Market Conduct Regulation Modernization – Comments Received

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Dear Chair Gillespie, Vice Chair Nelson, and Market Conduct Regulation Modernization (D) Working Group Members,

Thank you for the opportunity to provide comments on the Market Conduct Regulation Modernization (D) Industry Discussion Questions. We appreciate the thorough and transparent process this Working Group has taken in evaluating the future of market conduct regulation and identifying areas for increased efficiency and uniformity in market data regulation and collection. We provide the following comments, keeping in mind that questions surrounding specific data elements, administrative hurdles, and other technical considerations should be evaluated for *each* line of business instead of a one-size-fits-all approach. We hope to engage in further dialogue with this Working Group and are available to provide any follow-up information.

1. Market Conduct Data (Collection & Analysis)

Data Standards, Definitions, & Transport

1. **Are there data standards (e.g., API specifications, common data models, standardized layouts) that industry would adopt uniformly to reduce rework across states?**

   ACLI welcomes the opportunity to collaborate on the adoption of more uniform, standardized, and consistent data requirements across states. These improvements, where possible, would vastly improve industry responses. This includes uniformity in regulator questions as well as within lines of business. ACLI provides the following suggestions as a starting point for this uniformity:
   - Clear definitions (with examples) in the NAIC Market Regulation Handbook would assist with regulators' consistent interpretation across insurers, third-party administrators ("TPAs"), and outside contractors to be leveraged across multiple exams.
   - Likewise, clear definitions for *each* MCAS line of business would provide a better understanding for companies in preparing their data throughout the year, adjusting their internal systems where necessary, and informing their TPAs to provide more consistent data across companies.

- Other avenues for improvement would be regulator-approved data dictionaries, standardized file layouts, common data models, and clear API transmission specifications that are adopted consistently across states.
    - In particular, standardized layouts assist company IT individuals and TPAs in planning for queries prior to requests.
    - In the absence of API transmissions, where states utilize share files or other means of limited access, ensuring that all relevant companies and affiliates have appropriate permissions to access and transmit data would be beneficial. Including this type of guidance in NAIC handbooks and user guides would assist in consistent application.

- Prior to submission, validation tools such as an Excel Template file that flags warnings or errors prior to uploading the data to "Save and Validate" on the NAIC website would further enhance efficiency and quality of data.
    - In the absence of a cohesive template, companies have explored creating their own systems which can contain room for error across companies, resulting in less consistent use and submission of data. A standard Excel Template created by NAIC, rather than individual companies would alleviate this inconsistency.

In addition to standardized definitions and layouts, regulator-provided validation rules, edit checks, and test files would allow insurers to identify and resolve potential errors prior to submission, improving data quality and reducing post-submission clarification requests. Definitions could be supplemented with examples, inclusion criteria, exclusion criteria, and FAQs to promote consistent interpretation.

2. **Which specific data fields or definitions currently create the most friction, inconsistency, or manual work?**

Specific data fields and definitions that cause particular issues vary by lines of business. Consumer complaints and surrounding definitions are the most common examples of where companies currently experience the most friction or confusion. We provide specific suggestions related to consumer complaints in response to *Category 6: Consumer Complaints* below. However, there are some categories of data elements which consistently create issues across different lines of business:

- Data fields that require subjective judgment-based classification or vary by product or system, including complaint reason codes, can cause difficulty for companies in processing their own data.
    - As the MCAS Working Group considers edits or changes to MCAS lines, taking into account the way that company operational systems actually capture activities and transactions as well as providing industry with an explanation of what type of data each question hopes to elicit, can bridge the gap between what is feasible and the desired result for regulators.
    - Any data field or definitions that do not consider how operational systems function create manual work and often do not lead to clear, consistent, or useful data sets. Examples include:

    - The Travel MCAS interrogatories currently separately ask for TPA information and administrators without defining each or making a distinction between the two, creating room for inconsistent understanding and reporting across companies.
    - Data fields requesting data for lawsuits with multiple claimants cause friction. Currently companies are required to report those lawsuits as separate lawsuits, however that is not how the data is captured which makes it difficult to properly fulfill the request.
    - Some current requests for data regarding detailed licensing information cause friction due to this information being retained in the licensing system as opposed to the company's administrative system.
    - Requests reconciling examination data to previously submitted MCAS data when reporting definitions or interpretations differ.
    - Fields requesting historical account values or transaction data as of a prior date that require reconstruction from legacy systems rather than being maintained in a reportable format.
    - Requests for complaint reason code classifications where company complaint management systems do not align directly with regulatory reporting categories, requiring subjective mapping and manual review.
    - Resident-state, policy-issue-state, and complaint-state reporting requirements, where the same event may need to be categorized differently depending on the regulatory purpose.
    - Classification of reopened claims, withdrawn complaints, duplicate records, or multi-issue complaints, where differing interpretations can result in inconsistent reporting across companies.

- Two other areas for improvement and reduction in manual work are requests for values that are already in the financial statements and providing account values for a date in the past. Not all administrative systems provide for an "as of date" value calculation for all value feeds, which can require labor-intensive calculations, leading to manual and duplicative work.
- Where possible, avoiding questions that elicit a value for "median," which can be misleading and are prone to error (i.e., median processing time for claims), would be beneficial.

3. **Are there MCAS-related or market-conduct-related data elements needing clearer definitions to ensure uniform reporting?**

   There appears to be a gap between what examiners are looking for and company interpretation under current definitions. This subjectivity can make it difficult to compare companies 1:1. Additional guidance via examples in definitions, more thorough definitions, and FAQs can alleviate confusion and offer a reference text for all companies when providing MCAS data.

   An example of this is the difference between MCAS and initial market conduct examination data calls where similar data fields are expected to be provided primarily based upon a resident state versus exam data based on issue state. This can yield unclear and inconsistent results due to states having different definitions or interpretations of data elements, resulting in time-consuming reconciliation of exam data versus MCAS data and can distract from the scope and

risk-based purpose for the exam. Consistent definitions would assist companies across market conduct requests with training data owners, performing trend analysis, and configuring their own systems. Potential solutions could include:

- More open dialogue between industry and regulators on what regulators are seeking to learn in asking for certain data elements
- Clearer, more uniform definitions with examples, inclusion rules, exclusion rules, and calculation guidance, which will lead to better MCAS results
- Specific guidance on handling reopened claims, duplicate records, and withdrawn complaints

Additional guidance is needed where MCAS reporting definitions, examination data requests, and examiner interpretations do not align. Clarifying these differences through examples, calculation methodologies, and inclusion/exclusion criteria would improve consistency, reduce reconciliation efforts, and allow a focus on identifying meaningful consumer risks rather than resolving reporting differences. Clarification should also be provided on how examiners should evaluate and compare insurer-reported data when operational systems, legacy platforms, acquisitions, closed blocks, and TPAs result in different methods of capturing similar information. Uniform definitions alone may not fully address differences in underlying system architecture and business practices. Guidance regarding acceptable methodologies would improve consistency without forcing unnecessary system changes.

Another area for consideration in MCAS would be treatment of closed blocks of business or when a company does not write particular sub-lines of certain products. The inconsistent treatment of closed blocks of business routinely yields inconsistent data and interpretation. Sometimes in response to standard data requests, insurers report zero or low values to indicate no product activity or to reflect information related to closed blocks of business. Without additional context, these data points may be interpreted as indicating a broader market trend or a company-specific issue. As one example in MCAS, companies that do not write certain sub-lines where they report zero or very low percentages can skew average industry ratio results in a state, making companies that actually write those lines appear to be outliers. The appearance of outliers can lead to unwarranted MCAS market analysis inquiries, and exams, based on a misunderstanding of the data. These inquiries and exams are time-and resource-consuming for regulators and companies alike and will often not result in meaningful risk-based oversight that furthers consumer protection. Thus, the ability to indicate that a company does not write a certain sub-line would be beneficial for all parties.

In continuing this dialogue, better understanding of what regulators are seeking in inquiring about closed blocks of business would allow companies to provide solutions to these types of data elements. We are happy to provide further feedback on this issue and would welcome any further conversations on how to improve this particular area for data submission.

Systems, Feasibility & Legacy Constraints

4. **What changes to your internal systems (policy administration, claims, complaints, reporting) would modernization require—and what are realistic implementation timeframes?**

   Modernization and changes to current compliance requirements could necessitate significant updates across multiple internal systems, including policy administration, claims, complaint tracking, data reporting and vendor feeds. Material changes could also have an impact on data mapping, quality control processes, and governance workflows. The most time-intensive elements typically are those involving new data fields, historical data reconstruction, or integration with legacy systems and third-party vendors. Given these complexities, implementation timelines are expected to be substantial, particularly for companies maintaining older and/or non-integrated systems or those that support multiple lines of business and involve TPAs.

Data Quality, Validation & Minimization

5. **What data quality checks are insurers performing currently prior to submission, and where is regulator-provided validation logic necessary?**

   Insurers currently conduct a range of data quality checks prior to submission. These typically include:

   - **Reasonableness and trend reviews**: Companies review submitted data for year-over-year consistency, identify material changes, and evaluate whether results appear reasonable in light of prior filings and business activity.
   - **Completeness and source-system checks**: Insurers generally perform completeness reviews, reconcile data to source systems, check for duplicate records, validate date ranges, and conduct exception reviews.
   - **MCAS and examination comparisons**: For MCAS, some companies compare current results against prior-year data and NAIC state average ratios. For examinations, some companies compare exam data to MCAS data to confirm that the results are generally aligned.
   - **Financial statement reconciliation**: When applicable, companies reconcile reported values to financial statements and provide explanations where figures do not tie directly.
   - **Premium and Blue Book validation**: Some companies compare premium totals against the values reported in the current year's Blue Book.
   - **Internal review and sign-off**: Companies may also conduct management, legal, or other governance reviews before submission to support accuracy and consistency.

6. **Which data elements are unnecessary for modernized market conduct oversight and could be removed without sacrificing predictiveness?**

   Data elements to be considered for removal are any that are duplicative, inconsistently interpreted, not tied to a defined purpose, or not actually used for market analysis. Eliminating low-value fields that do not meaningfully contribute to market analysis would further reduce unnecessary burden. While exploring removal, we also encourage this Working Group to consider

which elements to retain, such as those that support the identification of consumer harm, systemic issues, claims concerns, and complaint trends.

A helpful approach would be to clearly document the purpose of each data element including how each element supports risk-based regulatory analysis and consumer protection and what the data is answering. Potential solutions could include:

- Test files
- Implementation guides
- Published validation edits
- Change-control procedures with a transition period before new requirements become effective
- Examples

Market Conduct Data (Collection & Analysis)

In addition to the questions already asked, are there any other issues or aspects of the scope of work that you believe are important for the working group to consider?

None at this time.

2. Examination Handbook & Processes

Pre-Exam Expectations & Feasibility

1. **What standardized pre-exam data sets or dashboards could your organization produce within 10 business days?**

   This question appears to be aimed at property and casualty insurance products which more routinely involve 10 business day turnaround times. Noting this, if the Working Group is able to provide more context, we are happy to provide a more thorough response at a later date. In particular, it would be helpful to understand from a life and annuity perspective, what requests would need to be made within a 10 business day timeframe? For example, is there a particular MCAS field that would be more helpful to have in this timeframe?

   Generally speaking, 10 business day response expectations are more easily met with data that is easily extractable in a reportable format and that does *not* require custom programming, legal review of large documents, other quality control measures, vendor extraction, or historical reconstruction. Another key timing factor for member companies is quality control of data. In order to make sure that there are no unintentional issues, companies have various quality-control checks to complete prior to submitting exam data. This helps ensure that examiners have the most accurate data and reduces back-and-forth communications that are costly, can introduce confusion into an exam, and do not provide an overall benefit to regulators or consumers. Any consideration of truncated timeframes for response should consider internal company quality control checks.

2. **Which items require longer lead times due to system complexity or third-party involvement?**

Noting that every exam or inquiry involves nuances that make generalization difficult, there are certain categories that typically do take longer due to third-party involvement. Custom historical extractions, transaction-level claim files, archived policy records, TPA data, vendor-administered platform data, requests requiring reconciliation across multiple systems, and data sets that require quality control can all lead to longer response times. Data sets may also take longer if they are fully housed in the administration platforms of TPAs. At the highest level, requests that require high volumes of data, unstructured data, or file sampling typically require longer to gather. For example, requests for complete call recordings or all correspondence for each file (which can include information that has been with a life insurer for decades) can often take significant time to extract and result in a large volume of data to transmit.

Overall, member companies note that typically examiners are understanding of delays in response due to third-party involvement and this level of understanding is extremely beneficial when responding to examiners. Flexibility and reasonable extensions for data responses based on scope, data age, legal review requirements, quality review requirements, and vendor availability should all be factored into response-time calculations.

3. **What standardized data extracts (policy files, claims inventories, complaint logs) are currently feasible within 10 business days?**

Without further context for life and annuity insurers and the type of information requested, it is difficult to promise data sets which could routinely be provided in 10 business days. As we noted above, there are some types of data and requests which will always warrant longer response times, however it is more complex to provide a blanket statement of data which can be consistently pulled and reported quickly. We are ready to provide more detail once we understand the context of this question.

Risk Identification & Targeting

4. **Which indicators—complaint trends, claim cycle times, denial rates, communication failures—best predict conduct-related risk from the insurer perspective?**

Risk indicators should always be reviewed in a holistic context. Historically, member companies have found that absent this context, there has been a pattern of regulators consistently misinterpreting or following a trail of data that does not yield meaningful results or consumer protection. Certain indicators may be difficult to interpret without sufficient business context, transaction volume, product complexity, or historical trends. Market analysis should distinguish between indicators of potential consumer harm and operational anomalies caused by low-volume populations, closed blocks, legacy systems, or unique product structures. Risk indicators are most effective when evaluated alongside business context, trend analysis, affected population size, and the actual consumer impact.

One area where there could be improvement for regulator understanding of risk indicators is MCAS data interpretation. For example, regulators focusing primarily on the percentage of

change in year-over-years reporting or vis-à-vis competitors as risk indicators can be misled by the data. Where small volumes of data are involved, minor changes in data can materially skew ratios and/or percentages but not demonstrate a true, risk-based change in the insurer's market conduct profile. For example, a 50% exception rate based on two claims may appear to be an outlier, but it represents only one transaction. Without considering the underlying population size, small-volume data can produce results that appear disproportionate to the actual consumer risk presented. Isolated metrics can inadvertently overstate potential concerns or prompt unnecessary follow-up. Reviewing MCAS data *holistically* provides a more accurate understanding of whether a result reflects meaningful conduct risk and could provide a pathway for improved Market Analysis Levels and Handbook language.

Member companies have also observed that regulator examination findings, market analysis results, or regulatory inquiries based on other jurisdictions may not always be directly comparable due to differences in products, populations, reporting methodologies, and prior remediation efforts. Additional context is often necessary before drawing conclusions regarding potential market conduct risk.

Data validation, a fresh review of the types of data pursued in exams that routinely lead to no finding of misconduct, and exploration into ways that regulators and industry can have more informal human-to-human conversations as opposed to formal letters via lawyers or external consultants could yield a better understanding of what should flag a risk indicator and what is a "red herring."

5. **How could regulators tailor exam scope using shared risk models so low-risk entities or topics experience lighter exams while higher-risk entities or areas undergo deeper reviews?**

As a starting point, more transparency from regulators would be helpful so insurers understand risk drivers and how to address those drivers proactively. One area for exploration is the distinction between routine cycle examinations and risk-based examinations. Risk-based examinations provide greater clarity regarding regulatory concerns and allow insurers to focus resources on addressing identified risks, whereas routine cycle examinations may result in broader scopes not directly linked to specific risk indicators. The latter type of exam does not always allow insurers to fully understand the risks they could proactively address and can lead to issues with scope creep. In some instances, a routine cycle or target exam results in regulators not being able to indicate a specific source of concern leading to that exam, providing insurers no context as to what the underlying issue is or how to be proactive in addressing the issue elsewhere.

Potential solutions in refining inquiry and exam scope could include:

- Improvement and refinement of relevant MCAS data and determination of what constitutes an outlier
- Considering data across true peers
- Re-evaluating how to handle closed blocks of business in data requests

Additionally, we would encourage regulators to have discussions with insurers prior to a deeper review to aid in efficient response times and efficient use of regulator resources. For example, oftentimes regulators request a sample on a determined amount of policies which requires just as much work as pulling documents for a larger amount of policies. If insurers were able to provide this context, regulators might tailor their request for the larger amount of policies or explore an alternative route. This initial understanding and translation between what regulators are actually seeking and how insurers can best provide that information would improve efficiency, trust, and opportunities for insurers to implement proactive measures to avoid future compliance issues and delays.

Lastly, it would be helpful to understand how the current Market Regulation Handbook is being used across states and examiners. If the Handbook is not utilized, any edits or improvements to the Handbook will not yield the intended results of uniformity and efficiency. If leveraged ubiquitously, the Handbook can offer a "translation" tool for insurers to understand how to be more cooperative in engaging in exams.

Consideration could be given to an insurer's recent examination history, prior corrective actions, complaint trends, effectiveness of remediation efforts, and demonstrated compliance controls. Where companies have successfully addressed previously identified concerns, future examinations could be more targeted toward emerging risks rather than previously remediated areas.

Exam Operations, Tools & Burden Reduction

6. **Which examination practices create unnecessary burden, and what alternatives would maintain regulatory goals while improving efficiency?**

Certain examination practices have proven to be unnecessary and can drain key resources from insurers and regulators, hindering consumer protection. Some of these practices include:

- Duplicative requests
- Changing the scope of the exam at varying stages of the exam
- Inconsistent use of definitions across states, examiners, and external resources (like the Handbook)
- Short or unreasonable deadlines for providing complex data
- Multiple states asking the same questions separately and at different times
- Requests for documents that have already been produced or that the Department already has access to
- Requiring data to reconcile to the financial statement (during an exam)
- Not sharing requests for enforcement action with insurers before finalization of exam reports, resulting in unreasonable implementation expectations
- Seeking penalties years after closure and publication of an exam
- Use of external consultants which can:

    - introduce higher costs.
    - yield inefficiencies when "green" examiners are getting up to speed during an exam.
    - create inefficiencies due to examiner's lack of insurance or product-line specific insurance knowledge.
    - create a disconnect between the insurer understanding of exam scope and examiner understanding of exam scope.
    - create inefficiencies due to lack of regulator discretion or decreased oversight over external examiner.
- Deployment of sample ratios without regard to risk-based factors (particularly for small sample sizes)
- Prescriptive billing or payment methodologies which do not allow for necessary flexibility
- Market conduct exams that run on a cycle rather than exams initiated due to risk indicators, cause, or material new business presence
- Lack of leveraging lead state or groupwide supervisor work product and exam work
- Pursuit of data or exams based on closed blocks of business where companies are reporting no data

Potential solutions to some of these problems would be a single request log, standardization of interrogatories, rolling productions where possible, clear scope statements that are not altered during an exam, acceptance of prior responses where still accurate, coordinated multi-state review, and more consistency across states in response times, extension request timeframes, and overall schedules for conducting exams. While we acknowledge some of these suggestions would conflict with state statutory requirements, the goal would be the most uniform possible for states not confined to those statutory requirements.

In addition to an internal review of current Market Regulation Handbook practices across states and how to promote the Handbook as a uniform resource, incorporating templates or quick resources would assist examiners who are less familiar with the Handbook, providing an avenue for uniformity.

Examinations could also be made more efficient by increasing reliance on previously completed regulator work within the examining state, including financial examinations, enterprise risk management reviews, lead state reviews, and other supervisory activities where relevant information has already been evaluated. This would reduce duplicative requests while allowing exam resources to focus on areas presenting new or emerging consumer risks.

7. **Are insurers experiencing consistency amongst regulators in the use or interpretation of the Market Regulation Handbook?**

No, member companies have not found consistency amongst regulators in the use or interpretation of the Market Regulation Handbook. Further, due to external consultants, inconsistencies can even be found in interpretation within the same state across different exams. Inconsistencies can include application of different sampling approaches, documentation

expectations, timeliness standards, interpretations of Handbook procedures, application of definitions, and even references to the Handbook itself.

In considering a path to uniformity and improvement, we recommend consideration of published interpretation guidance, consistent notes for insurers, and examiner training materials so insurers can rely on common expectations across jurisdictions. Member companies believe this would be a significant area to explore to establish better uniformity and efficiency in exams across states.

8. **I have heard frequently that insurers would like greater transparency into the reasoning or justification behind the examination. Why would that be helpful to an insurer?**

Transparency into reasoning behind exams would be helpful not only for insurers, but also for regulators. Better transparency would:

- Assist an insurer in identifying the relevant systems, business areas, data owners, vendors, and subject-matter experts necessary to respond to an exam or inquiry
- Translate regulators' concerns based on the particular data or information they are assessing
    - This would also assist in clarifying any easy-to-resolve misinterpretations or misleading data based on volume/sample size.
- Support more focused productions, better root-cause analysis, and faster remediation where issues exist

Overall, a clear explanation of the exam rationale reduces unnecessary burden on the companies and taxed regulator resources, while helping regulators obtain more responsive and meaningful information. We would also like to note that member companies have found if they ask regulators for transparency for non-routine exams, regulators will typically be transparent, which is helpful for insurers seeking to understand the potential issues the regulator is spotting so they can address any issues not self-identified.

9. **Which collaboration tools or secure data rooms would industry support for remote data exchange, tracked interrogatories, and version-controlled document sharing?**

Currently, members experience issues during exams regarding document-sharing and other collaboration tools, in particular struggling with transferring data due to their internal IT security parameters. Overall, a standard platform or minimum feature set with a repeatable process would be preferable to state-by-state tools. Any standard platform should include clearly-defined policies regarding confidentiality, retention, data security, and access-control expectations. However, it would be helpful for regulators or the NAIC to have conversations with various company IT professionals to determine potential issues prior to any platform creation. Additionally, if regulators do not wish to pursue a uniform portal, member companies did note that ShareFile has been the most positive experience.

One small improvement to file sharing that would have a significant and positive impact would be consistent and uniformly-used *file naming conventions and file structure conventions across states and examiners.* At present, member companies follow their own naming conventions when transferring files and examiners often change those conventions, creating confusion amongst

the examiners and insurers. A suggested file naming convention, included in the Handbook and used uniformly, would alleviate confusion and unnecessary back-and-forth communication.

10. **Are there common vendor platforms or tools the industry would be willing to adopt and utilize to reduce duplicative custom work? I have heard of platforms like Neota that have been used by some companies and states to experiment with.**

    Industry may be willing to use common platforms if they are secure, cost-effective, widely adopted by regulators, and do not require duplicative entry into multiple systems. We also note that with a solution like this, there is also a concentration of risk to a single or small number of vendors which can pose security issues. Another concern would be separation of data by state with sufficient firewalls to block this type of data (e.g., New Jersey exam data should not be viewable by other states). Adoption should not become mandatory until standards, data security, retention, user access, support, and interoperability requirements are clear.

Examination Handbook & Processes

In addition to the questions already asked, are there any other issues or aspects of the scope of work that you believe are important for the working group to consider?

In examining areas for market conduct modernization, it would be helpful to consider modernizing the exam process overall, in particular around the current use of the Handbook and how to promote consistency in using the Handbook moving forward. Other things that would be helpful, in addition to the above responses to the enumerated questions in this section, would be:

- A standardized pre-exam package, including checklists and templates in the Handbook for those providing these pre-exam tools.
- Realistic, consistent, and clear response timelines across states.
- Clear escalation procedures.
- Secure production tools.
- Proportional approach to sampling and follow-up requests.
- Improved examiner training, particularly for external consultants.
    - Examiner training should focus first on consistent use of the Handbook, disciplined data requests, confidentiality, and understanding operational limitations of legacy and vendor systems.

3. Interstate Collaboration

Definitions, Expectations & Uniformity

1. **What variations across states create the largest operational challenges—definitions, timelines, file formats, expectations?**

    As mentioned elsewhere, there are significant variations across market conduct exams in states, ranging from response timelines to definition interpretation to the extent of information requested. To the extent this question relates to exam preparedness, consistent file formats for data requests in all states would improve the current variations. Requirements to use outdated file formats for data (i.e. requiring commas to separate values) could also benefit from uniformity. Lastly, definition differences pose variations state-to-state, causing significant issues. Consistency could be implemented, where possible, by creating a uniform standard for states that do not have definitions embedded in their statutory requirements. Noting the complexity in

addressing this question, we appreciate the inclusion of this topic and would welcome an opportunity to provide further feedback if this question is further clarified at a later date.

2. **Where do statutory or handbook interpretations diverge the most today, and how could consistency notes be published for industry to rely on?**

   The Handbook is currently interpreted differently by each state, as examined in our answers to the *Category 2: Examination Handbook & Processes* questions. Overall, an examination of how the Handbook is used today, the intention of how it should be used in the future, and a united front on utilizing the Handbook in the future would allow for a better guarantee of the Handbook as a tool to execute uniformity. Understanding that the Handbook is a guidance tool, not a prescriptive set of requirements, the Handbook still offers an opportunity to provide a base-level of consistency that could be beneficial to interstate collaboration. Absent a thorough review of current and future use of the Handbook, however, consistency notes and other tools will not be as useful for improved insurer experiences.

"One-Ask" Principles & Simplification

3. **How can processes be designed so insurers answer once for all states (shared templates, standard definitions, uniform due dates)?**

   We appreciate the exploration into a "one-ask" regime and acknowledge the challenges that come with establishing a perfectly uniform system, especially where state-by-state differences exist in actual market conduct standards (along with differences in how to handle customer information and protect PII). As referenced elsewhere, some small and achievable steps that would have a large impact on consistency would be:

   - Standardized file naming conventions
   - Standardized file format expectations for large volumes of data
   - A central place to update each company's most up to date point of contact to be shared with all states
   - More ubiquitous use of the Market Regulation Handbook and updates to the Handbook including sample templates and checklists for examiners
   - More uniform timelines for responses and extension requests
   - Consistency in pre-exam requests and formats

   A larger step of adopting a portal or centralized location for all regulators would provide more stability and long-term uniformity, however, as a first step the concepts outlined above would promptly improve the current insurer experience across states.

4. **What templates, definitions, or filing expectations should be standardized across jurisdictions to reduce manual rework?**

   In addition to the answers to the previous question, we would encourage regulator-to-regulator conversations about current request timelines, particularly those that are shorter, to better understand why those are necessary, and, where there is flexibility, how to move to a more uniform standard. We also encourage regulator-to-regulator conversations about current Market Regulation Handbook use and how to promote this tool to be utilized as intended, prior to making substantial changes.

Standardization should include extension request processes, complaint coding definitions, document request formats, data file specifications, reconciliation procedures, and expectations regarding insurer responses to follow-up requests. Consistency in these operational areas would significantly reduce administrative complexity across jurisdictions

5. **How can insurers be encouraged or incentivized to remediate problems identified by one state to other states the insurer operates in?**

   Overall, regulator transparency can promote a better understanding of how insurers can improve processes and implement proactive changes to internal systems. The better that regulators and insurers can understand one another before and during an exam, the better insurers can implement remediation overall.

Pilot Strategy

6. **Which lines of business could be ideal to pilot or launch modernization initiatives (based on readiness, data availability, volume, diversity)?**

   Without a specific initiative under consideration it is difficult to point to a particular line of business. However, in considering some of the complexities involved in cash value of universal policies, term life products might provide a simpler avenue for initial exploration. We look forward to providing further feedback as this Working Group develops initiatives.

7. **What success metrics should be used to evaluate effectiveness?**

   Without a specific initiative under consideration, we are unable to provide a thorough response to this question. Overall, success could be marked by any initiative that:
   - Reduces turnaround times for exam data
   - Promotes more consistent approaches to exams
   - Reduces duplicate requests
   - Reduces reconciliation issues between MCAS and examination data
   - Improves consistency of examiner interpretations
   - Reduces supplemental data requests
   - Minimizes back-and-forth communications that lead to no significant findings
   - Increases focus on examinations resulting from identified risk indicators rather than routine data anomalies; and
   - Promotes a more transparent process for insurers.

   We look forward to providing more specific feedback as this Working Group explores initiatives.

Interstate Collaboration

In addition to the questions already asked, are there any other issues or aspects of the scope of work that you believe are important for the working group to consider?

None at this time.

4. Other Entity Oversight (Third-Party Oversight)

Documentation & Transparency

1. **What documentation (model cards, monitoring reports, validation materials) can insurers realistically provide during market-conduct reviews?**

   Insurers typically can provide audit materials, compliance testing materials, and other outputs from 1st line business tools and monitoring in support of insurer internal oversight and governance of consumer protection. However, much of the regulator-requested documentation resides solely with TPAs, which do not always collect, maintain, or report information in a consistent manner. As a result, insurers may need to aggregate and standardize data from multiple sources to respond to examination requests. Because TPAs frequently support multiple carriers, they may also be responding to similar requests for different companies at the same time. In addition, requested materials are often extensive in volume, maintained in non-standardized formats, or require manual compilation across multiple systems, making production both resource-intensive and time-consuming. The most significant documentation challenges during market conduct reviews often involve information maintained by TPAs as opposed to information maintained directly by insurers.

2. **What materials would be burdensome or infeasible without additional regulatory guidance?**

   One area that can pose burden or infeasibility are requests that require responses from TPAs, which can often yield significant response times, requiring a lot of back-and-forth for the insurer and administrator. The most burdensome documentation during market conduct reviews often involves records maintained by TPAs or information housed entirely within a TPA's systems. These requests can require the insurer to coordinate with the third party to identify the correct data owner, determine whether the information exists in the requested format, extract records from systems the insurer does not directly control, and then review the materials for completeness, accuracy, confidentiality, privilege, and responsiveness before production. This process can be especially time-consuming where the request involves historical data, claim-level documentation, call recordings, system notes, vendor-administered workflows, or data elements that are not captured in a standardized manner across the insurer and the third party.

   Generally speaking, regulators have been very understanding of the time it takes to engage with TPAs. Member companies appreciate this willingness to accommodate timelines and would encourage regulators to continue this practice.

Vendor and Model Governance

3. **How do you supervise third-party models and data sources today, and what standard artifacts could vendors reasonably provide to regulators?**

   Due to the existing NAIC workstreams related to the ongoing third-party models and data sources, these questions might be better suited and addressed in those working groups.

4. **What challenges arise when third-party vendors operate models or provide data used in underwriting, claims, or consumer interactions?**

   Due to the existing NAIC workstreams related to the ongoing third-party models and data sources, these questions might be better suited and addressed in those working groups.

Regulatory Expectations & Accountability

5. **How could regulators streamline expectations to ensure accountability while recognizing vendor constraints?**

   Continued leniency by regulators in accommodating extended timelines that may be required for insurers to coordinate obtaining responsive information from TPAs would be helpful, as well as the consideration of accepting data in the format that is used by administrators. Further, regulator recognition of contractual limitations between insurers and TPAs, while preserving insurer accountability for consumer outcomes, would be helpful in establishing regulator expectations. Regulators should also take into consideration the limitations on contract negotiation power of insurers with vendors, particularly where insurers adhere to regulatory requirements that make them an outlier amongst other financial services sectors.

Other Entity Oversight

In addition to the questions already asked, are there any other issues or aspects of the scope of work that you believe are important for the working group to consider?

None at this time.

5. Corrective Actions, Communications & Enforcement

Proportionality & Predictability

1. **What tiered corrective actions (warnings, remediation plans, restitution) are predictable and proportionate for common findings?**

   First and foremost, insurers have found that regulators providing notice and education or guidance to companies prior to taking further action has yielded the best results for consumer protection. For most companies, notice and guidance is all that is needed for appropriate remediation. If this Working Group does explore a framework for evaluation, consideration of the materiality of the harm, consumer impact, intent, duration, prior history, and the insurer's remediation efforts would all be helpful.

   For example, in some states, members might know the exact appointment or penalty fine amount, however, that level of knowledge does not exist in other states and would be helpful in establishing uniformity across states. Additionally, even when insurers receive a penalty, regulators often do not share the penalty amount that is attributed to each finding, further exacerbating the current confusing approach to corrective actions. Lastly, there are currently differences in whether or not there is a remediation plan state-to-state and, if there is, disparity in who determines the remediation plan. This inconsistency in remediation expectations can be frustrating and promote a further lack of uniformity.

2. **I have been told an industry frustration is inconsistency amongst states in terms of their approaches on self-reporting and fines generally. Is this an industry concern?**

   Inconsistent treatment of self-reporting and fines can discourage proactive disclosure and create uncertainty. Regulators encourage self-reporting, however self-reporting should not be a source of fear of fines but rather a showing that insurers want to do what is best for their customers. Regulators should adopt consistent principles recognizing voluntary self-reporting, prompt corrective action, restitution, and cooperation as mitigating factors. Clear expectations would support earlier remediation and better consumer outcomes.

Timelines & Feasibility

3. **What realistic timelines (30/60/90 days) can insurers commit to for specific fixes (policy language changes, claims workflow updates)?**

   Realistic timelines depend on the type of fix as well as the product or overall population impact.

   Absent further context, some things to consider in establishing realistic timelines would be:
   - Legacy systems and time to remediate longstanding practices
   - Extensive amount of time in implementing workflow updates
   - Considerable time in implementing quality-control changes
   - Significant time to implement targeted remediation
   - Policy language changes, system coding, vendor changes, form filings, and retroactive remediation may require longer timelines and are better planned through milestone-based corrective action plans

Verification & Consumer Impact

4. **Which artifacts best demonstrate that remediation worked (before/after metrics, audit trails, consumer communications)?**

   Most states typically confirm validation during the next exam. Useful verification artifacts include:
   - Before-and-after metrics
   - Sampling results
   - Audit trails / Tracking in insurer governance risk and control (GRC) systems
   - Revised procedures
   - Training records
   - System-change evidence
   - Quality-control reports
   - Post-remediation monitoring
   - Fewer re-opened cases
   - Low repeat complaint rates

5. **What metrics or narrative reporting could insurers produce to show improved consumer outcomes after remediation is completed?**

   Some common areas member companies could report to demonstrate improved consumer outcomes after remediation is completed:
   - Reduced error rates
   - Improved timeliness
   - Lower repeat complaint rates
   - Fewer reopened claims
   - Completion of restitution
   - Post-remediation monitoring results

Correction Actions, Communications & Enforcement

In addition to the questions already asked, are there any other issues or aspects of the scope of work that you believe are important for the working group to consider?

The Working Group should consider a predictable corrective-action framework that rewards self-identification, prompt remediation, and cooperation. Closure expectations should be clear, and regulators should avoid requiring broad enterprise remediation where evidence shows the issue is limited to a specific state, product, system, or time period. Allowing a rolling remediation schedule with reasonable timeframes would also be helpful.

6. Consumer Complaints

Transparency Into Complaint Coding

1. **How does the lack of visibility into whether a complaint is coded as confirmed or not confirmed affect your ability to conduct root-cause analysis and implement corrective action?**

   The absence of visibility into whether complaints are classified as confirmed or not limits insurers' ability to perform meaningful root-cause analysis and implement targeted corrective actions. In many cases, companies are not informed which complaints are confirmed or the rationale behind those determinations. Without insight into the criteria or reasoning used by regulators, it is difficult to identify trends, address underlying issues, validate internal findings, or ensure alignment with regulatory expectations. Ultimately, this creates a disconnect between internal complaint categorization and regulatory outcomes, which may result in missed systemic issues or misaligned remediation efforts.

2. **What type of transparency or feedback loop would help you understand how states determine confirmation status?**

   Greater transparency is needed regarding how states determine complaint confirmation status, including whether standards vary across jurisdictions and how insurers are informed of outcomes. A clearer feedback loop, such as notification of determinations, explanations of coding decisions, and visibility into appeal mechanisms, would promote consistency and fairness.

   Additionally, more uniform standards for what constitutes a reportable complaint would improve the overall reliability of complaint data, and companies would appreciate the opportunity for follow-up discussions or clarification of specific complaints as that would enhance alignment and learning. For example, complaints that the insured sends to the DOI in their resident state may be counted twice. This is because many insurers handle this type of complaint as non-jurisdiction. The insurer logs the complaint for the resident state, but then logs the complaint as a consumer complaint for the insured's policy issue state. Further transparency and feedback on confirmation status would assist in overall company complaint handling protocols.

3. **What definitions, examples, or coding criteria should be standardized across states to reduce variation?**

   Establishing consistent terminology and criteria across states would reduce variation and improve data comparability. This is particularly important where a complaint is received from a state other than the state in which the policy was issued or is administered. In those situations, companies may need to determine whether the complaint should be reported, coded, or analyzed

based on the complainant's residence, the issuing state, the state of administration, or the state regulator that received the complaint. Without clear guidance, similar complaints may be treated differently across jurisdictions, reducing comparability and creating unnecessary reconciliation issues.

Standardization should include clear definitions and examples for key terms such as confirmed, not confirmed, justified, unjustified, and complaint disposition. Coding guidance should also address how to classify more complex scenarios, including mixed-outcome complaints, consumer misunderstandings, and corrected errors.

State-to-State Variability

4. **What discrepancies among states—such as coding logic, investigation standards, timelines, or documentation requirements—create the greatest operational challenges for your teams?**

   The primary issue cited for discrepancies among states is the inconsistency in response timelines across states. Some states allow three weeks for a response, while some states require a response in seven days. This requires companies to allocate additional resources to states with shorter timelines, which may delay responses in other jurisdictions and create an uneven playing field for consumers. Relatedly, a standardized process to request an extension to respond would significantly improve the current lack of uniform standard among states for extension requests.

   In addition, investigation and documentation standards differ greatly between states. For example, one state might issue standardized letters with a significant number of questions, requiring a great level of detail and analysis that is not required in other states. Another state could request all correspondence, conversation notes, emails, and recordings, which can be especially burdensome when they are not relevant to the matter at issue. Potential solutions could include:

   - A standardized period of 2 weeks to respond to documentation requirements
   - National alignment on:
     - Complaint reason codes
     - Confirmation criteria
     - Closure status
     - Response-time calculations
     - Documentation expectations
     - Reconciliation processes
     - Public-records treatment
   - More standardized extension request timelines
   - Regulator specificity on exact date for reply due dates and regulatory citation (if any)

   Greater transparency is also needed regarding the treatment of complaints received by states other than the policy issuing state. Differences in how complaints are classified, coded, and

reported across jurisdictions can create reconciliation challenges and make it difficult to compare complaint data consistently.

5. **Which aspects of complaint handling are most in need of national alignment to ensure consistent expectations and reporting?**

   In addition to the above considerations, in examining efficiency, we would suggest use of a single electronic platform such as SBS for submission of all complaints to carriers rather than patchwork of state websites. Standardization should also address complaints involving multiple issues, duplicate complaints submitted across jurisdictions, and situations where the complaint state differs from the issuing state, resident state, or reporting state. Additionally, uniform timeframes for response would ensure more consistent national alignment.

Complaint Portals, Submission Processes & Tracking

6. **How does the absence of a uniform complaint portal across states impact your ability to organize, coordinate, and respond to complaints?**

   The absence of a uniform complaint portal creates administrative inefficiencies and operational challenges, as companies must navigate multiple systems with varying requirements. Issues such as multi-factor authentication (MFA) through individual phone numbers, as opposed to broader team access, complicates internal management, especially when staffing changes occur. Additionally, SMS-based MFAs blur the distinction between company systems and employees' personal devices. Potential solutions could include:

   - **Uniform portal access**: Use of a single electronic platform, such as SBS, for submitting complaints to carriers rather than requiring companies to navigate a patchwork of state-specific websites.
   - **Consistent response timelines**: Establish uniform response timeframes across states to support more predictable complaint-handling processes.
   - **Standardized extension process**: Adopt a consistent approach for extension requests, including clear procedures and expectations for when additional time is needed.
   - **Consistent information requests**: Align requests for information across states where it is possible to reduce duplicative or inconsistent submissions.
   - **Email-based verification and MFA**: Allow verification and multi-factor authentication through email or shared business-access protocols rather than requiring individual employees to register personal cell phone numbers for portal access.

7. **What minimum portal features (status visibility, communication logs, document exchange, audit trail) would meaningfully improve your complaint-handling operations?**

   A modern complaint portal should include features such as clear status visibility (including confirmation status), communication logs, document exchange capabilities, and a complete audit trail. In addition, systems should be capable of handling large document volumes without technical limitations that create additional administrative challenges. These capabilities would significantly improve coordination, accountability, and response accuracy.

8. **What challenges do you encounter when trying to determine whether a complaint remains open or has been closed, given current state systems?**

   The absence of clear and consistent status tracking can make it difficult to determine whether a complaint remains open or has been resolved. In many cases, companies must assume closure in the absence of clear information or a closure letter, which is not ideal as it introduces uncertainty and risk. Improved status visibility would provide greater clarity and support more accurate reporting and follow-up.

Reconciliation Processes

9. **In states that offer a reconciliation or correction process, what elements are most valuable (e.g., dispute correction, clarification opportunities)?**

   The current most valuable elements are the ability to correct factual errors, dispute coding inconsistencies, provide supplemental documentation, receive explanations of coding decisions, and obtain final resolution. A defined timeline and documented outcome are important so both regulators and insurers have a reliable record. Once the correction and supporting documentation have been submitted and then accepted by the regulators, removing said item from the final report would also be valuable. Consistency across the states in this aspect would vastly improve the current correction process.

10. **What would a functional and fair national reconciliation framework look like, and what process steps or timelines should it include?**

    A functional and fair national reconciliation framework should start with proven and effective processes demonstrated by existing state frameworks. The below suggested solutions reflect ACLI members' experiences to date with current frameworks:

    - Avenues for Corrections and Clarifications
        - Mechanism to correct factual errors
        - Defined period to request correction or clarification
        - Standardized correction categories
        - Ability to dispute coding inconsistencies
        - Method for providing supplemental and supporting documentation
        - Ability to receive explanations of coding decisions
    - Timeline and Methodology
        - Opportunity to obtain a final resolution
        - Defined timelines and documented outcomes, including specific dates in timelines (i.e. July 30th, not 10 business days).
            - Including regulator review within a stated timeframe (30-day insurer review period and a 30-60 day regulator response period)
    - Final Disposition & Post-Disposition
        - Removal of disputed items from the final report where corrections and supporting documents are accepted by regulators
        - Notice of final coding and final written disposition
        - Opportunity for insurer to question or challenge a confirmed status determination
        - Review at the end of each complaint individually rather than a single review conducted once a year by multiple states.
        - Audit-trail retention

11. **What kinds of coding errors or discrepancies most frequently need correction from your perspective?**

    Common discrepancies include complaint reason code assignment, confirmation status determinations, duplicate complaint treatment, product classification, jurisdiction assignment, complaint closure status, and response timeliness calculations.

Industry Engagement & Collaboration on Coding

12. **What opportunities for joint engagement with regulators—such as training sessions, calibration workshops, or a shared coding guide—would improve accuracy and fairness in complaint categorization?**

    In considering future goals of this Working Group, ACLI members would appreciate the opportunity to provide feedback or answer questions related to complaint categorization. To promote longstanding consistency, we would suggest prioritizing a shared coding guide as this would provide a more durable and accessible solution across all related stakeholders. However, in creating a guide or uniform document, member companies are ready to remain engaged as a resource in providing feedback, use cases, and answering questions regarding complaint categorization.

13. **How frequently should regulators and insurers collaborate or recalibrate on complaint coding to ensure alignment across the states?**

    As a starting point, regulators could explore annual formal calibration sessions, supplemented by interim discussions when significant coding changes, new complaint categories, or revised reporting expectations are introduced. This would provide an appropriate balance between consistency and operational practicality.

Confidentiality & Records Handling

14. **How do differing confidentiality standards among states affect your ability to provide complete, candid responses and share internal information appropriately?**

    Differing confidentiality standards create uncertainty about what can be provided safely, especially for privileged, proprietary, personal, or sensitive operational information. This may require additional legal review and can limit the candor or specificity of responses where public records treatment is unclear. One potential solution would be a uniform adoption of confidentiality and records handling, or a baseline suggestion.

15. **What uniform confidentiality protections would help balance consumer privacy with insurer transparency and operational clarity?**

    Uniform protections across states would provide a more thorough consumer understanding of their own privacy and more uniform treatment of consumers across states. These confidentiality protections should address:

    - How to handle transmission and access to personal information
    - Privileged material standards
    - Redactions or requirements in disclosing trade secrets
    - Proprietary business information
    - Vendor materials and access

- Internal audit materials
- Examination workpapers

Regulators should provide standard confidentiality markings, secure transmission requirements, retention rules, and clear limits on disclosure where possible. In creating any form of uniform requirements, consideration of state statutory constraints may provide a baseline so that any adoption or introduction of a uniform standard does not instead create a "51st state," contributing to more inconsistent standards.

16. **What guidance or clarification do you need regarding how complaint files are treated under public records laws to reduce uncertainty and risk?**

It would be helpful for any new guidance to clarify the following:

- What portions of complaint files may be public
- What information is protected
- How redactions are handled
- Whether insurer responses are subject to disclosure
- How privileged or proprietary materials should be submitted

This early guidance would prevent time-consuming communications which delay consumer complaint response times.

Consumer Complaints

In addition to the questions already asked, are there any other issues or aspects of the scope of work that you believe are important for the working group to consider?

Overall, industry participation would be improved by more informal and explanatory materials that provide an avenue for consistent interpretation and understanding across all parties. Collaboration and conversations with industry would assist in translating regulator understanding of data elements or questions and industry interpretation of those questions. This could include discussion of updates or creation of:

- Implementation guides
- Test files
- Sandboxes
- Validation rules
- Sample templates
- Checklists
- Change-control notices
- Realistic transition periods

Lastly, as far as implementation, early access to specifications would allow insurers to test feasibility before requirements become mandatory.

In conclusion, we thank this Working Group for exploring the different avenues for improved modernization of market conduct regulation. We are willing to provide any follow-up or assistance in response to our responses and the posed questions above. Please do not hesitate to reach out if there are any further questions and we look forward to continued engagement on this topic.

Sincerely,

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June 9, 2026

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Via email: Director Ann Gillespie, ann.gillespie@illinois.gov
Director Angela Nelson, angela.nelson@dci.mo.gov
Tim Mullen, tmullen@naic.org

Re: Market Conduct Regulation Modernization

On behalf of AHIP, thank you for the opportunity on May 26 to provide recommendations to the NAIC Market Conduct Regulation Modernization (D) Working Group ("Working Group") on efforts to improve and modernize the market conduct regulatory framework.

This letter is intended to provide further overall feedback to the Working Group through addressing questions raised and further clarifying responses provided during the listening session. We are also sharing a set of principles for market conduct regulation for your consideration in the attachment to this letter. Additionally, AHIP intends to submit written responses, where appropriate, to the Industry Discussion Questions that the Working Group released to stakeholders on May 8.

Risk-based Market Conduct Regulation. In determining where to focus efforts for market conduct regulation improvement and modernization, the Working Group should consider implementing oversight models consistent with the NAIC's financial analysis and examination processes and standards, including employing a holistic approach which begins with an analysis of the entire marketplace, similar to the approach already taken on the financial side. In the case of market conduct, this can is accomplished by leveraging existing regulatory data sources, including surveys, NAIC-developed required reporting (e.g., MCAS, annual and quarterly financial statements, regulatory actions in other jurisdictions and consumer complaints data), additional state-specific required reporting and data, and relevant public and private sector information. An analysis of this information is critical to establishing a baseline view of the market and identifying entities or practices that may materially deviate from peers, compared to the overall experience in the industry. It will also identify submissions from a particular entity that may differ greatly from prior submissions by the entity. This approach will allow regulators to identify the greatest potential for risk of consumer harm, consistent with the Market Regulation Handbook ("Handbook"). It will also prioritize state and insurer resources by identifying the areas most in need of further regulatory analysis and examination.

Prioritization of regulated entities for additional reviews across the continuum of market conduct regulatory tools should leverage NAIC-established and published risk indicators, which may include: claims denial rates, time to payment, complaint ratios and spikes, utilization management metrics, and material changes in an organization's corporate structure or financial or MCAS data. Providing workable ranges for data in advance can also help regulated entities prioritize their own outlier responses for internal quality reviews prior to submission.

Market conduct analysts should identify entity outliers relative to peers or established benchmarks to enable jurisdictions to prioritize oversight based on potential consumer harm. Once identified, regulators should apply the full range of market conduct tools consistent with the Handbook, always using the least intensive, most efficient method to identify the cause and extent of the problem. Analysts should complete Level 1 and Level 2 analyses before initiating an examination in most cases, again consistent with the Handbook. Additionally the analysis phase should assess the entity's corporate governance and compliance framework. When an examination is warranted, these findings should directly inform an exam's clearly defined and clearly communicated scope and objectives. This detailed information from this analysis, should be provided to the regulated entity as part of the initial examination call letter.

This approach would address industry concerns related to unclear scope and objectives that complicate resource allocation for states – directly or through contracted entities – and regulated entities.

Sampling Methodologies. Sampling is an essential component of a risk-based approach that can provide statistically valid results when conducted in alignment with the Handbook, and can enable greater speed to analysis and corrective action, where necessary. However, regulated entities are increasingly facing requests for large sample sizes – often hundreds or thousands of records, or requests that seek all data records of transactions that occurred, with a very short turnaround timeframe. Information requests should align with the identified risk indicators and balance regulators' need for data with regulated entities' operational, systems, and data-sensitivity constraints. While we support data-driven oversight, regulatory requests should weigh the benefit of increased precision against the cost, complexity, and delay associated with larger samples and response timelines should account for the resources required by companies to compile, validate, and safeguard responsive data.

Consistency in Process Across States. A core objective of NAIC market regulation is consistency across jurisdictions, even where state laws differ. The Handbook advances this goal through common process standards and business-line-specific guidance. However, variation in processes such as sampling methodologies, templates, and data requests – as well as inconsistency in how scope is defined, communicated to the entity being examined, and adhered to through the examination - creates inconsistency, increasing operational complexity, costs, and timelines that may frustrate the state's goal.

To improve consistency, states should work with regulated entities to develop additional guidance, illustrative examples, and model response frameworks that clarify expectations across jurisdictions. To promote a more uniform and predictable process, states should ensure contract examiners use state-approved standards and templates.

While financial regulation benefits from an accreditation framework that promotes accountability across states, today market conduct regulation lacks a comparable structure. To advance uniformity, states should encourage broader adoption of the NAIC's Market Conduct Surveillance Model Law (#693) and continue refining the certification program and increase participation among jurisdictions.

Requests that are Tied to Statutory Authority. States should ensure that lines of business or contract data requests align to a DOI's enforcement authority. This requirement is embodied in the current version of the Handbook and should serve to govern the scope of information requests for data and ultimately corrective action. Requests that exceed a state's enforcement authority risk being used beyond their purpose and authority. Again, statutory authority should therefore define and limit the scope of any request, which should remain anchored to markets, products, contracts, and activities regulators have the authority to regulate.

Oversight of Contract Examiners. As states embark on examinations, communication is critical so both parties understand objectives and points of view. Many state DOIs rely on contract examiners due to limited internal resources; however, the use of outside examiners should not replace or serve as a barrier to the direct relationship that should exist between the regulated entity and the regulator. Consultants must remain subject to clear state oversight to ensure practices, scope, and billing are transparent and aligned with regulatory objectives, and regulated entities should remain able to discuss examination issues directly with state regulators as they arise. Improved transparency and standardized expectations can strengthen confidence in examination processes and support more consistent outcomes. States should avoid inefficiencies, including:

- Prolonged examinations lasting one to five years or longer;
- Duplicative or conflicting information requests after submission of state-required materials; and
- Underuse of data already existing in data sources maintained by the state or NAIC, such as MCAS.

Limited visibility into state oversight of contract examiners raises real and/or perceived concerns regarding accountability, potential conflicts of interest, and billing incentives. These concerns can be addressed through clear and transparent standards, including certifications related to DOI supervision, conflicts of interest attestations, and guardrails for contract examiner billing. Regulators should also consider reviewing the financial regulation processes for established oversight models and best practices.

We appreciate your efforts to modernize market conduct regulation and your collaborative approach to this work. As always, please feel free to reach out with any questions as we remain available to provide additional detail as needed.

Sincerely,

LaCosta Wix
AHIP Senior Regulatory Counsel
State Affairs and Policy

Cc: Miranda Motter, AHIP Senior Vice President of State Affairs and Policy
Samantha Burns, Vice President, State Affairs and Policy

Attachment

[1]AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. Visit www.ahip.org to learn how working together, we are Guiding Greater Health.

Market Conduct Regulation Modernization Principles for Consideration

AHIP is grateful for the opportunity to respectfully submit the following set of policy principles for the Working Group's consideration. These principles support a modernized framework that enhances regulators' ability to identify and remediate consumer harm, while ensuring oversight is aligned with evolving market and data capabilities. Where appropriate, these policy recommendations draw on plans' experience and, to the extent feasible, lessons from the financial regulatory framework.

Principle #1: ***Market conduct regulation should be risk-based, focusing on the potential for consumer harm.***

- Market conduct regulation should provide for ***risk-based supervision*** grounded in credible data and strong insurer governance. Regulators should leverage clear risk indicators to identify outlier results that materially deviate from peer benchmarks and ensure oversight is proportionate to the risk of consumer harm.
- Modernization should:
  - ***Leverage existing tools*** such as the Market Analysis Prioritization Tool and the Market Conduct Annual Statement (MCAS), where applicable, as well as enhanced analytics, and appropriate external data to segment risk and prioritize follow-up.
  - Promote ***clear notice*** to regulated entities regarding the role these existing tools play in informing scope, prioritization, and review activities.
  - Encourage ***transparency, oversight, and accountability standards*** for regulator and NAIC use of enhanced analytics and related tools that are comparable to those imposed on regulated entities.

Principle #2: ***Market Conduct Modernization should result in consistency in process across states.***

- States should work to:
  - ***Centralize*** data collection and analysis;
  - ***Standardize*** data calls and templates in coordination with regulated entities; and
  - Rely on common datasets and definitions, ***using shared resources*** such as MCAS (for the lines of business to which it applies) to identify where this is feasible.
- Regulators should ***follow the Market Regulation Handbook's processes for analysis and examinations*** and require contract examiners to also adhere strictly to state-approved standards and templates.
- To promote greater consistency across jurisdictions and exam teams, states should work with regulated entities to develop ***additional guidance, illustrative examples, or model response frameworks*** that clarify what compliant submissions look like in practice. These tools can reduce unnecessary variation in expectations, improve the quality of responses, and support more consistent oversight.
- To the extent states are not preempted and reviews evaluate compliance with provisions of federal law, states should ***apply the relevant federal statutes, regulations, and guidance***

as the governing framework that would promote greater consistency and reduce the risk of conflicting interpretations across jurisdictions.

Principle #3: ***The scope and process of market conduct exams should be transparent and predictable***

- State market conduct exam teams should ***clearly state the purpose, scope and key questions up front and remain within the defined scope*** unless a documented, risk-based rationale supports an expanded review.
- Regulated entities should receive ***clear notice*** of potential violations and a meaningful opportunity to respond before findings are finalized.
- State market conduct requests should be ***specific, coordinated, and tied to clear regulatory objectives and statutory authority.*** Consistency in statutory interpretation is important for predictable and equitably applied findings.
- State market conduct examiners should use ***statistically valid sampling and issue requests that are specifically tailored*** to the defined scope of the exam.

Principle #4: ***Modernization should improve market conduct oversight, efficiency, focus, for regulators and insurers while maintaining consumer protections.***

- States should ***avoid scope creep and duplication, sequence requests logically, and align documentation and sample sizes*** to the risk and analytic purpose of the exam.
- State imposed deadlines should adequately ***reflect the operational effort required*** *by regulated entities* to retrieve and review data for quality, accuracy and responsiveness.
- State required processes should be ***streamlined***, and states should ***exercise oversight over examiner practices and billing*** that should be ***transparent and aligned*** to the agreed scope.

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July 13, 2026

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Director Angela Nelson, angela.nelson@dci.mo.gov
Tim Mullen, tmullen@naic.org

Re: AHIP Aggregated Responses to Market Conduct Regulation Modernization (D) Working Group's Industry Discussion Questions

Dear Directors Gillespie and Nelson:

On behalf of AHIP[1], we appreciate the opportunity to submit the attached document in response to the Industry Discussion Questions distributed by the NAIC Market Conduct Regulation Modernization (D) Working Group (Working Group) on May 8, 2026. The document represents question-by-question aggregated and de-identified feedback from our member plans.

The question-by-question responses were developed based on the member plans' understanding of the questions asked as of the time of exposure and could evolve as the Working Group's efforts progress and more context or details are provided.

Thank you for the opportunity to share this feedback. AHIP looks forward to continuing to engage with the Working Group on these important discussions.

Sincerely,

Miranda Motter
AHIP Senior Vice President of State Affairs and Policy

LaCosta Wix
AHIP Senior Regulatory Counsel
State Affairs and Policy

Cc: Samantha Burns, AHIP Vice President, State Policy

[1]AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. Visit www.ahip.org to learn how working together, we are Guiding Greater Health.

AHIP Aggregated Member Responses

NAIC Market Conduct Regulation Modernization (D) Working Group
Industry Discussion Questions

July 2026

Introduction and Overview of Document

AHIP submits these aggregated responses to the NAIC Market Conduct Regulation Modernization (D) Working Group Industry Discussion Questions on behalf of its member plans. It reflects input from member plans that collectively represent more than 120 million covered lives.

To compile this document, AHIP collected question-by-question responses from member organizations whose operations span national, regional, and single-state health insurance markets. AHIP aggregated and anonymized these responses; this document reflects the collective input of responding plans and attributes no statement to any individual organization.

Throughout, "plans" refers to responding member organizations. Where views diverged, we describe both the majority perspective and notable alternative views, and we present a distinct single-respondent point as the view of "one plan." Not every plan answered every question. Each synthesis reflects the plans that responded to that question.

AHIP organizes responses to follow the NAIC's survey structure. Most parts open with a summary of all responses in that category before offering aggregated responses to individual questions.

Executive Summary

Plans support modernization that makes market conduct oversight more risk-based, predictable, and efficient while maintaining strong consumer protections. Across all six topic areas, plans suggest that regulators tie every data request and examination to a clearly stated regulatory objective, modernize requirements collaboratively with regulated entities, and establish and implementation timelines that reflect operational constraints.

- On data collection, plans support uniform data standards, standardized templates, and common file layouts. Plans ask that any data request be necessary, relevant, and reasonably available for the stated purpose. Inconsistent definitions of foundational terms drive most of today's manual rework, because plans must translate the same enterprise data into many state-specific structures.
- On examinations, plans call for risk-based oversight modeled on the NAIC financial examination approach. This includes transparent risk indicators; defining scope based on identified risks; and aligning information requests with both the stated scope and with practical timelines—with sample sizes that are appropriate to that particular scope. Responding plans all report that the Market Regulation Handbook is not applied consistently and they identify oversight of contract examiners—including their qualifications, incentives, costs, and Handbook adherence—as a key priority for modernization.
- On coordination and enforcement, plans support "one-ask" principles within and across states, reciprocity for remediation completed in one state, proportionate and tiered corrective actions, and opportunities for pre-enforcement dialogue.

- On consumer complaints, plans seek greater transparency in confirmation coding, a reconciliation process to correct errors before regulators use complaint data for targeting, and movement toward uniform portals. They also urge stronger and more consistent confidentiality protections across the market regulation continuum, including for any new centralized data platform.

A. Market Conduct Data (Collection & Analysis)

Summary

Plans support uniform data standards, templates, file layouts, and technical specifications in collaboration with regulators. These standards should be tied to clearly defined objectives, aligned with data that plans already capture, and paired with confidentiality protections and practical implementation timelines. To reduce burden, plans recommend focusing on a smaller set of high-value fields tied to risk and consumer harm, rather than expansive field requirements. They identify inconsistent definitions as the single largest driver of manual rework. Additionally, plans caution against new reporting that duplicates MCAS and existing state filings and note that legacy systems may constrain implementation timelines.

Data Standards, Definitions & Transport

A1. Are there data standards (e.g., API specifications, common data models, standardized layouts) that industry would adopt uniformly to reduce rework across states?

Plans support uniform data standards, standardized templates, common file layouts, and clear technical specifications, with regulators connecting them to a defined regulatory objective and developing them in collaboration with regulated entities. Consistency matters more than any specific technology: uniform standards improve data quality, allow regulators and insurers to focus on consumer risk and lower implementation costs

Specific recommendations include: a single NAIC market conduct data model with standardized field definitions, layouts, metadata, and validation rules that apply across all states; uniform electronic submission standards (such as XML, JSON, API-based submissions, or layouts modeled on existing exchange file formats) in place of state-specific spreadsheets; a “core plus supplemental” data model; alignment with existing national standards (HIPAA transaction standards, CMS reporting definitions, HL7/FHIR data models, NCPDP standards) rather than new structures; secure direct file upload; and a “single submission, multi-state use” approach.

Any standard should specify field definitions, the reporting purpose, file-format requirements, validation logic, confidentiality protections, and implementation timelines. Plans also seek standardized definitions for foundational terms that vary today, including “claim,” “denial,” “complaint,” policy and product types, and utilization management terms. They also recommend standard layouts for commonly requested universes, such as paid and rejected claims, member and provider complaints, appeals, provider enrollments and terminations, networks, contracts, and pharmacy-specific universes.

Plans caution against standards that require custom logic or data not captured consistently across systems. Collaborative state practices offer a useful model: at least one state holds quarterly industry meetings and circulates draft data calls for feedback before finalizing them. That process surfaces definitional and data-availability issues early and reduces rework for regulators and plans.

A2. Which specific data fields or definitions currently create the most friction, inconsistency, or manual work?

Plans consistently point to the same root cause: states interpret common concepts differently or request similar data in different formats. Most administrative burden comes from translating enterprise data into many state-specific structures. Frequently cited friction points: definitions of complaints—e.g., what is reportable, complaint source, categorization; claim denial classifications/reason codes; definitions of key terms—paid, closed, reopened, pending, and "clean" versus "unclean" claims; timeliness measures—including business-day versus calendar-day methodologies; product and plan type definitions and universe criteria; provider network terminology; utilization management and authorization definitions; and member and policy counts (including dual eligibility and group versus individual coverage).

Plans also cite unclear exam scope across contract, resident, and provider states; requests that require reconciliation across systems, include protected health information; or requests for pharmacy-specific data—such as compound claims at the ingredient level—when the data exists only at the claim level.

One plan recommends that regulators define a small set of high-value data elements—roughly 8 to 15 fields—tied to specific exam objectives, with targeted follow-up when risk indicators warrant. Plans further urge states to keep MCAS focused on its original purpose of ongoing market conduct analysis rather than using it to validate financial or other reporting.

A3. Are there MCAS-related or market-conduct-related data elements needing clearer definitions to ensure uniform reporting?

Views on MCAS itself vary. Some plans find MCAS elements well defined but misaligned with other regulator requests; others identify specific gaps—straightforward behavioral health and substance use disorder definitions, clearer instructions for counting data within group policies, and better treatment of variation in utilization management and appeals reviews. Plans believe market-conduct elements need clearer definitions and recommend that regulators develop them collaboratively with industry.

Suggested priorities include uniform definitions for consumer complaints; standard definitions for claim outcomes; consistent treatment of appeals, grievances, external review, and utilization management determinations; standard reporting periods and timeliness methodologies; consistent metadata documenting sources, assumptions, and methods; and, for pharmacy data, an NCPDP crosswalk in the claims data dictionary. Plans report that most ad hoc requests supply only column headers without definitions; they urge that requests include a clearly stated purpose and seek necessary, relevant, and reasonably available data.

Systems, Feasibility & Legacy Constraints

A4. What changes to your internal systems (policy administration, claims, complaints, reporting) would modernization require—and what are realistic implementation timeframes?

Most plans cannot estimate timeframes without more detail on the specific requirements, because impacts depend on the fields requested, the number of systems involved, technical specifications, vendor dependencies, and the required output. Plans that offered ranges put system changes anywhere from six months to multiple years, for work that falls mainly in data governance and architecture rather than transaction processing.

Plans describe common constraints: data extraction pulls from multiple administrative, claims, and workflow systems with limited integration; many requested fields are not natively stored or standardized; and legacy systems remain in place for insurers and regulators alike. Plans recommend that any modernization proposal distinguish data already captured in structured systems from data that requires manual review, new development, or third-party coordination—the latter being far more time-consuming and costly.

Data Quality, Validation & Minimization

A5. What data quality checks are insurers performing currently prior to submission, and where is regulator-provided validation logic necessary?

Plans run substantial internal validation before submitting: completeness and required-field checks, formatting alignment, narrative explanations for blank fields, cross-field logic checks (for example, decision dates on or after receipt dates), scope assessments, source-system validation on samples, duplicate detection, referential integrity checks, reconciliation to source systems, and cross-year variance review. Because ad hoc state requests are largely unique, the quality checks for them are necessarily ad hoc—one reason adequate lead time is important.

Plans see value in regulators sharing validation rules and error-checking criteria in advance, which they see as improving accuracy and reducing resubmissions and plans recommends that regulators develop that logic collaboratively with industry: one plan found existing MCAS validations too rigid and purely comparative without context, and another noted that low-volume, highly segmented data can appear inconsistent even when it accurately reflects underlying activity.

A6. Which data elements are unnecessary for modernized market conduct oversight and could be removed without sacrificing predictiveness?

Plans recommend that regulators focus required fields to those tied to risk indicators. One plan offered candidates for removal or consolidation: free-text comment fields; administrative contact fields beyond an accountable attestor; repeated yes/no product-availability flags; fine product splits with sparse volume (such as catastrophic, student, and grandfathered or transitional products); metal-level reporting not linked to consumer-harm metrics; raw claim counts split into many in-network/out-of-network timing buckets; and dollar aggregates for member cost-sharing.

The highest-value fields measure potential consumer issues: complaint and grievance volume, prior authorization outcomes, claim denial rates, payment timeliness, appeals and external review outcomes, overturned decisions, and exposure denominators.

In short, modernization should eliminate fields that merely describe product taxonomy or administrative process and maintain fields that measure potential consumer friction, such as denial, delay, reversal, escalation, and consumer impact. Plans recommend identifying unnecessary elements through continued open review of MCAS templates with industry (citing the multi-day stakeholder meeting after the Health MCAS launch as a useful model) and a broader regulator review of existing reporting, data calls, and exam requests to reduce and eliminate overlap and redundancy.

Additional Considerations

A7. Are there other issues or aspects of the scope of work the Working Group should consider for market conduct data and examinations?

On MCAS mechanics, plans identified problems that create burden without improving consumer protection: locked templates that block collaboration with business partners and vendors, blacked-out fields that prevent copying complete lines, manual entry for totals rather than automatic calculation, rounding errors that force reconciliation, and fields that accept decimals the portal then rejects.

On examination conduct, plans ask regulators to define exam scope up front including lines of business, products, legal entities, and the exam timeframe. Regulators should set practical response times calibrated to complexity; allow rolling or phased submissions; adjust due dates when examiner delays affect the schedule; and sequence information requests rather than sending large batches at once.

Plans also ask regulators to set clear completion standards for draft reports, final reports, penalties, closure, and publication. Regulators should guard against potential "scope creep", including requests about unrelated third-party vendors or periods outside the noticed scope; set sample sizes aligned with scope; and accept an authorized coordinator's signature rather than requiring officer signatures on every response.

Modernization should prioritize a targeted, analysis-driven approach. Some exams consume disproportionate resources relative to the issues they identify; several states already use market analysis to decide whether a full exam is warranted which conserves regulator resources. Where statutes mandate routine exams regardless of risk, modernization should revisit whether those requirements should remain. Plans also ask regulators to coordinate across divisions to avoid duplicative exams and data calls within the same state.

B. Examination Handbook & Processes

Summary

> *Plans recommend modernization that shifts examinations toward risk-based, analytics-driven reviews that "collect once, use many times," reserve deep file review for outliers, and rely on the NAIC Market Regulation Handbook applied consistently by contract examiners. Because a universal 10-business-day pre-exam expectation is impractical for non-routine reports, plans propose phased, tiered timelines calibrated to complexity and third-party involvement. Plans support secure collaboration tools defined by functional requirements rather than a single mandated vendor, raise concerns relative to the*

> *contract-examiner incentive structure, and support greater transparency into the reasoning behind examinations.*

Pre-Exam Expectations & Feasibility

B1. What standardized pre-exam data sets or dashboards could your organization produce within 10 business days?

Plans believe that a universal 10-day requirement may be challenging. They note that the appropriate timeline depends on scope, complexity, data source, line of business, jurisdictions involved, and whether third-party data is required. Some plans question whether meaningful responses can be created within 10 business days or suggest that they can be done only for core operational data (policy, claims, complaints) or reports they already run routinely. Plans recommend flexible, risk-based timelines with clear requests, a stated purpose and scope, and reasonable extensions.

One plan described what a standardized pre-exam package could eventually include—an executive risk summary with trends and peer comparisons; operational dashboards spanning claims, prior authorization, appeals, complaints, grievances, provider issues, and compliance; standardized record-level extracts with normalized data dictionaries; and governance and control documentation—which could satisfy much of the Handbook's pre-exam needs while enabling risk-based scoping. This approach could reduce examination burden for regulators and insurers and improve consistency across examinations. Another plan cautioned against producing dashboards, because Key Performance Indicators (KPIs) should not be interpreted properly in isolation.

B2. Which items require longer lead times due to system complexity or third-party involvement?

Plans consistently name two categories: 1) customized data requests that require mapping across multiple systems, and 2) data held by third parties or delegated entities—such as pharmacy benefit managers, independent practice associations, third-party administrators, and managing general agents.

Claims, utilization management, producer, and commission data often take longer than examiners expect because the information: a) spans systems, b) requires business validation, or c) depends on manual review. Sample files extend timelines when examiners request supporting documentation—such as certificates of coverage—that staff must retrieve and review by hand. Legacy systems, archived records, call recordings, clinical documentation, and privilege-sensitive materials also extend timelines.

B3. What standardized data extracts (policy files, claims inventories, complaint logs) are currently feasible within 10 business days?

Plans identify a narrow set: DOI complaint data; reports the organization already produces routinely; and standard exam materials that require no new reporting, such as policies and procedures, company history, ID card copies, anti-fraud plans, and business-continuity documentation. Requests requiring new extraction or reconciliation generally are not feasible in 10 days. Plans note that the question presupposes standardization that does not yet exist—any data not already submitted routinely requires time to scope, design queries, coordination across systems, and execution. An early meeting between examiners and plans to understand data complexity and sources helps all parties manage expectations.

Risk Identification & Targeting

B4. Which indicators—complaint trends, claim cycle times, denial rates, communication failures—best predict conduct-related risk from the insurer perspective?

Most plans believe that complaint trends, claim denial rates, and claim cycle times are the indicators that best predict conduct-related risk, and that regulators should use them, with outlier analysis, to target higher-risk areas. Plans stress two refinements. First, combinations of related indicators and normalized rates predict better than raw volumes—for example, rising denial rates alongside higher appeal-overturn rates, or rising complaints alongside longer processing times. Second, complaint data should include context: regulators should weigh severity, confirmation status, duplication, batching, and campaign-driven volume before using complaint trends to prioritize exams. Additional useful indicators include prompt-pay reporting, internal audit results, appeals patterns, and material deviations from benchmarks. Aligning regulatory risk indicators with metrics plans already track would let companies spot their own outliers and act early.

Plans also offer cautions: clear trends and bright-line risks should drive exam agendas. One plan suggested that it may not be appropriate to use indicators to predict outcomes.

B5. How could regulators tailor exam scope using shared risk models so low-risk entities or topics experience lighter exams while higher-risk entities or areas undergo deeper reviews?

Plans support risk-based scoping built on published, transparent risk indicators. For lower-risk entities or topics, regulators should use narrower, statistically valid samples, shorter review periods (for example, six months to one year), and lighter Handbook tools (e.g., desk reviews and interrogatories). Regulators could also exclude plan types with minimal enrollment and, where appropriate, rely on a regulated entity's compliance governance. Aligned with a risk-based approach, regulators should use the most efficient method to identify the cause and extent of a problem.

One plan proposed a seven-phase risk-focused examination approach modeled on the NAIC Financial Condition Examination methodology—understand the company and its key market conduct activities, assess inherent risk, evaluate compliance controls, assess residual risk, perform targeted testing, determine the regulatory response, and report findings. Other plans register cautions: risk segmentation must keep oversight neutral and the playing field level, and prioritization should rest on the degree of risk of actual consumer harm.

Exam Operations, Tools & Burden Reduction

B6. Which examination practices create unnecessary burden, and what alternatives would maintain regulatory goals while improving efficiency?

Plans identify a consistent set of burdens: expansive, non-targeted data calls; very large sample requests (e.g., a contract-examiner request for 800 claim samples and a data-call interrogatory with nearly 100 questions on complaints alone); 100 percent production where sampling would suffice; duplicative requests—such as separate claims and utilization management samples where a combined approach would serve both; unclear scope and requests beyond the jurisdiction's authority; delays in examiner schedule after kick-off; direct systems access requests; bespoke checklists and unique naming

conventions for every sample file; short response times; inconsistent and irregular communication; and uncoordinated contract examiners—in one reported case, up to 10 working for a single state operated independently, issuing overlapping requests with conflicting timelines.

Recommended alternatives fall into several categories. First, regulators should adopt a "collect once, use many times" model that relies on standardized data first and requests file-level support when data show outliers. Instead, regulators should replace checklist exams with risk-based exams whose depth matches the entity's risk signals; they should also use modular playbooks by topic—such as claims, grievances, utilization review and prior authorization, network adequacy, mental health parity, and complaints.

Second, regulators should allow reusable evidence, including annually certified policies, procedures, vendor lists, system maps, and control descriptions. They should begin with smaller samples and escalate when needed. They should also use structured complaint and grievance codes to reduce manual narrative review.

Third, exam teams should explain scope, expectations, decision authority, and escalation paths at the outset. They should address questions informally where possible, ensure examiners have relevant line-of-business expertise, and provide oversight of contract examiners. Finally, regulators should apply proportionality. For example, minor documentation gaps may not draw the same response as higher risk harms.

B7. Are insurers experiencing consistency among regulators in the use or interpretation of the Market Regulation Handbook?

None of the responding plans report consistent use or interpretation of the Market Regulation Handbook across states, examiners, and contract examination teams. Plans report that contract examiners frequently do not use the Handbook, which adds time and expense. One contract examiner required two analyses outside the state's information requirements; another produced a detailed checklist the company had to complete for every sample file, each with unique naming requirements. Plans recommend that states ensure that staff and contract examiners are utilizing state-approved Handbook processes and templates, and that regulators develop guidance and examples in partnership with industry to reduce variation.

B8. Why would greater transparency into the reasoning or justification behind an examination help insurers?

Plans confirm that transparency would be highly valuable. Knowing why an examination commenced—the concerns, risks, or data indicators that prompted it—allows insurers to identify the right subject-matter experts, produce the correct records, flag jurisdictional or confidentiality concerns early, and tailor responses to the regulator's stated purpose. Such transparency reduces unnecessary document production and follow-up for both sides and encourages proactive correction. Plans report that some examinations now feel open-ended; focusing reviews on identified risk areas would improve efficiency while preserving regulators' full authority.

Plans also tie transparency to the contract-examiner framework, a recurring issue throughout these responses. Plans urge the NAIC and states to examine the incentive structure, suggesting that hourly billing can promote inefficiency and work beyond the stated scope, drive inconsistency among contractors, raise costs (auditor fees can exceed the fines at issue), and reduce transparency.

B9. Which collaboration tools or secure data rooms would industry support for remote data exchange, tracked interrogatories, and version-controlled document sharing?

Plans support using secure portals with straightforward upload and download capabilities, automatic notifications, and standardized input formatting. Several note that states already use exam portals effectively and identify widely-used commercial platforms (SharePoint-, ShareFile-, and Box-type tools) as the most user-friendly—urging continued use of proven tools. Plans ask the NAIC to set functional requirements rather than mandate a product, prioritizing encryption in transit and at rest, role-based access controls, multi-factor authentication, comprehensive audit logs, version control with document history, centralized request-and-response tracking with unique identifiers, linkage of requests to supporting documents, notifications, searchability, export capability, and retention policies.

Plans highlight the virtual data room model as a strong fit: one secure repository for all exam materials, less reliance on email attachments, controlled permissions, and a complete history of clarifications and revisions. A centralized request tracker would address one of the most common sources of inefficiency. Plans caution that any new tool should reduce duplicative work rather than create new state-specific requirements, and that access should reach only the regulator's exam team and the examined entity—not a centralized repository where all states can view reviews from other jurisdictions. If the NAIC or states pursue a centralized platform, confidentiality and security must be a primary design consideration, particularly in light of the recent NAIC security incident: market conduct submissions may contain confidential, proprietary, privileged, or sensitive business information, and consolidating it across jurisdictions adds risk unless regulators establish clear safeguards, access controls, retention standards, and confidentiality protections. Plans would also not support new vendor or platform fees on insurers given the costs already placed on them.

B10. Are there common vendor platforms or tools the industry would adopt to reduce duplicative custom work (for example, platforms such as Neota)?

Plans have not identified a single platform that regulators should require, and responding plans were not familiar with Neota specifically. Plans are open to working with regulators on platform adoption but believe the better objective is functional standardization: consistent technical requirements, secure document exchange, request tracking, version control, status updates, and reconciliation of outstanding items. Any new platform must be reliable, secure, easy to use, and must reduce burden rather than shift or add costs; regulators should first consider whether existing secure mechanisms suffice. If artificial intelligence or workflow automation tools enter market conduct processes, regulators should set governance expectations around accuracy, reliability, testing, explainability, confidentiality, and human oversight.

Additional Considerations

B11. Are there other issues the Working Group should consider on examination expectations and process?

Plans recommend that standardized pre-exam processes begin with a written scope memo identifying the licensed entity, products or lines of business, examination period, applicable statutes, requested data sets, purpose of the review, and how each request tests compliance. The kick-off should cover the regulator's risk-focused assessment drawn from complaint data, prior exam reports, and company reporting since the last exam. Regulators and companies should build in collaborative, regular, open communication and address confidentiality, redactions, and scope from the start. When multiple examiners are involved, the Examiner-in-Charge should coordinate information requests to prevent duplication and work beyond the stated scope.

Additionally, plans recommend that the Working Group first evaluate how the existing Handbook is used, why states apply it inconsistently, and what updates would modernize it—rather than building a new framework. Layering new standards on top of inconsistently adopted existing ones will add complexity unless states commit to consistent adoption.

C. Interstate Collaboration

Summary

> *Plans support interstate collaboration and "one-ask" principles—shared templates, standard definitions, and coordinated reliance on materials already produced—to reduce duplicative work. They also caution that market regulation rests on state-specific law, so substantive uniformity is not always feasible. Plans emphasize consistent definitions, file formats, timelines, and Handbook application; published consistency guidance; incentives that recognize cross-state remediation already underway; and phased pilots focused on high-volume, active jurisdictions.*

Definitions, Expectations & Uniformity

C1. What variations across states create the largest operational challenges—definitions, timelines, file formats, expectations?

All of the above. State-to-state—and sometimes intra-state—variation in definitions, universe criteria, timelines, file formats, templates, technical specifications, sample-selection methodology, case-file build instructions, and documentation expectations drives duplicative work and offers little predictability. Examples include inconsistent definitions of "paid claim" and "denied claim"; uncertainty over whether the situs state, resident state, or both are in scope; differing expectations about whether utilization management review covers medical necessity, administrative determinations, or both; and variation in reporting purpose (received versus processed dates). Because CSV and text files invite data loss/reconciliation work for complex submissions, file-format variation creates avoidable risk.

States also treat redactions inconsistently—some permit redaction of personal health information (PHI) and other sensitive information not needed for the review, while others request detail regardless—and treatment of confidential contract information varies, including by the role in which the entity is examined. Plans recommend a uniform standard that lets insurers focus submissions to the minimum

necessary information, explain the basis for redactions, and provide more detail only upon specific request, within the state's authority, and protected from public disclosure. On multi-state work generally, plans caution that multi-state examinations can add complexity and cost when a single process forces carriers to reconcile several state legal frameworks at once; multi-state data calls are easier to standardize than multi-state exams. Plans respectfully request the Working Group to define clear principles for when interstate collaboration is appropriate and how to govern it to reduce duplication.

C2. Where do statutory or Handbook interpretations diverge the most today, and how could consistency notes be published for industry to rely on?

Plans report the greatest divergence in definitions, turnaround times, scope interpretation, sampling, document and information requests, confidentiality treatment, and jurisdictional or preemption issues. Application of the Handbook varies broadly. For example, plans have experienced inconsistent use of its mental health parity chapter, and states diverge in interpreting federal parity requirements. Where states evaluate compliance with federal requirements or where preemption applies, federal statutes, regulations, guidance, and precedent govern. Plans recommend publishing consistency notes through an NAIC Technical Assistance Guide or similar guidance identifying standardized definitions, timelines, templates, file formats, Handbook interpretation principles, and collaboratively developed worked examples that industry can rely on and operationalize efficiently.

"One-Ask" Principles & Simplification

C3. How can processes be designed so insurers answer once for all states (shared templates, standard definitions, uniform due dates)?

The practical path is greater alignment on templates, definitions, file layouts, and timeframes, plus coordinated reliance on materials already produced when scope and legal authority align.

Plans prefer national templates over jurisdiction-specific ones and support one-ask principles, while recognizing that state-specific legal requirements may prevent a true single response for all states.

Plans handle enormous reporting volumes—one plan develops several thousand reports for state regulators each year—so even small differences in specifications or naming conventions create significant manual rework. One-ask principles should also apply within a single jurisdiction to avoid one plan's experience of receiving three separate requests in one state in a single year seeking substantially the same information.

Regulators should rely on information already submitted when scope, authority, and purpose overlap; consolidate existing requirements before adding new ones; and preserve rolling or staggered due dates.

One plan supported standardizing processes, templates, and definitions but opposed sharing underlying data across states, viewing it as problematic and potentially unlawful.

C4. What templates, definitions, or filing expectations should be standardized across jurisdictions to reduce manual rework?

Plans identify a broad list: data request templates, file layouts, sample protocols, confidentiality designations, redaction procedures, request trackers, response expectations, and exam processes; standardized definitions and checklists for claims, utilization management, appeals, and related review areas; standard definitions of "paid claim" and "denied claim"; clear guidance on exam scope (situs state, resident state, or both); consistent treatment of utilization management review; and standardized reporting purposes. Templates should specify whether requested data reflects contract state, provider state, or member residence state. Today, only MCAS functions as a standardized template. Practical recommendations include accepting test data before full sample production so the insurer and examiner can confirm the file meets expectations before producing the rest. Plans prefer Excel over text files to reduce data loss. Finally, plans emphasize developing standards with the regulated entities subject to them and treating greater Handbook adherence as a core modernization objective.

C5. How can insurers be encouraged or incentivized to remediate problems identified by one state to other states the insurer operates in?

Plans already consider whether remediation in one state should apply more broadly, accounting for differing state requirements. The strongest incentive regulators can create is reciprocity: recognizing and accepting completed remediation and corrective action plans from one state in another where the same root cause, time period, legal requirement, and consumer impact are involved; crediting corrective actions already taken or underway; accepting evidence of enterprise-wide implementation; and avoiding duplicative review or additional penalties for similar violations already being corrected.

Remediation timelines vary with the fix—template letter or disclosure changes may take roughly 30 to 45 days, while claims workflow, pharmacy system, authorization platform, vendor-dependent, or enterprise technology changes may take six months to two years—so regulators should not presume bad faith when complex fixes take time.

Pilot Strategy

C6. Which lines of business could be ideal to pilot or launch modernization initiatives (based on readiness, data availability, volume, diversity)?

Rather than naming a line of business, plans recommend sequencing.

First, pursue targeted reforms with clear impact: consistent use of the Handbook by regulators and contract examiners, broader adoption of the NAIC Market Conduct Surveillance Model Law (#693), expanded use of SBS and standardized complaint response processes, and stronger participation in the NAIC Market Regulation Certification program.

Second, pilot those reforms where regulator inquiry volume is greatest—in jurisdictions especially active in market regulation, where multiple reporting requirements, data calls, investigations, or examinations

are already underway in the same line of business—before expanding. Plans also caution that any health-focused pilot should consider the unique nature of health insurance: high volume of services, claims, and transactions; complexity of coding, billing, bundling, payment, and cost-sharing; multiple stakeholders with competing interests; and health insurers' simultaneous obligations to honor the contract, ensure member access, manage costs and utilization, and prevent fraud, waste, and abuse.

C7. What success metrics should be used to evaluate effectiveness?

Plans recommend measuring timeliness of responses to data requests, shorter examination cycles, and actual implementation of risk-focused approaches. Modernization should operate as a continual process rather than a one-time initiative: the Working Group should continue open meetings with interested parties, gather stakeholder input at each stage from design through implementation, evaluate both regulator effectiveness and feedback from regulated entities, and use that feedback to iterate.

Additional Considerations

C8. Are there other issues the Working Group should consider on interstate collaboration?

Because market regulation assesses compliance with state laws that legitimately vary, modernization should focus on consistent processes rather than identical outcomes. That means clear scope identification, transparent notice of the purpose of a review, standardized templates and data requests, consistent Handbook use, regular regulator-entity communication, and effective oversight of examination practices. Process consistency should be grounded in risk-based regulation, using credible data and published risk indicators to identify areas of greatest potential consumer harm and apply the least intensive effective response. Plans also recommend strong education, training, reimbursement, and oversight standards for regulators and contract examiners; allowing insurers to explain how requested information can be produced most accurately from existing systems; and improving cross-state coordination to reduce overlapping exams and requests.

D. Other Entity Oversight (Third-Party Oversight)

Documentation & Transparency

D1. What documentation (model cards, monitoring reports, validation materials) can insurers realistically provide during market-conduct reviews?

Plans can provide governance documentation, oversight frameworks, and the routine monitoring metrics and reports that delegated entities and vendors produce for the insurer under their contracts, where relevant to the defined scope. Plans recommend that regulators focus on these accountability artifacts rather than requiring unrestricted access to vendor-owned materials, and advise against requiring model cards, which contain proprietary vendor information. One plan opposed setting specific timing requirements for such productions.

D2. What materials would be burdensome or infeasible without additional regulatory guidance?

Materials become burdensome or infeasible when they are vendor-owned, proprietary, contractually restricted, client-specific, privileged, federally protected, outside the entity's possession or control,

unrelated to the review's scope, or not required to be maintained under statute or contract—especially materials not routinely tracked as part of contractual oversight. Plans also flag burden and feasibility concerns about highly confidential enterprise board and governance materials that include information about other affiliates. Before developing new expectations, regulators should identify the specific problem they are solving, confirm the statutory or contractual basis, and provide regulated entities a meaningful opportunity to weigh in on feasibility, confidentiality, legal authority, and operational impact.

Vendor and Model Governance

D3. How do you supervise third-party models and data sources today, and what standard artifacts could vendors reasonably provide to regulators?

Plans supervise delegated entities and vendors through structured delegation audit and oversight expectations set in the contract between the insurer and the vendor. Standard artifacts could include the routine oversight materials and reports the vendor is contractually required to provide to the insurer. Regulators should focus on these contractual oversight artifacts—governance and audit-outcome evidence—rather than requiring disclosure of proprietary vendor systems or models. Plans specifically flag that demands for direct system access to vendors have caused problems in audits.

D4. What challenges arise when third-party vendors operate models or provide data used in underwriting, claims, or consumer interactions?

The central challenge is contractual: vendors define the information, reporting, audit rights, and oversight materials available to insurers; plans cannot modify those contracts immediately or unilaterally when regulatory expectations shift. Plans ask regulators to identify specific objectives, confirm statutory or contractual basis, assess feasibility and confidentiality and, where new expectations are appropriate, provide clear guidance and reasonable implementation time so insurers can pursue necessary amendments. One plan said that, consistent with the NAIC Artificial Intelligence Bulletin, market conduct regulation should focus on regulated entities and consumer outcomes.

Regulatory Expectations & Accountability

D5. How could regulators streamline expectations to ensure accountability while recognizing vendor constraints?

Plans recommend standardizing templates and accepting reporting available to the insurer under vendor contracts. This supports accountability while recognizing that routine access to vendor information follows contractual delegation, oversight, audit, monitoring, and reporting obligations. One plan proposed that regulators review governance, controls, and risk-management frameworks when a demonstrated breakdown produces errors or violations broad enough to be systemic—keeping the focus on outcomes and consumer impact. Plans also urge examiner accountability by holding auditors to focused scope, reasonable timing, and justified findings, particularly given the inherent conflict between billable hour-structured arrangements and conducting exams expeditiously.

E. Corrective Actions, Communications & Enforcement

Proportionality & Predictability

E1. What tiered corrective actions (warnings, remediation plans, restitution) are predictable and proportionate for common findings?

Plans support tiering corrective actions by the nature, frequency, and consumer impact of each finding. Plans recommend the following structure:

- Technical or documentation issues: warnings, monitoring, or targeted process updates
- Isolated operational errors: correction, restitution where appropriate, and focused follow-up
- Systemic issues: corrective action plan with regulator oversight

Plans suggest that initial violations should draw warnings; monetary fines should apply to repeat violations that cause member harm. Regulators should retain discretion to forgo fines for first-time or limited offenses. Corrective actions should prioritize remediating the issue, making affected individuals whole, and preventing recurrence—not punitive remedies disproportionate to actual harm. Plans also note that some states have issued consent orders without first discussing the underlying issues. They urge regulators to pursue pre-enforcement dialogue before initiating formal enforcement.

E2. Is inconsistency among states in their approaches to self-reporting and fines an industry concern?

Plans consistently confirm this concern and report having experienced inconsistent state approaches. Plans report instances where states impose fines in absence of audit reports that clearly outline the findings and actions. Recommendations: encourage self-reporting through a collaborative, proportionate approach as punitive responses may discourage proactive disclosure; caution against fining for self-reported violations remediated in good faith; provide greater transparency into how fines are determined, including the portion attributable to each violation; and standardize corrective action frameworks so they are consumer-harm-driven, aligned to scope, predictable, and do not contain fine revenue incentives.

Timelines & Feasibility

E3. What realistic timelines (30/60/90 days) can insurers commit to for specific fixes (policy language changes, claims workflow updates)?

Plans uniformly respond that remediation timelines cannot be standardized: the specific facts should control, because timelines depend on the nature of the fix, the affected systems and business areas, third-party involvement, consumer impact, governance and funding processes, and the testing required to confirm effectiveness. Template letter or policy-language changes can often move quickly—though still subject to system release cycles and review—while claims workflow, pharmacy system, authorization platform, vendor-dependent, and enterprise technology changes may require six months to a year or longer. Plans support standardizing a collaborative approach, including establishing realistic timelines together and defining, at the outset, what evidence will demonstrate completion and effectiveness.

Verification & Consumer Impact

E4. Which artifacts best demonstrate that remediation worked (before/after metrics, audit trails, consumer communications)?

Plans believe the right artifacts depend on the corrective action and should be identified with the regulated entity. Before-and-after metrics and audit trails may provide strong evidence. Other useful artifacts: updated policies and procedures and governance records from the corrective action committee demonstrating that business owners reviewed and implemented the fix. One plan recommended a simple affidavit over extensive verification.

E5. What metrics or narrative reporting could insurers produce to show improved consumer outcomes after remediation is completed?

Appropriate metrics depend on the issue. Regulators should develop reporting expectations with the regulated entity so they align with existing internal tracking. Available evidence may include internal and external audits by compliance, internal audit, and business operations teams (including relevant third-party vendors). Some business areas can demonstrate quantifiable outcomes—reduced consumer complaints, call volumes, or claim denials—while others cannot. Remediation reporting should not require the adoption of new technology solely for reporting purposes.

Additional Considerations

E6. Are there other issues the Working Group should consider on corrective actions and enforcement?

Plans ask the Working Group to recognize that corrective action timelines often depend on governance, funding, technology release cycles, vendor coordination, and client impacts—clients may be directly affected and may expect notice or involvement—and consider not treating good-faith remediation delays as noncompliance. Plans also request clearer administrative-process expectations: exam closure, rights to challenge findings, and applicable timelines, which states approach differently. On framing, plans urge care with "accountability for all entities" language so any approach reflects the different roles and levels of control across parties. Plans support more uniformity while preserving flexibility for different business models and state priorities, and support risk-based approaches in principle—with clearer guidance on how risk is defined, what triggers an exam, and how scope is determined.

F. Consumer Complaints

Summary

> *Plans prioritize transparency into complaint coding—whether a complaint is confirmed or not confirmed—supported by reason codes, a short rationale, an opportunity to correct errors, and a defined reconciliation window. Plans recommend standardized definitions, coding criteria, and interpretive guidance applied consistently across states, and a uniform complaint portal, with broader adoption of State Based Systems (SBS) as a practical first step to replace the burden of monitoring many portals, email, and fax channels. Because complaint data drives market analysis and exam targeting, coding accuracy directly affects the fairness of risk signals and plans' own root-cause work. Plans also recommend clearer, more uniform confidentiality and public-records protections.*

Transparency Into Complaint Coding

F1. How does the lack of visibility into whether a complaint is coded as confirmed or not confirmed affect your ability to conduct root-cause analysis and implement corrective action?

Plans often do not receive clear feedback on whether a complaint is coded as confirmed/not confirmed. That limits meaningful root-cause analysis and effective corrective action, and may risk material divergence between the insurer's and regulator's complaint analyses. This is a significant concern because regulators use complaint data to prioritize market analysis and examinations. The concern intensifies when a complaint or batch includes multiple claims or issues and only some fall within scope. Without visibility into how the state evaluated each component, complaint data may overstate or mischaracterize risk. It may also drive targeting that is untethered from the actual issue or consumer impact.

F2. What type of transparency or feedback loop would help you understand how states determine confirmation status?

Plans recommend a feedback loop that provides the confirmation status, a reason code, a short explanation of the state's rationale, an opportunity to correct factual or coding errors, and a defined reconciliation window. The process should distinguish confirmed complaints from unconfirmed complaints, consumer inquiries, duplicates, and jurisdictionally out-of-scope matters—with particular visibility into how states evaluated individual claims or issues within a multi-issue complaint.

F3. What definitions, examples, or coding criteria should be standardized across states to reduce variation?

Plans recognize that the NAIC complaint coding framework—standardized elements such as coverage type, reason for complaint, and disposition—provides a sound foundation for cross-state comparability. The core problem is operational: definitions exist at the NAIC level, but states apply them with judgment, producing variability and, in some cases, complaints incorrectly coded as valid and then used to trigger additional oversight. Plans recommend that modernization standardize interpretive guidance and decision rules—not just data fields—with explicit coding examples, and include guidance for pre-screening complaints to determine whether an issue falls within the state's authority before routing it or counting it. Plans also recommend simplifying complaint submission templates, which currently require segregating data into numerous state-specific categories, and evaluating whether broader use of the SBS portal could promote consistency, provided security, confidentiality, and cost concerns are addressed.

State-to-State Variability

F4. What discrepancies among states—coding logic, investigation standards, timelines, or documentation requirements—create the greatest operational challenges for your teams?

Plans identify challenges across every listed category. The largest arise from state-to-state and intra-state variation in complaint intake methods, portal functionality, documentation requirements, response formats, file-size and format limitations, and turnaround times. These differences force teams to monitor multiple portals plus email, fax, and postal channels, manage technical access issues, and

maintain manual state-by-state trackers for requirements as granular as response formatting, "regarding" line content, and color-coding of submissions. On coding, plans have limited visibility into reconciliation or coding adjustments states make after submission; the most common apparent errors involve disposition codes, including whether a complaint is justified or unjustified.

F5. Which aspects of complaint handling are most in need of national alignment to ensure consistent expectations and reporting?

Plans support prioritizing national alignment on the core operational requirements that drive resource allocation: receipt method, response method, timeframes, documentation requirements, complaint case types, and coding standards. A single standardized portal would solve the need to monitor multiple channels, and standardized response requirements would reduce variation in submission and formatting. Plans also emphasize alignment in how states determine confirmation status, because complaint data feeds outlier identification, market analysis, and exam scoping. Consistent timeframes and documentation would improve prioritization, staffing, and response quality while maintaining consumer protection.

Complaint Portals, Submission Processes & Tracking

F6. How does the absence of a uniform complaint portal across states impact your ability to organize, coordinate, and respond to complaints?

The absence of a uniform portal forces plans to manage different intake and response processes for every state: monitoring multiple portals, email, and fax channels; maintaining credentials across platforms, including systems requiring individual user access; managing technical access issues; and keeping manual state-by-state trackers. These differences make automation difficult and delay intake, routing, investigation, and response. As one illustration, one plan spent three full days documenting a single state's complaint-intake process and identified 78 separate steps. Plans also describe compounding problems: portals vary in performance and security protocols, some conflict with company firewalls or multi-factor authentication, portal updates create downtime, and encrypted emails create access problems.

F7. What minimum portal features (status visibility, communication logs, document exchange, audit trail) would meaningfully improve your complaint-handling operations?

Plans recommend broader SBS adoption as a first step. Even with its limitations, broader adoption would improve consistency and reduce the number of systems complaint teams must access. Over time, a portal should include a uniform complaint template; jurisdictional confirmation before submission to the respondent entity; clearly posted due dates; all communication with the jurisdiction consolidated in one section; secure document exchange; one-click acknowledgment; confirmation and closure status with reason codes; the ability to request clarification or correct coding errors; and a dashboard showing aging, pending, and closed complaints. Plans also recommend that the NAIC and states agree on standardized definitions for evaluating and investigating complaints and publishing standardized investigation status and outcomes.

F8. What challenges do you encounter when trying to determine whether a complaint remains open or has been closed, given current state systems?

Current systems make it difficult to tell whether a matter remains open, closed informally, or closed as confirmed or not confirmed. States issue closure letters inconsistently—some occasionally, most not at all—and, when they do, not always timely. This inconsistency complicates internal reporting, resourcing, reconciliation, and complaint trend analysis, and plans also lose visibility when complaints disappear from a portal while still requiring follow-up.

Reconciliation Processes

F9. In states that offer a reconciliation or correction process, what elements are most valuable (e.g., dispute correction, clarification opportunities)?

Reconciliation processes remain rare. Responding plans identified only one state that offers a monthly coding report showing how the state coded and closed each complaint, and none on the pharmacy benefit side. That regular, complaint-level visibility into coding and closure is itself the most valuable element and a model worth extending.

F10. What would a functional and fair national reconciliation framework look like, and what process steps or timelines should it include?

A fair national framework would include clear guidance for coding and closing complaints; regular reports of coding and closure information to the respondent entity; lists of complaints that remain open, flagged for those still awaiting the respondent's reply; and an opportunity for the regulated entity to submit clarifying information or request corrections. The process must run fast enough to correct data before regulators use it for trend analysis, public reporting, or additional market regulation action.

F11. What kinds of coding errors or discrepancies most frequently need correction from your perspective?

Given today's limited visibility, plans can partly catalog errors, but the likely and observed categories include inquiries incorrectly coded as complaints; complaints coded against the wrong entity, product, or line of business; incorrect confirmation status; duplicate complaints; matters outside state jurisdiction; complaints the consumer's resolution does not reflect in the coding; and errors from unclear definitions, such as receive date versus process date and exclusionary criteria.

Industry Engagement & Collaboration on Coding

F12. What opportunities for joint engagement with regulators—training sessions, calibration workshops, or a shared coding guide—would improve accuracy and fairness in complaint categorization?

Plans support joint training sessions, calibration workshops, shared complaint coding guides, and periodic regulator-industry reviews. These forums could use de-identified examples to align on confirmation criteria, reason codes, closure practices, and reconciliation. Publishing coding FAQs and interpretive guidance on common areas of confusion would help complaint-handling teams and support

consistent application, and including regulated entities in developing that guidance would improve its usefulness.

F13. How frequently should regulators and insurers collaborate or recalibrate on complaint coding to ensure alignment across the states?

At least annually, with additional sessions when regulators introduce new complaint categories, portal changes, coding standards, or new market conduct initiatives.

Confidentiality & Records Handling

F14. How do differing confidentiality standards among states affect your ability to provide complete, candid responses and share internal information appropriately?

Inconsistent state response methods compound confidentiality and secure-transmission challenges. For states that accept complaint responses by email, TLS connections do not exist with all states, forcing plans to use encrypted email—which regulators then struggle to access, creating delays and follow-up work. Plans also report that states sometimes request information beyond their jurisdiction, such as materials on self-funded or ERISA plans, and regulators should limit investigations to matters within their authority. Uniform confidentiality standards, secure transmission protocols, and clear handling expectations would improve the process while protecting consumer privacy.

F15. What uniform confidentiality protections would help balance consumer privacy with insurer transparency and operational clarity?

Uniform protections should cover PHI, other personally identifiable information (PII), proprietary business information, client information, vendor materials, trade secrets, and privileged materials, and should address information outside the state's authority. Regulators should allow insurers to redact PHI, PII, and other sensitive consumer information not necessary to resolve the complaint or support the review, and should confirm how they will protect submissions from public disclosure and data breaches. To provide clarity to legal teams involved in these issues, modernization should preserve appropriate protections, clarify records-retention expectations, and avoid creating new risks of inappropriate disclosure.

F16. What guidance or clarification do you need regarding how complaint files are treated under public records laws to reduce uncertainty and risk?

Plans support clearer, more transparent standards for how regulators treat information submitted by regulated entities, and recommend broader adoption of the confidentiality protections in the Market Conduct Surveillance Model Law. Plans also suggest that regulators could add value by sharing aggregated, de-identified examples of common complaints and recurring examination findings, letting carriers benchmark their practices and address issues proactively without identifying individual companies.

Additional Considerations

F17. Are there other issues the Working Group should consider on consumer complaints?

Complaint modernization should avoid creating new operational burdens without improving consumer outcomes. Regulators should use complaint data as one indicator of risk, with context that differentiates consumer complaints from provider and pharmacy complaints and reflects emerging patterns affecting volume—such as AI-generated and third-party campaign-driven complaints—as well as severity and confirmation status. The Working Group should pursue complaint modernization in partnership with regulated entities, align it with ongoing PBM complaint-module work, and avoid duplicative or conflicting obligations.

G. General Discussion Questions

Summary

> *Across the closing questions, plans return to the themes running through the survey: a risk-based examination framework modeled on the NAIC financial examination process, standardized data collection and definitions, consistent use of the Market Regulation Handbook, and clear up-front communications and decisions from regulators. Plans identify broad requests for system-wide access—and aggregating data across legacy systems—as the biggest technical problem, and point to Handbook use and subject-matter knowledge as the training priority.*

G1. What one modernization change would deliver the greatest efficiency gain—and why?

Most plans point to a risk-based examination framework—modeled on the NAIC financial examination process—that prioritizes regulatory action by transparent risk indicators, potential consumer harm, and market impact rather than routine comprehensive review of all entities. Plans pair this with standardization: a national data template with concise field definitions and expected values; standardized data collection with multi-state coordination; reusable structured data and documentation; and consistent state adherence to the Handbook, which alone would let insurers prepare for and respond to exams far more efficiently.

G2. What would make industry participation easier (templates, sandboxes, test data, checklists)?

Continued open meetings and structured stakeholder engagement throughout both development and implementation. Early, ongoing engagement helps ensure reforms are risk-based, operationally feasible, and aligned with the Handbook. As recommendations move toward implementation, regulators should co-develop clear standards, templates, common formatting and submission requirements, validation expectations, and guidance with industry, and should leverage existing reporting and consistent checklists to prioritize areas of focus.

G3. Where do you need regulator decisions first (definitions, file specifications, timelines)?

Plans need regulator decisions first on clear definitions, scope, expectations, what is driving the review, confidentiality treatment, data specifications, file formats, and reasonable timelines—defined at the start of every examination or investigation, with an opportunity for the entity to ask questions before work begins. Uncertainty here can produce questions over jurisdiction and concern over unnecessarily compressed timelines, while bespoke checklists and unclear production expectations create manual

work without improving quality. Plans also ask for transparency about when and how regulators will use enhanced analytics. They urge states not to establish new rules through market conduct analysis or examinations, particularly when contractors rather than state officials conduct them.

G4. What requirement could be simplified tomorrow with no reduction in consumer protection?

Document production expectations. Regulators could immediately focus requests to materials clearly tied to the defined exam scope and within the jurisdiction's authority; use existing reporting the insurer already produces routinely; and set response timeframes that reflect and account for the resources companies need to compile, validate, and safeguard responsive data.

G5. What is the biggest technical blocker from the insurer side for modernization?

The biggest technical blocker is the gap between what regulators sometimes request and how insurer data is stored. Broad requests for system-wide access, "all" information, or data elements that do not align with existing reporting capabilities are difficult to satisfy because plans must pull information from multiple legacy systems with limited automation.

Plans note that those systems are not always organized by jurisdiction, line of business, product, or regulator-facing category. As a result, producing a validated response is not simply a matter of exporting a report. Plans must identify the relevant records, determine which are in scope and subject to state oversight, confirm which data elements are reportable, and validate the response with subject-matter experts.

Third-party data adds another layer of complexity. PBMs, TPAs, and other vendors often serve multiple clients, including clients or lines of business that may not be subject to the requesting state's insurance oversight. They may face contractual obligations to protect client data. These constraints may make broad or open-ended requests especially difficult to operationalize.

G6. Is there one area of training for examination staff states should focus their efforts on first?

Consistent use of the Market Regulation Handbook, paired with stronger subject-matter knowledge of the requirements being examined—for regulators, consultants, and contract examiners alike. Plans urge that training should cover jurisdictional concepts—such as situs and non-situs authority; specific areas such as mental health parity; and distinctions among plan types (HMO, PPO, indemnity) so examiners know which requirements apply. Examiners should begin with a walkthrough of the relevant business process—for example, the end-to-end claim process—and, where multiple examiners issue requests, the Examiner-in-Charge should coordinate so requests are not duplicative or disconnected from the approved scope.

American Property Casualty Insurance Association
INSURING AMERICA apci.org

July 13, 2026

Market Conduct Regulation Modernization Working Group
NAIC Central Office
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

VIA Electronic Mail: tmullen@naic.org

RE: APCIA Comments re: Market Regulation Modernization

Dear Members of the Market Conduct Regulation Modernization Working Group:

The American Property Casualty Insurance Association (APCIA)[1] appreciates the opportunity to provide comments regarding the National Association of Insurance Commissioners' ("NAIC") Market Conduct Modernization initiative and the questions outlined in the May 8, 2026 Industry Discussion Document. The insurance industry shares regulators' goals of enhancing consumer protection, improving regulatory effectiveness, and modernizing oversight processes through greater consistency, transparency, and efficient use of data.

Modernization should build upon existing NAIC tools and frameworks—including the NAIC Market Regulation Handbook, Market Analysis Handbook, and existing model laws—rather than creating entirely new regulatory structures. A primary objective should be improving consistency in application and interpretation across jurisdictions while preserving state-specific legal requirements.

APCIA recommends that modernization efforts be guided by the following principles:

- Consistent application and targeted modernization of existing NAIC frameworks.
- Risk-based, data-driven regulatory oversight focused on consumer outcomes.
- Data minimization principles that limit requests to information that is necessary, relevant, and reasonably available.
- Greater transparency in examinations, complaint coding, and regulatory expectations.
- Strong confidentiality, cybersecurity, and public-records protections.
- Flexible implementation timelines reflecting operational and technological realities.
- Interstate collaboration that reduces rather than increases duplication.
- Proportionate corrective action and enforcement frameworks that encourage remediation and self-reporting.
- Meaningful regulator-industry collaboration throughout development and implementation.

[1] The American Property Casualty Insurance Association (APCIA) is the primary national trade association for home, auto, and business insurers. APCIA promotes and protects the viability of private competition for the benefit of consumers and insurers, with a legacy dating back 150 years. APCIA members represent all sizes, structures, and regions-protecting families, communities, and businesses in the U.S. and across the globe.

1. Market Conduct Data (Collection & Analysis)

Data Standards, Definitions & Transport

The most significant opportunity for efficiency lies in adopting uniform national data standards, including standardized definitions, common data dictionaries, API specifications, and submission formats. A single market conduct data model should govern all participating jurisdictions.

APCIA supports efforts to establish common data standards, definitions, and reporting formats where they reduce rework and improve consistency across jurisdictions. Standardization can improve data quality and facilitate more efficient regulatory reviews. However, standardized definitions should not conflict with governing state statutes or regulations. Where legal requirements vary among jurisdictions, regulators should recognize necessary state-specific distinctions.

To ensure successful implementation, all data definitions, validation rules, and reporting specifications should be developed with meaningful industry input through an open and iterative process. Regulators should clearly articulate the purpose of requested data and how the information will be used to support regulatory objectives.

The Working Group should examine collaborative practices successfully used by some states, where regulators solicit industry feedback on data-call requirements before finalizing requests. Such practices improve data quality, identify definitional concerns early, reduce rework, and foster more effective regulator-carrier collaboration.

APCIA's Data Call Principles and Best Practices are attached for the Working Group's consideration.

Systems, Feasibility & Legacy Constraints

While many insurers are investing in modern data architectures, changes to policy administration, claims, complaint management, and reporting systems are often complex and resource intensive.

Reasonable implementation timelines should include:

- 12 months for modest reporting modifications;
- 18–24 months for enterprise-wide data standardization;
- Longer transition periods when vendor-supported systems require updates.

Data Quality, Validation & Minimization

Most insurers perform data validation prior to submission, including:

- Completeness testing;
- Reconciliation to source systems;
- Exception reporting; and

- Reasonableness reviews.

Regulators can substantially improve efficiency by publishing validation logic in advance and providing pre-submission testing environments.

Modernization efforts should adopt a formal data minimization principle. Regulators should request only information that is:

- Necessary to achieve a defined regulatory objective;
- Relevant to the issue under review; and
- Reasonably available to insurers through existing business processes.

Requests for information not maintained in the ordinary course of business should be carefully evaluated against the regulatory value produced. Data elements that do not contribute meaningfully to risk identification or consumer outcome analysis should be reevaluated and eliminated where appropriate.

Additional Comments

Any centralized data collection platform must be supported by robust governance, cybersecurity controls, confidentiality protections, access restrictions, retention standards, and incident-response protocols. Market conduct submissions routinely contain proprietary, confidential, privileged, and sensitive business information. Consolidation of these data sets creates additional risk and requires heightened protections.

New solutions should be adopted only when they demonstrably improve efficiency, reduce burden, and avoid imposing additional vendor or platform costs on insurers.

2. Examination Handbook & Processes

Pre-Exam Expectations & Feasibility

Many insurers can provide standardized dashboards, claim inventories, complaint summaries, and key performance metrics within 10 business days. More complex requests involving historical data, legacy systems, or third-party vendors may require additional time.

APCIA supports development of standardized pre-exam data requests that would apply across jurisdictions. States adopting uniform standards for required data elements and data definitions would be a big improvement for insurers. Today, states have independent requirements and define data elements differently, which creates operational complexity, adds to turnaround time, and leads to imprecise responses from insurers.

Risk Identification & Targeting

APCIA supports a market-analysis-driven examination approach. Market conduct examinations are most effective when focused on identified risks, complaint trends, or data-supported concerns rather than scheduled or routine examinations lacking a clear risk basis.

The following indicators generally provide meaningful insight into market conduct risk:

- Complaint frequency and severity trends;
- Claim cycle times;
- Reopen rates;
- Consumer communication failures;
- Regulatory inquiries;
- Litigation trends; and,
- Corrective action histories.

Examination resources should be directed toward elevated-risk areas, while low-risk entities and topics receive appropriately scaled reviews.

Exam Operations, Tools & Burden Reduction

Several examination practices create unnecessary burden, including:

- Duplicative requests from multiple states;
- Requests for data already submitted elsewhere;
- Non-standardized formats and definitions;
- Repeated production of identical governance materials;
- Duplication of crits requiring a response to each new item when it's been noted there is an issue related to process is very inefficient;
- A large number of crits given with very short response time;
- Repetitive questions related to the same issue requiring a new response each time;
- Multiple follow-ups without acknowledging earlier responses or noting what needs to be clarified; and,
- Varying levels of claim handling knowledge/experience with examiners.

APCIA supports:

- Secure shared data portals;
- Version-controlled document repositories;
- Standardized request templates; and,
- Centralized interstate information-sharing platforms.

Greater transparency regarding:

- Risk indicators;
- Examination triggers;
- Scope development;
- Sampling methodologies; and
- Escalation pathways

would improve examination efficiency and allow insurers to focus resources on addressing identified concerns.

Additional Comments

States should ensure examination personnel, including third-party contract examiners, possess appropriate subject-matter expertise relevant to the line of business being reviewed. Adequate oversight and accountability mechanisms are essential to maintaining consistency and avoiding unnecessary costs and delays.

The Market Regulation Handbook should be supplemented with published interpretation guidance addressing recurring areas where state practices diverge.

3. Interstate Collaboration

Definitions, Expectations & Uniformity

APCIA supports interstate collaboration when it genuinely reduces duplication and promotes consistency. However, collaboration should not result in expanded scope, layered requirements, or effectively nationalized oversight detached from state law.

Variations among states remain one of the largest drivers of compliance cost. Differences in:

- Definitions;
- Filing deadlines;
- Data formats;
- Complaint coding practices; and,
- Examination expectations

often require separate state-specific processes for substantially similar requirements.

Multi-state data calls may present greater opportunities for standardization than multi-state examinations because examinations frequently require jurisdiction-specific legal analysis and application of state-specific standards.

"One-Ask" Principles & Simplification

APCIA strongly supports a "collect once, use many" framework under which insurers submit a standardized response that may be relied upon by multiple jurisdictions.

The Working Group should prioritize:

- Uniform templates;
- Standard definitions;
- Common timelines;
- Shared work products;
- Single-response opportunities; and
- Recognition of remediation completed in other jurisdictions.

Pilot Strategy

APCIA does not have a suggested LOB for a pilot, but suggests, instead, that the pilot be limited to a subset of a LOB, such as basic homeowners or auto physical damage. Success metrics should include:

- Reduced examination cycle times;
- Reduced data requests;
- Greater consistency across states;
- Improved consumer outcomes; and,
- Reduced insurer compliance

4. Other Entity Oversight

Documentation & Transparency

Insurers are accountable for consumer outcomes, even when activities are performed by vendors or third parties. Regulatory expectations regarding third-party oversight should recognize both insurer accountability and practical limitations associated with vendor-controlled information. Insurers generally can provide:

- Governance frameworks;
- Due diligence documentation;
- Audit findings;
- Monitoring reports;
- Risk assessments; and,
- Model validation materials.

However, requests for proprietary source code, intellectual property, or highly confidential vendor materials may not be feasible absent additional guidance and protections.

Vendor and Model Governance

A principles-based approach should recognize differences among:

- Claims vendors;
- Technology providers;
- Data aggregators;
- Artificial intelligence vendors; and,
- Customer service contractors.

Regulators should establish clear expectations regarding artifacts that vendors can reasonably provide while preserving contractual and intellectual property protections.

5. Corrective Actions, Communications & Enforcement

Proportionality & Predictability

APCIA strongly supports a corrective action framework centered on remediation and consumer outcomes rather than punitive measures alone. Corrective actions should be proportional to the nature, scope, and consumer impact of identified issues.

States should engage insurers before initiating formal enforcement actions. Pre-enforcement discussions allow regulators to obtain additional context, evaluate corrective actions already underway, and promote more effective consumer-focused resolutions.

Similarly, self-reporting frameworks should encourage voluntary disclosure. Inconsistent treatment of self-reported issues can discourage transparency and undermine consumer protection goals. Many APCIA members have noted significant penalties after self-reporting and making restitution to policyholders. Regulators should recognize good-faith identification, prompt reporting, and timely remediation when evaluating enforcement outcomes.

Timelines & Feasibility

The timelines required to implement “fixes” vary widely depending on the complexity of the necessary changes and whether IT resources are necessary. Reasonable remediation periods typically include:

- 30 days for procedural corrections;
- 60–90 days for workflow changes; and,
- Six months or longer for enterprise technology modifications.

Verification & Consumer Impact

Successful remediation may be demonstrated through:

- Before-and-after metrics;
- Complaint trend reductions;
- Quality assurance testing;
- Consumer communications;
- Independent audits; and/or,
- Ongoing monitoring results.

Consumer Complaints

Consumer complaint modernization presents one of the most significant opportunities for improving both regulatory efficiency and consumer outcomes. Complaint handling processes, portal functionality, coding practices, response timelines, and confidentiality protections vary substantially among jurisdictions. These differences create unnecessary operational complexity and limit meaningful benchmarking.

Transparency Into Complaint Coding

Insurers often lack visibility into whether complaints are classified as confirmed, justified, or substantiated and are frequently not informed regarding coding changes made during regulatory review. This limits insurers ability to conduct meaningful root-cause analysis and implement targeted corrective actions.

Regulators should provide:

- Complaint disposition information;
- Coding rationales;
- Standardized definitions;
- Examples of coding application; and
- Opportunities for clarification or correction.

State-to-State Variability

Significant differences currently exist among states concerning:

- Coding methodologies;
- Investigation standards;
- Response timelines; and
- Documentation expectations.

National alignment would substantially improve reporting accuracy and comparability.

The Working Group should seek greater consistency regarding:

- Response deadlines;
- Documentation requirements;
- Portal functionality;
- Coding standards;
- Reconciliation opportunities; and
- Closure notifications.

Complaint Portals, Submission Processes & Tracking

The lack of a uniform portal is a significant challenge since insurers are required to manage multiple, varied logins and processes to manage the complaint receipt and response process. This makes it difficult to employ any consistent automation in the intake processes and other workflows.

A uniform complaint management portal should include:

- Case status visibility;
- Secure messaging;
- Document exchange capabilities;
- Audit trails;
- Closure notifications; and
- Standard reporting capabilities.

The NAIC should also evaluate whether broader utilization of SBS or a similarly standardized framework could improve efficiency while maintaining appropriate confidentiality, cybersecurity, governance, and cost controls.

For insurers with many underwriting companies it is difficult to manage the status when the insurer has to look at each complaint file individually within each underwriting company. Some form of reporting mechanism rolling up the closing data by underwriting company and by group would be helpful.

Reconciliation Processes

Reconciliation processes allow for correction of coding discrepancies and clarification of context, which is highly valuable. It is certainly critical that insurers can confirm that the state has coded the complaint correctly to the insurer's underwriting company and line of business and policy type to ensure the insurer is being properly charged with the complaint for indexing purposes.

A national reconciliation process should permit insurers to:

- Review complaint coding decisions;
- Submit supporting information;

- Request clarification; and
- Receive timely determinations.

Industry Engagement & Collaboration on Coding

Regular regulator-industry calibration sessions, annual training programs, and publication of standardized coding guides would improve consistency and fairness. Complaint handling focused forums, workshops or trainings would definitely be welcomed to discuss issues and share feedback. Greater documentation including guides addressing any and all aspects of the complaint handling process would be appreciated. One suggestion would be to revisit an update to the NAIC's "Consumer Complaints White Paper" document to address the complaint process in the current time particularly with the dramatic changes with consumer expectations, technology, AI, etc. when questions are presented about definitions and review process.

Regulators can further enhance consumer protection by sharing aggregated, de-identified information regarding:

- Common consumer issues;
- Emerging trends;
- Frequent examination findings; and
- Recurring complaint themes.

Such information would enable insurers to benchmark performance and proactively address emerging concerns before widespread consumer harm occurs.

Confidentiality & Records Handling

Differing state confidentiality standards impact how insurers provide internal details, document investigative findings, and balance transparency with legal/privacy constraints. The Working Group should pursue greater consistency in confidentiality protections applicable to complaint records and examination materials. Insurers need clarity regarding treatment of complaint files under state public-records laws and assurance that proprietary, privileged, and sensitive information will remain protected.

If the NAIC or states consider a centralized portal or other shared platform for market conduct data collection, confidentiality and security protections must be a primary consideration, particularly in light of the recent NAIC data breach. Market conduct submissions may contain confidential, proprietary, privileged, or sensitive business information. Consolidating information across jurisdictions could create additional risk if appropriate safeguards, access controls, retention standards, and confidentiality protections are not clearly established. Additionally, new platforms hosted by vendors may result in additional fees or costs. APCIA would not support additional costs on insurance companies associated with new platforms given the existing costs already placed on insurance companies.

Confidentiality protections also vary significantly across states. In some jurisdictions, market conduct submissions may be subject to public records requests, creating a risk that confidential, proprietary, or sensitive information could enter the public domain. APCIA supports stronger and more uniform

confidentiality standards, including clear protection of complaint and examination records from public-records disclosure where they contain confidential information. Enhanced and clarified protections would encourage carriers to respond more candidly and completely, which ultimately supports more effective regulation.

*****

The industry supports the Working Group's modernization efforts and encourages a framework grounded in national consistency, risk-based oversight, transparency, and efficient interstate collaboration. Modernization should reduce administrative burden while strengthening regulators' ability to identify genuine consumer harm and emerging market conduct risks. APCIA appreciates the opportunity to provide these comments and look forward to continued engagement as the initiative progresses.

Respectfully Submitted,

Lisa Brown
Assistant Vice President, Market Conduct and Counsel

APCIA Data Call Principles

Data Call scope must be within the specific authority of the regulator(s) and limited in subject to the regulator(s)' core mission of consumer protection (solvency and market conduct), related to existing business practices (not delving into issues only being contemplated by company research and development, and which may never come to fruition), balanced with effective and efficient regulation. Industry cooperation and trust will be supported by including in the Call Letter or earlier communication:

- The overall purpose and goal of the Data being collected including clear plans for how the Data will be aggregated;
- Citation to the specific regulatory and statutory authority to make the request;
- Citation to the specific regulatory and statutory confidentiality protection of the responses; and
- Disclosure of the involvement of any third parties in the collection or review of the Data.

The Data Call should only be issued if its subject matter cannot be reviewed or studied in data available through existing regulatory reporting (to the states, NCCI, ISS, ISO, or other recognized bureau or agent) or Data Calls that request the same or similar data.

- Data Call's on similar issues should be coordinated and standardized across states and with federal agencies, where appropriate.
- NAIC staff should be regularly educating DOI staff on existing and new templates and data definitions (including NAIC Standard Data Requests (SDRs)).
- States should be encouraged to utilize existing resources to support uniformity and efficiency.

The timing of the Data Call:

- Should not conflict with insurers' existing reporting and filing obligations as regulated entities (annual financial and regulatory reporting, licensing and Data Calls); i.e., insurers have a number of existing reporting requirements in March, April, and May of every year; and,
- Should provide a reasonable amount of time for insurers to respond, keeping in mind the size/breadth of the information requested and the desire for novel data elements.

Data Calls should be created in consultation with statistical agents, NAIC staff, and industry (through trade representation) to be efficient and effective to support the industry in providing timely and accurate responses by ensuring:

- Data requested is available/collectible and reportable;
- Format of data requested is feasible;
- Definitions match industry standards; and
- Instructions and FAQ's are adequate.

Establish a process to engage Industry during the response and aggregation phases to ensure issues and anomalies are addressed and resolved on an industry-wide basis and to avoid incorrect conclusions based on faulty data. Any changes made to the Data Call (including instructions or definitions) should be uniformly communicated to the industry.

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APCIA Data Call Best Practices

FORMULATING A DATA CALL

- Develop a clear consensus among participating regulators on the purpose and objective of the Data Call; its goal should be tied to a well-defined use of the Data.
  - If the Data Call will fulfill the goals of multiple regulators for a similar purpose, ensure all interested regulators are included as uniformity and consistency among jurisdictions will simplify procedures.

- Engage with the industry when formulating the Data Call for support.
  - Seek industry input on what collectible and reportable data elements will best provide meaningful information germane to the objective.

- Determine if data from existing Data Calls or other sources either fulfill the purpose/objective of the proposed Data Call or collect the data the regulators intend to use. Using available data or updating data previously collected increases efficiency and results in the production of more timely and accurate data. Support for this practice:
  - Connect with/research NAIC, statistical agents (e.g., ISO, NCCI), Annual Financial Statements, MCAS or other existing regulatory reporting requirements or Data Calls.
  - Engage with industry through trade associations to determine if other jurisdictions have done similar Data Calls.
  - H-Committee Study Group Goal (proposal): Creation of an industry-wide Data Call inventory - current system is heavily manual and anecdotal.

- If data previously collected is not on point or current, use similar Data Call s as a template. E.g., Post-Catastrophe Data Call developed by the NAIC NE Zone following Superstorm Sandy, currently in use by approximately 10 states.

- Consider the Timing:
  - Do not overlap with insurers' existing reporting and filing obligations as regulated entities (e.g., annual financial statements, annual industry-level Data Calls).
  - Provide a reasonable amount of time for all insurers to respond.
  - Data Calls relying on statutory annual statement data should be timed for response a reasonable period after the annual statements are finalized and filed.

- Have all information necessary to fully populate the Call Letter in place before it is issued.

continued

THE CALL LETTER

- Clearly communicate the purpose and objective of the Data Call - a general description of the Data to be collected, the regulatory objective being serviced and its intended ultimate use.
  - E.g., collecting policy count and premium written within a specific geographic area to determine the availability/affordability of coverage and if there is a deficit, appropriate ways to address including expansion of a FAIR Plan-type coverage or incentives to insurers to write in the area.
  - Specify if the Data Call is required by statute, either as a matter of course or with regard to evaluating the usefulness/efficacy of a specific statute, or is in furtherance of a potential legislative objective.
  - Identify whether the Data Call will or may become a recurring event.

- Provide the statutory or other authority under which:
  - The data is being collected; and
  - Confidentiality is being provided.

- Disclose the identity of any third parties participating in the collection or analysis of the data, including their confidentiality obligations and their firewall settings to ensure they can successfully receive Data Call information and any information about associated costs that will be passed on to industry.

- Disclose how the data will be aggregated for analysis and the confidentiality protections for individual company data.

- Disclose details of what happens after data has been submitted:
  - Timing for review and error testing; and
  - Timing of release of an aggregated report.

- Precisely define the scope and parameters of the Data Call. E.g.:
  - Admitted carriers, Non-admitted carriers or both.
  - Commercial Lines, Personal Lines or both.
  - Responses on group or individual statutory company level.
    - o If individual companies within the group, specify which must respond.

- Limit data requested to that required to meet the stated purpose of the Data Call. Should regulators desire additional data, “mandatory” fields needed for the stated purpose should be identified and other fields considered optional.

continued

- Provide clear instructions on population of the data template, including:
  - A "sample report" with proposed data fields populated to provide visual guidance.
  - Clear definitions of data elements. Utilize existing definitions through NAIC SDR, MCAS, or past Data Calls where possible.
  - Proactively address common industry requests for clarification, including:
    - o Time frame/Location for data to fit within the Data Call:
      - State, Zip Code, County lists
      - Policy Year vs. Accident Year
      - Policies in force vs. Policies issued or renewed
      - Policy State vs. Policy Situs vs. Accident State vs. Property Location State
    - o Lines of Business - ASLOB, Type of Insurance (SERFF TOI) or something else?
    - o How to report single policies containing multiple lines of business
    - o How to enter "no data".
    - o How to identify trade secret information.

- Provide detailed instructions for submission of the completed template.
  - Coordinate with industry trade group when considering the method of submission.
  - Seek industry feedback when utilizing new Data Call collection software or submission formats.
  - Test submission method with sample of insurers to ensure the Data can be transmitted and received in the designated format and size.
  - When submission will be through a regulator portal, provide a method in which the industry can download a copy of their submission.
  - If validation checks (errors and/or warnings) are built into the filing system, provide industry with a list in advance so carriers can complete pre-checks and avoid delays in submission.
  - Clarity on execution requirements, including use of electronic signatures on notarized affidavits.

- Have and articulate a process for "Null" templates, i.e., a company has authority to write the LOB subject to the Data Call, but does not write it at the time. A simple process for communicating that a company has no data should be established.

- If verification checks are being used after submission (Ie comparing a data element from a current request to data included in another filing/submission), include these in the initial requirements documents so that industry understands what mapping or analysis should be considered in their process and/or point out where the correlation may not make sense.

- Consider limiting the review (look-back) period required for companies to collect only data which is needed to meet the regulatory objective.

- Provide regulator staff contact name, phone number, and e-mail address to receive questions and concerns from industry.

- Ensure correct insurer contacts are receiving the call letter. For data calls initiated under a jurisdiction's market conduct authority, the data call letter should go to the company market conduct contact provided on the Financial Annual Statement. For data calls not initiated under a jurisdiction's market conduct authority, we suggest that the NAIC have a repository of company contacts provided by the company.

continued

DURING THE DATA CALL

- Maintain and clearly communicate a process to insurers for addressing questions and concerns that arise after the Data Call is issued, including specific methods of contact and regular cadence of responses.
- Make guidance available on an industry level instead of providing separate answers to inquiring insurers where possible.

POST-OP

- Engage with industry participants (including at the trade group level) during the aggregation to address issues including conflicting data results, missing data fields, numeric values that are not reasonable based on the defined data elements.

GENERAL CONCERN

- The NAIC should consider creating a catalog of existing Data Calls issued by their members – both regular reporting requirements and ad hoc Data Calls. This catalog could serve as a resource to states considering formulating a Data Call.
- The NAIC should consider adding a chapter to the Market Regulation Handbook addressing ad hoc Data Calls.

July 13, 2026

Ann Gillespie, Chair
Angela L. Nelson, Vice Chair
Market Conduct Regulation Modernization (D) Working Group
National Association of Insurance Commissioners
1101 K Street, N.W., Suite 650 Washington, DC 20005

Submitted via Email: tmullen@naic.org.

RE: National Association of Insurance Commissioners Market Conduct Regulation Modernization (D) Working Group

Dear Chair Gillespie and Vice Chair Nelson:

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to provide comments on the *Market Conduct Regulation Modernization – Industry Discussion Questions* (Discussion Questions) as distributed through the NAIC Market Conduct Regulation Modernization (D) Working Group. We commend the Working Group's open and inclusive process, including its engagement with industry, consumers, and other stakeholders.

BCBSA is a national federation of independent, community-based and locally operated Blue Cross and Blue Shield (BCBS) companies (Plans) that collectively provide health care coverage for 1 in 3 Americans. Our Plans contract with 97% of hospitals and 83% of doctors across the country and serve those who are covered through Medicare, Medicaid, an employer, or purchase coverage on their own.

BCBSA agrees with the Working Group that the key areas for market conduct regulation modernization include data collection and analysis, examination processes, interstate collaboration, third-party oversight, corrective action frameworks, and consumer complaints. As the Working Group evaluates these topics, BCBSA recommends a framework that is not only modernized, but also tailored to the distinct risks and regulatory considerations of each line of business.

Modernization efforts should account for meaningful differences in market structure, regulatory safeguards, risk profiles, and operational realities across insurance sectors, particularly health coverage, which operates in a high-volume, multi-party delivery system subject to overlapping state and federal requirements. Market conduct tools should be calibrated to those operational realities and to the distinct consumer protection issues presented by each line of business.

Consistent with the broader NAIC initiative to advance a more coordinated, data-driven, and risk-focused system of oversight, BCBSA supports the Working Group's market conduct regulation modernization efforts. BCBSA submits the following detailed comments to strengthen—not reduce—oversight by improving regulatory consistency, transparency, operational efficiency, and effective consumer protection across states.

BCBSA recommends a forward-looking, risk-based market conduct regulatory framework that would:

- Use standardized, data-driven analyses to identify risk, prioritize oversight, and assess consumer impact;
- Direct regulatory focus on areas with the greatest potential for consumer harm;
- Align supervisory intensity with demonstrated risk indicators at the carrier level, product level, and market segment level;
- Encourage innovation while preserving regulatory oversight of evolving carrier practices;
- Adapt as new risks emerge and market practices evolve;
- Enhance transparency in regulatory expectations, risk assessment, and supervisory decision-making; and
- Reduce unnecessary administrative burden for regulators and industry while enhancing consumer protections.

Together, these elements define the goals of BCBSA's recommended modernized framework.

BCBSA recommends the following six guiding principles to translate those goals into practical criteria for assessing risk, calibrating regulatory response, and directing regulatory resources to situations that present the greatest potential consumer impact:

Principle 1: Risk-Focused and Proportionate

The primary purpose of market conduct examinations is to protect consumers. Thus, a modernized framework should align the intensity of regulatory effort with the likelihood, severity, and scale of consumer harm. This approach would help regulators direct resources where they can have the greatest impact, identify emerging risks earlier, promote more consistent supervisory activity, and support an adaptive regulatory environment.

Modernization should formalize risk-based decision-making into a structured, transparent framework that uses market analysis and market conduct examinations to focus regulatory attention on areas where consumer risk is greatest. Illustrative areas may include claims handling, network adequacy, utilization management, affordability, fraud, and unfair discrimination practices. Risk indicators should be evaluated based on credible data signals, including patterns, trends, and outliers, with appropriate context for

isolated or unusual events. Risk-based surveillance should also consider the nature and scale of the consumer issue identified so that oversight prioritization remains neutral, proportionate, and grounded in credible indicators of consumer impact. This principle should be operationalized through examination planning, scoping, testing, and supervisory response decisions.

Consistent with this risk-based principle, BCBSA agrees that the scope of market conduct examinations should be guided by consistent risk assessment criteria so lower-risk entities and activities receive routine monitoring, while higher-risk entities and issues receive targeted inquiries, focused reviews, or comprehensive examinations as appropriate.

BCBSA encourages the Working Group to consider formalizing a *Risk-Focused Market Conduct Examination: 7-Phase Approach* (7-Phase Approach), adapted from the NAIC Financial Condition Examination methodology, for inclusion in the NAIC Market Regulation Handbook as a practical methodology for operationalizing a structured risk-focused framework. When properly adapted to market conduct objectives and structured to avoid duplication of the financial examination process, the 7-Phase Approach would strengthen the consumer protection purpose of market conduct examinations by creating a structured risk continuum that supports targeted, data-driven, outcomes-focused oversight and aligns regulatory responses with the level of consumer risk identified.

Within the overall modernization framework, the 7-Phase Approach would translate market analysis and risk identification into targeted testing, reassessment, corrective action, and reporting. In this way, it would help regulators move from risk signals to proportionate supervisory action while reinforcing the framework's core objectives of consumer protection, risk-focused oversight, transparency, consistency, and practical implementation.

Risk-Focused Market Conduct Examination: 7-Phase Approach and Key Questions

1. Understand the Company and Identify Key Market Conduct Activities
    - Where could market conduct risks arise?
2. Assess Inherent Market Conduct Risk
    - What could cause adverse consumer outcomes or noncompliance?
3. Evaluate Relevant Compliance Controls
    - What controls help prevent noncompliance or adverse consumer outcomes?
4. Assess Residual Risk
    - What risk remains after controls and mitigation steps?
5. Perform Targeted Testing
    - Are consumers being treated fairly and in compliance with laws?
6. Reassess Risks and Determine Regulatory Response

- What issues require corrective action or oversight?

7. Report Findings and Expectations
    - What did we find and what must be corrected?

Risk Assessment Should Drive a Spectrum of Regulatory Responses

The risk assessment developed through the 7-Phase Approach should then guide a proportionate continuum of regulatory responses, with supervisory intensity increasing as credible indicators of consumer impact become more significant:

1. Low: Routine monitoring
2. Moderate: Analyst inquiry or targeted data request
3. Elevated: Focused review
4. High: Targeted market conduct examination
5. Critical: Comprehensive or multi-state examination

This spectrum would help shift oversight away from a one-size-fits-all model and toward proportionate identification, assessment, and mitigation of the risks most likely to adversely affect consumers. This would strengthen regulatory effectiveness by allowing regulators to devote greater attention to higher-risk areas while reducing unnecessary effort devoted to lower-risk activities.

This approach is consistent with the Market Regulation Handbook, which already contemplates market analysis and market conduct examinations as part of a continuum of regulatory responses. A modernized framework should make that continuum more explicit by using more structured and standardized approaches to market analysis to identify trends, outliers, and emerging consumer risks, and to translate those risk signals into examination planning, scoping, sampling, and proportionate supervisory response.

A risk-focused framework is also better suited to a changing marketplace. As health insurers continue to increase their use of digital tools, artificial intelligence-enabled processes, advanced analytics, value-based care models, and new consumer engagement strategies, regulators should focus their market conduct efforts on the risks these innovations may create – not on the technologies themselves.

Principle 2: Data-Driven

The Discussion Questions emphasize data standards, common data models, standardized layouts, validation logic, reporting consistency, and reduced manual effort.

A modernized framework should use timely, reliable, and actionable data to support risk identification, supervisory prioritization, and regulatory decision-making. BCBSA recommends uniform standards that improve data quality, consistency, and comparability across jurisdictions, so regulators and insurers can focus on consumer risk rather than state-specific customization. Key considerations include:

- Use common data models, standardized field definitions, reporting formats, and validation logic to reduce rework while preserving applicable confidentiality, privacy, privilege, and state-specific legal protections.
- Provide common technical specifications, version control, and change-management processes to reduce variation in state interpretations and help distinguish true risk signals from reporting methodology differences.
- Prioritize existing nationally recognized standards and market conduct tools where practical to improve consistency and avoid new or duplicative reporting requirements.

This principle is particularly important for the Market Conduct Annual Statement (MCAS), an established NAIC framework for collecting standardized market conduct information used in market analysis, benchmarking, risk identification, supervisory prioritization, and examination planning. BCBSA recommends reviewing and standardizing MCAS-related data definitions as part of a broader data modernization approach to support more uniform reporting, improved comparability, and more effective market analysis.

BCBSA supports modernizing MCAS by improving the clarity, consistency, comparability, and governance of existing MCAS data elements, including clear parameters for how MCAS data are used and interpreted. Additional standardization would help regulators identify emerging consumer risks, compare results more effectively, and focus resources on areas of greatest potential consumer impact.

To support that objective, any material change to MCAS data elements, reporting instructions, or submission requirements should be tied to a clearly articulated market conduct purpose, transparent use and access protocols, and consideration of operational feasibility, confidentiality, privacy, and burden. This approach would allow regulators to strengthen the usefulness of MCAS while maintaining appropriate governance over how insurer data are collected, accessed, analyzed, and retained.

This purpose-driven approach is also important when MCAS data appear related to information collected through other regulatory reporting frameworks. Certain MCAS data elements may appear similar to data reported through financial annual statement reporting; however, the two reporting structures serve different regulatory functions and may reflect different instructions, timing, populations, aggregation levels, and methodologies. For example, MCAS premium elements for health lines of business are based on earned premium tied to MCAS instructions, state, line of business, reporting population, and calendar-year data calls, while financial annual statement reporting may reflect written premium and statutory accounting conventions, including adjustments, accruals, reclassifications, and different reporting bases. Claim-related elements may similarly use familiar terminology while measuring different concepts: MCAS focuses on market conduct indicators, while financial annual statement reporting reflects accounting-based measures.

As MCAS is modernized to support market analysis, benchmarking, risk identification, supervisory prioritization, and examination planning, cross-source comparisons should be framed around a defined market conduct question, transparent methodology, and appropriate context.

Where regulators may have specific market conduct questions involving data related to another regulatory source, those questions should be identified prospectively, tied to a defined market conduct purpose, and supported by transparent methodology, appropriate data-use safeguards, and an opportunity for insurers to provide relevant definitions, assumptions, data sources, timing differences, and operational context. This purpose-driven approach would help ensure that any cross-source analysis supports market conduct oversight without treating differences between MCAS data and financial annual statement data as exceptions requiring reconciliation or as reasons to redesign either reporting structure.

Practical opportunities to improve existing MCAS reporting include:

- **Apply data minimization principles:** Retain data elements that meaningfully measure consumer impact or identify market conduct risk, while periodically reviewing lower-value reporting requirements for removal, consolidation, or refinement. Examples of potentially lower-value reporting include: (1) older data breakouts, (2) product-level breakouts for low-volume segments, (3) duplicative administrative fields, (4) low-value volume measures, and (5) stratified reporting categories – such as metal-level reporting. Regular assessment will determine whether reporting requirements continue to produce reliable, decision-useful market conduct risk signals.
- **Adopt uniform definitions:** Standardize definitions for complaints, claim outcomes, appeals, grievances, external review, utilization management determinations, and related status categories.
- **Standardize timing and methodology:** Establish consistent reporting periods, timeliness calculations, data sources, assumptions, exclusions, and calculation methodologies, so results are comparable across jurisdictions and reporting cycles.
- **Clarify group policy and plan counting rules:** Specify how member, subscriber, certificate, policy, and plan-level concepts should be counted for group policies and plans.
- **Establish data governance safeguards:** Define the market conduct purpose, permissible uses, access protocols, confidentiality protections, retention expectations, and documentation needed to support transparent and appropriate use of MCAS data.

By strengthening existing MCAS definitions, methodologies, and governance in this way, the Working Group can make MCAS more reliable, comparable, and actionable for risk-focused market conduct oversight while reducing unnecessary variation and administrative burden.

Principle 3: Outcome-Oriented

A modernized framework should keep consumer outcomes at the center of market conduct regulation.

The Discussion Questions emphasize remediation effectiveness and verification that corrective actions address identified issues. While compliance with laws, regulations, and internal policies remains essential, regulatory frameworks should also evaluate whether consumers receive fair treatment and the intended protections.

BCBSA recommends that outcome-oriented market conduct oversight remain focused on regulated entity conduct as it affects enrolled consumers. Provider-related or broader healthcare delivery issues should be evaluated through a consumer impact lens — whether regulated entity conduct has, or is reasonably likely to have, direct consumer impact. Issues outside that scope are better addressed through complementary legislative, regulatory, or stakeholder processes.

Illustrative consumer-focused outcome measures may include:

- Complaint resolution effectiveness
- Claims handling timeliness and accuracy
- Access to covered benefits
- Consumer understanding and transparency
- Restitution and remediation effectiveness

An outcome-oriented framework should assess whether consumers received the protections and benefits required under applicable standards.

Principle 4: Coordinated

The Discussion Questions emphasize interstate collaboration, shared templates, common definitions, uniform expectations, and “one ask” concepts. BCBSA supports greater coordination among states to reduce duplication and improve supervisory efficiency.

BCBSA recommends that coordination efforts focus on the following activities:

- Standardize data collection, reporting specifications, and analysis expectations where practical
- Use shared templates
- Adopt common definitions
- Align due dates where practical
- Coordinate examination activities
- Apply consistent remediation approaches where practical

Greater coordination would improve regulatory effectiveness, support efficient multi-state supervision, and reduce unnecessary complexity while preserving consumer protections.

Coordination should focus on standardizing information requests, templates, definitions, specifications, timelines where practical, and supervisory expectations while preserving confidentiality, privilege, privacy, and state-specific legal requirements. A “one-ask” model would be most effective if it reduces duplicative requests through common templates and aligned expectations while avoiding approaches that depend on pooling, centralized retention, or unrestricted cross-jurisdictional use of insurer data. The model should enable regulators to coordinate planning and rely on consistent request structures, so insurers are not required to recreate substantially similar materials for multiple states.

Greater alignment in these areas would reduce duplicative mapping, improve comparability, and support more consistent identification of true market conduct risk signals.

Principle 5: Consumer-Outcome Accountability

The Discussion Questions focus on third-party oversight, model governance, validation materials, monitoring reports, and accountability frameworks.

Where credible indicators suggest a market conduct issue with potential consumer impact, regulators should appropriately conduct a proportionate review of the regulated entity’s issue-specific oversight, monitoring, escalation, vendor management, and remediation processes. BCBSA recommends that review remain tied to the targeted issue, the regulated entity’s accountability for consumer outcomes, and applicable confidentiality, privilege, proprietary, and sensitive operational protections, while coordinating with governance and control reviews addressed through financial analysis and examination processes to avoid unnecessary duplication.

Principle 6: Dynamic and Adaptive

A modernized framework should remain flexible and responsive to evolving risks, emerging technologies, changing market practices, and responsible innovation. The Discussion Questions recognize emerging considerations involving APIs, data transport, vendor oversight, model governance, and evolving examination practices.

Accordingly, BCBSA recommends modernization efforts that:

- Encourage responsible innovation while preserving consumer protection
- Periodically review supervisory tools and methodologies
- Strengthen regulatory training in risk-focused examination skills
- Enable timely responses to evolving market conditions

As new tools, models, and market practices emerge, regulatory expectations should evolve through transparent guidance, structured implementation engagement, and clear prospective compliance expectations. This approach would support responsible innovation, maintain consumer-focused oversight, improve predictability for regulators and regulated entities, and help ensure that examination findings are grounded in established expectations.

Other Considerations

The six principles above define the core attributes of BCBSA's recommended modernized market conduct framework. The following operational considerations address practical implementation issues for applying those principles to examination planning, information requests, corrective action, complaint handling, transparency, and continued collaboration.

Examination Planning, Pre-Examination Expectations, and Phased Response Model

BCBSA recommends that examination scope be clearly defined before an examination begins, based on the regulator's assessment of the individual carrier's risk profile, and that carriers have a meaningful opportunity to provide input on the proposed scope. Carrier response timelines for data extracts, documentation, and other examination or oversight requests should reflect the operational effort required to respond completely and accurately. Because requests vary in scope, complexity, source systems, confidentiality, privilege, privacy, and other legal review considerations, BCBSA encourages the Working Group to avoid preset or standardized response times that do not account for those factors. Instead, timelines should be calibrated to the nature of the request, the systems and third parties involved, and the effort required to produce reliable information. This approach would support more focused, efficient examinations while preserving regulators' ability to obtain information needed to evaluate potential consumer impact.

A phased approach can help operationalize this principle by distinguishing between information that is routinely available and higher-effort data that requires additional time due to system architecture, vendor dependencies, confidentiality or privacy review, legal review, or archived data limitations. Requests should include clear data definitions, file specifications, assumptions, and intended use, so insurers can provide reliable information in a standardized, easily interpretable format. Longer lead times may be appropriate for multi-system data, delegated vendor information, archived materials, clinical documentation, contract materials, or privilege-sensitive documents.

Examination Duration and Timeliness

Timely, well-scoped examinations are important to effective market conduct oversight. BCBSA recognizes that state insurance departments may rely on contract examiners and other external resources to support examinations. A modernized framework should encourage clear scope definition, transparent examination

objectives, regular status communication, effective management of supplemental requests, and reasonable milestones for completing reviews and issuing findings. These practices would support efficient and cost-effective use of contracted examiners and other examination resources. When examinations extend significantly beyond the period under review, findings may become less actionable for current operations and less useful in supporting timely consumer-focused improvements. A timely examination process would support meaningful remediation, improve predictability, and strengthen the usefulness of findings for consumers, regulators and regulated entities.

Examination Lookback Periods and Record Availability

BCBSA recommends that the Working Group consider a risk-based approach to examination lookback periods and historical data requests that ensures regulators receive the information needed to evaluate identified market conduct concerns while focusing requests on records that are relevant, reliable, and reasonably available. In practice, the appropriate timeframe should be guided by the nature of the issue under review, applicable record-retention requirements, the availability and reliability of historical records, and the level of consumer impact or risk identified. This approach would not limit regulators' ability to obtain older information when needed; rather, it would help align the scope of historical requests with the demonstrated regulatory purpose and the practical realities of producing accurate information from older systems or archived sources. Regulators should retain full flexibility to request additional historical information when warranted by circumstances indicating that older records are necessary to protect consumers and assess insurer conduct.

Recommended Definitions

Common definitions are foundational to consistent supervision. BCBSA recommends prioritizing those definitions that most affect comparability and operational feasibility, including complaint categories and confirmation status; claim processing and denial concepts; utilization management and appeal terms; timeliness methodologies; policy, member, subscriber, and group coverage counting rules; and documentation of assumptions, data sources, and calculation methods.

Corrective Actions, Communications & Enforcement

BCBSA supports corrective action, communication, and enforcement expectations that are proportionate to the nature of the issue, the severity and scale of consumer impact, the likelihood of recurrence, and remediation effectiveness, while promoting consistency across states.

BCBSA recommends that the Working Group consider corrective action expectations that:

- Align corrective actions with the nature of the issue, the severity and scale of consumer impact, and whether the issue is isolated, systemic, or recurring.

- Set corrective action timelines based on the facts and circumstances of the issue, the urgency and scale of consumer impact, and the operational effort required to implement sustainable remediation, including changes to claims workflows, systems, vendor processes, or policy language.
- Provide regulated entities notice of potential findings and a meaningful opportunity to respond before findings are finalized, particularly where findings involve outcome-based assessments, complaint coding, operational data interpretation, or extrapolation from samples.
- Focus remediation verification on practical evidence proportionate to the issue, such as attestations, focused validation, before-and-after metrics, audit trails, or consumer communications where appropriate.

Consumer Complaints

BCBSA recommends a focused workstream on consumer complaint handling. Greater consistency in complaint definitions, coding logic, confirmation standards, timelines, identifiers, closure visibility, and portal functionality would improve the usefulness of complaint data for trend analysis, root-cause analysis, and corrective action. In health coverage, complaint definitions should distinguish consumer complaints from provider grievances or inquiries, unless the provider is formally acting on behalf of the insured consumer.

Modernization should also address confidentiality and records handling. Uniform confidentiality protections and clearer guidance on public records treatment would help insurers provide complete, candid responses while at the same time protecting consumer privacy, proprietary information, privileged materials, and sensitive operational information.

Purposeful Transparency and Confidentiality

BCBSA supports transparency that strengthens consumer confidence, informs evidence-based policymaking, and promotes accountability. Transparency is most effective when information is reliable, contextual, actionable, and appropriately governed. Modernization should distinguish between information collected for supervisory oversight and information that is appropriate for public reporting.

Market conduct data, including MCAS and examination-related submissions, are collected primarily for supervisory oversight and market analysis. Public release of granular company-level, claims-level, or other supervisory datasets without appropriate context may be difficult to interpret and may not provide meaningful consumer information. Public-facing transparency is most useful when it focuses on standardized, contextual information, such as defined measures, explanatory methodology, appropriate comparisons, trend information, and plain-language interpretation.

Implementation Considerations and Continued Collaboration

Continued stakeholder collaboration will be important to translate these recommendations into practical implementation. BCBSA recommends that pilot efforts be scoped around defined market conduct objectives, feasible data requirements, realistic timelines, clear measures of success, and opportunities for regulator-industry feedback before broader adoption.

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The Working Group's modernization initiative is an important opportunity to strengthen market conduct regulation through timely risk identification, consistent interstate supervision, clearer expectations, proportionate corrective action, and effective deployment of regulatory resources. BCBSA appreciates the Working Group's leadership and looks forward to continued collaboration with regulators and stakeholders on a modernized framework that advances these shared consumer protection objectives while supporting consistent, practical, and risk-focused market conduct oversight.

If you have any questions regarding these comments, please contact Demetria Tittle at Demetria.Tittle@bcbsa.com or Randi Chapman at Randi.Chapman@bcbsa.com.

Sincerely,

Clay S. McClure
Senior Director, State Affairs

INSURED RETIREMENT INSTITUTE

Electronically Submitted to tmullen@naic.org

July 10, 2026

TO: The NAIC Market Conduct Regulation Modernization (D) Working Group ("Working Group")

Re: Exposure Question on Market Data and Scanning

On behalf of our members, the Insured Retirement Institute (IRI)[1] appreciates the opportunity to comment on the exposure question regarding whether technology can be used to improve market regulation related to advertising, marketing, and sales. IRI supports the Working Group's efforts to enhance market conduct regulation and consumer protection. We solicited input[2] from our member companies on the Industry Discussion Questions (the "Discussion Questions") shared by the Working Group, and there is strong member consensus around three themes that run through each section of the Discussion Questions: the need for standardized definitions, templates, and data layouts; more consistent and predictable timelines and examination procedures; and greater transparency into complaint coding, confirmation status, and examination reasoning. As such, we are providing more specific details on each topic area below, beginning with a broader issue for consideration by the Working Group.

A Foundational Consideration: Supporting the Use of Modern Technology in a Manner Consistent with Both Regulatory Requirements and Their Underlying Intent

Our members still report that certain regulations and examination standards may not be updated to reflect modern insurance operations. As a result, insurers are hesitant to rely on electronic delivery and digital data transfer, even where those methods are more efficient and create a better experience, out of concern that examiners will treat paper-based compliance as the only acceptable approach. A concrete example is the "duty to notify" requirement under the Life Insurance and Annuities Replacement Model Regulation (Model #613), which is frequently interpreted to require physical mailing of carrier-to-carrier notices even though the underlying

[1] The Insured Retirement Institute (IRI) is the leading association for the entire supply chain of insured retirement strategies, including life insurers, asset managers, and distributors such as broker-dealers, banks and marketing organizations. IRI members account for more than 95 percent of annuity assets in the U.S., include the top 10 distributors of annuities ranked by assets under management, and are represented by financial professionals serving millions of Americans. IRI champions retirement security for all through leadership in advocacy, awareness, research, and the advancement of digital solutions within a collaborative industry community.

[2] Please note that that responses to several of these questions are highly fact-specific and depend on variables such as company size, issue complexity, and internal processes. Accordingly, timelines and data production capabilities may vary significantly across companies and circumstances, and do not necessarily lend themselves to uniform or definitive responses.

replacement transaction may be processed entirely through digital channels and the receiving carrier is already informed before a mailed notice could arrive. As such, a carrier should be able to satisfy the duty to notify by electronic means, such as email, rather than only by physical mail. Second, where the existing carrier itself transmits the data that effectuates the replacement, that data transmission should be recognized as satisfying the duty to notify, because the receiving carrier receives the relevant information as part of the transfer itself. Additionally, given that this is a carrier-to-carrier process, it does not impact consumer protections. While this is a discrete example raised by our members, there may be other instances where similar allowances would be appropriate[3]. As such, IRI urges the Working Group to consider incorporating language into the Market Conduct Examination Guidelines that affirmatively recognizes that electronically delivered communications, the digital transmission of data, and digitally maintained records satisfy existing regulatory requirements because:

- Electronic processes meet the spirit of the regulation and of the Uniform Electronic Transactions Act (UETA) (as adopted by states) by ensuring relevant parties receive timely, accurate information more reliably than physical mail;
- Electronic processes provide a more reliable audit trail: digital transactions generate a time-stamped (with IP address and location), system-maintained record of what was sent, when it was sent, and that it was received, which improves the integrity of the notification process;
- Electronic processes produce more accurate information by reducing the transcription errors, delays, and version-control issues inherent in paper-based workflows; and
- Electronic processes are more secure: encrypted transmission with access controls provides substantially stronger protection for sensitive consumer and contract information than physical mail or fax.

IRI recommends that the Working Group explore an avenue to provide guidance or update the Market Conduct Examination Guidelines to confirm that electronic delivery and the digital transmission of data satisfy existing regulatory requirements. Establishing a consistent standard now will prevent inconsistent examiner-by-examiner interpretations and give insurers the confidence to commit to a modern digital compliance infrastructure.

[3] For example, according to members, some examiners have been reluctant to accept system-generated date stamps as sufficient evidence of a document's receipt or transaction date, indicating a preference for manually stamped paper records. Similarly, examination expectations sometimes assume that all documents comprising a policy file reside in a single location, whereas those records are increasingly maintained across distributed cloud storage, so assembling a complete policy file can require additional time. Recognizing system-generated date stamps and distributed digital recordkeeping as reliable would help align these expectations with modern operations.

1. Market Conduct Data (Collection & Analysis)

IRI members strongly support uniform data standards, including data definitions, standard style guides, common data models, and clear transmission specifications adopted consistently across states. The operational benefit would be significant: standardization allows insurers to build one repeatable compliance process rather than recreating state-specific data extracts, field mappings, and quality-control routines for each examination. As it stands currently, a significant amount of exam data file requests and/or requested data elements within files require a manual data pull, which is more costly and time-consuming for insurers and regulators[4].

Any new standard should be phased in and tested before required use, with clear specifications, examples, and validation rules so implementation does not create additional manual rework. Consistent state adoption would be important, but we understand the potential challenges to making this happen.

The data elements generating the most friction are those requiring judgment-based classification or varying in definition across products, systems, or states: complaint reason codes, confirmed/not-confirmed status, claim disposition codes, denial reasons, replacement indicators, and date-based timeliness calculations. Providing MCAS reporting by resident state while providing examination data by issue state is a persistent reconciliation burden. Additionally, data elements that are duplicative, irrelevant[5], inconsistently defined, rarely used by regulators, or not tied to predictive oversight should be reviewed for revision or removal.

In addition, the Working Group may want to consider the work being advanced through *IRI's Digital First for Annuities* (DFA) initiative, which is facilitating more consistent and efficient communication between industry participants when they send and receive data. This initiative is helping drive the industry towards a "common language" through promoting the standardization of data and a build-once-use-many approach that can be implemented across industry participants.

If such an approach were considered by the Working Group, it could reduce friction in data requests and support a more streamlined and efficient communication and data transmission process for market conduct requests that aligns with the other data requests across the

[4] Examples of data that commonly require a manual pull include: scan dates for paperwork received, or application dates, maintained in administrative systems; beneficiary information stored on secondary systems; claims paid following a Social Security Death Master File (DMF) match; surrender value, which is not retained across all systems and requires manual review of net versus gross pay; and agent licensing and appointment information, which is complicated by differing administrative systems and varying state tracking methods.

[5] For example, examiners sometimes request lapse dates in connection with annuity exams.

industry. This would also help alleviate pain points related to the retrieval, transmission, and analysis of data for both industry participants and regulators, as information would be standardized and widely understood, making it easier to interpret, implement and use.

2. Examination Handbook & Processes

A standardized pre-exam package (something that would be more feasible to produce in a shorter time period) should be limited to data that already exists in a reportable format: complaint logs, complaint trend dashboards, basic policy and claim inventory summaries, existing monitoring summaries, organizational contacts, prior examination status, and standard policies and procedures. Items requiring longer lead times include custom historical extracts, transaction-level claim files, legacy system data, third-party administrator data, and vendor-administered platform data. Additional time is also needed for data requiring custom programming, vendor extraction, or historical reconstruction.

Companies do look at conduct-related risk indicators such as complaint volume and rate trends, confirmed complaint patterns, and escalation trends. Our members shared that any indicators, however, should be evaluated in context: complaint trends relative to block size, for example. A tiered, transparent risk model drawing on MCAS results, prior exam findings, remediation history, and business volume should drive examination scope, with low-risk areas (such as closed or smaller blocks of business) receiving targeted reviews and higher-risk areas receiving deeper examination.

The examination practices generating the most unnecessary burden are duplicative requests, changing or overly broad scopes (i.e. multiple business lines, simultaneous exams of multiple of a company's insurers, multi-year exam scope), inconsistent definitions and/or interpretations of state requirements, short deadlines for complex data, and multiple states asking the same questions separately. For pre-exam requirements, it would be helpful for regulators to identify the transactions, populations, and products they intend to examine at the outset and request that information up front, rather than over the course of the exam. Because IT and other business resources are typically mobilized at the start of an exam, calling on those same teams again months later for information that could have been collected at the outset adds avoidable time and cost.

A critical burden is often timing: data requests frequently arrive when the same teams are supporting MCAS submissions, statutory reporting, year-end close, financial exams, or simultaneous market conduct exams from multiple states. Coordinating request timing, allowing rolling productions, and providing reasonable extensions would materially improve response quality.

Additionally, inconsistent sample sizes skew error ratios, and larger sets of files take more time to produce. Determining a set number of sample files for review and implementing that consistently would also help minimize production time. We would also recommend using one sample set to evaluate multiple transactions.

Consistency in the use of the Market Regulation Handbook remains uneven across and within states, both by state regulators and the third-party companies hired to perform exams; the NAIC could publish consistency notes and training materials available to both examiners and industry so that insurers can rely on common expectations across jurisdictions. Uniform examiner training could also be helpful to reduce examiner-to-examiner divergence, and training as to the role of the Interstate Compact would be especially useful. Greater transparency into examination reasoning, including its scope and rationale (such as the statutes or regulations underlying an inquiry and the basis for any criticism, so that insurers can respond accordingly), helps insurers direct the right resources, enables more focused productions, and supports faster remediation. Additionally, shorter, more efficient exams allow insurers to provide more accurate, timely information, and to conduct remediation swiftly, rather than waiting months or years for exam feedback/findings, and any subsequent resolution. IRI members would generally support secure data rooms with role-based access, request tracking, and confirmation of receipt, provided confidentiality, data security, retention, and access-control expectations are clearly defined and followed.

3. Interstate Collaboration

State-to-state variation in definitions, production timelines, data layouts, portals, confidentiality expectations, complaint coding, and follow-up request formats can create operational challenges through manual work, separate quality-control processes, and longer timeframes to respond. The NAIC could consider publishing consistency notes, FAQs, examples, or cross-state interpretation guidance that insurers can rely on when designing compliance programs, and/or consider leveraging the DFA standards, DFA data definitions, and DFA Style Guide to standardize data. This could help create a more efficient communication and data transmission process across the industry for market conduct requests across multiple states.

For multi-state examinations, IRI members support a coordinated one-ask framework: a single lead state, coordinated request list, data specification, production calendar, and response repository, with participating states avoiding separate follow-up requests. The lead-state model currently used in multi-state examinations is broadly viewed as an appropriate structure. Standardization should cover exam request templates, complaint coding definitions, MCAS data definitions, production file layouts, certification language, confidentiality markings, due-date calculations, and remediation plan templates. Such

standardization would then make it easier to achieve uniform examiner training and more consistent use of the Market Regulation Handbook. Regulators should also receive feedback from industry throughout any rollout of a revamped multi-state exam framework to ensure both regulator and insurer obligations are met and so both parties are clear on expectations and receive the information needed for a successful exam.

Insurers generally already remediate issues identified in one state on a broader basis; regulators can reinforce this by recognizing voluntary self-remediation and treating timely proactive remediation as a mitigating factor.

4. Other Entity Oversight

Insurers can generally provide governance frameworks, model or tool inventories, due diligence summaries, monitoring reports, validation summaries, policies and procedures, contract forms, licensure information, administration statistics and escalation records. Materials that are more burdensome or infeasible to provide include vendor proprietary information, source code, trade secrets, third-party confidential data, large data requests from across multiple third-party administrators, and model architecture not owned by the insurer. Regulators should focus on the insurer's governance, oversight, and controls, particularly where a risk-based model of oversight is employed and audits are routinely conducted, rather than requiring unrestricted access to vendor proprietary materials and should define minimum documentation expectations, such as allowing summaries or attestations where detailed documentation is unavailable, while recognizing contractual and confidentiality limits. The primary practical challenge is turnaround time; proactive communication about data sources and realistic production timelines can lead to workable outcomes. IRI members would also encourage removal of the requirement for onsite third-party administrator audits/examinations for those states that may still require it, as technology has made remote examinations practical and more efficient.

5. Corrective Actions, Communications & Enforcement

A tiered corrective action framework could begin with informal clarification or written feedback for minor technical or isolated issues and escalate proportionally, through corrective action plans, targeted remediation, enhanced monitoring, and formal enforcement, based on severity, recurrence, consumer harm, and the insurer's response. Greater transparency into what statutes/regulations/interpretations are relied upon and how fines are calculated would help insurers understand regulator concern and focus, evaluate internal risk and scope remediation appropriately.

Inconsistent treatment of self-reporting and fines was also a significant concern raised by our members. Regulators routinely encourage self-reporting, but the practical experience does

not always match the rhetoric as companies that self-report can face fines and remediation requirements that companies resolving issues internally avoid. This undermines the incentive for proactive disclosure. Greater consistency around treatment of proactive remediation and corrective action and cooperation as mitigating factors in enforcement proceedings would be helpful for our members. Additionally, verification artifacts for completed remediation can include before-and-after metrics, audit trails, revised procedures, training records, system-change evidence, quality-control reports, consumer communications where applicable, and evidence of sustained post-remediation improvement. Greater latitude on remediation timetables would likewise be helpful, as some findings cannot be remediated until a final consent order is received, and certain states impose a very short timeline after receipt within which to remediate. A rolling remediation schedule when/where appropriate with routine updates provided to regulators would also be something industry would support.

6. Consumer Complaints

Overall, our members reported that more alignment around complaint coding, closure notifications, standardized categories, regulator review and response timeframes would be helpful. Standardization of complaint coding definitions was consistently mentioned as a priority recommendation. Uniform definitions, examples, and coding criteria would be helpful for the following: confirmed, not confirmed, justified, unjustified, resolved, closed, complaint reason, disposition, line of business, allegation category, complainant (whether by Annuitant/Owner/Complainant), state (whether by issue state/complaint submission state, resident state, or state with regulatory jurisdiction) and company error. Further, standardization of complaint log formats would facilitate reporting and analysis of complaint data for regulators and insurers. Some states also classify lost policy inquiries as complaints, which can artificially inflate complaint counts where no service failure or consumer harm is alleged; this is an issue that should be addressed in any uniform coding standard. Also, many states do not inform companies which complaints have been confirmed, and no explanation is provided when a determination is made. The absence of feedback on confirmed complaint determinations limits companies' ability to understand the regulatory standard and design processes to meet it.

Response timeline inconsistency is one of the more operationally burdensome aspects of the current complaint framework, with deadlines ranging from seven days in some states to three weeks in others. Short deadlines force resource reallocation that increases the risk of incomplete responses. Our members recommend standardized response periods across states, with a standardized extension request process. This includes standardization around when the complaint response clock starts and the calculation of uniform response timeframes using either business or calendar days, but not both. The requirement of whether

and when an acknowledgment letter is needed should also be standardized, if one is required at all.

Documentation requirements should also be proportionate to the complaint and should only request what is necessary to facilitate a specific complaint's resolution. Enclosure page limits and portal upload limitations should be addressed and communicated, and more standardization across portals would be helpful. For example, status visibility with confirmation status, closure notifications, secure document exchange, due date tracking, and downloadable records with receipt confirmation would meaningfully reduce operational burden, rather than providing access only to a sole individual within the company. Portal access also should accommodate team sign-on credentials and email-based verification; individual employee cell phone registration requirements create operational and privacy challenges. Further, there should be self-service capabilities for insurers with portals, as requiring state administrators to add or remove access leads to delays. It is important, however, to ensure that any standardization across state portals appropriately includes uniform confidentiality standards addressing privileged material, trade secrets, proprietary business information, and consumer personal data.

In conclusion, IRI recommends that the Working Group focus on three themes across all the topics:

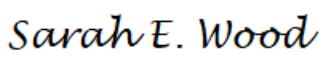
1. **Standardization.** Uniform national definitions, templates, data definitions and standard style guides, and response time requirements across market conduct data, examinations, complaints, and multi-state requests. Definitions and consistency are the foundational priorities. State adoption, however, is the key challenge and the Working Group should develop a concrete strategy for driving this.

2. **Consistency.** Predictable timelines, complaint handling requirements, examination procedures, and corrective action frameworks, including consistent self-reporting principles, uniform complaint response deadlines, standardized portal requirements, and published examiner training and consistency notes. Equally important is consistency in how data itself is defined, formatted, and exchanged: when data elements share standardized definitions, layouts, and transmission specifications across the industry, regulators can obtain the data they want more easily and more quickly, and insurers can respond through a single, repeatable process rather than building bespoke, state-by-state extracts for each request.

3. **Transparency.** Visibility into complaint coding and confirmation status, validation logic, examination reasoning, and fine calculation, supporting faster remediation, reducing unnecessary burden, and building constructive regulatory relationships that produce better consumer outcomes.

Cutting across all three priorities is the need to align regulations and examination standards with modern digital processes. Clear guidance recognizing electronic delivery, digital transmission of data and digital record-keeping as fully compliant with existing requirements (combined with targeted updates where express statutory language requires physical delivery) would deliver immediate efficiency gains and strengthen consumer protection. IRI and its members appreciate the Working Group's efforts and look forward to continued engagement. Please do not hesitate to reach out with any questions or if there is anything else with which we can assist.

Sincerely,



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July 13, 2026

Direct Gillespie (IL), Chair
Director Nelson (MO), Vice Chair
NAIC Market Conduct Regulation Modernization (D) Working Group
c/o Tim Mullen, Director, Market Regulation
Via email tmullen@naic.org

Re: Industry Discussion Questions 5.8.26

Dear Director Gillespie, Director Nelson and Members of the Working Group:

On behalf of our members, the National Association of Mutual Insurance Companies (NAMIC), thank you for the opportunity to respond to the Working Group's Industry Discussion Questions. NAMIC appreciates the time and thought invested in this effort, and the recognition of need for modernization. The attached responses reflect the collective, on-the-ground experience of our members operating across the nation and we offer our comments in that constructive spirit.

Of all of the themes in our response, none matters more than the need for consistency and uniformity across jurisdictions. The absence of common standards for data definitions, examination procedures, pattern and practice determinations, and corrective action frameworks imposes material operational burden with no corresponding regulatory or consumer benefit. Carriers operating in multiple states cannot build efficient compliance programs when each state applies its own interpretation to nominally identical standards. This Working Group has a rare opportunity to establish uniformity, reducing friction and cost for carriers while giving regulators cleaner, more comparable data.

Modernization of standards must be paired with modernization of infrastructure. The NAIC's current technology, including its complaint portals, data submission systems, and examination coordination tools, lags behind what carriers experience from commercial vendors in other parts of their business. That contrast is stark and creates avoidable friction for all involved. System modernization for regulators' and carriers alike will improve the process immensely. The system updates for regulators will help facilitate interstate collaboration.

Meaningful modernization requires better communication among regulators across jurisdictions, not just better tools and standards. Carriers today can receive conflicting guidance from two states on the same compliance question, or be examined simultaneously by multiple states on the same subject matter with little coordination between them. The NAIC is uniquely positioned to facilitate structured, ongoing dialogue among jurisdictions, not only at national meetings, but as a standing function of the market conduct regulatory framework. Industry strongly encourages the Working Group to build improved inter-jurisdictional communication mechanisms into any framework it recommends.

NAMIC remains committed to active engagement throughout the Working Group's process. The attached responses are a starting point, and our members stand ready for further dialogue as this work progresses. We are confident that, with sustained collaboration between regulators and industry, this Working Group can produce meaningful reform that strengthens both consumer protection and the efficient functioning of the insurance market.

Sincerely,

Erica Weyhenmeyer

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Senior Policy Vice President, Market Regulation & Workers' Compensation

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Draft: May 5, 2026

Market Conduct Modernization – Industry Discussion Document

Purpose

This document is designed to guide the insurance industry in providing structured, substantive feedback for the Market Conduct Regulation Modernization Working Group Discussion. Questions are grouped into five categories:

1. Market Conduct Data (Collection & Analysis)
2. Interstate Collaboration
3. Examination Handbook & Processes
4. Other Entity Oversight (Third-Party Oversight)
5. Consumer Complaints

A final list of general discussion questions is included for miscellaneous, rapid-input items.

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1. Market Conduct Data (Collection & Analysis)

Data Standards, Definitions & Transport

1. Are there data standards (e.g., API specifications, common data models, standardized layouts) that industry would adopt uniformly to reduce rework across states?
    - Yes. Industry supports standardized data layouts aligned with existing MCAS framework- a common data model with clear field definitions that lets carriers build once and report to all states.
        - Reliance on MCAS data for actual outliers before calling exams.
            - Training opportunity.
2. Which specific data fields or definitions currently create the most friction, inconsistency, or manual work?
    - The most problematic are claim closure reason codes (states define “closed without payment”, “denied”, and “withdrawn” differently), complaint confirmation status, and MCAS date distinctions between effective, expiration, and written dates. Litigated file counts are manual pulls. Standardizing these areas would yield significant efficiency gains.
3. Are there MCAS-related or market-conduct-related data elements needing clearer definitions to ensure uniform reporting?
    - Yes. “Denial rate” is counted at the claim level by some carriers and the coverage level by others; “timeliness” clocks start at different trigger event depending on the state. The NAIC could publish a MCAS data dictionary with plan-language definitions and FAQs that all states agree to apply uniformly. And encourage the use of the same language in definitions in the exam process.
        - Data requests do not match MCAS causing questions and appearance of discrepancy.

Systems, Feasibility & Legacy Constraints

4. What changes to your internal systems (policy administration, claims, complaints, reporting) would modernization require—and what are realistic implementation timeframes?
    - Most carriers will need new data extraction queries, and validation logic- and many run legacy systems that cannot produce structured extracts without custom development. A realistic timeline is 36 months from final specification adoption, with an industry comment period and parallel testing phase built in, and accommodations for smaller carriers. -Uniformity of data asks across states would help here.

Data Quality, Validation & Minimization

5. What data quality checks are insurers performing currently prior to submission, and where is regulator-provided validation logic necessary?
    - Carriers currently run completeness checks, range validation, and year-over-year variance analysis, but without knowing regulators' specific thresholds, pre-screening is limited. The NAIC should publish validation rules and provide a sandbox environment where carriers can test submissions before official reporting cycles- this would materially reduce submission errors.
6. Which data elements are unnecessary for modernized market conduct oversight and could be removed without sacrificing predictiveness?
    - Industry recommends a formal data minimization review benchmarked against demonstrated regulatory use. Duplicative line-of-business breakdowns already captured in statutory financial filings, granular sub-line codes with no exam trigger function, and legacy fields designed for paper-based review are strong candidates for elimination.

<u>Market Conduct Data (Collection & Analysis)</u>

In addition to the questions already asked, are there any other issues or aspects of the scope of work that you believe are important for the working group to consider?

- Data Security and transmission standards for sensitive fields.
- A reduction on states layering supplement data mandates on top of any uniform national standard
- A process for ongoing data dictionary maintenance as products and market evolve.

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2. Examination Handbook & Processes

Pre-Exam Expectations & Feasibility

1. What standardized pre-exam data sets or dashboards could your organization produce within 10 business days?
    - Within 10 business days, most carriers can produce aggregate claim counts by line, open/closed claim inventories, complaint logs by NAIC code, policy counts and premium summaries. These should become the standard Tier 1 pre-exam data set, with deeper file-level sampling coordinated during the exam itself.
2. Which items require longer lead times due to system complexity or third-party involvement?
    - File-level extracts from legacy claim systems, complete correspondence logs stored in separate imaging systems, TPA and vendor data, and statistical sampling frames with associated policy documents typically require 30-60 days. Examiners should build these timelines into exam scheduling from the outset.
3. What standardized data extracts (policy files, claims inventories, complaint logs) are currently feasible within 10 business days?
    - See Q1. The working group can develop a formal two-tier pre-exam data kit- Tier 1 available within 10 days, Tier 2 within 30-60 days, so exam scheduling proceeds against a known, predictable sequence rather than ad hoc requests that vary by examiner and state.

Risk Identification & Targeting

4. Which indicators—complaint trends, claim cycle times, denial rates, communication failures—best predict conduct-related risk from the insurer perspective?
    - The more predictive indicators are rising complaint ratios relative to premium volume and industry peers, increasing average time- to-close on first-party property claims, and significant unexplained year-over-year changes in denial rates. Regulators should weight these against industry benchmarks, not just a company's own prior year, to account for market-wide trends.
5. How could regulators tailor exam scope using shared risk models so low-risk entities or topics experience lighter exams while higher-risk entities or areas undergo deeper reviews?
    - Industry supports explicit low-risk corridors exempting companies meeting defined benchmarks from full-scope exams on a rotating basis, targeted/limited-scope exams as the default for first-time examinations, and a published MCAS-driven targeting algorithm so carriers understand how selection occurs. Remove examinations should be a default for low-risk entities.

Exam Operations, Tools & Burden Reduction

6. Which examination practices create unnecessary burden, and what alternatives would maintain regulatory goals while improving efficiency?

- The biggest burden sources are broad population-level document requests when sampling would suffice, simultaneous uncoordinated multi-state exams on the same subject, open-ended timeframes with no completion deadline, an mid-exam examiner turnover, duplicative requests, disconnect between external examiners and state exam expectations. Uniform sampling protocols in the Handbook and a coordinated exam calendar would help address these.

7. Are insurers experiencing consistency amongst regulators in the use or interpretation of the *Market Regulation Handbook*?
    - No- inconsistency in Handbook interpretation is one the most persistent industry complaints. Examiners in different state apply different sampling error thresholds and reach different violation conclusions on identical fact patterns. The NAIC should publish interpretation guidance and FAQs for the most contested provisions, and establish a formal process for industry to raise Handbook interpretation questions.

8. I have heard frequently that insurers would like greater transparency into the reasoning or justification behind the examination. Why would that be helpful to an insurer?
    - Knowing the specific risk indicator or complaint pattern that prompted an exam allows carriers to direct resources appropriately and, where warranted, challenge scope that is not supported by the identified indicator. Exam notice letters should include a plan statement of the primary trigger, this also creates accountability for regulators to document their targeting decisions.

9. Which collaboration tools or secure data rooms would industry support for remote data exchange, tracked interrogatories, and version-controlled document sharing?
    - With increased focus on data security, it is becoming more difficult to share data electronically. A single NAIC standard that has the appropriate SOC 1 reports that would verify to companies that there are adequate controls in place to allow for data sharing would be helpful.
    - All contractors should be held to the same confidentiality standards as regulators when handling sensitive company information, including after they leave their role. They should also be required to sign individual confidentiality agreements with the companies involved.

10. Are there common vendor platforms or tools the industry would be willing to adopt and utilize to reduce duplicative custom work? I have heard of platforms like Neota that have been used by some companies and states to experiment with.
    - No, actually to the contrary, companies have concerns around the use of vendors/contractors (see comments above).

Examination Handbook & Processes

In addition to the questions already asked, are there any other issues or aspects of the scope of work that you believe are important for the working group to consider?

3. Interstate Collaboration

Definitions, Expectations & Uniformity

1. What variations across states create the largest operational challenges—definitions, timelines, file formats, expectations?

Dimension	Example differences (state references)	Trade-friendly emphasis
Definition & scope	Some states define comprehensive vs. targeted exams in statute (e.g., Rhode Island distinguishing comprehensive vs targeted). Increased number of states labeling all inquiries data calls but include interrogatories etc.	Push for clear statutory scopes so carriers know when limited, desk-based reviews will be used.
Market analysis vs exams	Certain statutes explicitly distinguish market analysis from examinations and define "market conduct actions."	Favor states that require analysis first and use exams only when data justify deeper review.
Reliance on other states	Some laws permit accepting another state's exam report in lieu of a new exam (e.g., Florida's allowance to rely on other states' examinations).	Encourage broader adoption of cross-state reliance to avoid duplicative exams for multi-state carriers.
Triggers and frequency	Statutes may set special triggers (e.g., Florida's post-hurricane exam criteria for property insurers).	Seek clear, objective triggers and limits on exam frequency, tied to data and events, not ad hoc decisions.
Process rights and reports	States vary on requirements to provide draft exam reports, hearing rights, and timelines before making findings public (e.g., Illinois' process for notice, hearing, and orders).	Advocate for uniform notice, comment, and appeal rights before exam reports become public.
Penalties & self-reporting	Some states explicitly instruct commissioners to consider self-assessment, self-reporting, and remediation when levying fines (e.g., Washington).	Support statutory recognition that self-reporting and robust compliance programs mitigate penalties.
Desk vs on-site exams	Certain statutes define desk vs on-site targeted exams and distinguish them from comprehensive reviews (e.g., Rhode Island).	Prefer statutes that permit desk exams and remote work where risk is narrow or data volumes manageable.

Other differences that matter include whether TPA/vendor operations are explicitly within exam scope, how confidentiality and public records treatment are handled are exam workpapers, and whether multi-state coordination is expected or optional.

Nationwide adoption of a consistent model.

2. Where do statutory or handbook interpretations diverge the most today, and how could consistency notes be published for industry to rely on?

- Divergence in the definition of a "pattern and practice" of unfair claims practices.
- Members are seeing a growing number of states are citing single/low number examination findings as a "pattern and practice" of unfair claims settlement practices- bypassing any frequency-based analysis entirely. The Unfair Claims

Settlement Practices Act and its state counterparts require conduct committed "with such frequency as to indicate a general business practice." Frequency is not an optional element; a single finding cannot establish it.

The Market Regulation Handbook's 7% and 10% benchmark error rates exist precisely because some meaningful volume errors must be present before a pattern and practice finding is warranted. Labeling one instance of noncompliance a systemic violation conflates human error, which no compliance program can eliminate entirely, with repeated misconduct the statue is designed to address.

"One-Ask" Principles & Simplification

3. How can processes be designed so insurers answer once for all states (shared templates, standard definitions, uniform due dates)?
    - Shared templates, uniform response deadlines, and standard date layouts for individual and multi-state work, managed through a designated lead state.

4. What templates, definitions, or filing expectations should be standardized across jurisdictions to reduce manual rework?

    - The MC Guidelines WG has had a charge to create templates for standard documents, call letters, criticism documents, report layouts and explanations would create an ease for state to state review of findings and accuracy of the actual finding rather than repeating the specific statutory citation. Others include, pre-exam data request template, interrogatory questions banks by line of business, claim file review checklists, remediation plan formats

5. How can insurers be encouraged or incentivized to remediate problems identified by one state to other states the insurer operates in?

    - Voluntary self reporting remediation credit: where a carrier proactively identifies, correct, and notifies all affected state regulators of a system-wide issue, that action should be a meaningful mitigating factor in any subsequent penalty assessment.
    - Suggest that when a carrier agrees on corrective action with one state, there be a structured, non-punitive path to extend that fix to other states via notice rather than duplicative enforcement.

Pilot Strategy

5. Which lines of business could be ideal to pilot or launch modernization initiatives (based on readiness, data availability, volume, diversity)?

6. What success metrics should be used to evaluate effectiveness?

<u>Interstate Collaboration</u>

In addition to the questions already asked, are there any other issues or aspects of the scope of work that you believe are important for the working group to consider?

- Multistate Examination Approach-
    - Multistate examinations exist for a specific reason- to address a common,

identified issue affecting an insurer's operations across multiple jurisdictions in a single, coordinated process, eliminating duplicative demands, reducing carrier burden, and ensuring consistent findings on matters that are genuinely national in scope. When used as intended, they are one of most efficient tools available to regulators and one of the least burdensome for carriers. The problem arises when the multi-state process is invoked without a true common issue at its core- used instead as a mechanism to amplify state-specific concerns, expand exam scope beyond what a single state could justify independently, or pressure carriers through sheer volume of participating regulators. This misuse defeats the entire purpose of the framework. Rather than producing consistency, it produces a lowest-common-denominator result where the broadest interpretation of every participating state's law governs, and the carrier loses the benefit of the state-specific regulatory relationship and nuanced compliance history that a single-state examination would preserve. NAMIC suggests the working group establish clear criteria for when multi-state exam invocation is appropriate- grounded in evidence of common systemic issue, not convenience or coordination for its own sake- and to require that the scope of any multi-state exam be limited to that identified common issue through application of common statutory authority.

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4. Other Entity Oversight

Documentation & Transparency

1. What documentation (model cards, monitoring reports, validation materials) can insurers realistically provide during market-conduct reviews?
    - Insurers can provide vendor contracts specifying the scope of delegated functions, oversight policies and procedures, vendor performance scorecards, summary-level model validation reports (without proprietary model specifications), and audit results. Internal governance documents describing escalation procedures for underperforming vendors are also producible.
2. What materials would be burdensome or infeasible without additional regulatory guidance?
    - Requiring production of third-party vendors' proprietary model specifications, source code, or trade secret documentation is infeasible, these are contractually protected and often outside the carrier's legal right to disclose.

Vendor and Model Governance

3. How do you supervise third-party models and data sources today, and what standard artifacts could vendors reasonably provide to regulators?
    - Industry uses contractual audit rights, model validation reviews, performance monitoring, and escalation procedures for identified model drift.
4. What challenges arise when third-party vendors operate models or provide data used in underwriting, claims, or consumer interactions?

- Challenges may arise when regulators demand documentation that reveals proprietary model architecture. AI/ML explainability standards are also still evolving.

Regulatory Expectations & Accountability

5. How could regulators streamline expectations to ensure accountability while recognizing vendor constraints?
    - Recommend a clear allocation framework: insurers accountable for outcomes and governance; vendors accountable for providing standardize documentation to insurers, which can then be summarized for regulators.

Other Entity Oversight

In addition to the questions already asked, are there any other issues or aspects of the scope of work that you believe are important for the working group to consider?

- Clear guidance on which third-party functions are subject to market conduct examinations versus financial examinations.
- Establishing communication pathways for third parties with Department in a confidential manner.
- A safe harbor for carrier that exercised documented reasonable oversight of a vendor which conduct later proves problematic
- Coordination with state privacy and data security regulations to avoid conflicting mandates.
- Third Party Vendor Oversight- Trade Secret and Contractual Limits
    - As regulators increasingly seek access to the underlying models, algorithms, and data sources that carriers use through third-party technology vendors, industry cautions against approaches that pressure vendors to disclose legitimately proprietary information as a condition of carrier compliance. These vendors, many of whom develop tools for broad commercial markets well beyond insurance- are not obligated to expose core intellectual property that forms the basis of their business simply because one of their customers operates in a regulated industry. Carriers have contractual audit rights, but those rights have limits; compelling disclosure beyond what the contract permits puts carriers in an impossible position and risks destroying the vendor relationship entirely. That is not a theoretical concern — technology vendors who face regulatory demands for trade secret disclosure have little incentive to continue serving the insurance market when easier, less encumbered customers exist elsewhere. The insurance industry benefits enormously from access to these vendors: they bring sophisticated data science, predictive analytics, and automation capabilities that improve underwriting accuracy, accelerate claims handling, and ultimately benefit consumers. Driving them out of the market by making insurance an unattractive regulatory environment would set back the industry's technological capabilities significantly. Industry asks the working group to

develop an oversight framework focused on outcomes — model performance, disparity metrics, error rates — rather than one that demands disclosure of proprietary architecture, and to establish a clear safe harbor for carriers that have exercised reasonable contractual oversight of a vendor whose internal documentation remains legitimately protected.

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5. Corrective Actions, Communications & Enforcement

Proportionality & Predictability

1. What tiered corrective actions (warnings, remediation plans, restitution) are predictable and proportionate for common findings?
    - Published corrective action matrix:
        - Tier 1 (isolated/technical violations)- corrective action letter, no fine.
        - Tier 2 (systematic but self-corrected)- remediation plan and reduced fine.
        - Tier 3 (systematic with consumer harm)- fine, remediation, consent order.
        - Tier 4 (willful or repeated)- elevated fine, enhanced monitoring, and possible consent order.
    - Fines should be calibrated to severity and consumer impact.

2. I have been told an industry frustration is inconsistency amongst states in terms of their approaches on self-reporting and fines generally. Is this an industry concern?

    - Yes, significant source of industry frustration. Where self-reporting generated no credit or triggers expanded exam scope, carrier face a perverse incentive not to disclose problems proactively. Fine amount for identical violation vary by orders of magnitude across states, with no rational compliance signal.

        - In any case of self-reporting- where a fix was implemented and consumers were repaired/refunded- but the state still issues a fine.

Timelines & Feasibility

2. What realistic timelines (30/60/90 days) can insurers commit to for specific fixes (policy language changes, claims workflow updates)?
    - We are not sure there is a realistic timeframe that companies can consistently commit to without first assessing the dependencies involved. For example, if a system fix is required, it must be developed, tested, and scheduled for release. Some systems only have one or two release cycles per year, particularly those in runoff, which can significantly extend implementation timelines. Another example is when the policy language accurately reflects the intended coverage, but the policy form was filed incorrectly. In that case, the form must still be filed for approval, and the company has no control over how long the state takes to review or approve the filing. In the meantime, the unfiled policy language must continue to be used. That said, similar to financial examination requests, timelines may be more manageable if regulators are willing to accept extension requests or progress update reports, or partial responses, until the full fix is implemented.

- Truly depends on the issue and needed work to repair.
- At conclusion of the exam, it may be beneficial to provide a remediation plan that includes a timeline.

Verification & Consumer Impact

3. Which artifacts best demonstrate that remediation worked (before/after metrics, audit trails, consumer communications)?
    - It depends on the underlying issue. For example, if premium was overcharged, evidence that the consumer was made whole (either with a credit to owed premium, or payment to the insured).

4. What metrics or narrative reporting could insurers produce to show improved consumer outcomes after remediation is completed?
    - Post-remediation reporting should have a defined endpoint.
    - Not all remediation leads to improved consumer outcomes.

<u>Correction Actions, Communications & Enforcement</u>

In addition to the questions already asked, are there any other issues or aspects of the scope of work that you believe are important for the working group to consider?

- Right to cure for first-time, non-willful, non-harm causing violations before any fine is assessed.
- A uniform statute of limitations on how far back examiners can reach- consider record retention laws.
- Double jeopardy protection- being fined in multiple states for the same conduct during the same examination period.
- Should commercial insurance be treated differently than personal insurance?

Consumer Complaints

Transparency Into Complaint Coding

1. How does the lack of visibility into whether a complaint is coded as *confirmed* or *not confirmed* affect your ability to conduct root-cause analysis and implement corrective action?
    - Without knowing how a state coded a complaint, confirmed or not confirmed, carrier cannot determine whether the state found a genuine violation or simply processed an inquiry. That gap makes it impossible to distinguish systematic issues that need corrective action from complaint that were resolved without a finding.
    - The NAIC complaint index includes all complaints confirmed and not confirmed, given an inaccurate view of the insurer's practices.

2. What type of transparency or feedback loop would help you understand how states determine confirmation status?
    - At minimum, carrier should receive written notice of the confirmation status and the specific basis for it when a complaint is closed, including the regulatory provision the state found was violated, if confirmed. A structured feedback template standardized across

states, delivered within a defined number of data after closure, would allow carrier to build consistent internal tracking and root-cause systems.

3. What definitions, examples, or coding criteria should be standardized across states to reduce variation?
    - Definitions for "confirmed complaint", "not confirmed complaint", and "inquiry", along with a standardized classification code set for complaint type and subject matter would be helpful. Worked examples applying these definitions to common fact patterns, similar to how the market regulation handbook uses example to illustrate standard, would significantly reduce coder-to-coder and state-to-state variations.

State-to-State Variability

4. What discrepancies among states—such as coding logic, investigation standards, timelines, or documentation requirements—create the greatest operational challenges for your teams?
    - For the most part, we don't have transparency into coding logic, investigation standards or documentation requirements
    - Availability of extensions
    - Differences in complaint submission timelines across states, including some requiring 7 days and others allowing 21 business days

5. Which aspects of complaint handling are most in need of national alignment to ensure consistent expectations and reporting?
    - Clear contact information and procedures for follow-up questions and extension requests, which should include confirmations or denials from the state
    - Closure notices to confirm or dispute the coding logic prior to reporting

Complaint Portals, Submission Processes & Tracking

6. How does the absence of a uniform complaint portal across states impact your ability to organize, coordinate, and respond to complaints?
    - Managing complaints across 50+ state portal systems, with different formats, login credentials, document upload requirements, and communication logs- requires significant administrative infrastructure that has nothing to do with resolving consumer issues.

7. What minimum portal features (status visibility, communication logs, document exchange, audit trail) would meaningfully improve your complaint-handling operations?
    - Larger file size limits (50 gigabytes per document)
    - Status visibility – clear visibility of the phase of complaint (Open, closed, withdrawn)
    - Communication logs – permit visibility to examiner responses on follow-up requests as well as extension requests
    - Document exchange – ability to label document type, consistently across portals/states (similar to California and the Georgia Portal)
    - Single sign-on at group level, to avoid individual log-ins per company
    - Lack of uniform portal makes it difficult to follow the complaint history/timeline among several states

8. What challenges do you encounter when trying to determine whether a complaint remains open or has been closed, given current state systems?
    - Many state systems do not push status updates to carriers, carriers must log in and

manually check for changes, often across multiple portals with inconsistent interfaces. A closing letter with the justification and coding would help resolve this issue.

Reconciliation Processes

9. In states that offer a reconciliation or correction process, what elements are most valuable (e.g., dispute correction, clarification opportunities)?
    - Ability to dispute the DOI's determination of a "Confirmed" complaint.
    - Ability to clarify/correct coding (writing company and line of business).

10. What would a functional and fair *national* reconciliation framework look like, and what process steps or timelines should it include?
    - As an alternative to an onerous annual or quarterly process, a reconciliation done via closure notice for "confirmed" complaints, giving the company the opportunity to dispute or validate coding in real time
    - If the above is not an option, the reconciliation should be quarterly and should focus on "confirmed" complaints.
    - Reliance on facts rather than subjective interpretation of statutes- reflecting inconsistent application.

11. What kinds of coding errors or discrepancies most frequently need correction from your perspective?
    - Status as a "confirmed" complaint, Writing Company, and Line of Business

Industry Engagement & Collaboration on Coding

12. What opportunities for joint engagement with regulators—such as training sessions, calibration workshops, or a shared coding guide—would improve accuracy and fairness in complaint categorization?
    - Training sessions and shared coding guides would be helpful.

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13. How frequently should regulators and insurers collaborate or recalibrate on complaint coding to ensure alignment across the states?
    - Annually, or more frequently if updates are made to the complaint codes.

Confidentiality & Records Handling

14. How do differing confidentiality standards among states affect your ability to provide complete, candid responses and share internal information appropriately?
    - Attorney client privilege protections should be available across all states, along with safeguards for business secrets and proprietary business information. It is necessary to provide timely responses when complete claim files are requested.

15. What uniform confidentiality protections would help balance consumer privacy with insurer transparency and operational clarity?
    - A uniform standard should protect all carrier-produced documents and internal communications in complaint files from public records disclosure while the complaint is open and for a defined period after closure, with narrow exceptions for confirmed violation

referrals to law enforcement. Cosumer-identifying information should remain protected indefinitely consistent with applicable privacy law.

16. What guidance or clarification do you need regarding how complaint files are treated under public records laws to reduce uncertainty and risk?
    - The lack of pertinent information such as policy number and/or claim number makes it difficult to identify and respond to complaints.

Consumer Complaints

In addition to the questions already asked, are there any other issues or aspects of the scope of work that you believe are important for the working group to consider?

- Training issue with complaints handling staff- attempting to extend their scope of work into market conduct examination process where company information is not protected.
    - Once the handler deviates from core complaint issue there is a pass through expansion of documentation and the sharing of that information to the consumer and in some cases their attorney.

General Discussion Questions (5 Minutes)

- What **one modernization change** would deliver the greatest efficiency gain—and why?
    - Uniform pre-exam data templates adopted by all states. This single change eliminates the majority of pre-exam preparation burden, which today involves customizing data production to dozens of different state formats for the same underlying data.
- What would make industry participation easier (templates, sandboxes, test data, checklists)?
    - A sandbox environment where carriers can test submissions before official reporting cycles, standardized interrogatory question banks by line of business published in advance, and checklists tied to the market regulation handbook chapters most commonly at issue.
- Where do you need regulator decisions first (definitions, file specifications, timelines)?
    - On definitions- complaint confirmation status, denial rate calculation methodology, and the definition of “pattern and practice”. Without those anchors, all other modernization work will produce inconsistent results.
- What requirement could be simplified tomorrow with no reduction in consumer protection?
    - Requiring a single lead-state data request binding all participating states in a multi-state exam.
- What is the **biggest technical blocker** from the insurer side for modernization?
    - Size and momentum. -Very difficult for carriers to shut down and retool/modernize/change.
- Is there one area of training for examination staff states should focus their efforts on first?
    - Consistent application of the Market Regulation Handbook sampling protocols and error tolerance standards- examiner to examiner variation in how sampling errors are counted is one of the most significant drivers of exam unpredictability.

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July 10, 2026

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Re: Request for Comments Industry Discussion Questions (5.8.26)

Thank you for the opportunity to provide comments on the draft Industry Discussion Questions (5.8.26) developed by the NAIC Market Conduct Regulation Modernization (D) Working Group.

Introduction

To best understand our perspective, please note that Insurance Services Office, Inc. (ISO), a subsidiary of Verisk Analytics (Verisk), is licensed as an advisory, rating, and/or rate service organization under the appropriate section of individual state insurance codes.

Verisk, through its subsidiaries and affiliates, supports the insurance industry by providing information, including statistics, underwriting and claims information, fraud solutions, actuarial analyses, policy language, catastrophe models, and consulting and technical services in connection with multiple lines of property & casualty insurance, as well as information about specific properties. Our customers include insurers and reinsurers, as well as agents, brokers, self-insureds, risk managers, financial services firms, regulators, and various government agencies.

Market Conduct Data (Collection & Analysis)

From our perspective as an advisory, rating, and/or rate service organization, the most impactful modernization opportunities center on standardization, streamlined access, and minimizing similar and/or overlapping data requests. Varying definitions and data field requirements are a primary source of friction and manual effort today. Modernization efforts could benefit from greater visibility into information already available through existing regulatory reporting

channels and prior submissions. In addition, a consistent, industry-wide approach to data standards, definitions, and transport mechanisms is essential to improving regulatory insight. Technology-enabled data exchange tools such as ISO's Regulatory Data Exchange (RDeX) may help support market conduct data collection and analysis modernization efforts by allowing regulators to identify existing data sources (MCAS, Fast Track, ISO Statistical Data, etc.), reduce overlapping and/or similar requests, promote more consistent data call practices across jurisdictions by referencing the glossary of data definitions and inventory of requested regulatory data elements provided in these tools, and support more standardized data collection and analysis during the examination process.

Examination Handbook & Processes

We submit that data requests that may extend beyond materials specifically addressed in the applicable Handbook chapters should be clearly identified and accompanied by sufficient context regarding the purpose and need for the information requested for response. Initial data requests should allow at least 30 calendar days, particularly where requests are complex and require data aggregation across systems. Response timelines should take into account the scope of the request, relevant holidays and related operational constraints including the staffing resources needed to collect, validate, and submit responsive information. While some standardized extracts may be produced more quickly, large, multi-system data requests cannot reliably be completed within 10 business days.

To help streamline these examinations, including those that have spanned multiple years, greater clarity should be provided at the outset, including an introductory meeting to discuss the examination's scope, along with regulator expectations, objectives, and expected outputs, so that companies can prepare accordingly. Initial regulator requests should also align with standardized templates and definitions. To maximize efficiency, it is helpful to minimize iterative requests and requests requiring multiple versions of overlapping datasets. We submit that a more structured pre-exam data framework would significantly reduce exam duration and improve transparency. By providing such context and clarification about data requests issued during an examination, responses can be provided more efficiently and include more relevant information, potentially reducing the need for follow-up inquiries.

Consideration should be given to establishing periodic status updates and milestone communications during examinations to improve transparency regarding progress, outstanding items, and next steps.

In addition, greater transparency regarding consultant fees, when consultants are used by examiners in the course of the market conduct exam, including providing corresponding details within company invoices is requested. We submit that this would help companies better plan for examination-related costs and allocate resources appropriately.

With respect to collaboration tools to be used during an examination, given the confidential and/or proprietary nature of much of the information provided during an examination, it is essential that any system used for transmitting documentation utilizes rigorous security protocols and access controls to prevent any unauthorized dissemination of confidential information.

Interstate Collaboration

To maximize the efficiencies of multistate market conduct examinations, it is imperative that participating state regulators maintain a coordinated and consistent approach to examination requests and findings. Consider developing mechanisms to facilitate alignment across participating states and ensure that examination requests, findings, and recommendations reflect a unified regulatory approach, thereby reducing uncertainty, unnecessary delays, and avoiding conflicting expectations for companies. Also, the aforementioned regulatory data exchange tools may support such interstate collaboration.

Other Entity Oversight (Third-Party Oversight)

We also recommend carefully considering whether or to what degree to extend oversight third-party and non-regulated entities and develop express parameters for uniform communication throughout the insurance industry. We submit that the industry will benefit from additional guidance to promote consistent expectations, efficient information-sharing and greater clarity regarding third-party participation in regulated products. Updates to such oversight communications should establish distinct boundaries with respect to third-party and non-regulated entity inquiries and standardized expectations for third-party data. Such communications should also leverage reusable documentation to avoid repeated, individual insurer requests to vendors.

In addition, the working group should coordinate with the Third-Party Data and Models Working Group to reduce duplicative work and ensure market conduct modernization changes and third-party data and models framework development work together and complement one another.

Corrective Actions, Communications & Enforcement

While timely remediation is important, we encourage regulators to consider the practicality and feasibility of corrective action timelines. Appropriate timeframes for remediation efforts can vary significantly based on the scope and complexity of the required changes. Where remediation requires significant operational, technological, or organizational efforts, we encourage broader, more flexible timelines. Realistic implementation timelines would help companies devote their often-limited resources to develop lasting solutions while avoiding unintended adverse consequences.

General Discussion Questions

As a general overview, it is our perspective that cultivating greater transparency, consistency, and predictability throughout the examination process will improve efficiency and ultimately benefit consumers by supporting more timely, consistent, and targeted regulatory outcomes while allowing companies to remain focused on consumer service and compliance implementation. Additionally, with strong, uniform confidentiality standards upheld across all jurisdictions, regulators can more securely protect sensitive information provided during the examination process.

Conclusion

Again, thank you for the opportunity to comment on the draft Industry Discussion Questions (5.8.26). Please feel free to contact me should you require additional information concerning ISO's position relative to these matters.

Sincerely,

Laura L. Panesso, CPCU
VP, State Relations and Regulatory Reporting