Market Regulation Handbook Examination Standards Summary

2017

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Chapter 16—General Examination Standards

Chapter 16—Operations/Management Standards

The operations and management review includes, but is not limited to, the following standards addressing various aspects of a regulated entity's operations.

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17	Each licensee shall implement a comprehensive written information security program for the protection of nonpublic customer information**.**
18	All data required to be reported to departments of insurance is complete and accurate.

Chapter 16—Complaint Handling Standards	
The complaint handling review includes, but is not limited to, the following standards addressing various aspects of a regulated entity's operations.	
Standard Number	**Text of Standard**
1	All complaints are recorded in the required format on the regulated entity's complaint register.
2	The regulated entity has adequate complaint handling procedures in place and communicates such procedures to policyholders.
3	The regulated entity takes adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules and regulations and contract language.
4	The time frame within which the regulated entity responds to complaints is in accordance with applicable statutes, rules and regulations.

Chapter 16—Marketing and Sales Standards

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3	Claims are resolved in a timely manner.
4	The regulated entity responds to claims correspondence in a timely manner.
5	Claim files are adequately documented.
6	Claims are properly handled in accordance with policy provisions and applicable statutes (including HIPAA), rules and regulations.
7	Regulated entity claim forms are appropriate for the type of product.
8	Claim files are reserved in accordance with the regulated entity's established procedures.

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4	Business is diversified as required by statutes, rules and regulations.
5	There is a periodic review and testing of the title plant built, owned, controlled or maintained by a title agent.

Chapter 18—Complaint Handling Standards

Use the standards for this business area that are listed in Chapter 16

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Chapter 18—Claims Standards	
Standard Number	**Text of Standard**
1	Indemnification of a proposed insured solely against the loss of settlement funds may only be made for events as authorized by statutes, rules or regulations.
2	

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6	The regulated entity complies with the provisions of HIPAA and state laws regarding limits on the use of preexisting exclusions.
7	The regulated entity does not improperly deny coverage or discriminate based on health status in the group market or against eligible individuals in the individual market in conflict with the requirements of HIPAA or state law.
8	The regulated entity issues coverage that complies with guaranteed-issue requirements of HIPAA and related state laws for groups of 2 to 50.
9	The regulated entity issues individual insurance coverage to eligible individuals entitled to portability under the provisions of HIPAA and in compliance with applicable statutes, rules and regulations.
10	The regulated entity does not administer self-funded benefit plans for entities subject to state regulation (e.g., MEWAs) or provide insurance coverage to entities not entitled to such coverage under state or federal law.

Chapter 20—Claims Standards	
Use the standards for this business area that are listed in Chapter 16—General Examination Standards, in addition to the standards set forth below.	
Standard Number	**Text of Standard**
1	Claim files are handled in accordance with policy provisions, HIPAA and state law.
2	The company complies with the requirements of the federal Newborns' and Mothers' Health Protection Act of 1996.
3	The group health plan complies with the requirements of the federal Mental Health Parity Act of 1996 (MHPA) and the revisions made in the Mental Health Parity and Addiction Equity Act of 2008.
4	The group health plan complies with the requirements of the fede1.04 304.44 449.51--4e1.04 304.

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2	The health carrier verifies the credentials of a health care professional before entering into a contract with that health care professional.
3	The health carrier obtains primary verification of the information required by applicable state provisions equivalent to the *Health Care Professional Credentialing Verification Model Act* (#70) and accompanying regulations.

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Chapter 20—Utilization Review Standards	
The utilization review assessment includes, but is not limited to, the following standards related to the performance of utilization review activities by the health carrier.	
Standard Number	**Text of Standard**
1	The health carrier establishes and maintains a utilization review program in compliance with applicable statutes, rules and regulations.
2	The health carrier operates its utilization review program in accordance with applicable state statutes, rules and regulations.

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Chapter 20A—Prohibition on Excessive Waiting Periods Standards	
Standard Number	**Text of Standard**
1	A health carrier may not impose excessive waiting periods, as defined in applicable statutes, rules and regulations, to individuals determined by the health carrier to be otherwise eligible for coverage under the terms of the plan.

Chapter 20A—Grievance Procedures Standards	
Standard Number	**Text of Standard**
1	A health carrier offering individual health insurance coverage shall maintain records of all claims and notices associated with the internal claims and appeals process for the length of time specified

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Chapter 20A—Lifetime/Annual Benefit Limits Standards	
Standard Number	**Text of Standard**
1	A health carrier shall not establish any lifetime or annual limit on the dollar amount of essential health benefits (EHB)s for any individual, in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), U.S. Department of Labor (DOL) and U.S. Department of the Treasury (Treasury).

Chapter 20A—Prohibition on Preexisting Condition Exclusions	
Standard Number	**Text of Standard**
1	

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Chapter 20A—Utilization Review Standards	
Standard Number	**Text of Standard**
1	The health carrier shall operate its utilization review program in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), U.S. Department of Labor (DOL) and U.S. Department of the Treasury (Treasury).
2	The health carrier shall provide written notice of an adverse determination of standard utilization review and benefit determinations, in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), U.S. Department of Labor (DOL) and U.S. Department of the Treasury (Treasury).
3	The health carrier shall conduct expedited utilization review and benefit determinations, in a timely manner and in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), U.S. Department of Labor (DOL) and U.S. Department of the Treasury (Treasury).
4	The health carrier shall conduct utilization reviews or make benefit determinations for emergency services in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), U.S. Department of Labor (DOL) and U.S. Department of the Treasury (Treasury).

Chapter 21—Conducting the Medicare Supplement Examination

Chapter 21—Operations/Management Standards	
Standard Number	**Text of Standard**
1	The Medicare Select carrier's plan of operation complies with applicable statutes, rules and regulations.
2	The entity reports to the insurance department on an annual basis, each resident of the state for whom the entity has more than one Medicare supplement policy or certificate in force.
3	The entity certifies compliance with standards for claims payments on the Medicare supplement insurance experience reporting form.
4	The entity does not provide producer compensation that encourages replacement sales.

Chapter 21—Complaint Handling Standards
Use the standards for this business area that are listed in Chapter 16—General Examination Standards.

Chapter 21—Marketing and Sales Standards	
The marketing and sales review includes, but is not limited to, the following standards addressing various aspects of the marketing and sales function.	
Standard Number	**Text of Standard**
1	Entity rules concerning replacement are in compliance with applicable statutes, rules and regulations.
2	Outlines of coverage are in compliance with applicable statutes, rules and regulations.
3	The entity obtains receipts from applicants verifying that the outline of coverage has been received and that it is the outline of the policy for which the applicant has applied.
4	Guide to Health Insurance for People with Medicare is provided to the applicant within the time frame required by law and is in compliance with applicable statutes, rules and regulations.

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5	The entity maintains a system of control over the content, form and method of dissemination of all of its Medicare supplement advertisements.
6	Each advertisement of a Medicare supplement product is identified by form number or other means unique to that product and is labeled "insurance policy."
7	Advertisements that are invitations to join an association, trust or discretionary group—and that are also solicitations of insurance—contain a separate and distinct application for membership of the group and another for the insurance coverage.
8	Advertisements truthfully represent the Medicare supplement coverage being marketed.
9	Testimonials comply with applicable statutes, rules and regulations.
10	Advertisements that employ statistics accurately represent all relevant facts.
11	Advertisements do not disparage competitors or their policies, services or business methods.

12

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Chapter 22—Marketing and Sales Standards	
Use the standards for this business area that are listed in Chapter 16—General Examination Standards, in addition to the standards set forth below.	
Standard Number	**Text of Standard**
1	The entity has suitability standards for its products, when required by applicable statutes, rules and regulations.
2	Policy forms provide required disclosure material regarding standards for benefit triggers.

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Chapter 22—Underwriting and Rating Standards

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3	The applicable taxes are reported and are credited to the state.
4	If the surplus lines broker is responsible for such calculations, then unearned premiums are correctly calculated and returned to the appropriate party in a timely manner and in accordance with applicable statutes, rules and regulations.

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Chapter 25—Residual Market Functions—Plan Administration Standards

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Chapter 27—Marketing and Sales

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9	The viatical settlement provider, or its representative, has procedures in place to document and resolve complaints from viators and viatical settlement purchasers.
10	The viatical settlement provider has antifraud initiatives in place that are reasonably calculated to detect, prevent and report fraudulent insurance acts.

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Chapter 28—Claims Standards
Not applicable.

Chapter 28—Premium Finance Agreements Standards