Chapter 25—Conducting the Medicare Supplement Examination

IMPORTANT NOTE:
The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in Chapter 1—Introduction.

This chapter provides a format for conducting Medicare supplement insurance examinations. Procedures for conducting other types of specialized examinations may be found in separate chapters.

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

A. Operations/Management
B. Complaint Handling
C. Marketing and Sales
D. Producer Licensing
E. Policyholder Service
F. Underwriting and Rating
G. Claims
H. Grievance Procedures
I. Network Adequacy
J. Provider Credentialing
K. Quality Assessment and Improvement
L. Utilization Review

When conducting an exam that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the entity is meeting standards. Some standards may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.

When an examination involves a depository institution or their affiliates, the bank may also be regulated by federal agencies such as the Office of the Comptroller of the Currency (OCC), the Federal Reserve Board, the Office of Thrift Supervision (OTS) or the Federal Deposit Insurance Corporation (FDIC). Many states have executed an agreement to share complaint information with one or more of these federal agencies. If the examination results find adverse trends or a pattern of activities that may be of concern to a federal agency and there is an agreement to share information, it may be appropriate to notify the agency of the examination findings.

Examiners should note that some of the following market conduct standards may apply to all Medicare supplement insurance carriers, while others apply only to Medicare Select (managed care) carriers.

Examiners should also note that states may require, by law or regulation, that health plans receive certification by specific private accreditation organizations in order to obtain licensing. Other states may recognize accreditation as meeting specific state requirements. To the extent an examiner may take into account accreditation for specific operational areas (such as quality assessment and improvement, credential verification, utilization review, grievance processes or utilization management), when planning the examination and setting review priorities, the examiner should become familiar with the standards applied by the accrediting entity. Individual jurisdictions may have procedures in place for communicating deviations from such standards to the applicable accrediting entity in addition to administrative procedures.

A. Operations/Management

1. Purpose

The Operations/Management portion of the examination is designed to provide a view of what the entity is and how it operates. Normally, it is not based on sampling techniques; it is more concerned with structure. This review is not intended to duplicate financial examination review, but is important in providing the market conduct examiner with an understanding of the examined entity. Many troubled insurance companies have become so because management has not been structured to recognize and address the problems that can arise in the insurance industry. In addition to the general categories, examiners should also review Section J Provider Credentialing (Medicare Select carriers only) of this chapter.

a. Provider Credentialing

Examiners should determine that a Medicare Select carrier has established ~~written~~ documented verification programs to ensure that participating health care professionals meet minimum specific professional qualifications, both initially and on an ongoing basis.

Additional introductory material is located in Chapter 20—General Examination Standards.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 1
The Medicare Select carrier's plan of operation complies with applicable statutes, rules and regulations.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Plan of operations

_____ Information to enrollees

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

Ascertain that the plan of operation has been filed with the insurance commissioner.

Review the plan of operation for compliance with applicable statutes, rules and regulations.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 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.

Apply to: All Medicare supplement carriers

Priority: Essential

Documents to be Reviewed

_____ Reporting Medicare supplement policies form

_____ Records of issued Medicare supplement policies/certificates

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 9.2 and 22

Review Procedures and Criteria

Ascertain that the reporting Medicare supplement policies form has been filed with the insurance commissioner.

Review policy and certificate records to ascertain whether multiple sales of policies or certificates to individual enrollees have been made.

Review the reporting Medicare supplement policies form and compare with multiple sales findings during the examination to ensure that the entity has accurately reported multiple sales.

Verify plans after Jan. 1, 2020 are in compliance with Section 9.2 of Model # 651.

Verify the Benefit Chart of Medicare Supplement Plans Sold on or after Jan. 1, 2020 is correct pursuant to Model #651.

Verify the information provided by the carrier on Plan F or High Deductible F is correct pursuant to Model #651, for plans issued on or after Jan. 1, 2020.

Verify the information provided by the carrier on Plan G or High Deductible G is correct pursuant to Model #651, for plans issued on or after Jan. 1, 2020.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 3
The entity certifies compliance with standards for claims payments on the Medicare supplement insurance experience reporting form.

Apply to: All Medicare supplement carriers

Priority: Essential

Documents to be Reviewed

_____ Medicare supplement insurance experience reporting form

_____ Claims payment procedures manuals

_____ Claims training manuals

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)

Review Procedures and Criteria

Ascertain that the Medicare supplement insurance experience reporting form has been filed with the insurance commissioner.

Review the procedures and claims training manuals to ascertain whether the entity's standards for claim payments are in compliance with applicable statutes, rules and regulations.

Compare the entity's procedures and claims training manuals with the entity's Medicare supplement insurance experience reporting form. Discuss any discrepancies with the entity.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 4
The entity does not provide producer compensation that encourages replacement sales.

Apply to: All Medicare supplement carriers

Priority: Essential

Documents to be Reviewed

_____ Producer manuals

_____ Producer compensation agreements

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 16

Review Procedures and Criteria

Review procedures, producer compensation agreements and producer manuals to ascertain whether the entity's standards for producer compensation are in compliance with applicable statutes, rules and regulations concerning replacement sales.

B. Complaint Handling

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

C. Marketing and Sales

1. Purpose

The marketing and sales portion of the examination is designed to evaluate the representations made by the entity about its product(s). Typically, it is not based on sampling techniques, but sampling may be used as a review tool. The areas to be considered in this kind of review include all ~~written~~documented, verbal and electronic advertising and sales materials. The entity's website that informs about Medicare supplement availability and/or benefits, would be considered advertising and should be reviewed for accuracy.

2. Techniques

This area of review should include all advertising and sales material, including Internet advertising, and all producer sales training materials to determine compliance with applicable statutes, rules and regulations. Information from other jurisdictions may be reviewed, if appropriate. The examiner may contact policyholders, producers and others to verify the accuracy of the information provided or to obtain additional information. The examiner should be familiar with outlines of coverage and replacement regulations. Policyholder records are a good source for detection of multiple issues of Medicare supplement policies. Suitability should be considered in reviewing the entity's sales and marketing practices.

The entity must have procedures in place to establish and at all times maintain a system of control over the content, form and method of dissemination of its advertisements. All advertisements maintained by, or for, and authorized by the entity are the responsibility of the entity.

The same statutes, rules and regulations (such as the *Unfair Trade Practices Act* (#880)) that apply to conventional advertising also apply to Internet advertising. When the examiner is reviewing an entity's Internet advertisements, it is important to also review the safeguards implemented by the entity.

All advertisements are required to be truthful and not misleading in fact or by implication. The form and content of an advertisement of a policy shall be sufficiently clear ~~so as~~ to avoid deception. The advertisement must not have the capacity or tendency to mislead or deceive. Whether an advertisement has the capacity or tendency to mislead or deceive must be determined when reviewing the overall impression that the advertisement reasonably may be expected to create upon a person of average education or intelligence with the segment of the public to which the advertisement is directed.

Ensure that the entity actively offers all ~~of~~ its Medicare supplement products to eligible individuals. The company should not engage in marketing practices such as discriminatory commission levels or references to health conditions that discourage individuals with less favorable risk characteristics from seeking or obtaining coverage.

Determine whether producer training materials require the producer to report all sales of Medicare supplement policies and/or certificates.

Ascertain that the entity has procedures for distributing to producers and other company personnel any bulletins issued by state or federal regulators.

Ensure that the entity prohibits the sale of Medicare supplement policies or certificates to people enrolled in a Medicare ~~+ Choice~~ Advantage or private fee-for-service plans.

Ensure that the entity prohibits the sale of a Medicare supplement policy/certificate to an individual already covered under such a policy, unless the new policy/certificate is a replacement policy/certificate.

Ensure that producer commission schedules do not encourage replacement sales or sales of more than one Medicare supplement policy/certificate to an individual, or discourage eligible individuals with unfavorable risk characteristics.

Ensure that the entity offers to all eligible individuals all the Medicare supplement products it sells.

Determine whether individuals in the state have been eligible for ~~guaranteed issue~~ guaranteed issue because of termination of Medicare business by managed care organizations, and review company practices with respect to eligible individuals.

Determine whether individuals in the state have been eligible for guaranteed issue for other situations as described in NAIC Model References Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 12.

Review entity communications to company personnel, producers and applicants about open enrollment and guaranteed-issue rights.

3. Tests and Standards

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

STANDARDS
MARKETING AND SALES

Standard 1
Entity rules concerning replacement are in compliance with applicable statutes, rules and regulations.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ Bulletins, newsletters and memos

_____ Replacement register

_____ Underwriting guidelines and files

_____ Replacement comparison forms (if external replacement)

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)

Review Procedures and Criteria

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

Ensure that the application or other form asks whether the policy or certificate is intended to replace or add to any coverage currently in force.

Ensure that the application or other form asks all the questions required by state law to be asked.

Determine if the entity permits multiple sales of Medicare supplement policies to the same person.

Using a random selection of policyholders, have the entity run a policyholder/certificateholder history to identify the number of policies or certificates sold to those individuals.

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

Ensure that the entity, when determining whether a sale involves replacement, furnishes to the applicant prior to policy/certificate issue, or at the time of issue in the case of a direct response sale, the required notice concerning replacement of Medicare supplement coverage, obtains the signatures required by state law, and maintains one copy of the signed notice on file.

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

Determine if negative enrollment practices are permitted and used.

Determine if the entity has a system to discourage "over-insurance," as defined in the entity's underwriting requirements, of policyholders/certificateholders.

Determine whether individuals in the state have been eligible for ~~guaranteed issue~~guaranteed issue because of terminations of Medicare business by managed care organizations, and review entity practices with respect to eligible individuals.

Review entity communications to company personnel, producers and applicants about open enrollment and guaranteed-issue rights.

Determine that the regulated entity, upon replacement, does not impose any waiting periods, elimination periods or probationary periods in their replacement policies unless the replaced individual had not satisfied their ~~six month~~six-month preexisting condition period under their prior coverage.

STANDARDS
MARKETING AND SALES

Standard 2
Outlines of coverage are in compliance with applicable statutes, rules and regulations.

Apply to: All Medicare supplement carriers

Priority: Essential

Documents to be Reviewed

_____ Application files

_____ Outlines of coverage

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 17

Review Procedures and Criteria

Look for verification that outlines of coverage used have been approved by appropriate persons within the entity, and are authorized by the entity.

Ensure that outlines of coverage conform to the requirements of state law for format.

Determine whether mandated benefits, benefit limitations and premiums are completely and accurately described, and can be compared with other Medicare supplement policies or certificates offered by the entity and with other Medicare Select policies and certificates. The outline of coverage includes:

- A description of the principal benefits and coverage provided in the policy;
- A statement of the renewal provisions, including any reservation by the insurer of a right to change premiums and disclosure of the existence of any automatic renewal premium increases based on the policyholder's/certificateholder's age; and
- A statement that the outline of coverage is a summary of the policy issued or applied for, and that the policy should be consulted to determine governing contractual provisions.

STANDARDS
MARKETING AND SALES

Standard 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.

Apply to: All Medicare supplement carriers

Priority: Essential

Documents to be Reviewed

_____ Application files

_____ Outlines of Coverage

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 17~~C~~

Review Procedures and Criteria

Verify through signed receipts that outlines of coverage have been provided to applicants prior to the sale of a policy or certificate.

Verify that the outline of coverage provided reflects the benefits of the policy for which the applicant applied, and, if not, that the applicant has been provided with a copy of the correct outline of coverage and the required disclosure concerning the substitution.

STANDARDS
MARKETING AND SALES

Standard 4
The *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.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ Application files

_____ Underwriting files

_____ *Guide to Health Insurance for People with Medicare*

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 17~~A~~

Review Procedures and Criteria

Verify that the Guide to Health Insurance for People with Medicare was received by the applicant, by ensuring that the receipt for the guide contains the signature of the applicant.

Ensure that the applicant was provided with a copy of the guide prior to policy issuance or at the time of issuance, as required by state law.

Ensure that the guide was provided to the applicant within the time frame specified by state law.

Ensure that the guide is provided in the required format.

STANDARDS
MARKETING AND SALES

Standard 5
The entity maintains a system of control over the content, form and method of dissemination of all of its Medicare supplement advertisements.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ Guide to Health Insurance for People with Medicare

_____ Outlines of coverage

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660)

Review Procedures and Criteria

Ensure that the entity retains responsibility for all advertisements (as the term "advertisement" is defined by state law) regardless of by whom ~~written~~documented, created, ~~designed~~designed, or presented.

STANDARDS
MARKETING AND SALES

Standard 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."

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ Guide to Health Insurance for People with Medicare

_____ Outlines of coverage

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660)

Review Procedures and Criteria

Ensure that all advertisements are identified by form number or other means of identification that distinguishes that advertisement from all others.

Ensure that advertisements clearly state that an advertised Medicare supplement policy is an "insurance policy."

STANDARDS
MARKETING AND SALES

Standard 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.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660), Section 6

Review Procedures and Criteria

Ensure that advertisements containing applications provide applications for membership in an association, trust or other group, separate from the application for the Medicare supplement coverage.

STANDARDS
MARKETING AND SALES

Standard 8
Advertisements truthfully represent the Medicare supplement coverage being marketed.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ Guide to Health Insurance for People with Medicare

_____ Outlines of coverage

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660), Sections 6 and 7
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Ensure that advertisements do not contain words or phrases such as "all," "full," "complete," "comprehensive," "unlimited," "up to," "as high as," "this policy pays all that Medicare doesn't" or similar words or phrases in a manner that exaggerates any benefit beyond the terms of the policy.

Advertisements that are invitations to contract should:

- Disclose exceptions, reductions and limitations affecting the basic provisions of the policy;
- If a preexisting conditions limitation applies, ask a question immediately above the signature line concerning the applicant's understanding of the limitation; and
- Disclose renewability, modification, cancellability, termination, losses covered and premium changes due to age or other reasons in a manner that does not minimize or obscure the qualifying conditions.

Ensure that if the policy is not ~~guaranteed issue~~guaranteed issue or if a preexisting conditions limitation applies, the advertisement does not state or imply that health history will not affect the issuance of the policy or payment of a claim under the policy.

Ensure that provisions that are negative in nature, such as a preexisting conditions limitation, are presented in a negative light and that if the advertisement is an invitation to contract, the term "preexisting conditions limitation," if used, is defined.

Ensure that advertisements do not state or imply that claim settlements are "liberal" or "generous," or words of similar import, and do not mislead by quoting unusual claims that may have been paid.

STANDARDS
MARKETING AND SALES

Standard 9
Testimonials comply with applicable statutes, rules and regulations.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines, Section 8 (#660)
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Ensure that testimonials used in advertising are genuine, represent the current opinion of the author, are applicable to the policy advertised, are accurately ~~reproduced~~reproduced, and otherwise comply with all provisions of state law concerning the use of testimonials.

Ensure that the use of a spokesperson complies with all provisions of state law concerning disclosure of the interests of the spokesperson.

STANDARDS
MARKETING AND SALES

Standard 10
Advertisements that employ statistics accurately represent all relevant facts.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660), Section 9
Model Regulation to Require Reporting of Statistical Data by Property and Casualty Insurance Companies (#751)

Review Procedures and Criteria

Ensure that advertisements containing statistical data accurately represent all relevant facts.

Advertisements should state the source of all statistics used in the advertisement.

STANDARDS
MARKETING AND SALES

Standard 11
Advertisements do not disparage competitors or their policies, services or business methods.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660), Section 10
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Ensure that advertisements do not directly or indirectly disparage competitors.

STANDARDS
MARKETING AND SALES

Standard 12
Advertisements do not imply licensing of the entity beyond the jurisdiction in which the entity is licensed or imply a status with any governmental entity.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ Guide to Health Insurance for People with Medicare

_____ Outlines of coverage

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660), Section 11
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Ensure that advertisements do not imply that the entity is licensed in jurisdictions other than that in which it is licensed.

Ensure that advertisements do not imply that the entity's products are approved, ~~endorsed~~endorsed, or accredited, or connected with any governmental entity.

STANDARDS
MARKETING AND SALES

Standard 13
Advertisements state the name of the insurer and all other pertinent information required by applicable statutes, rules and regulations.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ Guide to Health Insurance for People with Medicare

_____ Outlines of coverage

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660), Section 12
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Ensure that the entity's name appears in all advertisements. The entity should not use the name of the parent entity, a group designation or any other designation, without disclosing the name of the actual insurer.

Ensure that advertisements—including stationery, envelopes, etc., do not use any word, symbol, etc., that may confuse or mislead applicants into believing that the solicitation is connected with any government agency. The advertisement must contain a statement that the advertisement is not connected with or endorsed by the U.S. government or the federal Medicare program.

Producers who contact the consumer through a lead-generating device must disclose that fact to the consumer in the initial contact with the consumer.

STANDARDS
MARKETING AND SALES

Standard 14
Advertisements do not state or imply that prospective insureds become group or quasi-group members under a group policy and, as such, will enjoy special rates or underwriting privileges, unless it is a fact.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660), Section 13
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Ensure that advertisements do not state or imply that an applicant will become a member of a group, and therefore, enjoy special rating or underwriting privileges, unless it is a fact.

Ensure that advertisements do not solicit a particular class, such as governmental employees, and imply that their occupational status gives them group privileges, when the policy advertised is sold only on an individual basis at regular rates.

STANDARDS
MARKETING AND SALES

Standard 15
Advertisements should not use incentives to purchase that mislead the prospective insured.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660), Section 14
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Ensure that advertisements for individual policies do not directly or indirectly represent that the policy offering is introductory or special, and that the advantages will not be available at a later date, unless it is a fact.

Ensure that advertisements for individual policies do not describe an enrollment period as special or limited, or use words of similar import, when the insurer uses such enrollment periods as the usual method of advertising.

Ensure that if an enrollment period is used for policies sold on an individual basis, that the lapse between enrollment periods is not less than that provided for by state law, and that the advertisement states the period specified by state law in which the application must be mailed.

Ensure that advertisements do not state that only a specific number of policies will be sold, or that a time is fixed for discontinuance of the sale of a particular policy because of its special advantages, unless it is a fact.

Ensure that advertisements do not advertise a reduced initial premium more frequently or more prominently than the renewal premium, and that the two premiums are stated in juxtaposition.

STANDARDS
MARKETING AND SALES

Standard 16
Advertisements do not contain statements about the entity that are untrue or misleading.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660), Section 15
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Ensure that advertisements do not contain statements that are untrue or misleading about the assets, corporate structure, financial standing, age or relative position of the insurer in the insurance business.

Ensure that advertisements do not contain recommendations by commercial rating systems, unless the advertisements clearly indicate the purpose of the recommendation and the limitations of the scope and extent of the recommendation.

D. Producer Licensing

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

E. Policyholder Service

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

F. Underwriting and Rating

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

G. Claims

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

H. Grievance Procedures

1. Purpose

The grievance procedures portion of the examination is designed to evaluate how well the Medicare Select carrier handles grievances.

A "grievance" means dissatisfaction in writing with the administration, claims practices or provision of services concerning an issuer of a Medicare Select product or network provider.

Note that these definitions may not include all ~~written~~ documented communications that the company tracks as "complaints" under the definition of complaint.

The examiner should review the company procedures for processing grievances. Specific problem areas may necessitate an overall review of a particular segment of the company's operation.

2. Techniques

A review of grievance procedures should incorporate consumer and provider appeals, consumer direct grievances to the company and those grievances filed with the insurance department. The company should reconcile the company grievance register with a list of grievances from the insurance department. A random sample of grievances and appeals should be selected for review from the company's grievance register.

The company's ~~written~~ documented grievance procedures should be reviewed. Determine how those procedures are communicated to plan members within membership materials and upon receipt of appeals and grievances.

The examiner should review the frequency of similar grievances and be aware of any pattern of specific types of grievance. Should the type of grievance noted be cause for unusual concern, specific measures should be instituted to investigate other areas of a company's operation. This may include modifying the scope of examination to examine specific company behavior.

3. Tests and Standards

The grievance handling review includes, but is not limited to, the following standards addressing various aspects of a company's operations. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
GRIEVANCE PROCEDURES

Standard 1
The entity defines as a grievance any dissatisfaction expressed in writing with the administration, claims practices or provision of services concerning an issuer of a Medicare Select product or network.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Sample documents and files, including electronic correspondence

_____ Outlines of coverage

_____ Policies and/or certificates of coverage

_____ Contracts

_____ Grievance procedures

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

Review the contracts, outlines of coverage, grievance procedures, sample grievance files and disclosures to determine if the company is correctly defining "grievance."

STANDARDS
GRIEVANCE PROCEDURES

Standard 2
The entity develops ~~written~~ documented grievance procedures that comply with applicable statutes, rules and regulations, and provides enrollees with a copy of its grievance procedures.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Procedures manuals

_____ Policies and/or certificates of coverage

_____ Outlines of coverage

_____ All forms used to process a grievance

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

Determine if the entity provides grievance registration information to the policyholder at the time of the issuance of a policy or certificate.

Determine if the entity has procedures to ensure that a copy of its grievance procedures is provided to any enrollee or prospective enrollee upon request.

Determine if the entity includes a copy of its grievance procedures in its policies, certificates (if applicable) and outlines of coverage.

Review the disclosure form(s) to determine if a description of the entity's grievances procedures is included.

Review the entity's grievance procedures to ensure that the procedures are aimed at mutual agreement for settlement and that, if applicable, any arbitration procedures are disclosed.

STANDARDS
GRIEVANCE PROCEDURES

Standard 3
The entity documents, resolves and records grievances in compliance with applicable statutes, rules and regulations, and their contract language.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Entity's grievance handling policies and procedures

_____ Sample of grievance files

_____ Outlines of coverage

_____ Policies and/or certificates of coverage

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

The entity maintains a grievance register ~~consisting of written records~~ that documents all grievances received during the calendar year.

The entity reports all grievances to the insurance commissioner annually, with the information and in the format required by law.

The entity complies with its ~~written~~ documented procedures when receiving and resolving grievances.

The entity considers grievances in a timely manner and transmits grievances to appropriate decision-makers.

The entity takes corrective action promptly on valid grievances.

The entity promptly notifies concerned parties of the results of a grievance review.

STANDARDS
GRIEVANCE PROCEDURES

Standard 4
The company provides to any enrollee, who has filed a grievance, detailed information concerning its grievance and appeal procedures, how to use them and how to notify the insurance department, if applicable.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Procedures for processing grievances

_____ Grievance forms and other information provided to an enrollee at the time the enrollee files a grievance

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

Review the entity's procedures for processing a grievance to determine if the required disclosures are provided.

Review the entity's procedures to determine if, when required by state law, the enrollee is advised of the right to contact the insurance department.

Review the grievance procedures to ensure that a provision is made for grievance registration information to be provided at the time of issue and upon request.

As grievances are detected throughout the entire examination, ensure that they have been handled and recorded properly.

STANDARDS
GRIEVANCE PROCEDURES

Standard 5
The company reports its grievance procedures to the insurance commissioner on an annual basis.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Procedures for processing grievances

_____ Procedures for annually reporting grievances to the insurance commissioner

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

The examiner should determine whether the entity has procedures in place for recording and reporting grievances to the insurance commissioner.

The examiner should ensure that the entity has reported on an annual basis and in the format prescribed by the insurance commissioner, the number of grievances filed in the previous year and a summary of the subject, nature and resolution of such grievances.

I. Network Adequacy

1. Purpose

The network adequacy portion of the examination is designed to ensure that companies offering Medicare Select plans maintain service networks that are sufficient to ensure that all services are accessible without unreasonable delay. The standards require companies to ensure the adequacy, accessibility and quality of health care services offered through their service networks.

The areas to be considered in this kind of review include the company's plan of operation and measures used by the company to analyze network sufficiency, contracts with participating providers and intermediaries, and ongoing oversight and assessment of access issues.

2. Techniques

To evaluate network adequacy standards, it is necessary for examiners to request from the company a statement or map that reasonably describes the service area. Additional items for review include a list and description by specialty of network providers and facilities. The examiner should determine whether the company has conducted studies to measure waiting times for appointments and other studies that measure the sufficiency and adequacy of the network. The examiner should also determine how the company arranges for covered services that cannot be provided within the network. Examiners should request the carrier's ~~written~~ documented selection standards for providers and review the plan of operation. Using the list of providers and facilities, examiners should request a sample of specific provider contracts. The review of provider contracts should include an evaluation of compliance with filing requirements and adherence to patient-protection requirements. In addition to direct contracts with providers and facilities, examiners should review the ~~written~~ documented guidelines and contractual requirements established for intermediary contracts. Availability of emergency care facilities and procedures should be evaluated. Examiners should obtain verification that accurate provider directories are provided upon enrollment, are updated and dispersed periodically, and that the company has filed its updated list of network providers with the insurance commissioner on a quarterly basis. Another area for review includes grievances related to provider access issues.

3. Tests and Standards

The network adequacy review includes, but is not limited to, the following standards related to the adequacy of the health carrier's provider network. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
NETWORK ADEQUACY

Standard 1
The company demonstrates, using reasonable criteria, that it maintains a network that is sufficient in number and types of providers to ensure that all services to enrollees will be accessible without unreasonable delay.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Selection criteria

_____ Documents related to physician recruitment

_____ Provider directory

_____ List of providers by specialty

_____ Reports of out-of-network service denials

_____ Company policy for in-network/out-of-network coverage levels

_____ Provider/enrollee location reports by ZIP code *MK Rodriguez comment: Should ZIP code be referred to as geographic location?*

_____ Any policies or incentives that restrict access to subsets of network specialists

_____ Computer tools used to assess the network's adequacy

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Benefit Plan Network Access and Adequacy Model Act (#74), Section 5
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

Reasonable criteria include, but are not limited to:

- Ratios of providers (primary care providers and specialty providers) to enrollees;
- Geographic accessibility, as measured by the reasonable proximity of participating providers to the business or personal residence of enrollees;

- Waiting times for appointments;
- Hours of operation; and
- Volume of technological and specialty services available to serve the needs of enrollees requiring technologically advanced or specialty care.

The company develops and complies with ~~written~~ documented policies and procedures specifying when the company will pay for out-of-area and out-of-network services that are covered by the policy, or as are required by state law. In any case where the company is required to cover services and it has an insufficient number or type of participating providers to provide a covered benefit, the company shall ensure that the enrollee obtains the covered benefit at no greater cost than if the benefit were obtained from participating ~~providers, or~~providers or shall make other arrangements acceptable to the insurance commissioner.

The company establishes and maintains adequate arrangements to ensure reasonable proximity of participating providers to the business or personal residences of enrollees. In determining whether a company has complied with this provision, the insurance commissioner shall give due consideration to the relative availability of health care providers in the enrollees' service area.

The company demonstrates that it monitors, on an ongoing basis, its providers, provider groups and intermediaries with which it contracts to ensure the ability, clinical capacity, financial capability and legal authority, including applicable licensure requirements, to furnish all contracted benefits to enrollees. There are standards pertinent to provider licensing in Section J. Provider Credentialing of this chapter.

The company complies with all applicable provisions of state law not expressly covered by any other of these standards.

STANDARDS
NETWORK ADEQUACY

Standard 2
The company has a plan of operation for each plan offered in the state, and files updates whenever it makes a material change to an existing plan.

Apply to: Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Plan of operation

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

The plan of operation contains evidence of at least the following:

- Covered services are available and accessible though network providers;
- Either the number of network providers in the service area is sufficient to deliver adequately all services, or that the company makes appropriate referrals for provision of such services outside its network;
- There are ~~written~~ documented agreements with network providers describing specific responsibilities;
- Emergency care is available 24 hours per day, 7 days per week;
- The provider agreements prohibit the provider from billing or otherwise seeking reimbursement from enrollees, other than for coinsurance, copayments or supplemental charges;
- A description or map of the service area;
- A description of the company's grievance procedures;
- A description of the quality assurance program, including the formal organizational structure, the criteria for selection, retention and removal of network providers and the procedures for evaluating quality of care and taking corrective action when warranted;
- A list and description of network providers, by specialty; and
- Any other information requested by the insurance commissioner.

STANDARDS
NETWORK ADEQUACY

Standard 3
The company ensures that enrollees have access to emergency services 24 hours per day, 7 days per week within its network and provides coverage for urgently needed services and emergency services outside of the service area.

Apply to: Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Provider manuals and contracts

_____ Policy forms

_____ Plan of operation

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

Within the network, the company operates or contracts with facilities to provide enrollees with access to emergency and urgently needed services on a 24 hours per day, 7 day per week basis.

The company covers in full, emergency services or services that are immediately required for an unforeseen illness, injury or condition, when it is not reasonable to obtain services through network providers.

STANDARDS
NETWORK ADEQUACY

Standard 4
The company files with the insurance commissioner all required contract forms and any material changes to a contract proposed for use with its participating providers and intermediaries.

Apply to: Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Provider manuals

_____ Sample of provider contracts

_____ Credentialing file

_____ Directory of providers

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10.

Review Procedures and Criteria

Determine if the provider contracts and endorsements have been filed (if required by state law).

Review provider contracts to determine if the provider is listed in the directory and to determine if credentialing is ~~up-to-date~~up to date.

STANDARDS
NETWORK ADEQUACY

Standard 5
The company executes with each participating provider ~~written~~ documented agreements that are in compliance with applicable statutes, rules and regulations.

Apply to: Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Provider manuals, contracts and intermediary subcontracts

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10.

Review Procedures and Criteria

Every contract between a Medicare Select carrier and a participating provider or provider group contains a "hold harmless" provision specifying protection for enrollees from being billed by providers for other than coinsurance, copayments or supplemental charges.

The contract provides an extension of benefits beyond the period during which the policy was in ~~force, if~~force if the enrollee suffers continuous total disability after contract termination.

STANDARDS
NETWORK ADEQUACY

Standard 6
The company's arrangements with participating providers comply with applicable statutes, rules and regulations.

Apply to: Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Provider manuals and contracts

_____ Credentialing and re-credentialing procedures

_____ Complaints made by providers

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Benefit Plan Network Access and Network Adequacy Model Act (#74), Section 6

Review Procedures and Criteria

When required by state law, the company complies with the following:

- The company establishes a mechanism by which the participating provider will be notified on an ongoing basis of the specific covered health services for which the provider will be responsible, including any limitations or conditions on services;
- The company develops selection standards for primary care professionals and each health care professional specialty. The standards are used in determining the selection of health care professionals by the health carrier, its intermediaries and any provider networks with which it contracts;
- The company makes its selection standards for participating providers available for review by the insurance commissioner;
- The company notifies participating providers of the providers' responsibilities with respect to the carrier's applicable administrative policies and programs, including, but not limited to, payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements and any applicable state insurance law;
- The company does not offer inducements to providers to provide less than medically necessary services to enrollees;
- The company does not prohibit a participating provider from discussing treatment options with enrollees, regardless of the health carrier's position on the treatment options, or from advocating on behalf of enrollees within the utilization review or grievance processes established by the carrier or a person contracting with the carrier;

- The company requires a provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of enrollees, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records;
- The company and the participating provider terminate provider contracts according to contract provisions and as provided by law;
- The company notifies participating providers of their obligations, if any, to collect applicable coinsurance, copayments or deductibles from enrollees pursuant to policy or certificate provisions, or of the providers' obligations, if any, to notify enrollees of their personal financial obligations for non-covered services;
- The company does not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare;
- The company establishes a mechanism by which participating providers may determine in a timely manner whether a person is covered by the carrier; and
- The company establishes procedures for resolution of administrative, payment or other disputes between providers and the health carrier.

STANDARDS
NETWORK ADEQUACY

Standard 7
The company provides at enrollment a directory of providers participating in its network. It also makes available, on a timely and reasonable basis, updates to its directory and files the directory with the insurance commissioner.

Apply to: Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Provider directory and updates

_____ Provider contracts

_____ Credentialing and re-credentialing documentation

_____ Internet directory

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

Request information regarding the carrier's frequency of updates to the provider directory.

Verify that the company is providing directory updates to enrollees and to the insurance commissioner at the frequency required by state law.

Review how provider data is maintained. If the provider directory is not produced from the same system(s) that handles the administration functions, determine if the data is maintained consistently between systems.

If the provider directory is made available on the carriers' website, verify that a paper version can be requested, as an option, by the enrollee.

J. Provider Credentialing

1. Purpose

The provider credentialing portion of the examination is designed to ensure that companies offering Medicare Select plans have verification programs to ensure that participating health care professionals meet minimum specific standards of professional qualification.

The areas to be considered in this kind of review include the company's ~~written~~ documented credentialing and re-credentialing policies and procedures, the scope and timeliness of verifications, the role of health professionals in ensuring accuracy and the oversight of any delegated verification functions.

2. Techniques

Prior to reviewing records for specific providers, examiners should request all ~~written~~ documented credentialing procedures from the company. Examiners should determine the composition of the carrier's credentialing committee. Examiners should use the company's provider directory to select a sample of specific provider credential files, drawing from a variety of provider types and facilities. For each provider selected, the examiner should request:

a. The provider application;
b. Credentialing verification materials, including materials obtained through primary and secondary sources;
c. Updates to credentialing information; and
d. Copies of correspondence to providers that relates to the credentialing process.

Examiners should determine how the credentialing committee permits providers to correct information and provide additional information for reconsideration. In the event the credentialing process is subcontracted, examiners should determine whether the contracting entity is following applicable standards.

3. Tests and Standards

The provider credentialing review includes, but is not limited to, the following standards related to the adequacy of the health carrier's provider credentialing and contracting processes. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
PROVIDER CREDENTIALING

Standard 1
The company establishes and maintains a program for credentialing and re-credentialing of providers in compliance with applicable statutes, rules and regulations.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Credentialing plan

_____ Credentialing policies and procedures

_____ Minutes of the credentialing committee

_____ Credentialing plan evaluation reports (if any)

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70), Section 5

Review Procedures and Criteria

The company establishes ~~written~~ documented policies and procedures for credentialing and re-credentialing of all health care professionals with whom the company contracts and applies those standards consistently.

The company ensures that the carrier's medical director or other designated health care professional has the responsibility for, and participates in, the health care professional credentialing verification process.

The company establishes a credentialing verification committee consisting of licensed physicians and other health care professionals to review credentialing verification information and supporting documents in order to make decisions regarding credentialing verification.

The company makes all application and credentialing verification policies and procedures available for review by the applying health care professional upon written request.

The company keeps confidential all information obtained in the credentialing verification process, except as otherwise provided by state law.

The company retains all records and documents relating to a health care professional's credentialing verification process for at least the number of years required by state law.

The company's policies and procedures for credentialing and re-credentialing of providers are in compliance with state law.

STANDARDS
PROVIDER CREDENTIALING

Standard 2
The company verifies the credentials of a health care provider before entering into a contract with that health care provider.

Apply to: All Medicare Select plans

Priority: Essential

Documents to be Reviewed

_____ Provider credentialing files

_____ Provider contracts

_____ Provider credentialing policies and procedures

_____ Provider directory

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70), Section 5

Review Procedures and Criteria

Ensure that the company verifies that providers are properly credentialed, prior to entering into a contract with the provider and placing the provider name in the provider directory. This can be achieved by comparing the effective date of the provider's contract with the date of credentialing and the date the provider's name is entered in the provider directory.

STANDARDS
PROVIDER CREDENTIALING

Standard 3
The company obtains primary verification of the information required by state law relating to provider credentialing.

Apply to: All Medicare Select plans

Priority: Essential

Documents to be Reviewed

_____ Checklist for credentialing

_____ Checklists and forms for site visits (if any)

_____ Reports made from site visits (if any)

_____ Sample of credentialing files

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70), Section 6

Review Procedures and Criteria

If required by state law, the company verifies the following:

- Current license, certificate of authority or registration to practice his or her particular profession in the state and history of licensure;
- Current level of professional liability coverage (if applicable);
- Status of hospital privileges (if applicable);
- Specialty board certification status (if applicable);
- Current Drug Enforcement Agency (DEA) registration certificate (if applicable);
- Graduation in his or her specialty from an accredited school;
- Completion of post-graduate training (if applicable);
- The provider's license history in all states;
- The provider's malpractice history (if applicable); and
- The provider's practice history.

STANDARDS
PROVIDER CREDENTIALING

Standard 4
The company obtains, at the interval provided for by state law, primary verification of the information required by state law relating to provider credentialing.

Apply to: All Medicare Select plans

Priority: Essential

Documents to be Reviewed

_____ Checklist for credentialing

_____ Checklists and forms for site visits (if any)

_____ Reports made from site visits (if any)

_____ Sample of credentialing files

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70), Section 6

Review Procedures and Criteria

The company verifies the following:

- Current license, certificate of authority or registration to practice his or her particular profession in the state and history of licensure;
- Current level of professional liability coverage (if applicable);
- Status of hospital privileges (if applicable);
- Specialty board certification status (if applicable); and
- Current Drug Enforcement Agency (DEA) registration certificate (if applicable).

STANDARDS
PROVIDER CREDENTIALING

Standard 5
The company requires all participating providers to notify the individual designated by the company of changes in the status of any provider information that is required to be verified by the company.

Apply to: All Medicare Select plans

Priority: Essential

Documents to be Reviewed

_____ Credentialing policies and procedures

_____ Provider contracts

_____ Credentialing files

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70), Section 6

Review Procedures and Criteria

The company identifies for participating providers the individual to whom they should report changes in the status of provider information required to be verified by the company.

STANDARDS
PROVIDER CREDENTIALING

Standard 6
The company provides the provider with the opportunity to review and correct information submitted in support of the provider's credentialing verification.

Apply to: All Medicare Select plans

Priority: Essential

Documents to be Reviewed

_____ Credentialing policies and procedures

_____ Provider manual

_____ Listing of active and terminated providers

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70), Section 7

Review Procedures and Criteria

The company makes available to each provider who is subject to the credentialing verification process, the information and the source of the information obtained by the company to satisfy the company's credentialing process.

The company notifies the provider of any information obtained during the company's credentialing verification process that does not meet the company's credentialing verification standards or that varies substantially from the information provided to the company by the provider, if the information is required to be verified by state law, unless such disclosure is prohibited by law.

The company permits the provider to correct any incorrect information and request a reconsideration of the provider's credentialing verification application through a formal process by which the provider may submit supplemental or corrected information to the company's credentialing verification committee or the entity delegated to perform credentialing.

STANDARDS
PROVIDER CREDENTIALING

Standard 7
The company monitors the activities of the providers and provider entities with which it contracts and ensures that the requirements of state law are met.

Apply to: All Medicare Select plans

Priority: Essential

Documents to be Reviewed

_____ Provider credentialing and re-credentialing policies and procedures

_____ Intermediary contracts

_____ Periodic reports from intermediaries

_____ Reports of entity reviews and audits (if any) of credentialing activities by the company

_____ Minutes of the credentialing committee

_____ Minutes of the board of directors

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70)

Review Procedures and Criteria

The company ensures that providers and provider entities with which it contracts meet the requirements of state law applicable to such providers and provider entities.

K. Quality Assessment and Improvement

1. Purpose

The quality assessment portion of the examination is designed to ensure that companies offering Medicare Select plans have quality assessment programs in place that enable the company to evaluate, maintain and, when required by state law, improve the quality of health care services provided to enrollees. For Medicare Select plans that limit access to health care services 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~~ documented quality assessment and improvement policies and procedures, annual certifications, reporting of disciplined providers, communications with members about the program and oversight of delegated quality-related functions.

2. Techniques

In some jurisdictions, the quality assessment and improvement function may be monitored jointly by the Department of Insurance and Department of Health (or similar agency). To evaluate quality assessment and improvement activities, examiners should request information relative to the composition of the quality assessment and improvement committee. Examiners should also determine frequency of quality assessment and improvement meetings. To obtain an accurate assessment of a company's quality assessment and improvement program, it is advisable to review quality assessment and improvement committee meeting minutes for all meetings conducted during the examination period. Ascertain whether the quality assessment program reasonably encompasses all aspects of the covered health care services. Determine whether the carrier has obtained certification from a nationally recognized accreditation entity. Determine which standards will be met by virtue of the certification process. Examiners should evaluate the process by which quality assessment and improvement information and directives are communicated to network providers. Review procedures such as peer review, for including network providers in the quality assessment and improvement process. Ascertain whether outcome-based goals and objectives are being monitored and met.

3. Tests and Standards

The quality assessment and improvement review includes, but is not limited to, the following standards related to the assessment and improvement activities conducted by the health carrier. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 1
The company develops and maintains a quality assessment program that is in compliance with state law to evaluate, maintain and improve the quality of health services provided to enrollees.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Quality assessment policies and procedures

_____ Quality assessment plan (if any)

_____ Minutes of the quality assessment committee

_____ Minutes of the board of directors

_____ Evaluations of the quality assessment program

_____ Job descriptions of the chief medical officer or clinical director

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Quality Assessment and Improvement Model Act (#71)

Review Procedures and Criteria

The company develops a quality assessment program and procedures to ensure effective corporate oversight of the program.

The company develops and maintains the infrastructure and disclosure systems necessary to measure the quality of health care services provided to enrollees on a regular basis and appropriate to the types of plans offered by the company.

The company establishes a system designed to assess the quality of health care provided to enrollees. The system includes systematic collection, analysis and reporting of relevant data in accordance with statutory and regulatory requirements.

The company communicates findings in a timely manner to applicable regulatory agencies, providers and consumers as provided for by state law.

The company appoints a chief medical officer or clinical director to have primary responsibility for the quality assessment activities carried out by, or on behalf of, the company (*Quality Assessment and Improvement Model Act* (#71), Section 7).

The chief medical officer or clinical director approves the ~~written~~ documented quality assessment program, periodically reviews and revises the program documents and acts to ensure ongoing appropriateness. Not less than semi-annually, the chief medical officer or clinical director reviews reports of quality assessment activities (*Quality Assessment and Improvement Model Act* (#71), Section 7).

The company has an appropriate ~~written~~documented policy to ensure the confidentiality of an enrollee's health information used in the company's quality assessment programs (*Quality Assessment and Improvement Model Act* (#71), Section 9).

The company complies with all applicable provisions of state law not expressly covered by any other of these standards.

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 2
The company develops and maintains a quality improvement program that is in compliance with applicable statutes, rules and regulations to evaluate, maintain and improve the quality of health services provided to enrollees.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Quality improvement policies and procedures

_____ Quality improvement plan

_____ Minutes of the quality improvement committee

_____ Minutes of the board of directors

_____ Evaluations of the quality improvement program

_____ Job descriptions of the chief medical officer or clinical director

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Quality Assessment and Improvement Model Act (#71)

Review Procedures and Criteria

The company develops a quality improvement program and procedures to ensure effective corporate oversight of the program (*Quality Assessment and Improvement Model Act* (#71), Section 7).

The company develops and maintains the infrastructure and disclosure systems necessary to measure, on a regular basis, the quality of health care services provided to covered persons and appropriate to the types of plans offered by the company.

The company establishes a system designed to improve the quality and outcomes of health care provided to enrollees. The system includes systematic collection, analysis and reporting of relevant data in accordance with statutory and regulatory requirements (*Quality Assessment and Improvement Model Act* (#71), Section 6C).

The company has a ~~written~~ documented quality improvement plan that includes:

- A statement of the objectives, lines of authority and accountability, evaluation tools, data collection responsibilities, performance improvement activities and annual effectiveness review of the program;
- Intent to analyze processes and outcomes of care to discern the causes of variation;
- Identification of the targeted diagnoses and treatments to be reviewed each year;
- Methods to analyze quality, including collection and analysis of information on:
    - Over- or under-utilization of services;
    - Evaluation of courses of treatment and outcome of care; and
    - Collection and analysis of information specific to an enrollee or provider gathered from multiple sources and documentation of both the satisfaction and grievances of the enrollee(s);
- A method to compare program findings with past performance and internal goals and external standards;
- Methods for:
    - Measuring the performance of participating providers;
    - Conducting peer review activities to identify practices that do not meet the company's standards;
    - Taking action to correct deficiencies;
    - Monitoring participating providers to determine whether they have implemented corrective action; and
    - Taking appropriate action when they have not;
- A plan to utilize treatment protocols and practice parameters developed with clinical input and using evaluations described above or acquired treatment protocols and providing participating providers with sufficient information about the protocols to meet the standards; and
- Evaluating access to care for covered persons according to the state's standards, and a strategy for integrating public health goals with services offered under the plan, including a description of good faith efforts to communicate with public health agencies.

The company establishes an internal system to identify practices that result in improved health care outcomes, identify problematic utilization patterns, identify those providers that may be responsible for either exemplary or problematic patterns and foster an environment of continuous quality improvement (*Quality Assessment and Improvement Model Act* (#71), Section 6A).

The company ensures that participating providers have the opportunity to participate in developing, implementing and evaluating the quality improvement system (*Quality Assessment and Improvement Model Act* (#71), Section 6D).

The company provides enrollees with the opportunity to comment on the quality improvement process (*Quality Assessment and Improvement Model Act* (#71), Section 6E).

The company uses the findings generated by the system to work on a continuing basis with participating providers and other staff to improve the health care delivered to enrollees (*Quality Assessment and Improvement Model Act* (#71), Section 6B).

The company appoints a chief medical officer or clinical director to have primary responsibility for the quality improvement activities carried out by, or on behalf of, the health carrier (*Quality Assessment and Improvement Model Act* (#71), Section 7).

The chief medical officer or clinical director approves the ~~written~~ documented quality improvement program, periodically reviews and revises the program document and acts to ensure ongoing appropriateness. Not less than semi-annually, the chief medical officer or clinical director reviews reports of quality assessment activities (*Quality Assessment and Improvement Model Act* (#71), Section 7).

The company has an appropriate ~~written~~ documented policy to ensure the confidentiality of an enrollee's health information used in the company's quality improvement programs (*Quality Assessment and Improvement Model Act* (#71), Section 9).

The company complies with all applicable provisions of state law not expressly covered by any other of these standards.

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 3
The company files with the insurance commissioner a ~~written~~ documented description, in the prescribed format, of the quality assessment program, which includes a signed certification by a corporate officer of the company that the filing meets the requirements of applicable statutes, rules and regulations.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ ~~Written~~ Documented description of the quality assessment program

_____ Signed certification by a corporate officer

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Quality Assessment and Improvement Model Act (#71), Section 5D

Review Procedures and Criteria

Determine if the forms have been filed.

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 4
The company monitors the activities of the entity with which it contracts to perform quality assessment or quality improvement functions and ensures that the requirements of applicable statutes, rules and regulations are met.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Quality assessment and improvement policies and procedures

_____ Contracts with entities

_____ Minutes of the quality assessment and improvement committees

_____ Minutes of the board of directors

_____ Evaluations of the quality improvement program

_____ Reports of entity reviews and audits (if any) by the company

_____ Periodic reports from the entity

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Quality Assessment and Improvement Model Act (#71)

Review Procedures and Criteria

The company establishes, implements and enforces a policy to address effective methods of accomplishing oversight of each delegated activity.

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 5
The company reports to the appropriate licensing authority any persistent pattern of problematic care provided by a provider that is sufficient to cause the company to terminate or suspend contractual arrangements with the provider.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Quality assessment and improvement policies and procedures

_____ Reports made to the licensing authority

_____ Files of terminated and suspended provider contracts

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Quality Assessment and Improvement Model Act (#71), Section 5C

Review Procedures and Criteria

Determine that policies and procedures address reporting requirements.

Ascertain whether applicable terminated and suspended contract files reflect compliance with reporting requirements. Examiners should note that some terminated and suspended contracts will involve issues that are not necessary to report.

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 6
The company documents and communicates information about its quality assessment program and its quality improvement program to enrollees and providers.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Quality assessment and improvement policies and procedures

_____ Enrollee materials (e.g., enrollee newsletters and advertisements, etc.)

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Quality Assessment and Improvement Model Act (#71), Section 8

Review Procedures and Criteria

The company includes a summary of its quality assessment and quality improvement programs in marketing materials.

The company includes a description of its quality assessment and quality improvement programs, in addition to a statement of patient rights and responsibilities with respect to those programs, in the certificate of coverage or handbook provided to new enrollees.

The company makes available annually to providers and covered persons, findings from its quality assessment and quality improvement programs, as well as information about its progress in meeting internal goals and external standards, where available. The reports shall include a description of the methods used to assess each specific area and an explanation of how any assumptions may have affected the findings.

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 7
The company annually certifies to the insurance commissioner that its quality assessment and quality improvement program, along with the materials provided to providers and consumers, meets applicable statutes, rules and regulations.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Certification filings

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Quality Assessment and Improvement Model Act (#71), Section 8

Review Procedures and Criteria

The company makes the certified materials available for review by the public upon request, subject to a reasonable fee (except for those materials subject to confidentiality requirements and materials that are proprietary to the health plan).

The company retains all certified materials for at least 3 years from the date the material has been used or until the material has been examined as part of a market conduct examination, whichever is longer.

L. Utilization Review

Check state-specific laws to determine if utilization review is applicable to Medicare supplement insurance within a state.