.,
  - Nonpayment of premium
  - Fraud
  - The insured‘s request

- The insured moving outside of the service area
- The insured terminating required membership in an association.

  Group coverage may also be terminated for violation of applicable participation/contribution rules. Individuals within groups may lose coverage when they become covered by, or eligible for, Medicare. An insurer may non-renew if it discontinues offering all individual, small group, or large group health benefit plans in a particular state, but the insurer must sit out of the market for a period of five years after the date of notice to the Commissioner.

✓ Refer to state statutes, rules, and regulations for the examination of specific situations.

✓ Ensure that the company is complying with the provisions of COBRA and HIPAA with respect to continuation of coverage, including required notice periods for withdrawing products from the market.

Checklist for Examining Declinations

✓ Determine that the reasons for declinations are not unfairly discriminatory and that the particular type of insurance allows for declinations.

✓ Verify that the notice of this adverse underwriting decision was provided to consumers in accordance with regulatory requirements.

Checklist for Examining Rescissions

✓ Determine that coverage was rescinded within whatever time frame is allowed after coverage is effective, that the reason for rescinding was valid, that the covered person was notified of the rescission in a timely manner, and that the correct amount of premium was returned. This determination requires a review of (1) the application for coverage, (2) dated documentation of any return of premium, (3) dated documentation of the insured‘s notification of rescission, and (4) possibly one or more claim files.

✓ The receipt of a claim is usually a trigger to begin the investigation leading to rescission of coverage. Therefore, review for timely processing of any initial requests for medical records needed to process the claim and timely processing after receipt of the medical records.

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Claims

Insurers have a responsibility to their policyholders to pay all valid claims, which includes the responsibility for determining which claims are valid and which are not. Thus, insurers must establish procedures to ensure that all claims are evaluated promptly and accurately. All but a few states have enacted legislation based on, or similar to, the NAIC model *Unfair Claims Settlement Practices Act*. Laws based on the Model Act list a number of actions that represent unfair claims practices when committed by an insurer transacting business in the state if they are (1) in conscious disregard of the law or (2) committed so frequently as to indicate a general business practice. A few states have adopted regulations based on the NAIC *Unfair Life, Accident, and Health Claims Settlement Practices Model Regulation*. Such regulations establish minimum standards that insurers must meet in handling life and health insurance claims.

Company information source material used by market conduct examiners in the review of claims should include claim procedures and claim handling practice manuals, any interoffice claim bulletins, and the insurer‘s claim forms. These should be reviewed in order to determine compliance with regulatory requirements and policy provisions.

Examining Claims Processing

Random samples, using an audit software package, of —paid” and —denied” claim files are usually selected to review for accuracy of claim processing in accordance with a particular state‘s insurance laws. When reviewing managed care claims, it is beneficial to obtain a listing of each type of claim; i.e., contracted provider fee-for-service claims, out-of-network claims, hospital and medical facility claims, emergency services, etc. The following facts are usually evaluated from the material in the file:

- Whether files contain adequate and accurate documentation including the following:

  Notice of claim, claim forms, medical records, bills, proofs of loss, correspondence to and from insureds or their representatives, claim investigation documentation, pre-admission certification or utilization review documentation, copies of Explanation of Benefits (EOB) statements and/or Remittance Advice (RA) forms, copies of checks or check numbers and amounts, complaint correspondence, all applicable notices and correspondence used for determining and concluding claim payments or denials, and any other documentation necessary to support claim handling activity.

- Whether the claim was reviewed and handled in a manner consistent with the stated policies and procedures of the company. For example, if the company‘s procedures manual states that the

Attending Physician's Statement (APS) is the primary document for evaluation of a disability claim, does the file reflect that the APS was obtained and given appropriate weight?

- Whether the amounts of claim payments made were accurately calculated.
- Whether the claim payment or denial of payment corresponds to the coverage/exclusions reflected in the policy.
- Whether the policy covering the claim was in force during the date of service.

Examining Timeliness of Claim Payments

Although not absolutely necessary, a separate sample of both paid and denied claims can be selected solely to review for timeliness of payment, denial, or some method of settlement. This may involve one sample of claims received electronically and another of those received non-electronically if the state conducting the examination has insurance laws that require different time periods for processing depending on the method used for submitting the claim. A determination should be made as to:

- Whether the length of time required to pay, deny, or settle claims is in compliance with what is required by the particular state's law.
- Whether, if required by the particular state for late payment of claims, interest/penalties were paid and calculated correctly.
- Codes used to generate comments on EOBs or RAs may provide clues as to previous handling of a particular claim, or of unique claims handling practices. Data pulls used to select samples should include payment/denial comment codes. A dictionary of such codes should be provided to help target examination efforts and reduce the length of the market conduct examination.

Whether the company is using correct procedures to allow a determination of the period of time used to process claims.

Utilization Review

Efforts to reduce costs have come mainly in the form of managed care initiatives that were pioneered by HMOs but that have been adopted by other insurers. A number of policy provisions adopted by insurers are designed to encourage the cost-effective delivery of care. Utilization Review (UR) is one of these efforts. It is defined by the NAIC in its Utilization Review Model Act as a set of formal techniques designed to monitor the use, or evaluate the clinical necessity, of appropriateness, efficacy, or efficiency of health care services, procedures, or settings.

Following is a list of techniques that should be included:

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- Ambulatory Review (Utilization review of health care services performed or provided in an outpatient setting)
- Prospective Review (Utilization review conducted prior to an admission or course of treatment)
- Second Opinion (An opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed health service)
- Certification of Services to be Provided
- Concurrent Review (Utilization review conducted during a covered person‘s hospital stay or course of treatment)
- Case Management (A coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other, health conditions)
- Discharge Planning (The formal process for determining, prior to discharge from a facility or service, the coordination and management of the care that a patient receives following discharge from a facility or service)
- Retrospective Review (Any utilization review, that is not a prospective review but does not include the review of a claim, that is limited to veracity of documentation or accuracy of coding)
- Clinical Peer Review (An evaluation of current or possible treatment by a second provider with comparable credentials and training that can properly evaluate the treatment being considered).

Information sources that should be requested from the company for review prior to beginning review of individual files include the company‘s written utilization review policies and procedures, annual summary reports, copies of any form letters used, copies of contracts, if any, between the company and any outside utilization review organization or entity, and procedures for oversight of delegated utilization review functions.

The following are practices and documents that can be reviewed prior to selection and review of the sample of individual files:

- The establishment and maintenance of a utilization review program, if required, that is in compliance with statutes, rules, and regulations. Verify that the program is certified by URAC or an equivalent body.
- If a health carrier contracts with an entity to provide utilization review services, it should monitor the activities of the entity and ensure that the contracting organization complies with the particular jurisdiction‘s statutes, rules, and regulations.

- A procedure should be in place to ensure that all contracting providers are informed of the pertinent aspects of the carrier‘s utilization review program.
- If required, it should be determined that any summary reports of utilization review activities have been filed with the Commissioner.
- Covered persons should be provided with access to the company‘s utilization review staff by a toll-free number or collect-call phone line.
- Membership cards should reflect the toll-free number to call for utilization review decisions.
- A clear and accurate summary of the health carrier‘s utilization review program should be provided to prospective covered persons.
- A clear and comprehensive description of the company‘s utilization review program should be provided in the Certificate of Coverage (COC) or Member Handbook provided to covered persons.
- It should be determined whether utilization review requirements are consistent with language in the policy, COC, and marketing materials.
- No incentives to make inappropriate review decisions, direct or indirect, should be included in the compensation provided to persons providing utilization review services for the health carrier.
- The health carrier should have written procedures to address the failure or inability of a provider or a covered person to submit the information necessary to make a determination.

Whether a carrier conducts its own utilization review or uses another entity for this purpose, a sample can be selected from (1) all cases processed, (2) reconsiderations of adverse determinations of certification, and (3) appeals that were conducted during the period of the examination. Utilization review issues that need to be addressed may also be noted during the examiner‘s review of claims, complaints, and grievance procedures.

Following are some specific determinations to be made from a review of the sample files. For each specific type of determination, there is a required time frame and method of notification that should be met.

Checklist for Examining a Standard Utilization Review

- ✓ Verify that notification of certification for a prospective review determination was made within a reasonable period of time appropriate to the covered person‘s medical condition but in no event later than 15 days after the date the health carrier receives the request. This time period may be extended one time by the health carrier for up to 15 days if:

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1. It is determined that an extension is necessary due to matters beyond the health carrier‘s control; and
2. Notification is furnished to the covered person prior to the expiration of the initial 15-day time period, including the circumstances requiring the extension of time and the date by which the carrier expects to make a determination.

- ✓ If this extension is necessary due to the covered person's failure to submit the necessary information, verify that the notice of extension:
  1. Specifically describes the required information necessary to complete the request; and
  2. Gives the covered person at least 45 days from the date of receipt of the notice to provide the specified information.
- ✓ Verify that notification of an adverse determination was provided in writing, either on paper or electronically. There are numerous requirements to be set forth in this notification.
- ✓ For an adverse determination regarding a prospective review decision that occurs during a covered person‘s hospital stay or course of treatment, verify that the health care service, or treatment for which the determination was issued, was continued without liability to the covered person until the covered person was notified of the determination by the carrier.
- ✓ For retrospective review determinations, verify that the carrier made the determination and notified the covered person and the person‘s provider within a reasonable period of time, but in no event later than 30 working days after receiving all necessary information. If the determination is a certification, the carrier, at its discretion, may notify in writing the provider and the covered person. This time period may be extended one time by the health carrier for up to 15 days if:
  1. It is determined that an extension is necessary due to matters beyond the health carrier‘s control; and
  2. Notification is furnished to the covered person prior to the expiration of the initial 30-day time period, including the circumstances requiring the extension of time and the date by which the carrier expects to make a determination.
- ✓ If this extension is necessary due to the failure of the covered person to submit the necessary information, verify that the notice of extension:

1. Specifically describes the required information necessary to complete the request; and
2. Gives the covered person at least 30 days from the date of receipt of the notice to provide the specified information.

Checklist for Examining an Expedited Utilization Review

- ✓ For an urgent care request, unless the covered person has failed to provide sufficient information for the health carrier to make a determination, verify that the health carrier notified the covered person and the covered person‘s provider of the carrier‘s determination as soon as possible, taking into account the medical condition of the covered person. This notification shall in no event be later than 72 hours after the receipt of the request by the health carrier.

If the covered person failed to provide sufficient information for the carrier to make a determination:

- ✓ Verify that the covered person was notified either orally or, if requested by the covered person, in writing. This notification is to state what specific information is needed as soon as possible but in no event later than 24 hours after receipt of the request.
- ✓ Verify that the carrier gave the covered person no less than 48 hours after notification to submit the necessary information. Notification of the determination under these circumstances is to be given to the covered person and the covered person‘s provider no more than 48 hours after the earlier of:
    1. The health carrier‘s receipt of the requested specified information; and
    2. The end of the period provided for the covered person to submit the requested information.
- ✓ Verify that notification of an adverse determination was provided orally, in writing, or electronically. If notice of the adverse determination is provided orally, the carrier must provide written or electronic notice within three days following the oral notification. There are numerous requirements to be set forth in this notification.

Concurrent urgent care review requests extend the course of treatment beyond the initial period of time or the number of treatments authorized. For such requests:

- ✓ If a request was made at least 24 hours prior to the expiration of the authorized period of time or authorized number of treatments, verify that the health carrier made a determination and notified the

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covered person and the covered person's provider of the determination as soon as possible but in no event more than 24 hours after the carrier's receipt of the request.

- ✓ Verify that notification of an adverse determination was provided orally, in writing, or electronically. If notice of the adverse determination is provided orally, the carrier must provide written or electronic notice within three days following the oral notification. There are numerous requirements to be set forth in this notification.

  Within 180 days after the receipt of a notice of an adverse determination, a covered person may file a grievance with the carrier requesting a first level review of the determination.

- ✓ Review the processing of standard first level appeals or reviews of an adverse determination to ensure that:

  - Appeals are evaluated by a physician who consults with an appropriate clinical peer (or peers), unless the reviewing physician is a clinical peer. This physician and clinical peer(s) should not have been involved in the initial adverse determination. This is an important issue: The clinical peer must possess the same qualifications as to specialty as the treating physician. For instance, it is not acceptable for an orthopedic surgeon to act as a clinical peer for a cardiac case.

  - With respect to notification of an adverse determination involving either a prospective or a retrospective review request, the decision is sent in writing or electronically to the covered person within a reasonable period of time that is appropriate given the covered person's medical condition, but no later than 30 days after the date the carrier received the grievance requesting the first level review.

  - The written decision includes numerous notification requirements, including the covered person's right to submit the adverse determination to a voluntary second level review and a description of the procedures for obtaining an independent external review of the adverse determination if the person chooses not to file for a voluntary second level review. A description of the external review is to be included also.

Within 30 days after the receipt of a notice of an adverse determination for the first level review, a covered person may file a request with the carrier requesting a voluntary second level review of the adverse determination.

- ✓ Review the processing of voluntary second level reviews or appeals of an adverse determination to ensure that:

- The denial was reviewed by a health care professional with appropriate expertise in relation to the case being presented by the covered person. The reviewing health care professional cannot have been previously involved in the appeal and cannot have a direct financial interest in the appeal or outcome of the review.
- A review meeting was held within 60 days of receiving a request for a voluntary second level review, and the covered person was notified in writing at least 20 days in advance of the review date.
- Notification to the covered person of the review date reflects all rights and responsibilities of the covered person.
- The health care professional issued a written decision to the covered person within seven days of completing the review meeting. There are numerous required statements and information to be included in the notifications of decision.

✓ Review the processing of expedited reviews or appeals (not to be provided for retrospective adverse determinations) to ensure that:

- The appeal was evaluated by an appropriate clinical peer (or peers) in the same or similar specialty as would typically manage the case and who was not involved in the initial adverse determination.
- All necessary information, including the health carrier‘s decision, was transmitted between the carrier and the covered person or the provider acting on behalf of the covered person by telephone, facsimile, or the most expeditious method available.
- The carrier made a decision and notified the covered person or the provider as expeditiously as the covered person‘s condition required but in no event more than 72 hours after the review was commenced. If an expedited review is a concurrent review determination, the service must be continued without liability to the covered person until the covered person is notified of the determination.
- Written confirmation of a decision was provided within three working days after providing notification of the decision, if the initial notification was not in writing.

Independent External Reviews

Procedures required for External Review vary widely by state. It is imperative that the examiner review the specific requirements for his state.

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Some general procedures and criteria that should be checked to ensure that companies are in compliance are as follows:

- ✓ That in applicable instances covered persons are advised in writing of the right to request an external review.
- ✓ That the above notice includes what circumstances constitute sufficient grounds for a standard, expedited, or experimental/investigational review and the procedures to be followed to request a review.
- ✓ That an authorization form that allows the health carrier to disclose protected health information is included with the notice.
- ✓ That written records in the aggregate, and for each type of health benefit plan offered by the carrier, are maintained on all requests for external review.
- ✓ That a report of all requests for external review is submitted to the jurisdiction‘s Commissioner in the time frame and format specified by the Commissioner.
- ✓ That the cost of the independent review is being paid by the carrier to the organization conducting the external review.
- ✓ That a description of the external review procedures are in or attached to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage provided to covered persons including the telephone number and address of the Commissioner.

All state statutes, rules, and regulations should be considered in a review of a company‘s external review procedures. In jurisdictions where the NAIC‘s Health Care External Review Model Act has been adopted, for health insurance carriers, there is an Option 1, an Option 2, and an Option 3 choice of procedures and criteria that should be reviewed for compliance. This applies whether the request is for a standard, expedited, or experimental/investigational review.

External Review Option 1

The external review process resides in the office of the Commissioner and requires that covered persons file all requests for external review with the Commissioner. This option also requires the Commissioner to conduct a preliminary review of the request for external review to ensure that it meets all of the requirements to be eligible for external review. If a request for external review is determined to be eligible for external review, the Commissioner is required to assign an Independent Review Organization (IRO) to conduct the external review. This option requires the assigned IRO to provide the Commissioner with a written recommendation on whether to uphold or reverse the adverse determination or final adverse determination. After reviewing the recommendation, the Commissioner is required to communicate the external review decision to the covered

person, the covered person's authorized representative if applicable, and the health carrier.

External Review Option 2

This alternative is the same as Option 1 except that the IRO assigned to conduct the review determines whether the company's decision is to be reversed.

Standard External Review Checklist for Option 2

- ✓ Check that all documents and any information considered in making the adverse determination or the final adverse determination were provided to the assigned IRO within seven days.
- ✓ Check that the covered person or, if applicable, the covered person's authorized representative, the assigned IRO, and the Commissioner were notified by the company in writing of its decision upon making the decision to reverse its adverse determination or final adverse determination.
- ✓ Check that the coverage that was the subject of the adverse determination or final adverse determination was approved upon receipt of a notice of a decision reversing the original determination.

Expedited External Review Checklist for Option 2

- ✓ Check that all necessary documents and information considered in making the adverse determination or final adverse determination were provided in an expeditious manner to the assigned IRO upon receipt of notice that the case was accepted for an expedited external review.
- ✓ Check that the coverage that was the subject of the adverse determination or final adverse determination was approved upon receipt of a notice of a decision reversing the original determination.

Experimental or Investigational Treatment Checklist for Option 2

- ✓ Check that all necessary documents and information considered in making the adverse determination or final adverse determination were provided or transmitted in an expeditious manner to the assigned IRO.
- ✓ Check that the documents and any information considered in making the adverse determination or the final adverse

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determination were provided to the assigned IRO within seven days.

- ✓ Check that the coverage that was the subject of the adverse determination or final adverse determination was approved upon receipt of a notice of a decision reversing the original determination.

External Review Option 3

This option makes it the responsibility of the health carrier to provide for an external review process and requires that covered persons file requests for external review with the health carrier. The health carrier must also assign an IRO, from the list of approved IROs compiled by the Commissioner, to conduct a preliminary review of the request and conduct an external review of the request if the request has satisfied specified requirements to be eligible for external review.

Standard External Review Checklist for Option 3

- ✓ Check that a copy of the request for an external review was sent to the Commissioner.
- ✓ Check that the documents considered in making the adverse determination or the final adverse determination were provided to the assigned IRO within seven days.
- ✓ Check that the covered person or, if applicable, the covered person‘s authorized representative, the assigned IRO, and the Commissioner were notified by the company in writing of its decision upon making the decision to reverse its adverse determination or final adverse determination before a determination by the IRO.
- ✓ Check that the coverage that was the subject of the adverse determination or final adverse determination was approved upon receipt of a notice of a decision reversing the original determination.

Expedited External Review Checklist for Option 3

- ✓ Check that a copy of the request for an expedited external review request was sent to the Commissioner.
- ✓ Check that all necessary documents and information considered in making the adverse determination or final adverse determination were provided or transmitted in an expeditious manner to the assigned IRO.

- ✓ Check that the coverage that was the subject of the adverse determination or final adverse determination was approved upon receipt of a notice of a decision reversing the original determination.

Standard Experimental or Investigational Checklist for Option 3

- ✓ Check that a copy of the request for an expedited external review was sent to the Commissioner.
- ✓ Check that the coverage that was the subject of the adverse determination or final adverse determination was approved upon receipt of a notice of a decision reversing the original determination.

  Note: The IRO can (1) deny the request for an external review and (2) not choose or control the choice of the physicians or other health care professionals to be selected to conduct the external review.

Expedited Experimental or Investigational Checklist for Option 3

- ✓ Check that a copy of the request for an expedited external review was sent to the Commissioner.
- ✓ Check that all necessary documents and information considered in making the adverse determination or final adverse determination were provided or transmitted in an expeditious manner to the assigned IRO.
- ✓ Check that the coverage that was the subject of the adverse determination or final adverse determination was approved upon receipt of a notice of a decision reversing the original determination.

Quality Assessment and Improvement

The quality assessment portion of an examination is designed to assure that companies offering managed care plans have quality assessment programs in place. These programs should enable the company to evaluate, maintain, and when required by state law, improve the quality of health care services provided to covered persons. For managed care plans that limit covered persons to a closed network, the standards also require a quality improvement program with specific goals and strategies for measuring progress toward those goals.

The areas to be considered in this kind of review include the company‘s written quality assessment and improvement policies and procedures, annual certifications, reporting of disciplined providers, communications with

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members about the program, and oversight of delegated quality-related functions.

An examiner may take into account accreditation for the specific operational area of quality assessment and improvement when planning the examination and setting review priorities. In this instance, the examiner should become familiar with the standards applied by the accrediting entity. Individual jurisdictions may have procedures in place for communicating deviations from such standards to the applicable accrediting entity in addition to administrative procedures.

Policy Forms

The review of policy forms is not based on sampling techniques and may include a review of all plans, riders, and amendments issued in the state conducting the examination or just the most frequently sold plan and any plans mandated to be offered. Since an insurance product is by its very nature a contract, customers are asked to purchase a product in which they become a party to a contract that in many instances they have not read and would not understand if it were read. Because insurance contracts are complicated, they are subject to regulatory standards.

In most cases, policy forms must be approved by the regulatory authorities to ensure that the insurance-buying public is not subject to unfair provisions and, additionally, that the solvency of the insurers is protected against unreasonable commitments they might make under the stress of competition. In some states, new policy forms and endorsements need only to be filed with the Commissioner‘s office before they are put into use. Market conduct examiners must review these to make sure that they (1) contain required provisions, (2) contain required notifications, (3) reflect all mandated coverage, and (4) do not include prohibited provisions or exclusions.

Rates

Even under competitive rating systems (e.g., file and use, use and file, etc.), regulators believe it is important to verify that consumers are charged the rates that have been filed.

This can involve a separate sample of new business and renewal business files. However, a more efficient, and just as productive, method is to use the files already selected for new and renewal business. Examiners determine whether the insurer has filed premium rates, if required, and is applying premium rates consistently and in accordance with the rates that were filed and its own rating methods. An evaluation should be made as to whether the company is charging the correct premium for riders and endorsements and is implementing premium rate increases properly. Most of the information needed to make these determinations is already in the new and renewal

business files and, if used, eliminates the necessity of a separate sample being chosen.

All states (except Illinois, which does not currently have a rating law) provide for the regulation of insurance rates, requiring that the rates must be adequate, not excessive, and not unfairly discriminatory.

These criteria are generally not evaluated by market conduct examiners. Instead, an actuarial section within the Insurance Departments takes on this responsibility. All states have legislation requiring that rates be reasonable, adequate, and not unfairly discriminatory, yet the manner in which these requirements are enforced varies by line of insurance and from state to state.

Conclusion

By implementing the procedures suggested in this appendix, examiners have a better chance of experiencing an efficient and effective market conduct examination of health insurance companies, managed care entities, and HMOs.

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Endnotes

[1] National Association of Insurance Commissioners, *Market Regulation Handbook* (NAIC, 2301 McGee Street, Suite 800, Kansas City, MO 64108-2662), 2006.

Appendix E
- *Areas of Review by Line of Business – Property & Casualty*[1]

Introduction

Appendix C discussed Areas of Investigation for all lines of business, with some emphasis on Property & Casualty (P&C) and Life market conduct examinations. Appendix D focused on health lines, managed care, and Health Maintenance Organizations (HMOs). This appendix deals with specific types of P&C market conduct examinations and provides a checklist of those areas of investigation by line of business that should be reviewed.

Conducting the Homeowners Examination

Homeowners Policyholder Service

Checklist for Examining Homeowners Policyholder Service

Common elements of these examinations include the review of the company's established procedure for processing changes to a policy.

- ✓ Review changes to limits, deductibles, addition or deletion of optional coverages or increased limits on any coverage, addition or deletion of mortgagees, and the addition of any changes to the dwelling.
- ✓ Check for documentation that the insured requested and agreed-to changes, accuracy of changes made, timeliness of process, and accuracy and timely generation of bills.
- ✓ Check for notification and processing of involuntary changes – such as to protection classes. Protection classes may be upgraded or downgraded depending on the ratings of the fire protection capabilities within the protection class. This sometimes depends on the activities of a local fire department. Neither the insured nor the company has control over that process, but some states have specific notice requirements for any increase in premium due to a change in protection class. Changes in zip codes are another category over which neither contracting party has control.

Most homeowner policies are 12-month policies and are renewed automatically until canceled.

- ✓ Review the timing of renewal notices and bills for compliance with applicable laws.

- ✓ If the state has installment payment plan requirements, verify that the plans the company offers are in compliance.
- ✓ If the company's homeowners policies include specific requirements for insurance to value, review the policy provisions for inflation increases and the company's established procedures for assisting policyholders in maintaining the correct limits.

Homeowners Underwriting and Rating

Checklist for Examining Homeowners Underwriting and Rating

- ✓ Verify that all rating factors and surcharges are accurate. This is a common element in most examinations. Differences in examining the rating of homeowners and dwelling policies derive from the need to verify the use of the correct age for the home where specific discount or surcharge factors apply when age is a factor.
- ✓ Verify the correct application and calculation accuracy of factors applied to the premium for a protection class, construction type, roof type, style of construction, and deductible.
- ✓ Check the factors and the rating of various types of increased limit coverages. These include such coverages as unscheduled jewelry, furs, firearms, stamp collections, coin collections, and any other coverage that may have a special limit in an un-endorsed policy.
- ✓ Verify that the rating rules and rates for increased limits are properly utilized, correctly interpreted, and accurately calculated.
- ✓ Some companies allow the endorsement of a scheduled type of coverage to their homeowners policies. Other companies require a separate inland marine type of policy to cover any specifically scheduled items. Review these endorsements and special policies as part of a homeowners and dwelling policy examination.

Some companies apply special deductibles to certain types of risks in certain areas or to certain parts of dwellings. Examples are wind damage in coastal areas subject to hurricanes or wind and hail damage to roofs in areas prone to frequent, severe wind or hail storms. Some companies or some policies may cover roofs of certain construction – such as wood shingle roofs – only for actual cash value. This may be true even if the policy issued is a replacement-cost policy for any other part of the dwelling or for personal property. Some states have laws governing the policies issued in certain areas – such as coastal areas or earthquake zones – and the examiner checks for compliance with those laws.

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Homeowners Claims

Checklist for Examining Homeowners Claims

- ✓ Verify that homeowners policy deductibles are applied correctly, especially for those policies that have more than one – such as a special deductible for roof damage due to wind and hail.
- ✓ Verify that replacement cost provisions and calculations are completed accurately.
- ✓ In a state that requires such notification, verify that the company explained its policy provision regarding any deferred depreciation on a replacement cost policy to the insured.
- ✓ Determine that the company‘s depreciation calculations are accurate and correctly applied to the claim.
- ✓ Review the policy limits for each type of coverage.
- ✓ If the state‘s laws require notification of the specific coverage under which a claim payment is made, check for accurate identification and notification as required. This may be of particular concern in homeowners‘ claims, because it is likely that any claim for damage to the dwelling also includes additional living expense payments and personal property loss payments as well as payments for damage to the dwelling itself. There can be debris removal expense and payments for damage to other structures or outbuildings.
- ✓ If personal property with a specific limit were lost or damaged – such as jewelry or furs – verify that the limits, and any other policy restrictions or endorsements increasing the limits, were correctly applied and calculated.

Some states have prompt pay laws for homeowners‘ claims. Many replacement cost policies require completion of repairs or replacement of items within a specific time frame.

- ✓ Review the claims to verify that the correct time frame was applied, especially in any claim that was denied a deferred depreciation payment for exceeding that time frame.
- ✓ Review the files for indication that the time frame was clearly and timely communicated to the insured, if the state laws require such notification.

Some states have stated value laws that apply to the payment of property damage claims. Documentation in the claim file might include replacement cost calculations, sworn proof of loss, evidence of payments, and copies of correspondence.

- ✓ Review the documentation to verify that the company's decisions are adequately supported.

Finally, a situation may arise wherein an insured files for losses under different coverages or even different policies with the same company. Some states do not allow the company to withhold payment under one coverage in order to force the insured to agree to settle under a second coverage. This is particularly true if the state has an unfair claims practices act in its statutes.

Conducting the Private Passenger Automobile Examination

Automobile Rating

Checklist for Examining Automobile Rating

- ✓ Compare applications to policies to verify that automobile vehicle identification numbers (VINs) are recorded as submitted and are valid.
- ✓ Verify the correct symbol or other rating designation for each automobile and review the company's process for updating symbols.
- ✓ As with any rating examination, determine the correct application of each rating rule and factor and verify the calculations.

Automobile Claims

Examining private passenger auto claims is also very similar to examining the claims process and practices for any other line of business. The differences lie in such things as the need to determine liability for auto accidents, the method of determining the value of damaged property, and the need to provide substitute transportation for owners of disabled vehicles. Substitute vehicle coverage may be a matter of whether the insured purchased that coverage.

Checklist for Examining Automobile Claims

- ✓ Review claims files for support of the company's determination of liability. In some states that might include the ability to apportion comparative negligence and split the liability between drivers.
- ✓ States that have comparative negligence laws may also require reasonable investigations and substantial support before making a comparative negligence determination. Review claims files for any specifically required documentation.

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- ✓ If state law requires any certain process for determining the amount of damage, check for compliance with those laws. This most often applies to total losses since the cost of repairs may be determined by current costs of such repairs at several repair shops. Some states allow the use of used or crash parts in repair, perhaps requiring advance notification of the intent to use such parts. Other states prohibit such use.

In some states there are specific laws regulating prompt payment and resolution of simple and complete claims. There may be laws regulating the provision of rental vehicles or the payment for loss of use, storage costs, and title, taxes, and registration fees for totaled vehicles. There may also be laws prohibiting companies from steering claimants to certain repair facilities and requiring reasonably prompt responses to communications regarding claims.

States with no-fault laws require specific examination according to the applicable laws. No two states have exactly the same laws even though all may be called no-fault laws. The examiner generally uses the standards and tests provided by the regulator in those states.

Conducting a Title Insurance Examination

Examiners should request the following items upon initiating a title insurance company or title insurance agent examination:

- Issued Commitment files with No Policy Issued – A listing of all files or orders in which commitments have been issued but policies have not yet been issued (whether or not outstanding conditions have been met and reported).
- Issued Policies Not Yet Reported to Underwriter – A listing of all issued policies and endorsements for which reporting to the title insurer is pending, or not yet accomplished, as of the date of the request.

Title Insurance

An examination of title insurance agencies includes verification of compliance with issues that are both common to other types of insurance and unique to title insurance.

Checklist for Examining Title Insurance

- ✓ Review requirements involving licensing, appointment, disclosure, policyholder treatment, and record retention.
- ✓ Review issues relating to referrals, controlled business relationships, underwriting contracts with companies, bond and

errors and omission coverage requirements, escrow accounts, and audits.

Title Insurance Marketing and Sales

Examining the marketing and sales during a title insurance examination follows the same general procedures and reviews the same documents and areas of interest as an examination of any other line of business.

Checklist for Examining Title Marketing and Sales

- ✓ Determine whether all agents/producers engaged in the sale of title insurance for the title insurance company are appropriately licensed.
- ✓ Decide whether all training, marketing, and sales materials and practices are in compliance with applicable statutes, rules, and regulations. This is sometimes included in the underwriting part of the examination, or the information determined from the marketing and sales part of the examination is used for this part, or vice versa. Where possible, reviews that fulfill needs of various parts of the examination are not duplicated.

Title Insurance Policyholder Service and Claims

In title insurance, policyholder service includes claims handling. The examiner reviews claims as he would for any other line of business but does so under the policyholder service portion of the examination.

Checklist for Examining Title Policyholder Service and Claims

- ✓ Review correspondence to ensure that the title insurance company or agent provided a statement with each title commitment issued for the sale of residential real estate making those disclosures required by law in the jurisdiction. Required disclosures usually include notice that the subject real property may be located in a special taxing district, if that is the case, and that a certificate of taxes due listing each taxing jurisdiction shall be obtained from the county treasurer or the county treasurer‘s authorized agent.
- ✓ Check for information provided regarding special districts. The boundaries of such districts may be obtained from the board of county commissioners, the county clerk and recorder, or the county assessor.
- ✓ Check for information regarding policy exclusions for unfiled mechanics liens and requirements for ~~-g~~ap” coverage.

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Title Insurance Underwriting and Rating

Checklist for Examining Title Insurance Underwriting and Rating

- ✓ Review new policies issued to determine whether the company or agents review the newly issued policies prior to mailing to ensure that correct procedures, forms, disclosures, etc., are used.
- ✓ Check that policies and endorsements are issued in accordance with fees that meet the requirements of the applicable statute, rule, or regulation.

Conducting the Workers' Compensation Examination

Workers' Compensation Marketing and Sales

Examination of workers' compensation marketing and sales practices includes the elements common to all property & casualty examinations.

Workers' Compensation Underwriting and Rating

Checklist for Examining Workers' Compensation Underwriting and Rating

- ✓ Verify the use of the filed expense multipliers. To do this, review approved and/or filed rating plans, including risk modification plans and premium audits pertaining to the sample policies.
- ✓ Examine Workers' Compensation Experience Modification Rating Sheets (experience modifiers as published by the NCCI - National Council on Compensation Insurance).
- ✓ Review payroll records associated with the premium audits and the policy sample.
- ✓ Review copies of cost containment certificates and loss improvement criteria to determine the cost containment discount.
- ✓ Review final rate manual tables by classification codes applicable to the period under examination (tables maintained at the company level).
- ✓ The company should be using a combination of loss costs and expense multipliers filed with the regulator as required by that jurisdiction. Obtain from the company the filed expense multipliers that were applicable at the inception of the policy. This filing should be stamped either —Approved" or —Filed" by the regulator as required in that state.

- ✓ Obtain the company's table of rates for each classification code and check the sample's premium audit data (showing the actual rate charged to an employer for individual classification codes) against the table of rates, which includes the NCCI loss costs and the filed expense multiplier, to verify accuracy.
- ✓ Review the company documents and discuss any additional areas or lack of information with company management.
- ✓ Verify premium audit accuracy and the proper application of rating in order to determine whether the final premium charged to the employer is being applied correctly, fairly, and consistently.
- ✓ Compare the sample's information to the NCCI unit statistical report and to the company's rating plan. This is to verify accuracy in the application and reporting of the following factors when applicable:
  - Premiums by classification code
  - Payroll exposure
  - Schedule rating
  - Cost containment premium discounting
  - Designated medical provider discount
  - Expense loading
  - Application of the correct experience modifier small employer discount
  - Discount for rehiring previously disabled employees
  - Any other rating elements.
- ✓ Some states have specific rating requirements for various rating factors. An example of such a requirement is a statutory provision providing —If a risk is experience rated, the amount of the credit or debit derived from using a rate modification plan (Schedule Rating Plan) shall be applied to an experience-rated risk in a multiplicative manner after application of the experience modification and before the application of premium discounts and expense constants". In such a case, verify that this is being applied correctly.
- ✓ Verify that the experience modifier issued by the NCCI reflects the information reported to the NCCI using the unit statistical reports.
- ✓ Reconcile the experience modifiers to what is reported on the unit statistical reports and to what is shown on the workers' compensation experience modification rating sheets.

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- ✓ Verify that net loss reporting is properly applied to both large and small deductible policies.
- ✓ Review NCCI rules governing the reporting of losses on unit statistical reports, loss data pertaining to the policy sample and maintained by the company, and unit statistical reports pertaining to the policy sample and used to report company information to the NCCI. This is to verify loss reporting.
- ✓ Determine that losses under each policy are clearly and accurately maintained at the company so that paid amounts, reserves, and deductibles can be easily reviewed.
- ✓ Compare sample data to the unit statistical reports to verify accuracy of reporting of the following items:
  - Paid losses
  - Paid loss adjustment expenses
  - Net of deductible reporting on the unit statistical reports adjustments to reserves
  - Revised unit statistical reports
  - Any other adjustments – such as subrogation.
- ✓ To verify the company data provided in response to the NCCI data calls on deductibles, review the NCCI data call and resulting report made by the insurance company to the NCCI.
- ✓ Review loss data pertaining to sample policies written on a deductible basis and maintained by the company.
- ✓ Review unit statistical reports pertaining to sample policies written on a deductible basis and used to report company information to the NCCI. For this review, take a new sample, a —deductible sample", and sample policies with large and small deductibles separately.
- ✓ During the examination verify that losses are reported on the unit statistical reports to the NCCI net of deductibles and that the independent deductible data call that the NCCI requests is reported gross, including the deductibles. Verify this with the policy sample, unit statistical reports, and loss data maintained by the company.
- ✓ Verify that the company's underwriting practices are not unfairly discriminatory and that the company adheres to applicable statutes, rules, regulations, and company guidelines in the selection of risks. Pay particular attention to the company's criteria for placement of insureds into rating tiers.

- ✓ Verify that all forms and endorsements forming a part of the contract are attached to the policy, listed on the declarations page, and filed with the regulator as required in that jurisdiction.
- ✓ Verify that decisions were based on information that was reasonably developed at the inception of the policy or during initial underwriting and not, through audit or other means, after the policy expired.
- ✓ Determine whether decisions are based on information developed after a claim is submitted that reasonably should have been developed at the inception of the policy or during initial underwriting.
- ✓ Verify that audits, as applicable, are conducted accurately and timely by reviewing underwriting files and procedures to determine whether the company has a structured system for conducting payroll or other audits used to verify final premium.
- ✓ Verify the company procedure for waiving audits and check that the basis is reasonable and the actual practice is consistent with the procedure.
- ✓ Typically, companies have a time frame for completion of an audit following expiration of a policy. Determine that time frame and verify that the actual conduct of audits occurs within that time.
- ✓ Determine whether audits are conducted by company internal auditors or by independent auditors and perform an independent verification to ensure that return premiums are received by insureds in a timely manner.
- ✓ Review cancellation and non-renewal procedures by checking the policy contract and the actual notices.
- ✓ Review refund checks or computer documentation of refund, if canceled check information is maintained on the computer system.
- ✓ Calculate the unearned premium (short rate or pro rata method) in accordance with policy provisions or state law.
- ✓ Determine whether the company advances its audit date on auditable policies when cancellation occurs.
- ✓ Verify that any unearned premium was returned to the appropriate party in a timely manner and note whether delays identified are caused by the company, producer, or premium financier.

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Conducting the Bail Bond Examination

Bail Bond MGA Oversight

Checklist for Examining Bail Bond MGA Oversight

- ✓ Review MGA contracts and MGA audit reports to determine whether the company is adequately monitoring the activities of the MGA.
- ✓ Review the activities of the MGA to verify compliance with applicable MGA statutes, rules, and regulations.
- ✓ Check to determine compliance with licensing and continuing education requirements as required in that jurisdiction.
- ✓ There may be some states that formerly allowed company/MGA relationships that now prohibit them by permitting only resident individuals to conduct bail bond business in those states. Therefore, MGA arrangements no longer exist in those states. Determine, in those states, whether the company appears to be continuing with MGA relationships.
- ✓ In states that permit MGA arrangements, review the MGA contract to determine compliance with state statutes and contract provisions.
- ✓ Verify that the contract specifies the responsibilities of the MGA with regard to record keeping and the responsibilities of the company for conducting audits.
- ✓ Determine whether the company or the MGA has ultimate control over consumer‘s collateral, remittance of premium to the insurer, and powers of attorney in:
    - Who is responsible for printing, numbering, and distribution of Powers of Attorney, and
    - Whose address is on the Power of Attorney.

Bail Bond Marketing and Sales

There are no significant differences between the examination of marketing and sales practices for surety/bail bonds and other lines of property & casualty business. The primary focus is verifying that all advertising and sales materials comply with applicable statutes, rules, and regulations. It is equally important to determine whether the company‘s training of producers is adequate and compliant and that communications with producers is adequate, timely, and effective, as required by law.

Bail Bond Policyholder Service

There are no significant differences between the examination of policyholder service for surety/bail bonds and other property & casualty lines of business. The primary focus of the policyholder service part of the examination is to verify that all correspondence directed to the company is answered in a timely and responsive manner by the appropriate department within the company.

Bail Bond Underwriting and Rating

Checklist for Examining Bail Bond Underwriting and Rating

- ✓ Review the applicable laws, new business applications, and all underwriting information obtained with each application and during the underwriting process.
- ✓ Review the rating manuals and verify all rating factors, if applicable.
- ✓ Review the Powers of Attorney and the underwriter‘s file, including any file notes contained on a system log.
- ✓ Review the rates filed with the regulator, if applicable, and the producer‘s bail bond file.
- ✓ Verify the rating factors in much the same way they are verified in any other line of business by reviewing all documents and manuals and manually calculating the premium to verify that automated-premium calculating programs are programmed correctly.
- ✓ Determine whether forms and endorsements have been filed as required by the regulator, if applicable.
- ✓ Verify that the company lists all forms and endorsements that form a part of the contract, if applicable.
- ✓ Verify that the underwriting file documentation supports the decisions made by examining the producer bonding agreement files in addition to the other items reviewed.
- ✓ Determine whether the company engages in any practice that suggests anti-competitive behavior. If any is found, there may be a need to advise the regulator‘s legal counsel. Concerns that need consideration for legal help include the company engaging in collusive underwriting practices that may inhibit competition; e.g., entering into an agreement with other companies to divide the market within the jurisdiction or by territory.
- ✓ Review collateral files, collateral trust accounts, and producer bonding agreement files.

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- ✓ Determine whether the return of collateral was processed in a timely manner and that any unearned premium or collateral was returned to the appropriate party according to applicable statutes, rules, and regulations. Any failure to return collateral on a timely basis may indicate violations of fiduciary responsibility.
- ✓ Determine whether refunds are appropriately handled upon order by court. In some jurisdictions, there are no unearned premiums for bail unless ordered by the court. Check producer files to see if the returns under these circumstances were completed on time.
- ✓ Review to assure proper premium collection by the producer. Failure to collect all premiums due may constitute rebating.

Bail Bond Claims

Checklist for Examining Bail Bond Claims

- ✓ Verify that initial contact by the company with the claimant is within the required time frame, that timely investigations are conducted, and that forfeitures are resolved in a timely manner.
- ✓ Review company procedures, training manuals, and bulletins to determine whether company standards exist, and, where they do, determine whether the standards comply with state statutes, rules, and regulations.
- ✓ Determine whether subsequent responses and forfeiture handling delay notices comply with applicable statutes, rules, and regulations.
- ✓ Determine what entity will receive initial contact from the court by verifying the address on the power of attorney.
- ✓ Determine whether forfeiture resolutions; i.e., liability, determinations, coverage questions, and forfeiture payments, are made in accordance with state requirements.
- ✓ Perform time studies to measure settlement times of forfeitures and review investigations to determine compliance with requirements for initiation and conclusion.
- ✓ Some jurisdictions allow producers to write bonds. Others do not. Review the files to determine whether any producer is writing bonds in those jurisdictions in which it is not permitted.
- ✓ Review forfeiture procedures, training manuals, and bulletins to determine whether company standards exist and whether standards comply with state statutes.

- ✓ Determine whether correspondence related to forfeitures is responded to in accordance with the regulator‘s requirements.
- ✓ Review claims files to determine whether the quality of the claims documentation meets state requirements and whether the documentation is sufficient to support or justify the ultimate claim decision.
- ✓ Verify that the claims files are handled according to the policy provisions and that the company did not misrepresent relevant facts or policy provisions.
- ✓ Review the file retention/destruction program to determine whether it complies with state requirements.

Conclusion

By following the above checklists, examiners can utilize the experience of a variety of insurance departments and regulators to try to promote more effective and efficient P&C targeted market conduct examinations.

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Endnotes

[1] National Association of Insurance Commissioners, *Market Regulation Handbook* (NAIC, 2301 McGee Street, Suite 800, Kansas City, MO 64108-2662), 2006.

Glossary

Term	Definition
ACL	A computer-based sampling technique used to assure the sample selected represents all components being analyzed. This is the NAIC-endorsed tool for data analysis.
AICP	Association of Insurance Compliance Professionals
AIE	Accredited Insurance Examiner
Ambulatory Review	Utilization review of health care services performed or provided in an outpatient setting.
Appeal	Filed by the insured when a decision has been made and the findings are not agreeable to the insured.
APS	Attending Physician's Statement
ASCII	ASCII (American Standard Code for Information Interchange) is a character encoding based on the English alphabet. ASCII codes represent text in computers, communications equipment, and other devices that work with text. Most modern character encodings — which support many more characters — have a historical basis in ASCII.
Audit Manager	Normally the person in charge of all state examinations – sometimes known as Chief Examiner or Supervisory Manager.
Bait and Switch	An illegal tactic where a producer sells one thing but the consumer gets another.
Baseline Examination	An initial examination of a company conducted by a state. It is expected to provide a baseline of information on which to base future regulatory oversight or absence thereof.
Bulletin Board	A World Wide Web based facility that allows people to post messages and share information.
Bulletins	Documents expressing a Department's interpretation of, or position on, existing law, including both regulations and statutes. Different from regulations and statutes in that bulletins do not have the force of law.

CAD	Collaborative Actions Designee
Case Management	A coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.
CCYYMMDD	A date expressed in the format CCYYMMDD where CCYY is the numerical expression of the century CC and year YY, MM is the numerical expression of the month within the year, and DD is the numerical expression of the day within the month.
CDS	Complaints Database System – NAIC database that stores closed consumer complaint information indefinitely. This information can be retrieved by state name, types of coverage, complaint reasons and dispositions, and complaint trends and counts.
Census Sampling	Used where there are populations of so few numbers that the entire population comprises the sample - all members of a field are reviewed.
Certificate of Compliance	A signed affidavit stating that to the best of the signer's knowledge, information, and belief, the advertisements used by the company complied or were made to comply in all respects with the provisions of the regulations and the insurance laws of the state as implemented and interpreted by the regulations.
Chain of Custody	The ability to determine who has had access, possession, or control of data from one point in time to any other point in time.
Chief Examiner	Normally the person in charge of all state examinations – sometimes known as Audit Manager or Supervisory Examiner.
Chief Market Conduct Examiner	Person at the Department directly responsible for market conduct activities.
CIE	Certified Insurance Examiner
Claim	A notification from an insured that damage has occurred in which payment is requested.
Claim - Denied	A claim that has been determined by the insurance company to be invalid and, therefore, not payable based upon the findings and language of the policy.

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Claim - Paid	A claim that has been determined by the insurance company to be valid and, therefore, payable according to the policy.
Classification Code	Also called Class Code. The workers' comp premium rate commensurate with the risk associated with that workplace exposure.
Clinical Peer Review	An evaluation of current or possible treatment by a second provider with comparable credentials and training that can properly evaluate the treatment being considered.
COBRA	Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions passed by Congress in 1986. The law amends the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Service Act to provide continuation of group health coverage that otherwise might be terminated.
Comment Form *See also Crit / Critique	Form used by examiners to explain or describe alleged violations of law and/or regulations.
Company	The insurance company being examined.
Company Policy	A contractual agreement to provide services in exchange for a fee. A violation of a company procedure is one matter. A violation of a company policy is a contractual, legal concern.
Company Procedure	An internal procedure that company employees should follow for various lines of business – as opposed to a company policy.
Complaint	A written communication primarily expressing a "grievance" (meaning an expression of dissatisfaction). Filed by the insured to the insurance company or Department. The more formalized Department complaint is filed when the insured needs another party involved to help represent his interest.

Complaint Ratio / Complaint Index	Designed to compare a company's percentage of complaints to its percentage of market share. The complaint index is a ratio of the company's number of complaints per thousand dollars of premium written divided by the total number of complaints per thousand dollars of premium written for all companies for a particular line of business. The ratio is then multiplied by 100 to make it a percentage.
Comprehensive Examination	A full-scope examination that includes all areas of a company's business practices. As opposed to a targeted examination.
Concurrent Review	Utilization review conducted during a covered person's hospital stay or course of treatment.
Confidentiality	The possession of information that requires measures to ensure that the information is not disclosed to any third party and that the information is not used or allowed to be used by a third party in a manner detrimental to the owner of the information.
Contractual Employee	An individual employed or hired by the company to assist in the coordination of the examination.
Coordinator (company)	The person assigned by the company to act as the contact person.
Coordinator's Handbook	The Coordinator's Handbook is commonly referred to as the pre-examination packet. It is a packet/manual that is sent by a Department to the company prior to the examination. It covers items such as the timeframe of the examination, lines of business to be reviewed, amount of office space required for examiners, working materials needed, the billing process, the various computer runs needed, etc. It provides the company with direction prior to the arrival of the examiners and can also provide direction during the examination with regard to the process of closing a report.
CPT	Current Procedural Terminology - the list maintained by the American Medical Association to provide unique billing codes for services rendered.
Crit / Critique *See also Comment Form	Form used by examiners to explain or describe alleged violations of law and/or regulations.

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Data Call	Identifies the files, documents, lists, and reference materials to be available to the examiners.
Date Received	This is the date that a company receives a request or document.
Date Stamp	An imprinted date (not hand written) that is stamped on the document when received by the company.
Declination	For purposes of this textbook, upon receipt of a written nonbinding application or written request for coverage from a producer or an applicant, —Declination" means refusal of an insurer to issue a policy. It also includes any refusal of an agent or broker to transmit to an insurer a written non-binding application or written request for coverage or a refusal even to quote a premium for a risk.
Deliverable	The product of a step in an examination work plan. Deliverables consist of criticisms, findings, and confidential memorandums or management reports describing circumstances where company practices deviate from applicable state or federal laws, regulations, bulletins, and, perhaps, the company's own policies and procedures.
Department	The insurance department of a state.
Desk Audit	Areas of review that can be completed off-site rather than in the company's offices.
Director of Insurance	Individual responsible for enforcement of all state statutes and regulations.
Discharge Planning	The formal process for determining, prior to discharge from a facility or service, the coordination and management of the care that a patient receives following discharge from a facility or service.
DOI	Department of Insurance
EIC	Examiner-in-Charge; sometimes called lead examiner. The EIC establishes timelines, organizes work, assigns examiners to tasks, resolves issues that develop, and coordinates with the insurer so that the examination progresses at an adequate rate.
Encrypted data	Data that cannot be read by a computer (is illegible) unless a —key" is provided.

ERISA	Employee Retirement Income Security Act
Error Ratio	The number of files in error divided by the number of policies examined.
Examiner-in-Charge	Individual responsible for all work products and for coordinating work responsibilities for the examiners on the work site. Synonymous with EIC.
External Fraud	Refers to fraudulent activities by claimants, policyholders, vendors, or other individuals that are not employees of the insurance company.
ETS	Examination Tracking System (ETS), which is administered by the NAIC – Provides information as to whether another state is currently conducting an examination on the same company, has recently completed one, or is about to commence a new one.
Examination Report	A fact-based document prepared by an examiner once the review of company files and information has been completed.
Examiners Handbook	The *NAIC Market Regulation Handbook* is often called the Examiners Handbook. Describes in detail what to look for while performing a market conduct examination. The handbook is a yearly publication that can be obtained by contacting the NAIC.
Excel Random Sampling	A computer-based sampling technique in the Microsoft Excel software used to assure the sample selected represents all components being analyzed.
Exhibit	Documentation gathered by the examiner to provide proof of a company‘s business practice. This includes copies of documentation, the critique (criticism) form, and the company‘s response to the alleged violation. The Exhibit contains a number that references the violation in the Examination Report.
Exhibit Report	This is the examination report that has been numbered to reflect the referenced errors to the documents that form an exhibit.

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Experience Modification Factor	In Workers‘ Compensation insurance, an adjustment to manual premium calculated by an advisory organization (also known as rating bureaus) such as NCCI, based on historic loss and payroll data of a particular insured. Also called Experience Modifier, or Experience Mod.
External Fraud	Refers to fraudulent activities by claimants, policyholders, vendors, or other individuals that are not employees of the insurance company.
Fact Finder	A person (examiner) charged with the duty to report objectively what is found in the course of examining an insurer‘s records. Opinions are appropriate but a fact finder is not allowed to draw conclusions.
FAIR	Fair Access to Insurance Requirements Plan. This is Insurance that grew out of the urban demonstrations and riots of the 1960s. Because of the deteriorated social and economic circumstances in these areas, it became impossible for many business owners and homeowners to purchase property insurance. As a result, the federal government established the FAIR plans based on the stop loss reinsurance method.
FAQs	Frequently asked questions
File and Use	A rate filing method that allows companies to begin using the forms or rates filed with the Department as soon as the filing is submitted.
Financial Services Modernization Act	Also known as the Gramm-Leach-Bliley Act. This ended the compartmentalization of the financial services industry in the United States and allows full-scale affiliations among (1) commercial banking, (2) the insurance industry, and (3) the securities brokerage field.
Finder of Fact	A person possessing jurisdictional authority as exercised by a duly appointed or elected judge or by a legally convened jury.
First Level Grievance	Filed by the insured when satisfaction has not been obtained.
Formal Requests *See also Inquiries	Requests by the examiners to the company for information relevant to an examination.

Fraudulent Insurance Act	An act or omission committed by a person who, knowingly and with intent to defraud, commits or conceals material information related to any aspect of the insurance relationship.
FTP	File Transfer Protocol – the simplest and most secure way to exchange files over the Internet.
GAO	Government Accounting Office
Gramm-Leach-Bliley Act (GLB Act)	Also known as the Financial Services Modernization Act, this ended the compartmentalization of the financial services industry in the United States and allows full-scale affiliations among (1) commercial banking, (2) the insurance industry, and (3) the securities brokerage field.
Grievance	An expression of dissatisfaction.
HHS	Health and Human Services Department of the federal government.
HIPAA	The Health Insurance Portability and Accountability Act (HIPAA) enacted by the U.S. Congress in 1996.
HMO	Health Maintenance Organization
IIA	Institute of Internal Auditors
Implementation Function	Implementation of the planning function when management-directed policies and procedures are disseminated throughout the company to appropriate and affected persons.
IMSA	Insurance Marketplace Standards Association – Life companies‘ self-evaluation of marketplace performance.
Independent Review Organizations	Independent third parties certified by the Department to review the medical necessity and appropriateness of health care services provided or proposed to patients.
Inland Marine Coverage	Inland marine insurance covers loss to property where there is an element of mobility. This coverage is an outgrowth of ocean marine coverage. The coverage floats with the property as it is moved from place to place. For example, tools, equipment, etc.

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Inquiries *See also Formal Requests	Requests by the examiners to the company for information relevant to an examination.
Insurance Guaranty Association	Generally a non-profit, unincorporated legal entity created for the purpose of paying certain policy claims of insolvent licensed insurers.
Internal Fraud	Refers to fraudulent activities by insurance company personnel, stockholders, or management.
IRES	Insurance Regulatory Examiners Society
IRIS Ratios	Generally used to identify companies with potential financial problems. These ratios do not automatically indicate an adverse financial condition; rather, they provide a signal to the state to follow up to determine the cause of the changes at the company.
IRIS	Insurance Regulatory Information System - Designed to assist all insurance departments in monitoring the industry's financial condition. Generally used to identify companies with potential financial problems.
I-SITE	NAIC's web-based application that provides regulators access to NAIC applications.
ISQ	Information Systems Questionnaire
JUA	Joint Underwriting Association. An organization of insurance companies formed with statutory approval to provide a particular form of insurance. JUAs are usually formed because voluntary market availability is lacking. They are generally allowed by regulators to establish their own rates and develop their own policy forms.
Level 1 Analysis	A series of 16 questions about a company‘s history related to a specific product line.
Level 2 Analysis	Designed to look beyond the statistics and prewritten summary reports generated from various NAIC databases and a state‘s own analysis. Level 2 Analysis requires analysts to look at other information available within the Department – such as individual consumer complaints, enforcement actions, Examination Reports, and rate, rule and form filings – and from outside sources – such as the company‘s website, the media, and government agencies.

MAC	Market Analysis Chief
MAH	Market Analysis Handbook
Manual Premium	Workers' Compensation premium calculated by multiplying payrolls by appropriate rates, before application of experience modifier, schedule credit, or premium discount.
Market Analysis	A system of collection and analysis of data and other information that enables a regulator to identify important market conduct problems as early as possible and to eliminate or limit harm to consumers. It is seeking ways to gather and review data that indicates the need for regulatory interaction.
Market Conduct Annual Statement (MCAS)	Provides regulators with information not otherwise available for their market analysis initiatives. It promotes uniform analysis by applying consistent measurements and comparisons between companies, thereby allowing all companies to be compared on an equal basis.
Market Conduct Examination (traditional)	Typically reviews the results of an insurance company operation for error or violation of statute and reacts to that result – as opposed to a Procedure Review.
Market Initiative Tracking System/ MITS	A database used to track significant market conduct continuum responses that are tracked in neither the Exam Tracking System (ETS) nor the Regulatory Information Retrieval System (RIRS).
Market Regulation	Concerned with the fair treatment of policyholders and the prevention and detection of practices which are detrimental to the public – such as incorrect or untimely claims payments, discrimination in underwriting and rating, inaccurate advertising, and failure to relay in policy forms the mandated benefits to be provided.
MARS	Market Analysis Review System – Designed to assist all insurance departments in monitoring the industry's financial condition. Generally used to identify companies with potential financial problems.

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MAWG/Market Analysis Working Group	Identifies and reviews insurance companies that exhibit, or may exhibit, characteristics indicating a current or potential market regulatory issue that may impact multiple jurisdictions. The Working Group determines if regulatory action is being taken and supports collaborative actions in addressing problems identified.
MCO	Managed Care Organization
Measurement Function	Evaluates the results of planning and implementation. Measurements can be found in internal audits, management reports, supervisory reports, board meeting minutes, minutes of the compliance committee, minutes of the quality review committee, market conduct examination reports, etc.
MEWA	Multi-employer Welfare Arrangement
NAIC	National Association of Insurance Commissioners
NAIC Market Regulation Handbook	The NAIC's handbook is sometimes called the Examiners Handbook. This handbook describes in detail what to look for while performing a market conduct examination. The handbook can be obtained by contacting the NAIC.
NCCI	National Council on Compensation Insurance – Analyzes industry trends, prepares workers' compensation insurance rate recommendations, assists in pricing proposed legislation, and provides a variety of supporting services. Note: In health insurance NCCI may also be used as an acronym for National Correct Coding Initiatives. This use of NCCI describes proper coding rules for CPT codes as defined by CMS.
NCOIL	National Conference of Insurance Legislators
NCQA	National Council on Quality Assurance – Health companies' self-evaluation of marketplace performance.
NIPR	National Insurance Producer Registry – Provides information on producers, including information about agents disciplined in other states.
Password Protection	Protection afforded a computer or computer file by restricting access unless a secret code is provided.

PDB	Producer Database – NAIC database that contains licensing information and status for producers as well as disciplinary history and administrative actions.
PHI	Protected Health Information (related to privacy matters)
PIC	NAIC's Personalized Information Capture System – Automatically, among other notifications, sends notice to the regulator about companies whose IRIS ratios are outside the pre-established range of normal.
Planning Function	The planning function is where direction, policy, objectives, and goals are formulated. This function is found in the written policies and procedures of the company. These may also be called processes, strategies, or directives, and are tested for clarity, currency, functionality, and conflict with existing statutes.
Policies	The high-level general principles by which an entity guides the management of its affairs. Policies may be the basis for procedures. Policies are generally too vague to require any regulatory interaction unless they are obviously in conflict with a statute.
PPO	Preferred Provider Organization
PPO Re-pricing Company	Re-pricing companies have developed a system that allows them to offer Managed Care Organizations (MCOs) "custom networks" at significant discounts. If an MCO does not have the leverage to obtain discounts from providers, it can rent the network of a re-pricing company. (See also: Re-pricing Company)
Pre-examination Packet	A packet of information sent to a company from the insurance division prior to the start of an examination that details the items that will be needed during an examination. Also known as the Coordinator‘s Handbook.
Prior Approval	A rate filing requirement under which companies must wait for notification of approval before implementing the rate or form filed.
Prior Approval With a Deemer Clause	A rate filing requirement under which companies may implement a filed rate or form if no approval or disapproval is received within a certain time after filing. The time frame is usually 30-90 days.

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Procedure Review	A review of management structures and controls of areas impacting market related issues – as opposed to a conventional market conduct examination. A Procedure Review is very effective in identifying the causes for violations of statute.
Procedures	The specific methods or courses of action used to implement a policy or corporate directive. Procedures indicate whether a company is proactive or reactive in the management of its operations; whether the corporate compliance activities are a cause for concern; and whether particular areas of concern to the regulator are managed in a way to avoid the need for regulatory interaction.
Producer (in Title Insurance)	Whereas the term 'producer' in most lines of insurance is used to refer to an insurance agent or broker, the term 'producer' as it relates to title insurance refers to a person involved in mortgage loans or the buying and selling of real estate or to lenders or attorneys.
Professional Skepticism	To employ an attitude allowing the examiner to doubt what others accept to be true.
Prospective Review	Utilization review conducted prior to an admission or course of treatment.
Protection Class	The rating of the local fire department‘s capabilities and the availability of fire hydrants and other water supply sources. Protection classes are typically numbered one through 10, with one being best and 10 having essentially no fire protection. Used in pricing property insurance.
QuickLink	A NAIC developed tool that allows examiners to query the financial tables in the Financial Annual Statements directly using Microsoft Access.
Random Sampling	A theoretical concept meaning that all items in the field (before selection) have an equal chance of appearing in the sample. No items or units have been "pre-selected" out of the field. Random selection may be attained through use of a random numbers table or a random numbers generator in computer software.

Reaction Function	Where a company has the opportunity to insert into the process what it learned through the measurement of its procedures. The process requires a means of utilizing the information arising out of internal audits, management reports, and complaint systems.
Replacement	The exchange of a new policy for one already in force.
Regulated Entities	Each insurer or other organization regulated by the Insurance Department. In this textbook, 'regulated entity' is synonymous with 'company'.
Report by Exception	Format of Examination Report that lists only findings in noncompliance with the statutes and regulations of the state. As opposed to a "Report by Test" wherein all details are listed.
Report by Test	Format of Examination Report wherein all details are listed. As opposed to a Report by Exception that lists only findings in noncompliance with the statutes and regulations of the state.
Re-pricing company	Re-pricing companies have developed a system that allows them to offer Managed Care Organizations (MCOs) "custom networks" at significant discounts. If an MCO does not have the leverage to obtain discounts from providers, it can rent the network of a re-pricing company. (See also: PPO Re-pricing Company)
RESPA	Real Estate Settlement Procedures Act – RESPA is about closing costs and settlement procedures. RESPA requires that consumers receive disclosures at various times in the transaction and outlaws kickbacks that increase the cost of settlement services. RESPA is a HUD consumer protection statute designed to help homebuyers be better shoppers in the home buying process, and is enforced by HUD.
Retrospective Review	Any utilization review that is not a prospective review but does not include the review of a claim that is limited to veracity of documentation or accuracy of coding.

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RIRS	Regulatory Information Retrieval System – NAIC database that tracks adjudicated regulatory actions on companies, agencies, and producers by origin, reason, and disposition.
SAD	Special Activities Database – NAIC database that tracks investigative or suspicious activities by an entity and can only be accessed by regulators.
Sample	A representative sub-section of policies that has been selected from a complete set of files. A microcosm of the population or field from which it is drawn.
Second Opinion	In utilization review, an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed health service.
Selective Sampling	For example, selecting only the largest claims paid or underwriting the highest risks, etc.
SERFF	System for Electronic Rate and Form Filing – Enables insurers to submit rate and form filings electronically and facilitates electronic storage, management, analysis, and communication regarding filings. It improves the efficiency of the rate and form filing and approval processes and reduces the time and cost involved in making filings.
SHIIP	Senior Health Insurance Information Program
SOFE	Society of Financial Examiners
Solvency Regulation	Concerned with the early detection of potential insolvencies and the prevention of the detrimental effects for consumers when insolvencies occur.
Special Investigation Unit (SIU)	A unit of the company that oversees the company's fraud detection operations.
Standardized Data Request (SDR)	A uniform list of data fields that should be used by an examiner to request electronic data files during an examination of an insurance company. In its most simplistic format, it tells the insurance company what information the examiner wants to see and how he wants to see it.

StateNet	A computerized tracking system that delivers vital data, legislative intelligence, and in-depth reporting about the actions of government.
Supervisory Examiner	Normally the person in charge of all state examinations – sometimes known as Audit Manager or Chief Examiner.
Systematic Sampling	Attained by using a systematic interval throughout a listing of all files. To draw fifty files from 5,000, for example, select every hundredth file after a random start number. There are other methods for systematic sampling, such as changing the interval so that on average every one-hundredth file is selected.
Targeted Examinations	Targeted examinations are limited in scope and many times require looking at just one line of business or one function of the business (e.g., denied claims). As opposed to a comprehensive examination.
TeamMate	A NAIC-endorsed audit management tool developed by Price Waterhouse Coopers.
TeamMate Library	A template project file within TeamMate that is used when creating a new examination project file.
TeamMate Store	A repository within TeamMate that includes standard procedures and associated workpapers that can be incorporated into an existing project file.
Title Insurance	In title insurance there is risk elimination where potential defects that would produce loss are identified and specifically excluded from coverage or where certain risks are insured-over, excluded, or corrected. The policy is written to indemnify against losses to the title to real property as stated in the policy on the date of policy issuance. Coverage has no expiration and is provided at any time thereafter if the title is not as stated in the policy at that precise point in time.
Title Plants	Organizations that duplicate the public record affecting real property and reorganize those records, typically by legal description.
TPA	Third Party Administrator

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Underwriting File	The file or files containing the new business application, renewal application, rate calculation sheets, billings, binders, credit reports, all underwriting information obtained or developed, policy declaration page, endorsements, cancellation or reinstatement notices, correspondence, and any other documentation supporting selection, classification, rating, or termination of the risk.
User Community	A web-based facility that provides members of the community access to information and aids relating to a software program – such as technical documents, frequently asked questions (FAQs), training material, users and reference guides, newsletters, on-line training, the ability to contact the vendor‘s help desk, and a discussion forum or bulletin board.
Utilization Review	A set of formal techniques designed to monitor the use, or evaluate the clinical necessity, of appropriateness, efficacy, or efficiency of health care services, procedures, or settings.
UTPA	Unfair Trade Practices Act
VIN	Vehicle Identification Number

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