MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

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Draft Pending Adoption

Draft: 8/18/26

Market Regulation and Consumer Affairs (D) Committee
Columbus, Ohio
August 14, 2026

The Market Regulation and Consumer Affairs (D) Committee met in Columbus, OH, Aug. 14, 2026. The following Committee members participated: Ann Gillespie, Chair (IL); Angela L. Nelson, Vice Chair (MO); Heather Carpenter (AK); Charles Bassett (AZ); Jimmy Harris (AR); Dean L. Cameron (ID); Holly W. Lambert (IN); Sharon P. Clark (KY); Ned Gaines (NV); D.J. Bettencourt represented by Keith Nyhan (NH); Michael Humphreys represented by David Buono (PA); and Erin K. Hunter (WV). Also participating were: Brett Bache and Matthew Gendron (RI); Mary Block (VT); Joylynn Fix (WV); and Bryan Stevens (WY).

1. Adopted its July 27 Minutes

Director Gillespie said the Committee met on July 27. During that meeting, the Committee: 1) adopted its Spring National Meeting minutes (*see NAIC Proceedings – Spring 2026, Market Regulation and Consumer Affairs (D) Committee*); 2) adopted Chapter 21B—Conducting the Pet Insurance Examination for Inclusion in the *Market Regulation Handbook;* 3) accepted the referral of Pharmacy Benefit Manager (PBM) examination standards from the Pharmacy Benefit Management (D) Working Group to the Market Conduct Examination Guidelines (D) Working Group; and 4) adopted Market Conduct Annual Statement (MCAS) pet insurance blank revisions.

Director Nelson made a motion, seconded by Commissioner Clark, to adopt the Committee's July 27 minutes (Attachment One). The motion passed unanimously.

2. Received an Update on Market Conduct Regulation Modernization

Director Gillespie said the Market Conduct Regulation Modernization (D) Working Group met Aug. 13 and continued to receive strong feedback from Committee members. She thanked members for their participation and said the level of engagement has been phenomenal and is helping to inform the Working Group's draft recommendations. Director Gillespie reported that the Working Group completed its area-of-exploration session on third-party oversight.

Director Gillespie said the remaining areas of exploration are training and workforce development. These will be the subject of the Working Group's next two sessions, with additional, deeper discussions to follow as needed. The areas of exploration addressed to date include: NAIC market conduct data collection (April 22); NAIC market conduct analysis tools (April 30); a property/casualty (P/C) listening session (May 11); a health listening session (May 26); a life, insurtech, and specialty lines listening session (June 9); a consumer representatives listening session (July 7); interstate collaboration (July 21); the *Market Regulation Handbook* (Aug. 4); and third-party oversight (Summer National Meeting).

Director Gillespie said the goal is to have draft recommendations ready for public distribution ahead of the Fall National Meeting in November, when the Working Group and the Committee will consider the recommendations for adoption. She described the overall timeline as follows: 2026 will focus on listening, identifying issues, and framing where the work should go next; 2027 will be devoted to design work to determine the specific paths to pursue; and implementation is anticipated in late 2027 through 2028.

3. Received an Update on the Development of a Cybersecurity Incident Response Framework

Bache said the Cybersecurity Event Response Coordination Framework addresses an effort by state insurance regulators to develop a coordinated, multi-jurisdictional response to cybersecurity events involving regulated entities. He said the 2025 and 2026 NAIC leadership assigned the project as a high priority. Bache said the framework consists of six sections: 1) purpose, scope, and use of the framework; 2) evaluation and response process; 3) coordinating lead state selection; 4) coordinating lead state responsibilities; 5) a flow chart illustrating the proposed framework process; and 6) the

framework's relationship to other NAIC documents and projects, such as the Cybersecurity (H) Working Group's adopted Cybersecurity Event Response Plan (CERP) and the NAIC Cybersecurity Event Notification Portal.

Bache said a previous version of the draft framework was discussed before the Spring National Meeting during the Market Conduct Examination Guidelines (D) Working Group's March 12 meeting, where discussion centered on defining triggering thresholds and the complexities of identifying lead states. A revised draft was distributed May 14 and discussed during the Working Group's May 20 meeting, where discussion addressed the proposed process, assigning lead states, and whether to add language addressing a coordinated state insurance regulator response to multistate third-party vendor cybersecurity events. A comment due date of June 22 was announced and subsequently extended to July 24.

Bache said comments on the exposure draft were received from the California Department of Insurance (DOI), the New York State Department of Financial Services, the chair and vice chair of the Information Technology (IT) Examination (E) Working Group, the American Council of Life Insurers (ACLI), AHIP, the American Property Casualty Insurance Association (APCIA), the Blue Cross Blue Shield Association (BCBSA), and the National Association of Mutual Insurance Companies (NAMIC). The comments were posted to the Working Group web page and distributed to Working Group members, interested regulators, and interested parties on Aug. 5. Bache said the Working Group plans to meet after the Summer National Meeting to allow all comment authors to present their comments and discuss feedback received. Next steps will include proposing initial edits for issues where solutions to the submitted comments are readily evident, and identifying solutions to the larger issues raised, after which a revised framework document will be drafted and circulated for further discussion at a future Working Group meeting.

4. Heard a Presentation from the APCIA on Consumers' Use of AI for Complaints

Lisa Brown, Kristin Abbott (APCIA), and David Snyder (APCIA) presented a summary of an APCIA member survey on consumers' use of artificial intelligence (AI) in complaints and related communications. Brown emphasized that APCIA is not suggesting that complaints or other communications submitted with the assistance of AI should be dismissed or treated as invalid. Rather, the issue is the operational challenges that both companies and regulators face as AI-generated and AI-assisted communications become more prevalent. She said members first raised the issue in the prior year, and the concern has been increasing, and she framed the presentation as the beginning of an ongoing dialogue among regulators, industry, and consumer representatives.

Abbott walked through the survey results, which reflect aggregated, anonymized, and largely anecdotal observations from claims, legal, compliance, customer service, and complaint-handling teams across a diverse group of P/C companies. She said 86% of respondents reported at least some operational impact—approximately 43% describing significant impacts and 43% describing moderate impacts, while 14% reported minimal or no observable impact. AI-assisted activity was most frequently observed in claims disputes, total-loss valuations, regulatory complaints, settlement demands, appeals, and complaint rebuttals. Abbott said such communications tend to be longer, highly structured, and professionally written, often citing statutes, regulations, or case law—sometimes inaccurate, outdated, or out of jurisdiction—requiring additional review and verification, though some respondents noted AI can help consumers present concerns in a more organized and less emotional way.

Snyder suggested questions for future dialogue among regulators, industry, and consumer representatives, including whether regulators are seeing similar trends, whether current complaint-handling timelines remain appropriate, how to address repetitive follow-up submissions after an issue has been resolved, what qualifies as new information requiring a response, how AI agents should be authenticated and authorized, how to prevent fraudulent manipulation of consumer and service processes, what metrics should be tracked, and how to balance efficient resolution with consumer access to AI tools.

Director Nelson noted that the trend is not insurance-specific and is being observed across other state agencies and regulated industries. Commissioner Gaines described the challenge of tracking and responding to multiple follow-up

submissions on closed complaints when the complainants bypass the state complaint portals and send the complaint directly to the department or the governor's office. Commissioner Gaines and Commissioner Clark both said their departments post disclaimers on their website that the complainant must verify the accuracy of any AI-generated content. They noted that the AI-generated content often cites statutes or authorities that are inapplicable or nonexistent.

Stevens said the Wyoming Insurance Department scrubs complaints and suggested the NAIC explore technology in complaint-capture systems, such as State Based Systems (SBS) and Sircon, to help address AI-generated complaints. Gendron said that responding to an AI-assisted complaint is similar to responding to a traditional complaint. Director Gillespie said there are self-styled "advocates" who also drive this trend. Commissioner Gaines agreed and noted that if a complainant inputs a hostile tone into the AI engine, the AI engine will adopt the same hostile tone. Director Nelson suggested training on handling and de-escalating issues. Commissioner Harris cautioned that complaints should not be automatically dismissed simply because they appear AI-generated, emphasizing that a consumer remains behind each complaint. Director Gillespie asked whether the topic warranted inclusion in the Market Conduct Regulation Modernization (D) Working Group's training and workforce development sessions. Members indicated it may be premature to solidify recommendations, but that it could be revisited in the future.

Amy Bach (United Policyholders) said that while AI presents challenges in its manifestations, many of the problems consumers report stem from practices some insurers have adopted, such as claim-handling changes and reductions in coverage. She said that to the extent AI helps consumers make their voices heard and call attention to patterns, it can be a positive development, and she encouraged regulators to use tools to identify obvious inaccuracies while recognizing that these communications are important sources of information. She urged regulators to be clear with consumers about the limits of their authority to adjudicate disputes, but not to adopt hardline rules that decline to process a complaint merely because AI signals are present. Director Gillespie agreed that the underlying complaint should be addressed and noted the difficulty of identifying the actual complaint when submissions contain numerous references to statutes or obligations that do not exist, suggesting an opportunity for further dialogue with industry and consumer representatives on how to help consumers file effective complaints.

Peter Kochenburger (Southern University Law School) said he appreciated the APCIA presentation and its suggestion to include consumer representatives in the work. He noted that verifying the accuracy of communications has always been part of the insurers' responsibility to provide clear and accurate communications to policyholders, and he observed that insurers are increasingly using AI in multiple areas, including claims, raising the question of what tests for accuracy apply to AI-generated or AI-assisted responses on both sides. Director Gillespie agreed that the issue is not AI itself but how it is used and the accuracy of the resulting information, noting that regulators are also beginning to consider how AI can help analyze incoming data.

5. Adopted the Reports of its Task Forces and Working Groups

Director Gillespie noted that adoption of the Producer Licensing (D) Task Force report includes the adoption of a new charge to develop a Uniform Appointment Termination for Cause Form and the formation of an ad hoc subgroup to prepare an initial draft of the form for the Task Force's review.

Commissioner Gaines made a motion, seconded by Director Carpenter, to adopt the reports of the following task forces and working groups: 1) Antifraud (D) Task Force; 2) Producer Licensing (D) Task Force; 3) Advisory Organization (D) Working Group; 4) Market Actions (D) Working Group; 5) Market Analysis Procedures (D) Working Group (Attachment Two); 6) Market Conduct Annual Statement Blanks (D) Working Group (Attachment Three and Attachment Four); 7) Market Conduct Examination Guidelines (D) Working Group (Attachment Five); 8) Market Conduct Regulation Modernization (D) Working Group (Attachment Six); 9) Market Information Systems (D) Working Group; 10) Market Regulation Certification (D) Working Group (Attachment Seven); 11) Pharmacy Benefit Management (D) Working Group (Attachment Eight); and the 12) Speed to Market (D) Working Group (Attachment Nine). The motion passed unanimously.

6. Received an Update from the Big Data and Artificial Intelligence (H) Working Group on the AI Risk Evaluation Supplement

Block, co-vice chair of the Big Data and Artificial Intelligence (H) Working Group, provided an update on the AI Risk Evaluation Supplement, formerly known as the AI Systems Evaluation Tool. She said the name was changed to address feedback and confusion caused by the word "tool," which had implied that AI was used to create the resource. Block said the supplement is designed to complement existing examinations and other processes by providing AI-specific guidance and resources for regulating insurers' use of AI.

Block said the pilot officially started in March and involves 12 states: California, Colorado, Connecticut, Florida, Iowa, Louisiana, Maryland, Pennsylvania, Rhode Island, Vermont, Virginia, and Wisconsin. The pilot began with training and has transitioned to weekly meetings to share what each state is hearing from pilot participants. She said common themes that have emerged include the need to update or clarify the definitions of AI systems and models, materiality, and risk assessment, as well as the inclusion of generalized linear models (GLMs) in the scope and the use of the term "direct impact." Block said the Working Group is not yet ready to discuss the specific updates but will make changes to address the feedback received. She said the goal is to provide a copy of the updated supplement on the Big Data and Artificial Intelligence (H) Working Group's virtual open meeting agenda for Aug. 31, where the changes will be explained and initial clarifying questions taken, with feedback continuing to be accepted beyond that call so that input from the pilot can be leveraged.

Having no further business, the Market Regulation and Consumer Affairs (D) Committee adjourned.

Draft: 7/29/26

Market Regulation and Consumer Affairs (D) Committee
Virtual Meeting
July 27, 2026

The Market Regulation and Consumer Affairs (D) Committee met July 27, 2026. The following Committee members participated: Ann Gillespie, Chair (IL); Angela L. Nelson, Vice Chair (MO); Heather Carpenter represented by Molly Nollette (AK); Jimmy Harris represented by Teri Ann Mecca (AR); Charles Bassett (AZ); Dean L. Cameron (ID); Holly W. Lambert represented by Victoria Hastings (IN); Sharon P. Clark (KY); D.J. Bettencourt represented by Victoria Fowler (NH); Ned Gaines (NV); Michael Humphreys represented by David Buono (PA); and Erin K. Hunter represented by Joylynn Fix (WV). Also participating was: Brett Bache (RI).

1. Adopted its Spring National Meeting Minutes

Director Nelson made a motion, seconded by Director Bassett, to adopt the Committee's March 25 minutes (*see NAIC Proceedings – Spring 2026, Market Regulation and Consumer Affairs (D) Committee*). The motion passed unanimously.

2. Adopted Chapter 21B—Conducting the Pet Insurance Examination for Inclusion in the *Market Regulation Handbook*

Bache said the draft pet insurance chapter is a carryover from the Market Conduct Examination Guidelines (D) Working Group's work in 2025. He said subject matter experts (SMEs) developed the new chapter in 2025 based on the *Pet Insurance Model Act* (#633).

Bache said the chapter was exposed on May 22, 2025. On May 14, 2026, the chapter was re-exposed with the revisions suggested during 2025. He said the Working Group adopted the new pet insurance chapter on May 20, 2026.

Commissioner Gaines made a motion, seconded by Director Cameron, to adopt Chapter 21B—Conducting the Pet Insurance Examination for inclusion in the *Market Regulation Handbook* (Attachment xx). The motion passed unanimously.

3. Considered a Referral of PBM Examination Standards from the Pharmacy Benefit Management (D) Working Group to the Market Conduct Examination Guidelines (D) Working Group

Fix said the Pharmacy Benefit Management (D) Working Group drafted the pharmacy benefit manager (PBM) examination standards over 18 months. It adopted the standards at the Spring National Meeting. She said the standards will help state insurance regulators and the industry streamline examination processes, recognizing that PBM statutes vary widely.

Director Gillespie said the standards will be referred to the Market Conduct Examination Guidelines (D) Working Group for completion.

4. Adopted MCAS LTC Blank Revisions

Teresa Cooper (NAIC) said the Market Conduct Annual Statement (MCAS) long-term care (LTC) blank interrogatories and general information sections were revised for consistency and clarification purposes. She said

the Market Conduct Annual Statement Blanks (D) Working Group also removed duplicate data elements related to the reporting of lapses from the LTC MCAS and removed a data element that asked for the number of policies terminated or canceled due to nonpayment of premium.

Commissioner Clark made a motion, seconded by Director Cameron, to adopt the MCAS LTC blank revisions (Attachment xx). The motion passed unanimously.

Having no further business, the Market Regulation and Consumer Affairs (D) Committee adjourned.

Draft: 8/6/26

Market Analysis Procedures (D) Working Group
Virtual Meeting
July 30, 2026

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met July 30, 2026. The following Working Group members participated: Raymond A. Guzman, Chair (MD); Chelsy Maller (AK); Teri Ann Mecca (AR); Cheryl Hawley (AZ); Don McKinley (CA); Tracy Garceau (CO); Steve DeAngelis (CT); Sheryl Parker (FL); Chris Heisler (IL); Lori Cunningham (KY); Lisa Fullington (LA); Miranda Rampulla (ME); Danielle Torres (MI); Robert McCullough (NE); Ralph Boeckman (NJ); Larry Wertel (NY); Ben Hauck (OH); Landon Hubbart and Zach Palank (OK); John Haworth (OR); Karen Veronikis (PA); Brett Bache (RI); Rachel Moore (SC); Melissa Gerachis (VA); Isabelle Turpin Keiser and Jared Holshauser (VT); Sandy Ray (WA); and Jamie Adams (WI).

1. Adopted its June 18 Minutes

The Working Group met June 18 and took the following action: 1) adopted its April 27 minutes; 2) discussed the Market Conduct Annual Statement (MCAS) ratios; 3) discussed lender-placed insurance MCAS ratio 18; 4) discussed the MCAS rankings and their usefulness in analysis; 4) continued its work on the Market Analysis Review System (MARS) Level 2 guidance.

Bache made a motion, seconded by Torres, to adopt the Working Group's June 18 minutes (Attachment Two-A). The motion passed unanimously.

2. Discussed MCAS Ratios

Guzman said that during the Working Group's June 18 meeting, Maryland presented several possible revisions and proposed new ratios to the Working Group. This included new non-public private passenger auto and homeowners MCAS ratio 7's that measured lawsuits against exposure units. Among the proposed new ratios ratios utilizing new data elements such as digital claims data, or telematics.

Guzman made a motion to create three new ratios to measure 1) total lawsuits opened during the period to the total number of autos insured times 1000; 2) total lawsuits opened during the period to the total number of dwellings insured times 1000; and 3) lawsuits closed with consideration for the consumer to total lawsuits closed. Holshouser asked if multiplying the denominator by 1000 was necessary. Guzman said his staff did calculations and the result was small enough to benefit being multiplied by 1000. Randy Helder (NAIC) said it would not be hard to eliminate the multiplication in the next year if it turned out to be unnecessary. The motion did not receive a second.

Guzman said the next ratios to be considered are the life and annuity ratios. He said Maryland drafted a list of potential new and revised ratios. He said it would be circulated to the Working Group members, interested regulators and interested parties. Bache said that Rhode Island creates its own replacement and surrender fee ratios and would support adding those to the MCAS ratios. Torres noted that Michigan would find the surrender fee and free look ratios helpful. Guzman said the ratios will be discussed in more depth during the next meeting.

3. Discussed Lender-Placed Insurance MCAS Ratio 18

Guzman said the lender-placed insurance MCAS ratio 18 is affected by whether the company reports the gross placement as a percentage or as decimal. It is not consistent. He said the Working Group asked NAIC committee support has drafted a solution to the issue.

Helder said companies have two ways to submit MCAS filings—manually and via a CSV format upload. The CSV file only allows whole numbers, but by inputting manually, a company can either use a whole number or a decimal. NAIC staff is recommending that the manual input option be limited to whole numbers to match the CSV upload option. This way it will only be possible for companies to report the gross placement rate as a whole number. NAIC staff will then notify all companies that filed an LPI MCAS of the change and create a Frequently Asked Question entry explaining the process with and providing an example.

Gerachis made a motion, seconded by Moore, to have NAIC proceed as outlined in their proposal. The motion passed unanimously.

4. Discussed MCAS Rankings

Guzman said in the last meeting there seemed to be a consensus building to remove rankings from the MCAS reports. Gerachis said Virginia is still interested in removing the rankings and made a motion to remove them. There was no second to the motion and Guzman said it will be discussed again during the next Working Group meeting.

5. Discussed the Individual and Group Accident and Health Market Analysis Prioritization Tool (MAPT)

Guzman said his department's market analysis staff noticed that there are many more companies appearing on the individual and group health insurance Market Analysis Prioritization Tool (MAPT) for their state and asked if other states have noticed the same. Torres said Michigan also observed an increase in the number of companies in the annuity line of business MAPT. Guzman asked NAIC staff to look into this and see if there is an explanation for the unusual increase in the number of companies.

6. Discussed the Lunch-and-Learn Schedule

Guzman said the 2nd quarter lunch-and-learn was on July 23 and covered the MCAS process for collection and reporting. The next lunch-and-learn is scheduled for the 3rd quarter and the Working Group is still looking for a volunteer to lead a discussion on the health insurance MCAS ratios. Anyone interested in leading the discussion should contact Helder.

7. Discussed Revisions to MARS Level 2 Guidance

The Working Group reviewed the Market Analysis and Regulatory Actions section of the MARS Level 2 Guidance.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.

Draft: 7/11/26

Market Analysis Procedures (D) Working Group
Virtual Meeting
June 18, 2026

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met June 18, 2026. The following Working Group members participated: Raymond A. Guzman, Chair (MD); Cassie Soucy, Vice Chair (OR); Chelsy Maller (AK); Teri Ann Mecca (AR); Cheryl Hawley (AZ); Don McKinley (CA); Tracy Garceau and Jamie Crise (CO); Sheryl Parker (FL); Lori Cunningham (KY); Mary Lou Moran (MA); Timothy N. Schott (ME); Danielle Torres and Chris Gleason (MI); David Dachs (MT); Robert McCullough (NE); Ralph Boeckman (NJ); Larry Wertel (NY); Guy Self (OH); Landon Hubbart and Zach Palank (OK); Karen Veronikis (PA); Brett Bache (RI); Rachel Moore (SC); Tanji J. Northrup (UT); Melissa Gerachis (VA); Karla Nuissl and Jared Holshauser (VT); Sandy Ray (WA); Jamie Adams (WI); and Theresa Miller (WV).

1. Adopted its April 27 Minutes

The Working Group met April 27 and took the following action: 1) adopted its Feb. 23 minutes; 2) discussed its plans for working through the Market Conduct Annual Statement (MCAS) ratios in 2026; 3) discussed the MCAS rankings and their usefulness in analysis; 4) continued its work on the Market Analysis Review System (MARS) Level 2 guidance.

Soucy made a motion, seconded by Gerachis, to adopt the Working Group's April 27 minutes (Attachment Two-A1). The motion passed unanimously.

2. Discussed MCAS Ratios

Guzman said the Working Group will continue its discussions on the MCAS private passenger auto (PPA) ratio 7 and then begin working through all the MCAS ratios by line of business, beginning with PPA and homeowners. He said the goal is to make the ratios more accurate and effective and perhaps also incorporate data elements, such as telematics data, that have been added to MCAS since the ratios were first developed.

Guzman said ratio 7 has been changed to include only claims-related lawsuits, but the lawsuits are measured against claims closed without payment. Many lawsuits are filed for reasons other than non-payment of a claim. He said two better options would be to measure against all claims or against exposure units, such as the number of autos or dwellings insured. When measuring against exposure units, he recommended using the number of lawsuits per 1,000 exposure units. Guzman said that an option could be to change the ratio 7 denominator to "total claims" and create two non-public ratios (8 and 9) that would measure lawsuits against the number of autos insured (times 1,000) and the number of homes insured (times 1,000). He also suggested a non-public ratio to measure lawsuits closed with consideration to the consumer-to-total policies in force (times 1,000).

Parker said the litigation ratios are very important to Florida and suggested that if any change is made to ratio 7, it should be to break it into two ratios, one measuring lawsuits against claims closed with payment, and one measuring lawsuits against claims closed without payment. She said that would allow the analyst to determine the types of claims that may be generating the lawsuits.

Guzman also introduced additional ratio suggestions for the auto and homeowner MCAS that provide measures of the percentage of policies enrolled in telematics, percentage of policies that are non-standard, percentages of policies with the various coverages reported in MCAS (e.g., comprehensive, collision, and personal injury

protection [PIP]), percentage on new policies to the total policies in force, and the percentage of claims handled digitally, non-digitally, or as a hybrid. He said we could even have non-public ratios that measure the percentage of policies canceled at the insurer's request versus those canceled due to non-payment.

Holshauser reminded the Working Group that in the MCAS-Market Analysis Prioritization Tool (MAPT), all ratios are ranked from high to low, even though the low ratios are of greater concern. He suggested that the Working Group bear in mind that the ratios incorporated into the MCAS-MAPT be ratios where a high value is the concern until the ranking issues can be resolved. Holshauser also noted that the denominator may be more useful if it were "all claims" or "all policies" because if the denominator is too narrow, the expectation would be that it should be near 100%, for example, claims below the deductible measured against the number of claims closed without payment. The denominator would be better if it was "all closed claims."

Wertel said that in states where PIP is mandatory, the percentage of policies with PIP coverage would be 100%. He also noted that the definition of non-standard is left to the company and may not be a useful ratio for comparing companies.

Dachs suggested that some of the ratios may be better addressed as interrogatories, such as the percentages of non-standard or other types of coverages.

Soucy said the proposed ratio for measuring telematics may not be inherently good or bad, but if multiple complaints arise from its use, it becomes a very useful ratio to know. The ratio may not tell the whole story, but it can point the insurance regulators in the right direction.

3. Discussed Lender-Placed Insurance MCAS Ratio 18

Guzman said this ratio can be affected by whether a company reports its gross placement rate as a whole number percentage or as a decimal. Teresa Cooper (NAIC) said that the lender-placed insurance (LPI) MCAS blank allows a company to report either as a decimal or as a whole number. She noted, however, that if a company uses the CSV creator to upload a CSV file, it cannot include decimal points. She said no instructions have been given to companies on whether to report as a decimal or a whole number. She suggested that companies be provided guidance in the frequently sked Questions (FAQ) document on the MCAS web page. She said that all companies that have reported LPI MCAS can also be directly notified. Torres asked how many companies are reporting with a decimal or a whole number. Cooper said most are using whole numbers because the CSV creator does not accept decimal numbers.

Guzman asked NAIC committee support to draft a proposal for ensuring consistency in the reporting of the gross placement rate and bring it back to the Working Group at the next meeting.

4. Discussed MCAS Rankings

Guzman said that during the last meeting, the Working Group discussed how the MCAS-MAPT rankings always order the ratios from high to low, implying that the higher the ratio, the more concerning it is. He said Palank developed a formula to rank ratios from lowest to highest. He asked whether it is possible to make these adjustments in MCAS-MAPT for ratios identified as more concerning if they are low. Cooper said this would require significant time and effort that may not be justified, since the NAIC will be replacing MCAS reporting with a new system in a couple of years. Soucy asked when the new reporting system would be in place. Cooper said in 2029 for the reporting of the 2028 data year. Soucy asked whether NAIC committee support could provide guidance to states on how to calculate rankings, from low to high, for those identified as needing ranking. Wertel said New York would find that helpful.

Randy Helder (NAIC) said that all the rankings do is sort the ratios high to low and break them into 21 bands. An analyst can simply sort any ratio high to low or low to high and duplicate what the rankings are doing. If the analyst wants to identify outliers with a low specified ratio, they only need to sort in ascending order by that ratio. He suggested it would be better to remove the rankings altogether because they have little value and only add confusion. Gerachis, Gleason, Self, Moran, and Cunningham supported removing the rankings.

Guzman said the Working Group will consider removing the rankings during its next meeting. Hawley asked for more information on the impact of removing the rankings and which columns in the MAPT would be affected. Helder said that it can be done.

5. Discussed the Lunch-and-Learn Schedule

Guzman said the lunch-and-learn requested by the Life Insurance and Annuities (A) Committee leadership will be moved to after the Summer National Meeting. Guzman said that Torres suggested a lunch-and-learn covering the MCAS ratios for the health line of business. If there are volunteers, the Working Group will try to have this as the next lunch-and-learn in July.

6. Discussed Revisions to MARS Level 2 Guidance

The Working Group continued its review of the MARS Level 2 guidance, concentrating on the Interdepartmental Communication section. Recommendations included initial conversations with the market analysis chief (MAC) and the collaborative action designee (CAD), and defining what is meant by the document's reference to "outreach programs." During its next meeting, the Working Group will review the Market Analysis and Regulatory Action sections.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.

Draft: 5/26/26

Market Analysis Procedures (D) Working Group
Virtual Meeting
April 27, 2026

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met April 27, 2026. The following Working Group members participated: Raymond A. Guzman, Chair (MD); Cassie Soucy, Vice Chair (OR); Chelsy Maller (AK); Teri Ann Mecca (AR); Cheryl Hawley (AZ); Don McKinley (CA); Jamie Crise and Isaac Nevole (CO); Steve DeAngelis (CT); Pratima Lele (DC); Chris Heisler (IL); Charles Thomas (KS); Lisa Fullington and Joshua Guillory (LA); Timothy N. Schott (ME); Danielle Torres (MI); David Dachs (MT); Martin Swanson and Robert McCullough (NE); Ralph Boeckman (NJ); Elouisa Tyler (NM); Larry Wertel (NY); Guy Self (OH); Landon Hubbart and Zach Palank (OK); Karen Veronikis (PA); Brett Bache (RI); Rachel Moore (SC); Tanji J. Northrup (UT); Melissa Gerachis (VA); Karla Nuissl and Jared Holshauser (VT); Sandy Ray (WA); Darcy Paskey (WI); and Tom Whitener (WV).

1. Adopted its Feb. 23 Minutes

The Working Group met Feb. 23 and took the following action: 1) adopted its Nov. 3, 2025, minutes (*see NAIC Proceedings – Fall 2025, Market Regulation and Consumer Affairs (D) Committee, Attachment Two*); 2) discussed its charges for 2026; 3) heard a report on the Market Analysis Prioritization Tool (MAPT) recommendations; 4) heard a report from the Market Regulation Certification (D) Working Group on the Market Analysis Review System (MARS) Level 1 requirement; 5) discussed revisions to the Market Conduct Annual Statement (MCAS) private passenger auto (PPA) ratio 7; 6) discussed adding a new line of business to the MCAS; and 7) discussed the 2026 lunch-and-learn schedule.

Soucy made a motion, seconded by Veronikis, to adopt the Working Group's Feb. 23 minutes *(see NAIC Proceedings – Summer 2022, Market Regulation and Consumer Affairs (D) Committee, Attachment Two)*. The motion passed unanimously.

2. Discussed MCAS Ratios

Guzman said the Working Group will continue its discussions on the MCAS PPA ratio 7 and then begin working through all the MCAS ratios by line of business, beginning with PPA and homeowners. He said the goal is to make the ratios more accurate and effective and perhaps also incorporate data elements, such as telematics data, that have been added to MCAS since the ratios were first developed.

Guzman said ratio 7 has been changed to only include claims-related lawsuits, but the lawsuits are measured against claims closed without payment. Many lawsuits are filed for reasons other than non-payment of a claim. He said two better options would be to measure against all claims or against exposure units, such as the number of autos insured or the number of dwellings insured. When measuring against exposure units, he recommended using the number of lawsuits per 1,000 exposure units. Guzman said a ThoughtSpot answer could be developed to compare the original and proposed ratios and encouraged interest regulators to look closer into this suggestion. Guillory said the Louisiana Department of Insurance has used the proposed ratio of lawsuits per 1,000 exposure units, and it has worked very well. Guzman said the Maryland Insurance Administration also found the lawsuit ratio based on exposure units very useful and thought it could be a public ratio or, if preferred, a non-public ratio.

3. Discussed MCAS Rankings

Guzman said that, though the Working Group considered the MCAS rankings along with its discussion of ratios in the last meeting, he thought the Working Group should consider the rankings separately from the ratios. He said the Working Group's consensus at the last meeting was that the rankings were not very useful and that little attention was paid to them. Additionally, he said the rankings are designed to rank high ratios as more concerning than low ratios. However, some health and pet ratios are more concerning when low than when high. In those cases, the rankings reflect the opposite of what is concerning. Palank said he developed a formula that applies the ranking from lowest to highest ratio to adjust for those ratios. He also noted that the ratio ranks are aggregated to develop a claim rank or an underwriting rank, which is then aggregated again into the overall rank. This makes the overall rank inaccurate insofar as it incorporates any rank that should be reversed.

Soucy said that if some ranks are inaccurate and states are using them to make decisions about actions, it should be addressed. Instructions should be provided on how to find the raw data used to develop the ratios and the rankings. Palank suggested perhaps turning off the incorrect rankings.

Guzman asked the NAIC about the timeline for correcting the rankings or turning them off. Guzman, however, was hesitant to suggest turning off the inaccurate rankings.

4. Discussed Adding a New Line of Business to the MCAS

Guzman suggested adding a personal articles line to the MCAS, since homeowners and dwelling policies often limit coverage for high-value personal items. He said there may not be much premium volume in this line. He did note that many of the homeowners ratios could be used for this proposed line. He asked the Working Group to consider, and there will be more discussion at the next meeting.

5. Discussed the Lunch-and-Learn Schedule

Guzman said the Life Insurance and Annuities (A) Committee leadership requested that the Working Group's June 22 lunch-and-learn focus on analysis techniques surrounding annuity illustrations. He asked for any volunteers to lead the lunch-and-learn.

Guzman said that Torres suggested a lunch-and-learn covering the MCAS ratios for the health line of business. He said this may be for the third quarter lunch-and-learn.

6. Discussed Revisions to MARS Level 2 Guidance

The Working Group continued its review of the MARS Level 2 guidance, concentrating on the Examination section. Recommendations included a caveat about assumptions arising from a large number of examinations and the need to consult with department management before making requests to other states/jurisdictions. During the next meeting, the Working Group will review the Interdepartmental Communications and Market Analysis sections.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.

Draft: 6/11/26

Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
May 21, 2026

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met May 21, 2026. The following Working Group members participated: Joshua Guillory, Chair (LA); Tolanda McNeal, Vice Chair (AZ); Rachael Lozano (FL); Paula Shamburger (GA); Chris Heisler (IL); Charles Thomas (KS); Lori Cunningham (KY); Mary Lou Moran (MA); Salama Karim-Camara (MD); Danielle Torres (MI); Julie Hesser (MO); Matt Fischer (ND); Guy Self (OH); Spencer Peacock (OR); Karen Veronikis (PA); Rachel Moore (SC); Rhonda Bowling-Black (TN); Melissa Gerachis (VA); Sandy Ray (WA); Jamie Adams (WI); and Theresa Miller (WV).

1. Adopted the Removal of Duplicative LTC MCAS Blank Data Elements Nos. 39–40

Guillory referred members to the long-term care (LTC) Market Conduct Annual Statement (MCAS) blank (Attachment XX) adopted during the May 7 meeting. He explained that, during final review, questions 39 and 40 appeared to request the same information. Specifically, question 39 requests the number of lapses during the reporting period, while question 40 requests the number of policies terminated or canceled due to nonpayment of premium.

Guillory further noted that the LTC data column definitions (Attachment XX) define a lapse as the termination of the entire policy or contract, or the termination of the LTC benefit, due to nonpayment of premium. He indicated that this definition appears to encompass the concept described in question 40, raising the concern that the two data elements may be duplicative.

Guillory opened the floor for comments from Working Group members and regulators. Hearing none, he invited comments from interested parties. Hearing none, he requested a motion to address the potentially duplicative data elements.

Gerachis made a motion, seconded by Hesser, to remove question 40 and retain question 39, noting that lapses are already defined in the data column definitions. The motion passed unanimously.

2. Adopted LTC MCAS Edits

Guillory began by considering updates to the interrogatory section, including language defining “actively writing policies” as premium written during the reporting period. Hearing no comments or concerns from Working Group members or interested parties, he proceeded to definitions for managing general agents (MGAs) and third-party administrators (TPAs), which were sourced from other MCAS lines. Hearing no objections, the definitions were accepted as presented.

Gerachis made a motion, seconded by Veronikis, to approve the updates to the data call and definitions for the interrogatory section. The motion passed unanimously.

The Working Group next considered general information updates, including direct written premium and direct earned premium. Guillory noted that no revisions were initially identified as necessary; however, McNeal stated that the language had been added from the financial annual statement to support reporting consistency. Later discussion clarified that definitions for these premium items would be retained to provide additional guidance for reporting.

Guillory then asked whether additional guidance was needed for the newly added data elements for applications received, approved, pending, or denied. Hearing no concerns, the Working Group proceeded to termination and cancellation data elements.

Guillory reviewed proposed cancellation and termination definitions adapted from the homeowners MCAS, noting that revisions would be required for applicability to LTC. He indicated that references specific to property coverage would be removed and that language would be updated to align with LTC terminology. Cooper clarified that the definition of lapse would remain, consistent with the earlier decision to retain the associated data element. Hearing no objections to the revised cancellation definition, the Working Group agreed to use the adapted language.

The Working Group then reviewed definitions of adverse determination, overturned decisions, and upheld decisions, drawn from the health MCAS. McNeal stated that including these definitions was necessary to support newly added data elements. Hearing no opposition, the Working Group agreed to include the definitions as drafted.

McNeal made a motion, seconded by Gerachis, to adopt the updates to the LTC MCAS data call and definitions. The motion passed unanimously.

Guillory noted that the updated data call and definitions would be forwarded to the D Committee for further consideration.

3. Discussed the Pet MCAS Proposal Form Regarding Maximum Benefit Limit Reporting

Guillory introduced the agenda item regarding the pet MCAS proposal form related to maximum benefit limit reporting for partial payments (Attachment XX). He noted that the proposal, submitted by John Fielding (Fielding Strategy), requests the removal of data element 109, which asks for the number of claims closed during the period with partial payment due to maximum benefit limit, and proposes revising the definition of "partial payment" to exclude claims reduced by maximum benefit limits.

Guillory noted that the proposal had been discussed at the May 7 Working Group meeting, and industry representatives were invited to provide additional information regarding reporting capabilities. Fielding explained that, based on discussions with members of the North American Pet Health Insurance Association (NAPHIA), companies may track when policies reach maximum benefit limits but do not track claims in a way that allows reporting of the requested data elements. He further stated that claims paid up to the maximum benefit limit are considered full payments under the contract rather than partial payments.

Caren Alvarado (Crum & Forster A&H) confirmed that, while information on maximum benefit limits may appear in explanation-of-benefits documentation, it is not captured in a format that is reportable. She indicated that system programming changes would be required for companies to report such data and noted that similar data elements are not required in other MCAS lines.

McNeal inquired whether the data element could be revised to capture the number of claims closed due to maximum benefit limits without referencing partial payments. Alvarado responded that such information is not currently captured in a reportable manner. Thomas questioned how claims paid at maximum benefit limits are tracked in industry systems and whether such data would have value. Alvarado explained that the information exists at a transactional level but is not aggregated or reportable without additional system development and requested clarification regarding the regulatory objective.

Gerachis noted that similar data elements are tracked in other lines, such as comprehensive health, and suggested there may be precedent for collecting this information. Guillory sought clarification on how maximum benefit limits apply within pet insurance policies, and Alvarado provided examples illustrating that payments up to policy limits are treated as full payments.

Bache provided background on the origin of the data element, explaining that it was developed to assist regulators in distinguishing partially paid claims and identifying common reasons for partial payments, including maximum benefit limits and inadequate documentation. He stated that the intent was to provide regulators with additional context to evaluate claims handling and determine whether further review may be warranted.

The Working Group discussed potential revisions to wording and the relationship between the data element and the definition of partial payment. Industry representatives emphasized that, under the contract, claims paid up to maximum benefit limits are not partial payments and that the current reporting requirement cannot be met as written.

Guillory requested motions from the Working Group to address the proposal. Hearing no motion to remove data element 109 or to adopt the requested changes, no action was taken.

The Working Group agreed that no changes will be made to the pet MCAS at this time. The item will remain on the agenda for future discussion, including potential revisions to language or data elements for future reporting periods.

4. Exposed the Draft FAQ on Other Health Accident-Only Coverage

Guillory stated that, following prior Working Group discussions, Alvarado had prepared a draft of frequently asked questions (FAQ) for consideration (Attachment XX). The draft FAQ addressed whether the definition of “other health” includes occupational accident insurance issued to independent contractors and proposed clarifying that such coverage is excluded from that definition.

Guillory opened the floor for comments from Working Group members, regulators, and interested parties. Hearing no comments or questions, he requested a motion to adopt the proposed FAQ clarification. Hearing no motion, the Working Group did not take action on the proposal.

Guillory stated that the draft FAQ would be exposed for a 30-day comment period ending June 20, and the Working Group will revisit the item following the close of the comment period.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.

Draft: 5/26/26

Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
May 7, 2026

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met May 7, 2026. The following Working Group members participated: Joshua Guillory, Chair (LA); Tolanda McNeal, Vice Chair (AZ); Teri Ann Mecca (AR); Sheryl Parker and Karen McGlynn (FL); Paula Shamburger (GA); Patrick Tallman and Chris Heisler (IL); Charles Thomas (KS); Lori Cunningham (KY); David Lindquist (MA); Raymond A. Guzman (MD); Amy Bonito (MI); Teresa Kroll (MO); Martin Swanson (NE); Elouisa Tyler (NM); Ben Hauck (OH); August Hall (PA); Rachel Moore (SC); Tony Dorschner (SD); Rhonda Bowling-Black (TN); Melissa Gerachis (VA); Sandy Ray (WA); Darcy Paskey (WI); and Theresa Miller and Letha Tate (WV).

1. Adopted its April 9 Minutes

Shamburger made a motion, seconded by Swanson, to adopt the Working Group's April 9 minutes (Attachment Four-A). The motion passed unanimously.

2. Considered LTC MCAS Edits

Guillory referred members to the draft long-term care (LTC) Market Conduct Annual Statement (MCAS) reporting blank included in the meeting materials. He acknowledged the extensive time, effort, and collaboration by Working Group members and interested parties in developing the draft and expressed appreciation for their participation. He noted the Working Group's goal of finalizing the draft during the meeting, if possible.

Guillory opened the floor for comments from Working Group members and regulators. Hearing none, he invited comments from interested parties.

Kirsten Wolfford (American Council of Life Insurers—ACLI) explained that the ACLI and AHIP submitted comments reflecting member company feedback and identified four areas of concern within the draft. She noted that their comments were intended to ensure that the data collected would be meaningful and practical for reporting entities.

Ray Nelson (AHIP) addressed the first concern regarding lines 16–21, stating that these items appeared duplicative of earlier questions (lines 4–15). He suggested that the newer, broader questions may encompass the existing items and questioned whether the earlier items were necessary. He also identified an editorial issue regarding parenthetical language following "LTC" that should be removed.

Hal Marsh (NAIC) confirmed the parenthetical language was included in error and would be removed. The Working Group members discussed whether the items were duplicative.

Charles suggested that earlier questions might represent more objective standards, while the newer items could introduce subjectivity. McNeal noted that the newer questions were broader in scope and could result in more robust responses. Nelson concluded that clarity in data definitions may help distinguish the items if both sets are retained.

Public comment was provided by Bonnie Burns (California Health Advocates), who inquired whether certain critical illness riders were captured in the LTC reporting. Guillory clarified that the Working Group's current scope

is limited to LTC products and that other products would need to be addressed separately. Additional discussion indicated that such products may be partially captured under hybrid categories or other blanks, and it was suggested that further consideration could be referred to the Market Analysis Procedures (D) Working Group if warranted.

Nelson then addressed lines 30–31, recommending removing premium-related data elements due to concerns about data availability and limited value, particularly for hybrid products. He noted that similar premium data is already reported through other mechanisms. Gerachis expressed support for this concern and suggested that, if feasible, existing data sources could be leveraged.

Nelson also proposed editorial revisions to policy termination categories (lines 41–43), suggesting clarification to avoid overlap and improve categorization. Working Group members indicated general support for these edits.

Wolfford presented the final concern regarding lines 52–56, recommending removal due to potential reporting burden and a lack of clarity in definitions, particularly regarding appeals and adverse determinations. She suggested that, if retained, clearer definitions be developed in subsequent data column definitions.

Guillory acknowledged the feedback and reminded participants that the Working Group would later review data column definitions and FAQs, which may address concerns regarding clarity.

Additional discussion included questions about claim categorization and whether certain claim-closure scenarios were captured. Guillory indicated that such distinctions may be addressed in data definitions and could be revisited if necessary.

Following the discussion, Guillory moved the Working Group to the voting phase and explained that proposed edits would be considered by the reporting section.

3. Adopted Edits to the Interrogatories Section

Guillory presented the proposed edits to the interrogatories section, including questions on identifying outliers, year-end company activity, and the use of managing general agents and third-party administrators.

Gerachis made a motion, seconded by Thomas, to adopt the interrogatory section as presented, with removal of the erroneous parenthetical language. The motion passed unanimously.

4. Adopted Edits to the General Information Section

Guillory then presented the proposed edits to the general information section, including additions related to premiums, application activity, policy terminations, and adverse determinations. The discussion included clarification of reporting instructions and potential alignment with existing data sources.

Charles made a motion, seconded by Ray, to adopt the general information section with specified edits, including revisions to policy termination categories to improve clarity and avoid duplication. The motion passed. Maryland abstained.

5. Declined Proposed Class Action Lawsuit Data Element

Guillory then opened a discussion on adding a data element to capture the number of class-action lawsuits. Hearing no discussion, he requested a motion. Hearing no motion, the proposal failed.

The Working Group agreed that the class action lawsuit data element would not be added to the LTC MCAS blank at this time.

6. Considered the Pet MCAS Proposal Form Related to Maximum Benefit Limit Reporting

Guillory introduced the agenda item regarding the Pet MCAS Proposal Form on maximum benefit limit reporting for partial payments. He referred members to the proposal form included in the meeting materials and noted that it had been presented at a prior meeting, with no comments received during the exposure period.

Guillory explained that the proposal requested the removal of a data element that captures the number of claims closed with partial payment due to maximum benefit limits, and the revision of the definition of "partial payment" to exclude claims reduced by maximum benefit limits.

McNeal asked whether the proposed change reflected current industry reporting practices. Caren Alvarado (Crum & Forster A&H), speaking on behalf of the North American Pet Health Insurance Association (NAPHIA), confirmed that the proposal would memorialize current reporting practices and align reporting with how claims are administered. She explained that claims paid up to the maximum benefit limit are considered fully paid claims by carriers and are not treated as partial payments.

Baytop inquired whether insurers maintain any indicators to identify claims affected by maximum benefit limits. Alvarado responded that such distinctions are not currently captured in a standardized manner and would require additional system programming. She noted that these claims are reported as fully paid claims.

Ray asked whether insurers track when policies reach their maximum benefit limits. Alvarado indicated that such information may be reflected in insurer systems or explanation-of-benefits documentation but may vary across companies. She offered to provide additional information following further review with industry members.

Following the discussion, Gerachis suggested deferring action on the proposal to allow additional time for the industry to provide information regarding potential indicators for maximum benefit limits.

Guillory noted that any decision would need to be made before the upcoming deadline to be effective for the next reporting cycle. He further indicated that an additional meeting was scheduled later in the month, allowing the Working Group to revisit the proposal within the required timeframe.

Hearing no objection, the Working Group agreed to defer consideration of the proposal and revisit the item at its next meeting.

7. Reviewed LTC MCAS Data Call and Definitions Edits

Guillory introduced the agenda item regarding the review of the LTC MCAS data call and data column definition edits developed by NAIC committee support to reflect the Working Group's approved changes.

Guillory noted that draft language had been prepared; however, due to time constraints, the Working Group would not review the edits during the current meeting. He requested that Working Group members and interested parties review the proposed data call and definition updates in advance of the next meeting, emphasizing the need to move quickly through the edits and reach decisions at that time.

Guillory stated that timely review and approval are necessary to ensure that the data call and definitions are consistently updated with the adopted changes and to avoid confusion during implementation.

McNeal clarified that the LTC data column definitions document must be approved by July 1 to be effective, while an FAQ document could be developed and applied more immediately as needed.

Marsh noted that the updated blank reflecting the Working Group's adopted changes would be posted and distributed to members for review prior to the next meeting to facilitate preparation.

The Working Group agreed to defer detailed review of the data call and definitions edits to the next meeting.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.

Draft: 4/23/26

Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
April 9, 2026

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met April 9, 2026. The following Working Group members participated: Joshua Guillory, Chair (LA); Tolanda McNeal, Vice Chair (AZ); Karen McGlynn (FL); Paula Shamburger (GA); Chris Heisler (IL); Desirée Neyens (KS); Lori Cunningham (KY); Raymond A. Guzman (MD); Danielle Torres (MI); Julie Hesser (MO); Robert McCullough (NE); Ryan McConnell and Ben Hauck (OH); Spencer Peacock (OR); Karen Veronikis (PA); Rachel Moore (SC); Tony Dorschner (SD); Rhonda Bowling-Black (TN); Melissa Gerachis (VA); and Darcy Paskey (WI).

1. Adopted its Dec. 18, 2025, and Feb. 5, 2026, Minutes

Veronikis made a motion, seconded by McNeal, to adopt its Dec. 18, 2025, (*see NAIC Proceedings – Spring 2026, Market Regulation and Consumer Affairs (D) Committee, Attachment Four*) minutes. The motion passed unanimously.

Hesser made a motion, seconded by Torres, to adopt its Feb. 5, 2026, (*see NAIC Proceedings – Spring 2026, Market Regulation and Consumer Affairs (D) Committee, Attachment Three*) minutes. The motion passed unanimously.

2. Discussed the Pet MCAS Proposal Form on Maximum Benefit Limit Reporting

Guillory said the Working Group will consider a submitted pet Market Conduct Annual Statement (MCAS) proposal regarding the reporting of maximum benefit limits regarding partial payments. He noted the proposal was included in the meeting materials and had been submitted by John Fielding (Fielding Strategies).

Fielding stated that he represents the North American Pet Health Insurance Association (NAPHIA) and noted the association's prior involvement in the development of the pet MCAS. He explained that although a prior revision clarified the definition of partial payments, reporting issues and confusion remain. He summarized his proposal, which would revise the definition of "partial payment" to expressly exclude claims reduced by maximum benefit limits and would delete Interrogatory 3.109 regarding claims closed with partial payments involving maximum benefit limits. Fielding stated that claims that reach the maximum benefit limit constitute full payments under the policy terms and should not be reported as partial payments. He indicated that the proposed changes would improve consistency and clarity for both regulators and reporting entities.

Lisa Brown (American Property Casualty Insurance Association—APCIA) expressed support for the proposed changes.

Guillory noted that the proposal had been submitted in early February and had been discussed at multiple meetings. He asked whether any Working Group member wished to make a motion to adopt the proposed revisions. No motion was made.

Guillory indicated that the Working Group would allow an additional comment and review period and would consider the proposal again at the next meeting. He stated that if no motion is made at the next meeting, the Working Group may decide not to take any further action on the proposal. Guillory requested that the item be included on the next meeting agenda, and NAIC committee support confirmed the request.

3. Discussed the Required-to-File Procedures for MCAS Filings

Guillory noted that this topic had been discussed previously and that concerns regarding the current required-to-file process had originally been raised by Peacock. Guillory referenced a prior discussion in which NAIC committee support outlined the existing process and potential options for improvement. He noted that Peacock had recently submitted a proposal to enhance the required-to-file process, which was included in the meeting materials, and asked Peacock to present his proposal.

Peacock explained that the proposal reflects work conducted in Oregon to identify companies that may not have properly complied with MCAS required-to-file obligations. He stated that the analysis focused on identifying companies that either did not submit the required form despite meeting premium thresholds, submitted blank forms, responded "no" where reporting was expected, or may have relied on prior exemptions. He explained that the review was limited to life, annuity, homeowners, and private passenger auto lines and to companies with more than $1 million in written premium. Through this analysis, Oregon identified a number of companies across these lines that appeared to be out of compliance and conducted outreach to request clarification or correction.

Peacock stated that the majority of responses indicated inadvertent errors and that companies intended to correct their reporting. He indicated that the purpose of the proposal was to determine whether similar analytical reports could be made available by the NAIC for use by all interested states, thereby reducing duplicative state efforts and helping identify companies that may have unintentionally failed to comply with required-to-file reporting. He stated that the proposal was shared as an example of Oregon's approach and as a potential framework for broader use.

Guillory thanked Peacock and opened the discussion to Working Group members, state regulators, and interested parties. No questions were raised. He then noted that NAIC committee support had been asked to review the proposal and invited them to provide feedback.

Teresa Cooper (NAIC) stated that she supported the proposal and agreed with the logic presented. She indicated that the NAIC has the capability to develop reports of this nature, though some data preparation would be required to make the information easier to report. She noted that such work could be placed in the NAIC backlog, though timing for completion could not be determined. Cooper expressed support for moving forward with the concept.

Guillory noted a comment from a West Virginia regulator indicating that West Virginia already tracks lines of business annually against premium thresholds and compares that information to the NAIC required-to-file list for outreach purposes. He then asked whether Working Group members or state regulators had additional questions or comments regarding the creation of similar reports to support required-to-file indicators.

Guillory specifically asked state regulators whether such reports would be used if developed, noting the importance of ensuring the value of the effort. Multiple state regulators responded affirmatively. Guillory stated his support for the proposal. NAIC committee support indicated that a vote was not necessary and that work could begin without formal action. Guillory requested that NAIC committee support proceed with exploring the development of the proposed reporting enhancements and thanked staff and participants for their input.

4. Discussed the Reporting of Accident-Only Coverage on MCAS Blanks

Guillory stated that this issue had been brought to the Working Group by Caren Alvarado (Crum & Forster) and asked Alvarado to present the issue.

Alvarado explained that she had previously raised this topic during earlier other health MCAS discussions and was requesting additional clarification due to continued confusion regarding the reporting of accident-only coverage. She noted that the MCAS provides clear guidance on certain exemptions, such as blanket coverage; however, ambiguity remains regarding group types that do not qualify as employer groups but do not clearly meet the definition of an association under various state eligibility rules. She stated that this lack of clarity has led to inconsistent reporting.

Alvarado highlighted occupational accident coverage as a primary source of confusion. She explained that occupational accident coverage is typically issued to independent contractors and offered in lieu of workers' compensation, although it is filed as accident and health insurance. She stated that she does not believe this coverage was intended to be captured as accident-only coverage in the other health MCAS. She further noted that some carriers are being instructed to report occupational accident coverage as accident-only, while others are instructed to exclude it because it functions as a workers' compensation substitute. Alvarado stated that this inconsistency has resulted in uneven reporting and requested either clarification or exclusion of occupational accident coverage from accident-only reporting to ensure consistent treatment across carriers.

Alvarado suggested that the issue could be addressed by clarifying the MCAS FAQs. Alvarado agreed that updated FAQ guidance would be helpful, noting that the current instructions are silent on this issue.

JP Wieske (Health Benefit Institute) expressed support for Alvarado's comments and stated that clarification would be very helpful. No further questions or comments were raised.

Guillory proposed providing a 30-day public comment period on the issue and requested that NAIC committee support prepare a draft FAQ or definitional language for consideration at the next Working Group meeting, with the intent of voting on a resolution thereafter. No objections were raised.

NAIC committee support indicated that assistance could be provided, but requested subject-matter input to ensure appropriate language. Alvarado offered to draft proposed language for staff review and to be available for follow-up discussion as needed.

5. Considered LTC MCAS Edits

Guillory said the Working Group will review the draft long-term care (LTC) MCAS blank, which was provided in the meeting materials. He stated that the objective of the discussion was to review each proposed edit to determine whether it should remain in the draft. He noted that, time permitting, the Working Group would also discuss updates to the related data call and definitions. Guillory indicated that NAIC committee support would clean up and repost drafts following the meeting for comment, with the intent of taking final action at the next Working Group meeting.

Guillory noted that written comments had been received from the American Council of Life Insurers (ACLI) and AHIP.

Ray Nelson (AHIP) and Ayah Abedali (ACLI) provided a summary of their joint comments on the draft blank. They expressed concern about a proposed interrogatory regarding the number of class action lawsuits, noting that this issue had been previously considered during the original development of the LTC MCAS and that existing lawsuit activity questions already capture this information. They recommended removing the proposed addition to avoid duplication. They further requested clarification on whether the newly proposed items shown in the draft were intended to be added in addition to or in lieu of existing questions.

Industry representatives also commented on proposed additions, requesting direct written and earned premium information. They noted that LTC premiums are already reported to the NAIC through annual statements and experience exhibits and that hybrid products present challenges because financial statements capture total product premiums rather than LTC-specific amounts. They requested the removal of the proposed premium items due to redundancy and limited added value.

Additional concerns were raised regarding proposed edits related to application activity, including applications approved, pending, or denied. Industry representatives stated that underwriting practices and systems vary significantly across companies and that such data may not be readily available or comparable. They also raised concerns about policy terminations and adverse determinations, noting the need for clarification, definitional consistency, and the potential burden of collecting such data. Industry representatives requested confirmation of the implementation timeline, which Guillory confirmed would apply to calendar year 2027 data, reported in 2028, provided the blank is adopted by mid-2026.

Guillory confirmed the target timeline and emphasized the goal of adopting the blank by June 1, 2026, to avoid delaying implementation. He then opened the floor for Working Group members and regulator questions and comments.

During the discussion, Guillory conducted an informal line-by-line review of proposed changes to the draft blank. For each item, Working Group members were asked to provide feedback and informal indications of support or opposition. No formal motions were taken during the meeting, though general support was expressed for several proposed interrogatories, including free-form explanatory questions, questions regarding whether companies remain actively writing business in a state, use of managing general agents (MGAs) or third-party administrators (TPAs), and several general information items.

With respect to the proposed class action lawsuit item, the Working Group expressed interest in retaining the concept but agreed that it would be more appropriately placed in the lawsuit activity section rather than as a separate interrogatory. NAIC committee support agreed to revise the draft accordingly.

Discussion continued on proposed items regarding application tracking, policy terminations, and adverse determinations. Regulators requested additional industry input on the feasibility, given the implementation timeline. NAIC committee support noted that reporting reasons for denied applications would require predefined categories, as free-text entries are not supported. Guillory indicated that the Working Group would further consider whether to include reasons for denial or to limit reporting to summary counts, and whether such information may already be available through other regulatory reporting sources.

Following completion of the informal review, Guillory summarized the next steps. He stated that all proposed items would remain in the draft pending formal motions and votes at the next Working Group meeting. NAIC committee support will revise the draft to reflect the discussion, including relocation of the class action lawsuit item, and repost the updated blank for review. Guillory noted that votes will be required on the LTC MCAS blank at the next meeting and that the data call and definitions would also need to be reviewed and acted upon prior to June.
Guillory confirmed that data call changes require higher-level Working Group approval, while FAQs do not. He reiterated that additional meetings may be scheduled in April or May to complete remaining work prior to the June deadline.

Guillory thanked industry representatives for their comments and invited continued participation during the upcoming line-by-line review and voting process.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.

Draft: 5/26/26

Market Conduct Examination Guidelines (D) Working Group
Virtual Meeting
May 20, 2026

The Market Conduct Examination Guidelines (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met May 20, 2026. The following Working Group members participated: Brett Bache, Chair, (RI); Danielle Torres, Vice Chair, Airic Boyce, Sheri Clark, and Joe Keith (MI); Chelsy Maller and Molly Nollette (AK); Tolanda Coker and Katherine Jessen (AZ); Nick Gill (CT); Tina Ching, Pratima Lele, and Sudi Tasissa (DC); Simone Edmonson, Elizabeth Nunes, and Paula Shamburger (GA); Will Speicher (IA); Jack Engle and Chris Heisler (IL); Mary Lou Moran (MA); Julie Hesser, Teresa Kroll, and Win Nickens (MO); Tracy Biehn and Teresa Knowles (NC); Tyler Erickson and Colton Schulz (ND); Victoria W. Fowler (NH); Ralph Boeckman and Melinda Stalter (NJ); Roger Hayashi and Peggy Willard-Ross (NV); Rodney Beetch (OH); Landon Hubbart, Shelly Scott, and Zach Palank (OK); Sandra Emanuel and Cassie Soucy (OR); David Buono, Michael Humphreys, and Paul Towsen (PA); Rachel Moore (SC); Monica Lopez, Stephen Mondini, Stacie Parker, and Matthew Tarpley (TX); Andrea Baytop, Zuhairah Tillinghast, Bryan Wachter, and James Young (VA); Isabelle Turpin Keiser and Karla Nuissl (VT); Alice Cryer and Sandy Ray (WA); and Jamie Adams, Barbara Belling, Monica Hale, Lori Luder, Darcy Paskey, and Mark Prodoehl (WI).

1. Adopted the Draft of Chapter 21B—Conducting the Pet Insurance Examination for Inclusion in the *Market Regulation Handbook*

Bache said the pet Insurance draft chapter was a carryover item from the Working Group in 2025. State insurance regulator pet insurance subject matter experts (SMEs) developed the chapter in 2025, based upon the *Pet Insurance Model Act* (#633). As of the date of the Working Group meeting, Model #633 has been adopted in some form by 20 jurisdictions, up from 12 since the draft last appeared on the Working Group's agenda in the summer of 2025.

Bache said comments were received on June 23, 2025, on the chapter from Virginia; those comments were distributed and presented by Baytop at the Working Group's July 23, 2025, meeting. Bache had suggested at the July 23, 2025, meeting that the marketing and sales exam standard 3 be removed from the marketing and sales section of the chapter to the underwriting and rating section of the chapter as a new underwriting and rating exam standard 1, where the subject matter would be a more logical fit. Bache said the Working Group decided at the July 23 meeting that the suggested revision would be appropriate to address Virginia's concern.

The change described by Bache was, therefore, made to the May 14 draft; the marketing and sales exam standard 4 was renumbered as marketing and sales exam standard 3; and the typographical error that Virginia noted was corrected.

Schulz made a motion, seconded by Ray, to adopt the May 14 draft of the new Chapter 21B—Conducting the Pet Insurance Examination (Attachment XX). The motion passed unanimously.

2. Discussed the May 14 Draft New Cybersecurity Event Response Coordination Framework

Bache said that at both the 2025 Summer and Fall National Meetings, the Market Regulation and Consumer Affairs (D) Committee discussed developing a Cybersecurity Incident Response Framework to address an effort by state insurance regulators to develop a multi-jurisdictional, coordinated response to regulated entity cybersecurity events. Bache stated that the 2025 and 2026 NAIC leadership have assigned this project to be a high priority.

Bache said a previous version of the draft framework document had been distributed ahead of the Working Group's March 12 meeting and presented at that meeting by Schulz and Buono, who are, respectively, the vice chair of the Cybersecurity (H) Working Group and the chair of the Market Actions (D) Working Group. The Working Group discussion at the March 12 meeting centered on defining triggering thresholds and the complexities of defining lead states.

Miguel Romero (NAIC) presented the revised draft of the Cybersecurity Event Response Coordination Framework document, which was distributed on May 14, to the Working Group. The framework consists of six sections: purpose, scope, and use of this framework; evaluation and response process; coordinating lead state selection; coordinating lead state responsibilities; a flowchart illustrating the framework process; and the framework's relationship to other documents and projects, such as the Cybersecurity (H) Working Group's adopted Cybersecurity Event Response Plan and the NAIC Cybersecurity Event Notification Portal.

Romero said the framework is intended as a starting point for discussion and will be refined based on stakeholder feedback. The framework:

- Includes criteria for determining event scope, such as direct premium written, type of data involved, number of policyholders affected, etc.
- Allows for information gathering, which will be the basis for a recommendation whether or not the framework should apply to a given cybersecurity event.
- Outlines communication protocols for recommendation to NAIC leadership of affected committees.
- Provides for information sharing on market conduct as well as financial solvency concerns.
- Identifies communication protocols for affected stakeholders, as well as for external inquiries.
- Provides a process for identifying a coordinating lead state, based on criteria such as a state with the largest number of domestic insurers, the largest premium volume, etc.
- Outlines the responsibilities of a coordinating lead state.
- The framework is not prescriptive; it is designed to be flexible, so that it can be utilized to allow for a regulator-coordinated response to multiple types of large-scale regulated entity cybersecurity event scenarios.

Schulz said that language should be added to the framework to accommodate a coordinated state insurance regulator response to multistate third-party vendor cybersecurity events.

Bache requested that comments on the framework be sent to Petra Wallace (NAIC) by June 22, 2026. The SME group will reconvene after the comment period to review feedback on the cybersecurity event response framework and discuss revisions at a future working group meeting.

3. Discussed its 2026 Charges and Work Plan

Bache said one of the 2026 charges of the Pharmacy Benefit Management (D) Working Group is to develop new examination standards for pharmacy benefit managers (PBMs) and related regulated entities for inclusion in the *Market Regulation Handbook*. Bache said the Pharmacy Benefit Management (D) Working Group adopted a new Conducting the Pharmacy Benefit Management chapter in late April 2026. Bache said the PBM chapter will be referred to this Working Group for re-exposure, where the Working Group will leverage its members' expertise to incorporate appropriate market conduct examination procedures into the draft PBM chapter.

Bache said that state insurance regulator pharmacy benefit management experts are needed at Working Group meetings when discussion begins on the PBM chapter draft. Bache asked for regulator volunteers with PBM expertise to join the Working Group now, so that productive discussion can occur during the discussion of the draft at future Working Group calls.

Bache said the Working Group will: 1) re-expose a draft of a revised Chapter 21A—Conducting the Property and Casualty Travel Insurance Examination, which was revised in 2025 to take comments received from the U.S. Travel Insurance Association (USTIA) and the American Property Casualty Insurance Association (APCIA) into consideration; 2) continue to develop pet insurance standardized data requests (SDRs) for pet insurance in force policies, claims, and complaints for Working Group exposure; and 3) develop market conduct examiner guidance for inclusion in the handbook based upon the Regulatory Guidance Document adopted by the Accelerated Underwriting (A) Working Group on Aug. 6, 2024, and by the Life Insurance and Annuities (A) Committee at the 2024 Summer National Meeting.

Bache said to address the Working Group's charge to develop a shared regulator-only collaborative space for uniform market conduct procedural guidance and to address the Working Group's charge to coordinate with the Innovation, Cybersecurity, and Technology (H) Committee, the Working Group will: 1) continue to discuss developing a shared regulator-only collaborative space on the Working Group's page in NAIC Connect, which went live in February 2025, to enhance the sharing of regulator-only tools across multiple jurisdictions and 2) continue its ongoing coordination with the Innovation, Cybersecurity, and Technology (H) Committee and its NAIC committee support regarding any recommendations/work products arising out of its 2026 discussions that could lead to developing artificial intelligence (AI)-related market conduct examiner guidance for inclusion in the handbook.

Bache said all forthcoming exposure drafts before the Working Group, such as the accelerated underwriting market conduct examination guidance, the travel insurance chapter revisions, the pet insurance SDRs and the PBM chapter, are subject to the Working Group's standard adoption process (exposure, a comment period or periods, review and discussion at Working Group open meetings, where regulators and non-regulators will have the opportunity to submit and present comments, and ultimately, adoption).

Bache recognized the state insurance regulator insurance SMEs who worked in 2025 on the various Working Group projects, and for their forthcoming work in 2026.

Having no further business, the Market Conduct Examination Guidelines (D) Working Group adjourned.

Draft: 8/25/26

Market Conduct Regulation Modernization (D) Working Group
Columbus, Ohio
August 13, 2026

The Market Conduct Regulation Modernization (D) Working Group met in Columbus, OH, Aug. 13, 2026. The following Working Group members participated: Ann Gillespie, Chair (IL); Angela L. Nelson, Vice Chair (MO); Christine Marasigan (AK); Jimmy Harris (AR); Pam O'Connell (CA); Sheryl Parker (FL); Shannon Hohl (ID); Timothy N. Schott (ME); Danielle Torres (MI); Eric Dunning and Martin Swanson (NE); D.J. Bettencourt (NH); Avani Shah and Mostafa Mahmoud (NY); Todd Oberholtzer (OH); Landon Hubbart (OK); David Buono (PA); Brett Bache and Matthew Gendron (RI); Larry D. Deiter (SD); Tanji J. Northrup (UT); Andrea Baytop and Julie Fairbanks (VA); Mary Block and Karla Nuissl (VT); Sandy Ray (WA); Darcy Paskey and Jamie Adams (WI); and Erin Hunter and Joylynn Fix (WV). Also participating was: Bryan Stevens (WY).

1. Adopted its July 7 Minutes

The Working Group met July 7. During this meeting, it took the following action: 1) adopted its June 9 minutes; 2) received comments from NAIC consumer liaisons on how to modernize market conduct regulation, through enhanced data collection and analysis and expanded public reporting of market conduct trends.

Director Nelson made a motion, seconded by Harris, to adopt the Working Group's July 7 minutes (Attachment Six-A). The motion passed unanimously.

2. Received an Update on its Aug. 4 and July 21 Regulator-to-Regulator Meetings

Director Gillespie said the Working Group met Aug. 4 and July 21 in regulator-to-regulator session pursuant to paragraph 6 (consultation with NAIC staff members related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings. Director Gillespie said the Working Group discussed the NAIC *Market Regulation Handbook* (Handbook) and multistate collaboration. She said the discussions produced constructive feedback on specific changes to the Handbook, including a suggestion to make the Handbook more searchable and interactive as an online tool. She said the Working Group discussed a full spectrum of options regarding multistate collaboration, from the current approach to a more structured process used on the financial side. Director Gillespie said the Working Group began identifying areas where collaboration could be made smoother.

Director Nelson said these discussions identified problems and issues encountered in the multistate process rather than specific processes going forward. Director Gillespie said the Working Group is developing recommendations in 2026 on an overall framework for the modernization effort, will use 2027 to refine the framework's elements and design, and will begin implementing changes in 2028.

3. Discussed Third-Party Oversight and Market Conduct Regulation

Director Gillespie said entities that are not insurance carriers, particularly those involved with data, are increasingly part of the insurance marketplace. Director Nelson opened the discussion by referencing early regulatory experiences with credit scoring in which credit-modeling companies were asked to submit their models for regulatory review. Director Nelson described a market-conduct friction point in examinations in which a company under examination relies on a third-party vendor's model and cannot answer questions about it, while the vendor asserts that the

information is confidential under contract. She said this leads to challenges for state insurance regulators being unable to validate compliance with state laws and said Missouri relies on its statutory authority to access all books and records for examination purposes.

Stevens said examiners increasingly encounter layered subcontracting and that some lower-tier subcontractors believe they are exempt from examination laws. Stevens recommended more stringent requirements for examined companies to disclose all subcontractors and their responsibilities, noting that carriers are sometimes unaware of the layers within their vendor arrangements. Baytop said Virginia law requires insurers to provide convenient access to their files and documents, and a separate statute makes the insurer responsible for a third party's conduct where the insurer lacks controls.

The Working Group discussed a range of third parties in use, including managing general agents (MGAs), third-party administrators (TPAs), and vendors handling specific functions such as proof of mailings and cancellation notices. Baytop described examinations in which a TPA handles all or part of a book of business, with insurer oversight of TPAs varying widely. Fix, speaking from the health insurance and pharmacy benefit manager (PBM) perspective, said there is extensive delegation in prior authorization and utilization review to third-party entities with insurers exercising little oversight. O'Connell reported similar experiences with MGAs, TPAs, and third-party vendors that support specific underwriting functions such as estimating annual mileage.

Nuissl said it is concerning that a violation or complaint attributable to a TPA can be enforced against a particular insurer but not directly against the TPA, which may be working with many insurers. Swanson said Nebraska has the authority to hold insurers accountable, but he suggested the NAIC *Third Party Administrator Guideline* (GL 1090) may need to be revised to hold TPAs more accountable for their practices. O'Connell said California holds insurers accountable for the practices of TPAs with reasonable success. Stevens noted that enforcement mechanisms, such as suspending or revoking a TPA's or insurer's license, harms policyholders and urged the development of solutions that encourage compliance rather than suspension or revocation of a license. Mahmoud said New York's audit program reviews whether a company's internal audit function tests a TPA's compliance with state laws at least annually.

Director Gillespie asked whether there is a need to develop standards, potentially through a model law, to address insurer oversight of these entities. Gendron said he agrees with Virginia's comments and noted that GL 1090 requires insurance companies to perform periodic audits of TPAs operations, while also emphasizing that an insurer remains responsible for the claims or underwriting functions that are contracted to a third party to perform.

The Working Group discussed whether states need additional authority for direct regulation of TPAs. Swanson suggested starting with a review to identify which states have adopted GL 1090. Mahmoud said New York licenses TPAs only for the health line of insurance but reviews all insurance company TPA agreements during examinations, and it holds companies responsible for their audit obligations. Block said Vermont adopted the GL 1090 years ago and is seeking to update its laws due to the increased use of third parties and recent market conduct work. Carpenter said Alaska is moving to full licensure of TPAs and PBMs to close regulatory gaps and the need for additional oversight tools.

J.P. Wieske (Monument Advocacy) said several NAIC health model acts already presume insurer responsibility and cautioned that any TPA guideline updates avoid creating conflicting standards or competitive disparities in states that have adopted the health model acts.

Peter Kochenburger (Southern University Law Center—SULC) raised concerns about the use of artificial intelligence (AI) in claims and by TPAs. Eric Eversman (Automotive Education & Policy Institute—AEPI) urged the Working Group to consider expanding regulation of third parties or making clear to insurers that they are responsible for the acts of their TPAs and lower-tier contractors.

4. Discussed the Use of Financial Data for Market Conduct Insights

Jeff Czajkowski (Center for Insurance Policy and Research—CIPR) presented an example of integrating financial and market data to support pre-examination analytics and the identification of potential target examinations. Czajkowski described the recently released *Examining Homeowner Property Insurance Health Dynamics* report leveraging Market Conduct Annual Statement (MCAS) data, focusing on one element (the number of claims closed with payment during the period) normalized by the number of policies in force. He said that for 2024, the data showed an average of 71.2 claims closed with payment per 1,000 policies across NAIC zones and company types, with claim frequency generally increasing since 2018. To capture claim severity, Czajkowski said NAIC financial data was matched to company codes within the MCAS filings, reflecting roughly $98.1 billion in total losses for 2024, and average claim severity ranging from about $12,500 to $14,500 across NAIC zones. Czajkowski also presented underwriting profit as a percentage of direct premiums earned, which reflects sustained pressure on the homeowners market since 2018.

Czajkowski said the financial analysis helps explain why market adjustments occur and that supplementing market conduct data with financial data provides additional insights to analyze the overall market. Director Nelson said that many financial statement data elements may be more predictive for identifying companies and lines of business to review, and she asked whether any elements stood out. Director Nelson and Czajkowski discussed litigation costs as a traditional indicator of claims resistance and the value of partnering with NAIC committee support to understand additional data elements that would be beneficial.

Tim Mullen (NAIC) said the Market Analysis Prioritization Tool (MAPT) incorporates premium, loss, and expense information, as well as certain financial Insurance Regulatory Information System (IRIS) ratios, and he suggested the MAPT be reviewed in more detail. Stevens said the MAPT provides raw data but does not indicate what the values mean. Baytop said a substantial amount of financial data is used for market analysis and that additional financial data should demonstrably improve the market analysis process.

The Working Group discussed comparing completed examination findings against financial and market analysis data, with several Working Group members noting that market analysis has proven predictive and that consumer complaints remain the single best predictor of issues. Harris expressed interest in a tool, ideally added to State Based Systems (SBS), to help states analyze complaints and identify trends.

5. Discussed Other Matters

Director Gillespie said the Working Group plans to next meet Sept. 2 and Sept. 15 in regulator-to-regulator session, pursuant to paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings, to discuss state training needs and state workforce development, respectively.

Having no further business, the Market Conduct Regulation Modernization (D) Working Group adjourned.

Draft: 8/3/26

Market Conduct Regulation Modernization (D) Working Group
Virtual Meeting
July 7, 2026

The Market Conduct Regulation Modernization (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met July 7, 2026. The following Working Group members participated: Ann Gillespie, Chair (IL); Angela L. Nelson, Vice Chair (MO); Heather Carpenter (AK); Jimmy Harris (AR); Pam O'Connel and Don McKinley (CA): Sheryl Parker (FL); Tia Nichols (ID); Lisa Fullington (LA); Timothy N. Schott (ME); Danielle Torres (MI); Martin Swanson (NE); Yewande Jordan (NH); Hermoliva Abejar (NV); Avani Shah (NY); Todd Oberholtzer (OH); Ashley Scott (OK); Dave Buono (PA); Elizabeth Kelleher Dwyer and Matt Gendron (RI); Travis Jordan (SD); Tanji J. Northrup (UT); Andrea Baytop and Julie Fairbanks (VA); Karla Nuissl (VT); Sandy Ray (WA); Jamie Adams (WI); and Joylynn Fix (WV).

1. Adopted its June 9 Minutes

The Working Group met June 9. During this meeting, it took the following action: 1) adopted its May 26 minutes; and 2) heard comments from life insurance industry representatives.

Director Nelson made a motion, seconded by Director Dwyer, to adopt the Working Group's June 9 minutes (Attachment Six-A1). The motion passed unanimously.

2. Received Comments from NAIC Consumer Liaison Representatives

Commissioner Gillespie welcomed the NAIC consumer liaison representatives, coordinated by Harold M. Ting (Individual Health Care Consumer Advocate), for the Working Group's fourth listening session. Representatives presented comments across several themes.

A. Data Collection and Infrastructure

Eric Ellsworth (Checkbook Health/Center for the Study of Services—CSS) offered recommendations on data collection and infrastructure, noting the broader trend across the insurance industry toward storing data in data lakes and warehouses. Ellsworth recommended orientation toward centralized data lake architectures for market conduct data, which would allow regulators to collect and review more granular data. He encouraged state insurance regulators to have insurers send large-scale data uploads directly to regulatory infrastructure, rather than the current submission methods, which include filing PDFs or spreadsheets. Ellsworth said this would be similar to the data exchanges insurers already conduct with third parties.

Ellsworth suggested using standardized application programming interfaces (APIs) across insurance lines of business, which is commonly used between health insurers and third parties. Ellsworth further suggested increased public release of data similar to what the federal government releases. Ellsworth said state insurance regulators would also benefit from asking insurers to write into contracts with third parties contractual provisions granting regulators access to the third-party vendor platform.

Ellsworth then suggested using automated monitoring tools to detect patterns, such as dark patterns on insurer websites. Ellsworth said new artificial intelligence (AI) tools, such as large language models (LLMs), make it possible to build an application to observe company behavior.

B. Company-Level Performance Metrics

Ting recommended that states collect and publish company-level performance metrics that are valuable to consumers. For property/casualty (P/C) insurance, Ting suggested regulators publish the average time to settle claims, dispute rates, and policy cancellation rates. For health insurance, Ting suggested regulators publish prior authorization denial rates, medical necessity denial rates, and appeal reversal rates.

Ting said states should use a different regulatory authority to collect Market Conduct Annual Statement (MCAS) data to enable public disclosure. Director Gillespie asked if this information would be aggregated or company-specific. Ting said the data should be reported at the company level and added that additional recommendations on publishing prior authorization data would be provided.

Carl Schmid (HIV+Hepatitis Policy Institute) supported additional granular public reporting, including plan-level and claim-level data, particularly in the health care sector. Schmid referenced public reporting in California as an example of information that assists consumers in deciding which health care plan is best for them. Schmid noted that the NAIC currently releases only aggregated, national health care MCAS ratios and requested that the NAIC release state and company-level health care MCAS ratios.

C. Public Reporting of Exam Findings

Wayne Turner (National Health Law Program—NHeLP) cited the Oregon Division of Financial Regulation as a model for public reporting of market conduct findings under the Reproductive Health Equity Act. Oregon publishes plan-level findings, carrier responses, and next steps on a public website. Turner acknowledged the importance of regulators examining companies' practices but said that, similarly, public reporting of information is important for consumers.

D. National Public Exam Report Portal

Brendan Bridgeland (Center for Insurance Research—CIR) provided his views on what he hears about the insurance industry's reputation and said he is concerned about the depiction of the insurance industry on social media. Bridgeland said public access to insurance records, market conduct, and financial information needs to be improved. He recommended that the NAIC collect closed market conduct exam reports from each state and create a public, searchable electronic repository. Bridgeland said obtaining access to such records currently requires extensive Freedom of Information Act (FOIA) requests and website searches for consumers, consumer advocates, and academics. Bridgeland requested a formal Market Regulation and Consumer Affairs (D) Committee charge to develop such a repository, noting that an earlier initiative to do so was not completed.

E. AI and Telematics Data

Chuck Bell (Consumer Reports) raised concerns about the sale of manufacturer-collected telematics data and mobile-app data to insurers without meaningful consumer disclosure. He cited investigations involving General Motors, LexisNexis, Verisk, Allstate, and Arity, and referenced the Texas Attorney General's lawsuit against Allstate and Arity for violating Texas privacy and insurance laws. Bell referenced the NAIC *Model Bulletin on the Use of Artificial Intelligence Systems by Insurers'* notice and access provisions and recommended regulatory investigation of insurers' receipt and use of such data.

F. P/C Market Conduct Exam Practices

Erica Eversman (Automotive Education & Policy Institute—AEPI) raised concerns regarding insurers' responses to market conduct exam questions that rely on proprietary or branded terminology. She characterized this behavior as "intentional obtuseness" and asked regulators not to accept it. Eversman also raised concerns about the limitations of random sampling in identifying systemic issues and the proportionality of sanctions imposed on insurers compared with those imposed on service providers subject to consumer protection laws. Eversman also recommended greater public access to complete market conduct exam reports.

G. Structural Critique

Birny Birnbaum (Center for Economic Justice—CEJ) offered a critique of market conduct regulation, suggesting the ongoing regulatory discussion focuses on costs to insurers and minor changes in other areas, but does not address structural issues or gaps in consumer protection.

Birnbaum cited delayed monitoring of consumer market outcomes (noting that MCAS data is analyzed 18 to 20 months after the beginning of the experience period); slow enforcement actions after violations occur; limited publicly available data to consumers to evaluate insurer practices; limited publicly available data for academic and consumer research (contrasted with Home Mortgage Disclosure Act data); the absence of a defined disparate impact testing standard; the lack of rigorous consumer testing of consumer education and disclosure tools; unaddressed antitrust and collusion risks associated with third-party data and model vendors; and insufficient resources for market regulation relative to financial regulation.

Birnbaum advocated for transaction-level data collection through statistical agents, citing Texas' 1995 implementation and workers' compensation reporting as precedents. Birnbaum said that granular transaction-level data would not typically be used by individual consumers, but it would support summary reporting for state insurance regulators, consumer groups, and academics. Birnbaum said the use of the transaction-level data could be modeled on how Home Mortgage Disclosure Act data has supported research and analysis in the lending market.

H. Claims Handling Transparency

Ken Klein (California Western School of Law) emphasized the information asymmetry between insurers and consumers, particularly in claims handling. He described claims handling as the point at which consumer protection concerns most concretely arise and noted that litigation is currently the primary consumer remedy in the absence of regulator intervention. Klein recommended a more extensive public-market conduct examination of claims-handling practices.

I. Market Actions (D) Working Group Collaboration

Buono, chair of the Market Actions (D) Working Group, offered to coordinate ongoing efforts with consumer representatives. Schmid acknowledged the standing offer and reiterated his interest in formalizing the mechanism allowing consumer representatives to present on those patterns of company conduct to the Working Group.

3. Discussed Other Matters

Director Gillespie said the Working Group would conduct additional deep-dive discussions in late summer and early fall. Tim Mullen (NAIC) said the next Working Group meeting will occur at the Summer National Meeting and will focus on third-party oversight. Mullen said regulator-only meetings will occur on July 21 to discuss interstate collaboration and Aug. 4 to discuss the *Market Regulation Handbook*.

Having no further business, the Market Conduct Regulation Modernization (D) Working Group adjourned.

Draft: 7/7/26

Market Conduct Regulation Modernization (D) Working Group
Virtual Meeting
June 9, 2026

The Market Conduct Regulation Modernization (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met June 9, 2026. The following Working Group members participated: Ann Gillespie, Chair (IL); Angela L. Nelson, Vice Chair (MO); Heather Carpenter (AK); Jimmy Harris (AR); Pam O'Connell (CA); Sheryl Parker (FL); Timothy N. Schott (ME); Danielle Torres (MI); Gregory Maus (MN); Martin Swanson (NE); Ned Gaines (NV); Avani Shah (NY); Todd Oberholzer (OH); Landon Hubbart (OK); David Buono (PA); Matthew Gendron (RI); Tony Dorschner (SD); Adrea Baytop and Julie Fairbanks (VA); Mary Block (VT); Karen Brooks (WA); Jamie Adams (WI); and Joylynn Fix (WV). Also participating was: Colton Schulz (ND).

1. Adopted its May 26 Minutes

The Working Group met May 26. During this meeting, it took the following action: 1) adopted its May 11 minutes; and 2) heard comments from health insurance industry representatives.

Commissioner Harris made a motion, seconded by Director Carpenter, to adopt the Working Group's May 26 minutes (Attachment Six-A1a). The motion passed unanimously.

2. Heard Comments from Life Insurance Representatives

Director Nelson led the Working Group's third industry listening session, focused on life insurance, insurtech, and specialty lines insurance. Kristen Wolfford (American Council of Life Insurers—ACLI) and Sarah Wood (Insured Retirement Institute—IRI) provided comments, noting that written feedback with more detailed examples and recommendations would follow.

A. Market Conduct Data Collection and Analysis

Wolfford said this is the area where the ACLI expects to provide the most written detail. She said insurers want to understand why specific data elements are requested and how they will be used because without that context, data can inadvertently signal something unintended or fail to get to the real issue. Wolfford said clearer explanations, frequently asked questions (FAQs), and more standardized understanding of data elements would be helpful.

Wood said there is broad support for standardization that allows insurers to build one repeatable process. Wolfford noted interest in standardized file layouts and validation tools to improve data quality and efficiency.

Consumer representative Birny Birnbaum (Center for Economic Justice—CEJ) commented that one granular data report can be more efficient than multiple limited data calls and cited detailed principles-based reserving (PBR) reporting in life insurance as an example of a more efficient model.

B. Examination Handbook and Processes

Wolfford stated that ACLI members frequently cite inconsistency in the interpretation of the NAIC *Market Regulation Handbook.* She said members want greater transparency about why exams are being conducted and what information is needed so they can involve the right internal staff and provide the best information. She also noted that secure collaboration tools should account for file size and format limitations. Wood said IRI members also reported issues with scope changes during exams, short deadlines for complex data requests, and overlapping follow-up requests from multiple examiners.

C. Interstate Collaboration

Wolfford stated that while full uniformity is not possible because of statutory differences, the required timeliness of company responses often varies significantly and can create a non-uniform consumer experience because companies must devote disproportionate resources to some states. She also noted practical issues with how deadlines are calculated and suggested that providing actual due dates, rather than ambiguous day counts, would be helpful. Wolfford said the ACLI supports exploration of the "one ask" principle across jurisdictions and proposed one, centralized point for companies to update contacts for insurance departments.

Wood said that a lead-state model for multistate exams generally works well and that complaint handling may be a strong pilot candidate for improved coordination.

Schulz asked whether industry groups already promote common data standards or definitions that state insurance regulators could leverage. Wolfford said the ACLI would address that question in its written comments. Gendron said some standardized response-time rules exist in NAIC model regulation, but lack of adoption can contribute to inconsistency.

D. Other Entity Oversight (Third-Party Oversight)

Wolfford stated that the ACLI had less-developed feedback at this stage but noted practical problems involving third-party permissions and access. Wood said turnaround times for answering requests involving third-party administrators (TPAs) are also a recurring challenge.

E. Corrective Actions, Communications, and Enforcement

Wolfford stated that ACLI members have seen examples where informal dialogue prior to a formal inquiry or exam clarified issues early and avoided a more time-consuming process. She said the ACLI would provide more detail on opportunities for informal communication, realistic timelines, and tiered approaches to corrective action.

F. Consumer Complaints

Wolfford stated that ACLI members report wide variation in definitions, such as confirmed/not confirmed, justified/unjustified, resolved/closed, complaint reason, disposition, line of business, allegation category, and company error. She said ACLI members want greater visibility into whether a complaint has been confirmed or justified so they can conduct root-cause analysis. She also said there is significant state-to-state variation in the amount of detail requested for complaints and that any complaint portal or communication system, which could be developed, should support large files and secure, company-based authentication.

Wood stated that IRI members reported similar concerns, including the need for standard definitions, better visibility into complaint status, and more consistent timelines.

3. Discussed Other Matters

Tim Mullen (NAIC) said the Working Group plans to next meet July 7 and will focus on consumer representatives. Director Gillespie outlined several themes she would like consumer representatives to address, including their reactions to issues raised during the industry sessions, broad consumer issues, what data they seek and how they would use it, and where the market conduct exam process remains unclear.

Erica Eversman (Automotive Education & Policy Institute—AEPI) and Ken Klein (California Western School of Law) asked whether consumer representatives could raise concerns with NAIC-imposed data access and transparency restrictions. Director Gillespie said the Working Group would be open to receiving comments on those issues.

Having no further business, the Market Conduct Regulation Modernization (D) Working Group adjourned.

Draft: 6/3/26

Market Conduct Regulation Modernization (D) Working Group
Virtual Meeting
May 26, 2026

The Market Conduct Regulation Modernization (D) Working Group met May 26, 2026. The following Working Group members participated: Ann Gillespie, Chair (IL); Angela L. Nelson, Vice Chair (MO); Heather Carpenter (AK); Pam O'Connell (CA); Christina Huff for Sheryl Parker (FL); Tim Schott (ME); Danielle Torres for Anita Fox (MI); T.J. Patton (MN); Ned Gaines (NV); Victoria Fowler (NH); Todd Oberholzer (OH); Landon Hubbart (OK); Michael Humphreys (PA); Matt Gendron for Beth Dwyer (RI); Travis Jordan (SD); Tracy Klausmeier (UT); Scott White (VA); Daniel Nussbaum (VT); Sandy Ray (WA); Joylynn Fix (WV); and Jamie Adams (WI). Also participating was: Mary Lou Moran (MA).

1. Adopted its May 11 Minutes

The Working Group met May 11. During this meeting, it took the following action: 1) adopted its April 9 minutes; 2) received a public update on its April 22 and April 30 regulator-to-regulator meetings; and 3) heard comments from property/casualty (P/C) industry representatives.

Director Nelson made a motion, seconded by Commissioner Humphreys, to adopt the Working Group's May 11 minutes (Attachment Six-A1ai). The motion passed unanimously.

2. Heard Comments from Health Insurance Industry Representatives

Director Nelson led the Working Group's second industry listening session, focused on health insurance. She said that today's meeting would follow the same approach as the Working Group's May 11 meeting, when it heard comments from P/C industry representatives. She added that this meeting would use the same format, guided by the discussion questions sent in advance to encourage conversation and feedback. She said the first topic to cover would include data collection and data analysis, which could also include discussions on data standards, definitions, systems, legacy constraints, and data quality to ensure regulatory efforts are effective and efficient.

LaCosta Wix (America's Health Insurance Plans—AHIP) provided comments on behalf of the health insurance industry. She said detailed written responses will follow this discussion.

A. Market Conduct Data

Wix stated that reviews should be risk-focused, proportionate to the level of consumer harm, and tied to specific statutory authority. She said that state insurance regulators should rely on existing tools such as the Market Analysis Prioritization Tool (MAPT) and the Market Conduct Annual Statement (MCAS) and that use of those tools should be transparent. Wix said there should be guardrails for document and data access that balance regulator needs with operational burden and the protection of trade secrets and non-public information. She added that templates, definitions, and data elements should be consistent where feasible and that industry input should be sought in their development.

Wix credited the NAIC's work on the Innovation, Cybersecurity, and Technology (H) Committee's Data Call Study Group and its ongoing work to inventory data as a helpful initiative. Director Nelson acknowledged the chair of the Study Group, Colton Schulz, for his ongoing efforts.

Director Nelson asked Wix to clarify the distinction between reviews tied to the law and assessments of operational methodology. Wix stated that a well-defined scope, communicated up front with opportunity for input, helps keep examinations risk-focused. Commissioner Gaines requested specifics be provided in the health insurance industry's written comments on where industry feels exams are unfocused. Director Nelson asked how state insurance regulators can better facilitate dialogue with industry, and Wix said that industry input at the outset, when scope is being defined, is most valuable.

B. Examination Handbook and Processes

Wix said the exam scope should be defined up front, with an opportunity for entities to raise concerns early and again if the scope changes. She recommended state insurance regulators develop additional guidance and model response frameworks. She said sampling should be statistically valid and consistent with the *Market Regulation Handbook* (Handbook) and that anything beyond handbook-aligned samples be tied to articulated risk indicators. Wix stated response timelines should reflect operational effort. She recommended stricter handbook adherence by contract examiners. Additionally, she said examiner practices and billing should be transparent and tied to the exam scope. She stated exam efficiency is itself a consumer protection issue.

Director Nelson asked whether there is a perceived difference between insurance department employees and contract examiners. Wix stated she would address this in written comments, but she acknowledged that at times, sample sizes can get large when contract examiners are used. Moran stated that in Massachusetts, contractors operate under close department supervision and requested specifics in written comments. Director Nelson questioned whether sampling is necessary for automated health claims. Director Carpenter requested more detail on contractor concerns. Director Gillespie asked for specific examples of risk-based versus non-risk-based approaches. Wix provided broad examples that would indicate possible consumer harm, such as worsening complaint ratios, deterioration in claims handling, increased litigation, and changes in the company's financial condition. Wix said they would address this in more detail in their written comments. Director Gillespie also highlighted trends in how prior authorization is used, noting that state insurance regulators sometimes find it necessary to inquire about operational matters as well. Commissioner Gaines noted that states have unique laws with real consumer impact that can be the basis for targeted exams.

Wix said that exams should focus on the governance and risk management practices of the regulated entity, with deeper inquiry warranted where risk indicators support it. Director Nelson noted the importance of this topic for health insurance, given reliance on third parties for utilization review. She asked for written feedback on how state insurance regulators can access third-party data and ensure good company governance.

C. Interstate Collaboration

Wix acknowledged that state law variations make interstate collaboration particularly challenging on the health insurance side. She stated that centralized data collection, process consistency, avoiding duplicative requests, and using existing NAIC tools are helpful. Director Nelson asked how state insurance regulators can best encourage companies to make needed programming fixes, such as a diagnostic code that is incorrectly cross-referenced, on a national basis rather than just state-specific fixes. Director Gillespie noted emerging legislation on data-driven claims determinations, and she asked Wix to address in written comments how regulators can balance legislative requirements with industry concerns in multi-state exams. Wix stated that confidentiality is the top concern. Director Nelson asked members to identify any gaps in existing confidentiality protections.

D. Corrective Actions, Communications, and Enforcement

Wix stated that entities should be given clear notice of potential violations and an opportunity to respond before findings are finalized. She added that penalties should be proportionate to the risk of harm and consumer impact. Director Nelson asked whether AHIP's members feel they are being given adequate opportunity to provide a rebuttal during exams, and Wix said she would seek more feedback.

E. Consumer Complaints

Wix agreed with concerns regarding coding inconsistency and reconciliation variability. She stated that if a complaint portal is explored, it should be developed with a strong focus on protecting confidentiality, particularly given protected health information (PHI) and other non-public health information.

Having no further business, the Market Conduct Regulation Modernization (D) Working Group adjourned.

Draft: 5/20/26

Market Conduct Regulation Modernization (D) Working Group
Virtual Meeting
May 11, 2026

The Market Conduct Regulation Modernization (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met May 11, 2026. The following Working Group members participated: Ann Gillespie, Chair (IL); Angela L. Nelson, Vice Chair (MO); Heather Carpenter (AK); Jimmy Harris (AR); Pam O'Connell (CA); Sheryl Parker (FL); Dean L. Cameron represented by Shannon Hohl (ID); Timothy N. Schott (ME); Amy Bonito and Renee Campbell (MI); Sara Payne (MN); Martin Swanson (NE); Victoria Fowler (NH); Kaitlin Asrow (NY); Guy Self (OH); Michael Humphreys and David Buono (PA); Elizabeth Kelleher Dwyer, Matthew Gendron, and Brett Bache (RI); Travis Jordan, Tony Dorschner, and Haelly Pease (SD); Tanji J. Northrup (UT); Scott A. White, Andrea Baytop, and Julie Fairbanks (VA); Karla Nuissl and Mary Block (VT); Sandy Ray (WA); Jamie Adams (WI); and Joylynn Fix (WV). Also participating was: Colton Schulz (ND).

1. Adopted its April 9 Minutes

The Working Group met April 9 and discussed its charges and plans for 2026. Director Nelson made a motion, seconded by Swanson, to adopt the Working Group's April 9 minutes (Attachment Six-A1aii). The motion passed unanimously.

2. Received a Public Update on Regulator-to-Regulator Calls of April 22 and April 30

Director Gillespie stated that summary materials of the regulator-only calls held April 22 and April 30 were included in the meeting materials. The calls focused on the Market Conduct Annual Statement (MCAS) data, NAIC Market Conduct Systems, and the NAIC's capabilities to support data analytics. Director Gillespie said Jeff Czajkowski (NAIC) and Scott Morris (NAIC) will advise the Working Group throughout the process. Director Gillespie encouraged all parties to review the materials and said that any questions should be raised as the Working Group's discussions continue.

3. Heard Comments from Property/Casualty Industry Representatives

Director Nelson led the Working Group's first industry listening session focused on the property/casualty (P/C) industry. Director Nelson said the Working Group would like to receive structured, substantive feedback on what is working and where modernization can deliver value for regulators, consumers, and insurers. Director Nelson said a detailed set of questions for the industry was distributed with the meeting materials. Industry representatives were given until July 15 to submit written responses.

A. Market Conduct Data

Nelson said the goal is to gather input on both how regulators collect market conduct data and how that data is used to inform regulatory actions. Nelson requested feedback on whether data collection could be streamlined, whether existing definitions and submission processes are working effectively, and how concerns about data validation and data quality might be addressed to improve regulatory analysis and decision-making.

Lisa Brown (American Property Casualty Insurance Association—APCIA) said the industry's primary request is for more uniform definitions of data elements across states, which would allow companies to program queries once

and reuse them to produce data to states in a more efficient and consistent manner. Brown said state-specific data calls using different definitions result in costly reprogramming and lower-quality data. Brown recommended the NAIC develop standardized data call templates and regularly train department staff on available resources, citing the Northeast Zone post-disaster data call template as a successful model. Brown said short turnaround times contribute to data quality issues. Brown said the NAIC has standardized data requests in the NAIC *Market Regulation Handbook*, and that there is a need to raise greater awareness about these requests and their use in a uniform manner. Erica Weyhenmeyer (National Association of Mutual Insurance Companies—NAMIC) reinforced the consistency theme, noting that legacy systems make reprogramming particularly costly.

Schulz described the work of the Data Call (H) Study Group of the Innovation, Cybersecurity, and Technology (H) Committee, which is indexing all existing data definitions to create a single inventory and reduce duplicative ad hoc data elements. He explained the goal as identifying authoritative definitions for data elements so regulators and the industry can reference a shared inventory of data definitions and eliminate the need for regulators to request data already collected through standardized NAIC data collections, such as MCAS. Miguel Romero (NAIC) stated that he was coordinating a briefing by Schulz for the Working Group's leadership.

J.P. Wieske (Council for Affordable Health Coverage—CAHC) introduced a concept drawn from HIPAA's "minimum necessary" principle, stating that regulators should request only the minimum amount of information necessary to meet regulatory goals. Brown offered to share the APCIA's board-adopted data call principles and best practices document, which recommends pre-issuance consultation with the industry.

B. Examination Handbook and Processes

Director Nelson said the Working Group wants feedback on exam processes, starting with pre-exam expectations, risk identification, targeting, operational exam tools, and ways to reduce burdens on the industry while recognizing that burdens also fall on regulators.

Brown stated that the handbook provides a roadmap for both regulators and the industry, but many states are not using it, which undermines uniformity. Weyhenmeyer stated the handbook was appropriately developed as a guideline but noted significant variation in state statutes, which creates inconsistency in exam triggers, scope, and expectations.

Director Nelson said insurers have expressed a desire for greater transparency into the reasoning behind exams. Brown said this helps companies determine which staff to engage to address examination questions. Chris Palmieri (Travelers) suggested developing an information-sharing tool, similar to the System for Electronic Rates & Forms Filing (SERFF), to capture regulator requests during an examination. Weyhenmeyer noted that the Market Conduct Examination Guidelines (D) Working Group has a charge to develop standardized templates for reports and criticisms, though progress has been slow.

C. Interstate Collaboration

Director Nelson said interstate collaboration is a challenge in market regulation compared to financial regulation due to differences in state laws and the complexity of coordinating multi-state actions. She emphasized interest in ideas that reduce duplication and asked how insurers could be incentivized to remediate problems identified in one state across all impacted states, rather than limiting remediation to the initiating state.

Brown stated that companies would be more willing to self-audit and remediate across states if they did not face the potential of fines for self-reporting, describing this as the self-audit privilege issue. Brown recommended the NAIC compile and publish anonymized common exam findings so the industry can proactively self-audit against trends. Carol Emory (APCIA) stated that more than 50% of states make some exam information publicly available and offered to provide a summary of her findings. Brown said that if regulators could share common criticisms across states, this might reveal unclear statutes/regulations (leading to differing carrier interpretations) or widespread errors that carriers could identify through self-audits. There was discussion about a self-audit privilege model act, which Tim Mullen (NAIC) mistakenly referenced as an NAIC model rather than a National Council of Insurance Legislators (NCOIL) model act. Brown said she would include a proposed plan regarding the self-audit privilege in written comments.

D. Corrective Actions, Communications, and Enforcement

Director Nelson asked for feedback on realistic remediation timelines that could potentially be standardized. She also asked what data sets or metrics could demonstrate that remediation worked and what reporting could show improved consumer outcomes. Weyhenmeyer said standardized timelines for corrective actions are difficult because each corrective action depends on the issue and the company system involved. Industry representatives indicated that additional details would be provided in their written responses after they have had an opportunity to confer with their member companies.

E. Consumer Complaints

Director Nelson said consumer complaint processing is a frequent topic and previewed multiple sub-issues, including transparency in complaint coding, state-to-state variability, complaint reconciliation practices, and how complaints can be a primary factor for initiating examination activity.

Brown emphasized the need for consistency in complaint coding and raised concerns about NAIC complaint data released on the NAIC's Consumer Insurance Search being used by academics and media to rank companies. Brown supported a centralized complaint portal and raised the growing challenge of AI-generated complaints. Weyhenmeyer agreed on coding consistency, especially regarding the coding of confirmed and non-confirmed complaints.

Amy Bach (United Policyholders) cautioned against discounting complaints because they appear AI-generated and emphasized that market conduct exams evaluating claim handling remain a core regulatory function. Ken Klein (NAIC Consumer Representative) urged caution before marginalizing any consumer complaint, noting that most consumers who experience problems do not file complaints. Brendan Bridgeland (Center for Insurance Research) stated that consumers need public information on insurer market conduct performance for competitive market purposes. Brown and Weyhenmeyer clarified that they were not suggesting that complaints be ignored and offered to participate in a follow-up session after collecting member input.

4. Discussed Other Matters

Director Gillespie said the next meeting is scheduled for May 26 and will be a listening session with health insurance industry representatives.

Having no further business, the Market Conduct Regulation Modernization (D) Working Group adjourned.

Draft: 5/6/26

Market Conduct Regulation Modernization (D) Working Group
Virtual Meeting
April 9, 2026

The Market Conduct Regulation Modernization (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met April 9, 2026. The following Working Group members participated: Ann Gillespie (IL), Chair; Angela L. Nelson (MO), Vice Chair; Heather Carpenter (AK); Jimmy Harris (AR); Pam O'Connell and Don McKinley (CA); Sheryl Parker (FL); Dean L. Cameron (ID); Danielle Torres (MI); Martin Swanson (NE); Emily Doherty, Victoria Fowler, and Michelle Heaton (NH); Avani Shah (NY); Todd Oberholtzer (OH); Landon Hubbart (OK); Michael Humphreys and David Buono (PA); Matthew Gendron (RI); Tony Dorschner (SD); Tanji J. Northup (UT); Andrea Baytop and Julie Fairbanks (VA); Mary Block and Karla Nuissl (VT); Sandy Ray (WA); Jamie Adams (WI); and Joylynn Fix (WV).

1. Discussed its Work Plan

Director Gillespie reviewed the Working Group's charge to assess, with input from NAIC members and interested stakeholders, the current market conduct regulatory framework and the potential need for changes in response to evolving markets, business models, and consumer expectations. She said the Working Group is charged with developing recommendations to improve and modernize the market conduct regulatory framework. Director Gillespie said the Working Group's recommendations are intended to identify priorities and future workstreams rather than implement immediate, detailed regulatory changes. She stated that technical implementation work would occur beyond the current year.

Director Gillespie said the Working Group will review the following areas, noting that they are intentionally broad and serve as a starting point for discussion: 1) market conduct data collection and analysis; 2) interstate collaboration for analysis and examinations; 3) the *Market Regulation Handbook*; 4) NAIC support and systems; 5) training; and 6) other entity oversight.

Director Gillespie reviewed the timeline of the Working Group's efforts, noting initial discussions occurred earlier in the year and that the Working Group is now beginning a series of biweekly meetings. She said a progress update would be provided to commissioners at the Commissioners' Mid-Year Roundtable, and the goal is for the Market Regulation and Consumer Affairs (D) Committee to consider adoption of the Working Group's recommendations at the Fall National Meeting.

Director Gillespie said regulator-to-regulator meetings in April and May will focus on regulator-only databases at the NAIC and analytical tools. These discussions will address current capabilities, planned enhancements, and resource considerations. Public updates regarding these meetings will be provided.

Director Gillespie said the Working Group will hold listening sessions with interested parties between April and the Summer National Meeting. The listening sessions will be organized by product line, and industry is encouraged to identify concerns, challenges, and recommendations. Consumer input will also be solicited through the NAIC consumer liaison representatives, and a meeting will be devoted to receiving this input.

Director Gillespie said the regulator-to-regulator meetings in July and August will address interstate collaboration, the *Market Regulation Handbook*, state insurance regulator training needs, and third-party oversight. Public updates regarding these meetings will be provided.

Director Gillespie said the Working Group will conduct deeper discussions through September, October, and November to focus on developing formal recommendations.

Erica Eversman (Automotive Education & Policy Institute—AEPI) asked if consumer input could be organized by line of business to reflect differing consumer issues. Director Gillespie said this approach would be accommodated. J.P. Wieske (Council for Affordable Health Coverage—CAHC) expressed support for the initiative, noting the potential benefits of improved data use and enhanced interstate coordination.

Having no further business, the Market Conduct Regulation Modernization (D) Working Group adjourned.

Draft: 6/29/26

Market Regulation Certification (D) Working Group
Virtual Meeting
May 21, 2026

The Market Regulation Certification (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met May 21, 2026. The following Working Group members participated: Bryan Stevens, Chair (WY); T.J. Patton, Vice Chair (MN); Chelsy Maller (AK); Jimmy Harris (AR); Daniel Mathis (IA); Chris Heisler (IL); Mary Lou Moran (MA); Penny Schuster (MD); Win Nickens (MO); Teresa Knowles (NC); Martin Swanson (NE); Victoria Fowler (NH); Landon Hubbart (OK); Gary Jones (PA); Rachel Moore (SC); Tanji Northrup and Tracy Klausmeier (UT); Julie Fairbanks and Mel Gerachis (VA); Jared Holshouser (VT). Also participating were: Darcy Paskey (WI).

1. Adopted its Nov. 17, 2025 Minutes

The Working Group met on Nov. 17, 2025 and adopted the new requirement 12 – Market Analysis.

Patton made a motion, seconded by Ray, to adopt the Working Group's Nov., 17 minutes *(see NAIC Proceedings – Fall 2025, Market Regulation and Consumer Affairs (D) Committee, Attachment Four)*. The motion passed unanimously.

2. Discussed the Status of the Voluntary Market Regulation Certification Program

Stevens said that while the Market Regulation and Consumer Affairs (D) Committee continues with its priority to consider and make recommendations towards the modernization of market conduct regulation, no actions will be taken on the adopted market analysis requirement 12, or the implementation of full certifications of jurisdictions. He said the work to provisionally certify jurisdictions will continue. He encouraged jurisdictions who have not submitted self-certifications to send them to Randy Helder (NAIC). Stevens said that Jo LeDuc's (MO) position on the peer review group will be filled by Maria Ailor (AZ). Stevens said that the self-certifications will be reviewed by the peer review group which will provide feedback to the jurisdiction.

Paskey said Wisconsin had not received feedback and this was confirmed by other insurance regulators. Stevens said he will double-check on the status of the feedback and have those sent to the jurisdictions that self-certified.

Stevens said the NAIC Connect page for the Market Regulation and Consumer Affairs (D) Committee has a page with materials for the Certification program including policies and procedures and other materials provided by the state of Washington to assist other jurisdictions in creating procedures and processes in their market regulation departments.

Stevens said he spoke to the chair of the Market Regulation and Consumer Affairs (D) Committee, Director Gillespie, and the Market Conduct Regulation Modernization (D) Working Group will be considering what role the Voluntary Market Regulation Certification Program will play in implementing their recommendations.

Having no further business, the Market Regulation Certification (D) Working Group adjourned.

Draft: 8/18/26

Pharmacy Benefit Management (D) Working Group
Columbus, Ohio
August 12, 2026

The Pharmacy Benefit Management (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met in Columbus, OH, Aug. 12, 2026. The following Working Group members participated: Joylynn Fix, Chair (WV); Kayla Erickson and Sarah Bailey (AK); Kelli Littlejohn Newman (AL); Daniel Holland (AR); Sophie Thomas and Lila Cummings (CO); Kurt Swan (CT); Jessica R. Luff (DE); Sheryl Parker (FL); Paula Shamburger (GA); Andria Seip (IA); Shannon Hohl (ID); Jack Engle (IL); Grant Lindman (IN); Steven Karrer and Josh Carlson (KS); Shaun Orme (KY); Frank Opelka (LA); Mary Lou Moran (MA); Joe Stoddard (MI); Norman Barrett (MN); David Dachs and Matthew Eberhardt (MT); Robert Croom (NC); John Arnold (ND); Cheryl Wolff and Martin Swanson (NE); Ralph Boeckman (NJ); Maria K. Garg and Gail Ross (NY); Timothy Schirmer (OH); Ashley Scott (OK); Keith Turner and Colette Hittner (OR); Holly Lehman, Richard L. Hendrickson, and Gary Jones (PA); Rachel Moore and Ryan Basnett (SC); Jud Jones (TN); Tanji J. Northrup (UT); Julie Blauvelt (VA); Jamie Adams and Lori Luder (WI); and Lauren White and Jill Reinking (WY). Also, participating was: Jill Kruger (SD).

1. Adopted its April 23 and Spring National Meeting Minutes

The Working Group met April 23. During this meeting, the Working Group took the following action: 1) adopted the draft pharmacy benefit manager (PBM) examination standards chapter and its referral to the Market Conduct Examination Guidelines (D) Working Group for its consideration for inclusion in the *Market Regulation Handbook*.

Hohl made a motion, seconded by Bailey, to adopt the Working Group's April 23 (Attachment Eight-A), and March 23, (*see NAIC Proceedings – Spring 2026, Market Regulation and Consumer Affairs (D) Committee, Attachment Six*) minutes. The motion passed unanimously.

2. Heard a Discussion from a Panel of Contract Examiners on Common PBM Examination Findings/Observations and Recommendations to State Insurance Regulators to Address Them

The Working Group heard a discussion from a panel of contract examiners—Dave Dillon (Lewis & Ellis), Craig Moore (Examination Resources), Rick Nelson (Noble Consulting Services), and Shelly Schuman (The INS Companies)—on common PBM examination findings and observations. The panelists highlighted common issues, including: 1) spread pricing tactics; 2) differential pricing with significant differences in pricing between affiliated and nonaffiliated pharmacies and between large chain pharmacies and independent pharmacies; 3) lack of transparency and data issues with PBMs often delaying providing requested data, providing redacted documents, and/or providing incomplete data; 4) legal pushback and bifurcated examinations due to Employee Retirement Income Security Act (ERISA)-related issues; and 5) subcontracting complexity because PBMs often subcontract to other PBMs, making data collection and accountability difficult.

The panelists also discussed the challenges they have found in conducting PBM examinations, as PBMs are not used to being subject to such examinations. Given this, the panelists discussed the importance of educating PBMs about a state's examination authority and the process. The panelists noted that in some instances, this lack of understanding has led to examination delays due to heavy oversight/participation by legal staff in the examination process. The panelists also noted that these challenges result in delays, which unnecessarily increase examination costs.

The panelists also provided recommendations on how state insurance regulators could address some of their findings and observations. Those recommendations include: 1) developing an NAIC model law to align state PBM laws to aid in consistency across the states; 2) developing training for PBM examiners and educational programs for PBMs; 3) reviewing major PBM information technology (IT) systems, particularly claims adjudication systems and their integration with health plan, pharmacy, and other third-party administrators' (TPAs') IT systems; 4) strengthening state contract requirements for contractor reimbursement and cooperation; and 5) improving coordination and communication between the states and PBMs.

Seip asked the panelists how they determined the PBM payment differential between affiliated and nonaffiliated pharmacies. Moore said examiners can find this information from the point-of-sale data they receive from the PBM. However, he noted that reaching this determination depends on the state's determination of timing. Schuman agreed but noted that examiners need to make sure it is an "apple-to-apple" comparison based on the prescription drug, dosage, and other relevant factors.

Newman explained her experience with conducting audits and examinations of other entities. She said she has not experienced the level of pushback, delays, and lack of cooperation with these other entities that she is now experiencing with PBMs. She asked the panelists if they had any suggestions for addressing this problem. Dillon suggested that state departments of insurance (DOIs) consider hiring a pharmacist because PBM representatives are much more likely to engage with a pharmacist who can question some of their gray-area assertions than with state DOI staff. Schuman agreed, citing an example of how a PBM changed its tone when it realized a pharmacist was part of the examination team. She also said PBM examinations are a relatively "new" phenomenon, and because of this, it will take time for PBMs to become accustomed to being examined and the regulatory process used to conduct the examinations. Nelson agreed with Schuman's comments. He also said that Noble Consulting Services has found that educating PBMs on the examination process, including expectations, goals, and purpose, before the examination begins has been helpful. Moore noted that although these examinations are challenging, they are necessary to meet a state's objectives and comply with state statutory requirements.

Fix remarked that although it may be helpful to have a pharmacist on the state's DOI PBM compliance team, not all states have that ability. She said that because of this, states rely on the contract examiners they have hired to conduct the PBM examination to bridge this gap as part of this partnership.

3. Discussed the Working Group's Future

Fix said she is interested in hearing from the Working Group members on the Working Group's future work and configuration. She noted that the Working Group has completed all its substantive 2026 charges, particularly its work in developing a PBM examination chapter for inclusion in the *Market Regulation Handbook*. She said one suggestion she wants the Working Group to consider is placing the Working Group under the Market Actions (D) Working Group so it can continue its work on PBM examinations, as the PBM examination discussion during this meeting illustrates the need for additional work in this area. If the Working Group is moved under the Market Actions (D) Working Group, it can use its protections to discuss PBM examination findings and compliance issues in regulator-to-regulator meetings, ensuring examination information is protected. Fix said the Prescription Drug Coverage (B) Working Group would continue its work on policy issues related to prescription drug coverage regulation, including pharmaceutical drug pricing and transparency, formularies, pharmacy payments, and PBMs. She asked the Working Group to think about her suggestion, which will be the subject of a future meeting. Fix said she has shared her suggestion with the chair and vice chair of the Market Regulation and Consumer Affairs (D) Committee and expects to hear their thoughts on it in the coming weeks.

Fix asked for comments. Newman expressed support for Fix's suggestion but also emphasized the need for the Working Group to continue to meet regularly. Fix confirmed that if the Working Group moved under the Market Actions (D) Working Group, it would continue to meet regularly but would be able to more effectively meet in regulator-to-regulator session to thoroughly discuss issues with PBM compliance and enforcement and find solutions. Joel Kurzman (National Community Pharmacists Association—NCPA) encouraged the Working Group, in whatever its future configuration, to continue its work to strengthen PBM compliance and enforcement. He also asked about the Working Group's progress on instituting changes to State Based Systems (SBS) to better handle PBM complaints. Fix said she anticipates the changes to be finalized in the coming months. She said she and members of her team at the West Virginia DOI recently met with the SBS team working on the changes. During that meeting, she learned that work on the PBM complaint portal and other necessary changes is progressing and will meet the end-of-year initial target date for completion. Fix urged Kurzman and any other stakeholders to reach out to her for any questions about the project.

Having no further business, the Pharmacy Benefit Management (D) Working Group adjourned.

Draft: 4/29/26

Pharmacy Benefit Management (D) Working Group
Virtual Meeting
April 23, 2026

The Pharmacy Benefit Management (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met April 23, 2026. The following Working Group members participated: Joylynn Fix, Chair (WV); Marcus Wilson, Vice Chair (VT); Heather Carpenter and Kayla Erickson (AK); Kelli Littlejohn Newman (AL); Tolanda McNeal (AZ); Sophie Thomas (CO); Kurt Swan and Tricia Davé (CT); Jessica Luff (DE); Sheryl Parker (FL); Melanie Frechette (GA); Andria Seip (IA); Shannon Hohl (ID); Matthew Pickett and Chris Heisler (IL); Grant Lindman (IN); Julie Holmes (KS); Shaun Orme (KY); Nina Hunter (LA); Mary Lou Moran (MA); Joe Stoddard (MI); T.J. Patton and Norman Barrett (MN); David Dachs (MT); Robert Croom (NC); Tahmidur Rahman (ND); Cheryl Wolff (NE); Ralph Boeckman and Erin Porter (NJ); Maria K. Garg (NY); Sara Donlon (OH); Ralph Magrish (OR); Richard L. Hendrickson (PA); Gwendolyn Fuller McGriff and Rachel Moore (SC); Jud Jones (TN); Ryan Jubber (UT); Stephen Hogge (VA); Sandy Ray (WA); Lori Luder (WI); and Jill Reinking (WY).

1. Adopted the Draft PBM Examination Standards Chapter and Referral to the Market Conduct Examination Guidelines (D) Working Group

Fix said the draft pharmacy benefit manager (PBM) examination standards chapter that the Working Group is considering for referral to the Market Conduct Examination Guidelines (D) Working Group reflects a balanced approach, which the Working Group developed after multiple rounds of comments and collaborative discussion with various stakeholders. She explained that the draft PBM examination chapter is guidance, not a model law, and given this, the states will implement it differently based on their laws. Fix noted that, despite differences in state law, the proposed chapter is important because it will bring uniformity to the PBM examination process.

Wilson expressed support for Fix's comments. He also praised the collaborative effort and the timeliness of the draft PBM examination chapter.

Fix requested comments on the draft PBM examination chapter from Working Group members. Seip commended the Working Group leadership and others for their work in completing the draft, noting the complexity and challenging nature of the work. Fix requested comments from interested regulators. There were no comments.

Carl Schmid (HIV+Hepatitis Policy Institute), speaking on behalf of the NAIC consumer representatives, said the NAIC consumer representatives appreciate the Working Group incorporating language on treatment guidelines and Pharmacy and Therapeutics (P&T) committees, including references to federal law along with state law references, and addressing issues like artificial intelligence (AI) use and copay accumulators. Franca D'Agostino (The Cigna Group), speaking on behalf of the Industry Coalition, which includes the Cigna Group, CVS Health, Elevance Health, and UnitedHealth Group, acknowledged the Working Group's effort in developing the draft, but she raised concerns about its unintended consequences, which could increase friction in future PBM examinations. She said the Industry Coalition is committed to ongoing engagement and collaboration with state insurance regulators to address remaining issues as the draft PBM examination chapter moves forward.

Seip made a motion, seconded by Lindman, to adopt the draft PBM examination chapter (Attachment Eight-A1) and refer it to the Market Conduct Examination Guidelines (D) Working Group for its consideration. The motion passed unanimously.

Fix said there is still work to be done related to PBMs and that she looks forward to the continued regulatory collaboration in this area.

Having no further business, the Pharmacy Benefit Management (D) Working Group adjourned.

Draft 4/7/26

Adopted by the Pharmacy Benefit Management (D) Working Group and Referred to the Market Conduct Examination Guidelines (D) Working Group, April 23, 2026.

Chapter XX—Conducting the Pharmacy Benefit Manager Examination

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

This chapter provides a suggested format for conducting pharmacy benefit manager (PBM) examinations and reviews. In addition to this chapter, the examiner should be familiar with the NAIC white paper *A Guide to Understanding Pharmacy Benefit Manager and Associated Stakeholder Regulation* (NAIC White Paper*)*.

Background, Scope and Types of Examinations

"Pharmacy Benefit Manager" is defined in the NAIC White Paper as entities that negotiate and contract with all the various types of pharmacies, including independent pharmacies and pharmacy chains of all sizes, on reimbursement and pharmacy network related terms. Insurers, employers, other payors, and even other PBMs contract with PBMs to design, negotiate, implement, and manage formulary designs for prescription drugs, including negotiating rebates and drug coverage terms with pharmaceutical manufacturers. PBMs may be delegated the design and implementation of preferred and non-preferred pharmacy networks, metric-based payment arrangements, and formulary design elements (drug coverage, out-of-pocket responsibilities for patients and utilization management protocols). PBMs engage in negotiation and financial transactions between pharmaceutical manufacturers, health plans, and pharmacies.

PBM examinations can be either comprehensive or targeted. A PBM examination can be conducted by one jurisdiction or as a multistate cooperative examination. To the extent that the PBM's systems and procedures are similar, if not identical, for every state, the examination and resulting report should be acceptable in all states, regardless of which jurisdiction conducts the examination.

Unlike insurance company examinations, currently there are generally little, if any, "market analysis" procedures or tools developed to assist in the conduct of PBM examinations. Similarly, PBMs are not regulated for solvency. Rather, PBMs negotiate on behalf of insurers and other PBMs and contract with all the various types of pharmacies, including independent pharmacies and pharmacy chains of all sizes, on reimbursement and pharmacy network related items. PBMs design, negotiate, implement, and manage formulary designs for prescription drugs, including negotiating rebates and drug coverage terms with pharmaceutical manufacturers. In addition, PBMs contract directly with Pharmacy Services Administrative Organizations (PSAOs), who provide administrative services to independent pharmacies, including, but not limited to, contract negotiations with PBMs.

For additional information on background and scope, please refer to Chapter 12 and Chapter 13 of this handbook.
Key Terms:

Regulators must consider state specific definitions when conducting a PBM Examination.

340B Pharmacy – a pharmacy that dispenses outpatient drugs purchased at significant discounts by eligible "covered entities" such as safety-net hospitals, clinics, and health centers under the federal 340B Drug Pricing Program. These pharmacies are often excluded from additional drug manufacturer rebates for certain drug claims.

Note: The term "340B" is derived from the section of the Public Health Service Act (PHSA), 42 U.S.C. 256b, from which the 340B Program is defined.

Affiliated Pharmacies – refers generally to pharmacies that are formally connected to or associated with a larger organization, such as a health system, hospital, or a PBM, through ownership, partnership, or contracted arrangement.

Biologic Drugs - are distinct from traditional brand-name and generic drugs because they are made of living cells, such as monoclonal antibodies, antitoxins, certain vaccines, and cell and gene therapies. Biologics are sometimes referred to as "large- molecule drugs." Manufacturers of biologic drug products are also required to receive approval from the U.S. Food & Drug Administration (FDA) to sell their products through a separate application process. Biologics approved by the FDA are granted 12 years of exclusivity, which is substantially longer than the five years typically granted to traditional small-molecule brand-name drugs.

Biosimilar Drugs - are FDA approved as having no clinically meaningful difference from the referenced product and may be produced following the expiration of the biologic's patent and exclusivity period. Biosimilar drugs are listed in the FDA Purple Book and are not considered "generic" of their brand referenced biologic product.

Brand Name Drugs - are medications discovered, developed, and marketed by a pharmaceutical company under a specific, patented, and trademarked name. These original, FDA-approved, or regulatory-approved drugs have exclusive marketing rights for a set period to recoup research costs, often making them more expensive than generic alternatives. Brand name drugs are often designated as the "Reference Listed Drug" in the FDA Orange Book.

Chain Pharmacy – Unless otherwise defined in the state, a chain pharmacy is owned, operated, or controlled by a corporate-owned entity, generally defined as four or more locations, often operating under a shared corporate banner and utilizing centralized management.

Covered Entity – means, as defined in 45 CFR 160.103, a health plan, a healthcare clearinghouse, or a health care provider who transmits health information electronically in connection with covered transactions.

Generic Drugs - are small molecule drugs that are therapeutically equivalent to their reference brand name drug. Once a brand-name drug is no longer patent-protected, generic manufacturers may begin producing therapeutically equivalent generic drug products. Like brand-name drugs, the FDA must approve a generic drug application called an Abbreviated New Drug Application to ensure its bioequivalence to the brand-name drug before it can be produced. Generic drugs comprise the largest portion of the pharmaceutical market.

Independent Pharmacy – unless otherwise defined in the state, a pharmacy that is privately and independently owned and operated by one or more pharmacists or under common ownership with not more than three pharmacies and whose primary function is to provide direct pharmaceutical care to patients. These services can include dispensing drugs, providing immunizations, performing health screenings, testing at point-of-care, and providing medication counseling in a community setting.

Insurers – entities that contract with PBMs to manage the pharmacy benefit portion of their health care benefits provided to their insureds and enrollees. Insurers contract with PBMs because of the increasing complexity of prescription drug benefit management. In addition, in response to increasing prescription drug costs some insurers contract with PBMs for their services that help reduce costs, including, but not limited to, utilization management, prescription drug rebates, and negotiation of pharmacy fees and prescription drug reimbursement, and access to pharmacy networks. Ultimately, the scope of the PBM's role in managing this benefit depends on the insurer.

Some insurers are part of integrated health systems, in which a common entity owns an insurer, hospitals, and employs networks of providers and provides all health care services to their enrollees. Because these entities more closely coordinate all care under their roof, insurers in integrated systems may not utilize PBMs to the same extent as more traditional insurers.

Long-Term Care (LTC) Pharmacy – is a licensed "closed door" (i.e. not open to the public) pharmacy that dispenses medications and delivers them directly to a licensed long-term care facility, such as a nursing home, group home, or specialized health care facility, and generally does not provide medications to inpatient hospitals.

Mail-Order Pharmacy – is a licensed "closed door" (i.e. not open to the public) pharmacy that dispenses prescription medications and delivers them directly to a patient's home, workplace, or preferred location through the mail or courier service.

Payors - include health insurance providers, large and small employers, and government entities, such as state employee plans and Medicaid agencies. The entity making decisions about benefits – including the use of PBMs and the design of the prescription drug benefit – may depend on the market (individual, small group, large group, government programs) and the arrangement that the payor chooses. In this chapter, when PBM functions are referenced, payors may choose to do those tasks internally.

Pharmaceutical Manufacturers or Manufacturers - research, develop, produce, market, and sell prescription drugs to treat medical conditions. The development of a new pharmaceutical product involves an investment of resources to create a product ready to be tested during clinical trials, where the safety and clinical efficacy of the drug are evaluated for a specific disease or condition. Pharmaceutical manufacturers may also partner with the federal government to develop drugs, or license drugs developed with federal research funding. Pharmaceutical manufacturers may also purchase prescription drugs developed by other manufacturing companies to market as their own. Pharmaceutical manufacturers may also offer patient assistance programs and direct-to-consumer programs for some of the drugs they market.

Pharmacies - a place licensed by a state Board of Pharmacy in which prescriptions, drugs, medicines, medical devices, chemicals, and poisons are sold, offered for sale, compounded, or dispensed. A pharmacy may also provide services that include providing immunizations, performing health screenings, testing at point-of-care, and providing medication counseling, and other health care related functions, as permitted by the state in which the pharmacy is licensed.

Pharmacists - are licensed and trained health care providers that assess the safety and efficacy of prescriptions from physicians and other authorized prescribers before dispensing a medication to a patient to ensure patients do not receive the wrong drug or take an incorrect dose of medicine. Pharmacists also provide counseling on the use of prescriptions. In addition to the medication expertise pharmacists contribute during the dispensing process, pharmacists also provide numerous patient care services to their patients to optimize the safe and effective use of medications, increase access to acute and preventative care, and work collaboratively with other members of the healthcare team to assist patients in reaching their therapeutic goals. Pharmacists are licensed by a State Board of Pharmacy and are permitted to conduct various levels of health care services in different states, depending on state licensure requirements.

Pharmacy and Therapeutics (P&T) Committee – are expert, multidisciplinary groups, which are usually comprised of physicians, pharmacists, and other health care professionals, that evaluate clinical, safety, and economic evidence for prescription drugs. P&T Committees determine which medications are covered, create formularies, and manage utilization policies, such as prior authorization.

Pharmacy Benefit Managers (PBMs) - provide claims processing services or other prescription drug services on behalf of insurers or administer an insurer's prescription drug coverage pursuant to its contract or under an

employment relationship with an insurer or health plan that directly manages the prescription drug coverage provided by the insurer or health plan. Insurers determine through contractual delegation which activities a PBM may perform on their behalf, which may include negotiating and contracting with all the various types of pharmacies, including independent pharmacies and pharmacy chains of all sizes, on reimbursement and pharmacy network related terms. PBMs may also develop, negotiate, implement, or administer clinical, formulary, or other preferred lists for prescription drugs, including negotiating and the administration of rebates and drug coverage terms with pharmaceutical manufacturers and other entities. PBMs may be delegated the responsibility of the design and implementation of preferred and non-preferred pharmacy networks, metric-based payment arrangements, and formulary design elements (for example ,drug coverage tiers, and utilization management protocols). PBMs engage in the negotiation and financial transactions between pharmaceutical manufacturers, health plans, and pharmacies. PBMs may also be delegated the adjudication of appeals or grievances related to prescription drug coverage or the performance of drug utilization reviews (DURs).

Pharmacy Benefit Manager Network –is a contracted, organized group of retail, mail-order, specialty, and other pharmacies established by a PBM to provide covered prescription drug services to health plan members. Pharmacies within the network have specific reimbursement rates, terms, and, in some cases, performance-based quality measures.

Pharmacy Services Administrative Organizations (PSAOs) - are organizations that provide administrative services to independent pharmacies. In most cases, an independent pharmacy contract is with the PSAO, rather than with the PBM directly. The PSAO's overall administrative function is to assist with contract evaluation and execution with the PBM or wholesaler, customer service, central payment and reconciliation, and patient data evaluation. In many instances a PSAO is owned by a wholesaler.

Rebates or Manufacturer Rebates – are a post-purchase discount or price concession paid by pharmaceutical manufacturers directly or indirectly to rebate aggregators, group purchasing organizations (GPOs), PBMs, covered entities, or health insurers. These payments are typically negotiated in exchange for favorable placement of a drug on a health plans' formulary and may be described as reducing the overall cost of drugs for covered entities or payors.

Note: Rebates may also apply when speaking of wholesaler or pharmacy rebates, which are contractual incentives paid to pharmacies based on specific performance metrics. For purposes of this chapter unless otherwise specified, the term "rebates" includes "manufacturer rebates."

Specialty Drugs - is a term that generally refers to drugs and biologics that are typically high-cost, and can be complex to ship, or store, require specialized administration, subject to limited or exclusive distribution, or may require specialized clinical care, such as frequent dosage adjustments, intensive patient monitoring or counseling, or ongoing clinical support (i.e. high-touch).It often references medications used to treat rare, complex, life threatening, or chronic conditions. Because of this, these drugs often dispensing through a specialty pharmacy, rather than traditional retail pharmacies.

Note: There is no unified regulatory definition of the term "specialty drug." Examiners should consult applicable state law and impacted health plan formulary definitions.

Specialty Pharmacy – is a type of pharmacy that dispenses specialty medications. Specialty pharmacies often hold limited-distribution contracts with a pharmaceutical manufacturer to be one of just a few pharmacies authorized to dispense a particular specialty medication. Specialty pharmacies may offer in-depth patient support such as clinical patient management.

Utilization Review – which is also known as utilization management or DUR, includes using predetermined criteria for appropriate drug therapy, utilizing patient-specific information to ensure safe and effective use of drug therapy to potentially lower the overall cost of health care. Types of utilization review include prospective, concurrent, and

respective utilization review. PBMs and/or payors may develop utilization review standards to evaluate and approve or deny services when compared to clinical need, cost, and established national guidelines.

Wholesalers/Distributors - Wholesalers purchase drugs from manufacturers, store those drugs, and then sell and distribute them to pharmacies, hospitals, provider offices and mail-order pharmacies. Wholesalers own several of the largest PSAOs used by independent pharmacies.

Qualifications of Examiners

Information on qualifications, please refer to Chapter 14 of this handbook**.** In addition, states might want to include a pharmacist or other PBM-specific qualifications to the examination team.

Types of Examinations

When planning the examination, it is helpful to first identify which services and products are regulated and the impact on regulated entities. A PBM examination can take the form of a comprehensive examination, a targeted examination, a risk-focused examination, a re-examination, a multistate cooperative examination or a desk examination. Most of the elements found in Chapter 13—Types of Examinations will apply to the PBM examination. Because most operations for these entities remain consistent in all states, it is recommended to coordinate examinations or communicate with the NAIC, especially when conducting comprehensive reviews.

Scheduling, Coordination and Planning Scope

The procedures discussed in this section are to assist the regulator in determining if an examination or other type of regulatory action needs to be scheduled. It will also assist in developing a plan for conducting examinations, investigations, desk audits, interrogatories, letters or interviews when deemed necessary.

1. Determine the jurisdiction's requirements for licensing and examining the PBM and determine if the jurisdiction is permitted to accept the examination report of another state;
2. Survey appropriate divisions within the insurance department to identify potential areas of concern or interest relating to PBMs operating in the jurisdiction.
3. For those PBMs for which a recent and current examination report has been made public and no unaddressed regulatory concerns exist, no additional analysis should be necessary. If analysis indicates that a market regulation action—such as a desk audit, letter, interrogatory, interview, investigation or examination—is appropriate, consider the possibility of coordinating with other jurisdictions with similar requirements or market regulation issues. Consider use of NAIC tools such as the Market Action Tracking System (MATS) for recording continuum types of regulatory responses and communicating with members of the Pharmacy Benefit Manager Examination Oversight (D) Working Group for multistate coordination of regulatory responses.
4. Survey the NAIC Research Division for relevant information to identify potential areas of concern in the evaluation process; and
5. Determine what specialists may be necessary to assist with the examination, such as a licensed pharmacist (ideally one with experience with the functions of a PBM or pharmacy operations).
6. Due to the complexity of pharmacy claims data, a comprehensive data dictionary shall be developed for all requested datasets. The data dictionary must clearly define all data fields, formats, and required inputs and shall be reviewed and finalized to ensure mutual understanding and agreement among all parties before data collection begins. The regulator may develop the data dictionary or may work with the PBM to develop the dictionary. The final regulator-approved data dictionary shall be used by the PBM. Any questions, clarifications, or necessary revisions must be addressed and resolved before data extraction occurs in order to minimize discrepancies, ensure data integrity, and prevent delays during the examination process.

For very narrow or specific regulatory issues, or for situations in which an examination is not required by statute, consider use of regulatory options other than an examination. For example, certain issues can be handled by a telephone call, letter or email; a data request; policy and procedure review; interrogatories; or desk audits. The remainder of this chapter is primarily written to facilitate examinations; however, certain information may be adaptable for the above-mentioned "continuum" type responses. An additional discussion of continuum of market actions is in Chapter 2 of this handbook.

Procedural Considerations

Although not an insurance company examination, the basic procedures for a market conduct examination in Chapter 20 of this handbook should be followed in a PBM examination:

- Scheduling an examination.
- Determining the scope of the examination;
- Calling the examination;
- Notification of the examination;
- Preexamination procedures;
- On-site coordination, if applicable;
- Data calls;
- Sampling;
- Test procedures;
- Communication management;
- Post-examination procedures; and
- The examination report.

Where possible, each state's defined examination protocols applicable to the examination of insurers—such as time frames and report submissions—should be applied to PBM examinations, as well.

Writing the Examination Report
The report preparation elements as outlined in Chapter 19 of this handbook are generally applicable to PBM examinations. However, the following special considerations also apply:

- In addition to safeguarding the confidentiality of individual policyholder information, care should be taken to not disclose trade secret information of the examinees or insurers that are customers of the examinees (e.g., individual insurer information in class or territory detail, or the processes and procedures of the examinee). The PBM should be given the opportunity to mark exhibits and/or portions of the report as "confidential and proprietary," if such is allowed under state law and these are not subject to otherwise applicable public release laws outside the regulatory community; and
- The PBM should be given the opportunity to review the examination findings prior to issuing a final report, if such practice is consistent with the state's insurers' examination act or other applicable statute.

Use of Examination Standards
Each of the following examination standards may be applicable to specific functions performed by a PBM. The examination plan should indicate which standards for review will be used for each specific examination.

A. PBM Operations/Management
B. PBM Pricing and Methodologies
C. Contracts
D. Pharmacy Claims
E. Pharmaceutical Manufacturer Rebates

F. Pharmacy Network Adequacy
G. Utilization Review
H. Drug Formulary, Placement, and Specialty Drug
I. Complaints, Grievances, and Appeals
J. Pharmacy Audits

A. PBM Operations/Management

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

The following standards would be the most applicable to a PBM examination.

Standard 1 – The PBM has an up-to-date, valid internal or external audit program.
Standard 2 – The PBM has appropriate controls, safeguards and procedures for protecting the integrity of computer information.
Standard 3 - The PBM has antifraud initiatives in place that are reasonably calculated to detect, prosecute and prevent fraud.
Standard 4 - The PBM has a valid disaster recovery plan.
Standard 6 - The PBM is adequately monitoring the activities of any entity that contractually assumes a delegated business function or is acting on behalf of the PBM.
Standard 7 - Records are adequate, accessible, consistent and orderly and comply with state record retention requirements.
Standard 9 - The PBM cooperates on a timely basis with examiners performing the examinations.
Standard 11 - The PBM has developed and implemented written policies, standards and procedures for the management of client information.
Standard 12 - The PBM has policies and procedures to protect the privacy of nonpublic personal information relating to its customers, former customers and consumers that are not customers.
Standard 15 - The PBM's collection, use and disclosure of nonpublic personal financial information are in compliance with applicable statutes, rules and regulations.
Standard 16 - In states promulgating the health information provisions of the *Privacy of Consumer Financial and Health Information Model Regulation* (#672), or providing equivalent protection through other substantially similar laws under the jurisdiction of the insurance department, the PBM has policies and procedures in place so that nonpublic personal health information will not be disclosed, except as permitted by law, unless a customer or a consumer who is not a customer has authorized the disclosure.
Standard 17 - Each PBM licensee shall implement a comprehensive written information security program for the protection of nonpublic customer information.
Standard 18 - All data required to be reported to the departments of insurance is complete and accurate.

B. PBM Pricing and Methodologies

STANDARDS
PHARMACY BENEFIT MANAGERS
PBM PRICING AND METHODOLOGIES
(BETWEEN PBMS AND HEALTH PLANS)

Standard 1
The PBM demonstrates it does not charge a covered entity, payor, or health plan an amount greater than the reimbursement paid to a pharmacy for a prescription drug as required by applicable statutes, rules and regulations.

Apply to: All PBMs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ An index of all policies and procedures relating to PBM's billing with health plans.

_____ Complete and unredacted contracts between the PBM and health plan.

_____ Complete and unredacted contracts between the PBM and pharmacy.

_____ An index of periodic reports, certifications, or real-time systems made available to health plans to monitor services provided and PBM charges.

_____ A schedule of claims data for a specified time period and in a standardized template to capture all required claims information that may include but not be limited to:
- The total reimbursement amount paid to the pharmacy for each prescription drug claim.
- The total amount charged to the covered entity, payor, or health plan for each prescription drug claim.

_____ Documentation of health plan billings during the exam period including a itemized breakdowns.

Others Reviewed

_____ _____

_____ _____

Review Procedures and Criteria

Review the PBM's policies and procedures to determine if internal standards regarding the PBM pricing exist and whether those standards comply with state requirements.

Determine if applicable policies and procedures were actually communicated to employees responsible for the implementation of the policies and procedures.

Determine if contracts between the PBM and health plans are consistent with state requirements and with the PBM's policies regarding PBM pricing.

Determine if amounts charged to health plans are supported by claims data, are consistent with contracts between the PBM and the health plan and are consistent with state requirements.

STANDARDS
PHARMACY BENEFIT MANAGERS
PBM PRICING AND METHODOLOGIES
(BETWEEN PBMS AND HEALTH PLANS)

Standard 2
The PBM demonstrates the difference in its payment rates received by a covered entity, payor, or health plan compared to the reimbursement paid to a pharmacy for a prescription drug as required by applicable statutes, rules and regulations.

Apply to: All PBMs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ An index of all policies and procedures relating to PBM's billing with health plans.

_____ An index of all policies and procedures relating to the PBM's payment to pharmacies.

_____ Complete and unredacted contracts between the PBM and health plan.

_____ Complete and unredacted contracts between the PBM and pharmacies.

_____ Request all claims data for a specified time period and in a standardized template to capture all required claims information that may include but not be limited to:

- The total reimbursement amount paid to the pharmacy for each prescription drug claim.
- The total amount charged to the covered entity, payor, or health plan for each prescription drug claim.

Others Reviewed

_____ _____

_____ _____

Review Procedures and Criteria

Review the PBM's policies and procedures to determine if internal standards regarding the PBM pricing exist and whether those standards comply with state requirements.

Determine if applicable policies and procedures were actually communicated to employees responsible for the implementation of the policies and procedures.

Determine if contracts between the PBM and health plans are consistent with state requirements and with the PBM's policies regarding PBM pricing.

Determine if amounts charged to health plans are supported by claims data, are consistent with contracts between the PBM and the health plan and are consistent with state requirements.

STANDARDS
PHARMACY BENEFIT MANANGERS
PBM PRICING METHODOLOGIES
(BETWEEN PBM AND PHARMACIES)

Standard 3
The PBM demonstrates it has transparent payment methodologies for reimbursement of all drugs that enable a pharmacy to understand the reimbursement amount for each claim prior to the pharmacy submitting the claim for reimbursement.

Apply to: All PBMs

Priority: Essential

Documents to be Reviewed

Applicable statutes, rules and regulations.

_____ Pharmacy contracts and manuals in an unredacted format.

_____ PBM to provide an index of all policies and procedures relating to pharmacy reimbursement.

_____ Based on information submitted with the policies & procedures index, all policies and procedures that are applicable to the pharmacy reimbursement method being examined. Request documents in an unredacted format.

_____ PBM contracts with pharmacies in an unredacted format.

_____ All notices, amendments, updates, or other informative documents describing any changes to the PBM's pricing methods that it sends to pharmacies.

_____ All documents provided to pharmacies that support or describe the PBM's reimbursement amounts to specific pharmacies, including but not limited to mail order, specialty, or affiliate pharmacies.

____ All contracts between the PBM and any third-party entities that may process prescriptions on behalf of the PBM or the PBM's clients, including but not limited to, any drug discount coupons or programs from manufacturers or drug discount entities.

_____ Contracts with the PBM and the insurer or employer group that include any references to the requirements for PBM's reimbursement to pharmacies and that describe the insurer's or employer group's oversight of the processes. Request the entire contract in an unredacted format.

_____ Request all claims data for a specified time period and in a standardized template to capture all required claims information that may include but not be limited to:

- Pharmacy information including but not limited to name, NPI, and address.
- Pharmacy network name associated with each claim.
- Chain, independent, mail order, LTC, 340B, and specialty drug pharmacy claims.
- The drug pricing source used for reimbursement of each claim.
- The percentage *and* actual amount of any "discount" or other price reduction from the drug pricing source, drug copay discount program, copay accumulator or maximizer program, or any other discount/price adjustment that the PBM applied as part of its payment to the pharmacy.

- The amount of any fees or amount of any other price reduction that is not related to the drug or dispensing fee. For example, any claims processing fee applied to the claim.
- The final reimbursement amount of each claim for the drug.
- The final reimbursement of any dispensing fee.
- The type of health coverage being reimbursed, for example, commercial vs. Medicare and self-funded vs. fully insured.
- The status of the claim, for example paid, rejected, adjusted, under appeal, etc.
- The dates of when the claim was submitted (generally referred to as "Date of Service") and when it was paid (if applicable) to ensure the PBM is timely when paying clean claims.
- If the claim was rejected or is under appeal, provide reasons. *The regulator should verify the PBM provides a reasonable basis to pharmacies for the status of the claim.*

Others Reviewed

_____ _____

_____ _____

Review Procedures and Criteria

Review all contracts between the PBM and pharmacies, including but not limited to, the provider manual, network reimbursement forms, maximum allowable cost list information, drug discount or manufacturer coupon contracts. Ensure all contractual language is transparent and sufficiently clear to enable the pharmacy to understand the payment rate prior to the pharmacy being paid.

- Assess how the PBM determines the drug pricing source it uses to reimburse each drug type including generic, brand and specialty drugs. Confirm the selection of the drug pricing source is communicated to the pharmacies in clear and concise language that is easily understandable and cannot be misinterpreted to mean more than the plain language.
- Assess the PBM's ability to change the drug pricing source selection, for example through application of the "lessor of logic" method. Confirm the "change" process is transparent and communicated to pharmacies in clear and concise language that is easily understandable and cannot be misinterpreted to mean more than the plane language. If the PBM contract language gives the PBM authority to change this drug pricing source, assess how that change occurs, how often it occurs, how it is communicated to the pharmacies, and whether the change can be done with or without the pharmacies' consent.
- Assess whether the PBM applies any "discounts" or other methods of reducing the amount of the selected drug pricing source. If the PBM does reduce the amount of the drug prior to paying the pharmacy, ensure that the "discount" reduction amount is transparent and communicated to pharmacies in clear and concise language that is easily understandable and cannot be misinterpreted to mean more than the plane language. In addition to the PBM's own "discounts," other discounts may include drug copay discount program, copay accumulator or maximizer program, or any other discount/price adjustment.
- If the PBM does apply "discounts" or otherwise reduce the amount of the drug pricing source, ensure the contract language describes the extent of the PBM's ability to change this "discount," how that change occurs, how often it occurs, how and when it is communicated to the pharmacy, and whether the change can be done with or without the pharmacy's consent.

Review contracts between the PBM and the insurer or employer group to determine whether the pricing methodologies described to pharmacies are consistent with the PBM's requirements described in the insurer's or employer group's contract with the PBM.

Review a sample of (or all) claims to ensure the PBM follows its own policies and procedures regarding

reimbursement of pharmacies. Review claims data to assess if there are differing standards based on the type of pharmacy: chain, retail, mail order, LTC, 340B, specialty or affiliate. Review "discount" amounts applied for claims to assess whether the PBM's description of the "discounts" to pharmacies is consistent with the actual reimbursement amounts. Standards should be applied in a non-discriminatory manner such that PBM does not favor affiliate over non-affiliate pharmacies, for example. Payment should be consistent across pharmacies within the same network.

STANDARDS
PHARMACY BENEFIT MANAGERS
PBM PRICING AND METHODOLOGIES
(BETWEEN PBM AND PHARMACIES)

Standard 4
The PBM demonstrates it has transparent effective rate reconciliation methods for all drugs that enable a pharmacy to understand the reimbursement amount for each claim that is part of the reconciliation process.

Apply to: All PBMs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Pharmacy contracts and manuals in an unredacted format.

_____ PBM to provide an index of all policies and procedures relating to the effective rate reconciliation process.

_____ Based on information submitted with the policies & procedures index, all policies and procedures that are applicable to effective rate reconciliation process being examined if the regulator is not examining the entire process. For example, all generic effective rate (GER) policies or all brand effective rate (BER) policies. Request documents in an unredacted format.

_____ PBM contracts with pharmacies or PSAOs in an unredacted format.

_____ All notices, amendments, updates, or other communications describing any changes to the PBM's effective rate reconciliation process that it sends to pharmacies.

_____ All documents provided to pharmacies that support or describe the PBM's effective rate reconciliation process and calculation to specific pharmacies, including but not limited to retail, mail order, specialty, or affiliate pharmacies.

_____ All reports or accounting documents provided to pharmacies or PSAOs showing the PBM's quarterly and annual reconciliation amounts. This should include but not be limited to summary reports and claims data.

_____ Request all claims data for a specified pharmacy and time period in a standardized template showing how each claim was "reconciled" by the PBM. Claims detail may include but not be limited to:

- Pharmacy information including but not limited to name, NPN, and address.
- Pharmacy network name associated with each claim.
- Chain, independent, mail order, LTC, 340B, and specialty drug pharmacy claims with clear indication of each category;
- The drug pricing source used for reimbursement of each claim.
- The percentage *and* actual amount of any 'discount' or other price reduction from the drug pricing source drug copay discount program, copay accumulator or maximizer program, or any other discount/price adjustment that the PBM applied as part of its initial payment to the pharmacy when the pharmacy submitted the claim.
- The amount of any fees or amount of any other price reduction that is not related to the drug or

dispensing fee. For example, any claims processing fee applied to the claim.

- The total initial drug reimbursement amount of each claim (meaning the amount the PBM paid the pharmacy when it submitted the claim; the amount should not include the dispensing fee).
- The total initial reimbursement of any dispensing fee.
- The reconciled percentage of "discount" applied to each claim or batch of claims.
- The total final reimbursement amount for each drug claim or batch of claims after reconciliation. This should not include the dispensing fee amount.
- The difference between the total initial drug reimbursement amount and the final reconciled amount for each drug. Request the dollar amount and percentage differences.
- The total reconciled amount owed to or from each pharmacy group or PSAO.
- The type of health coverage being reimbursed. For example, commercial vs. Medicare and self-funded vs. fully insured.
- The status of the claim. For example, paid, rejected, adjusted, under appeal, etc.
- The dates of when the claim was submitted (generally referred to as "Date of Service") and when it was paid (if applicable) to ensure the PBM is timely when paying clean claims.

_____ Contracts with the PBM and the insurer or employer group that include any references to the requirements for PBM's effective rate reconciliation process with pharmacies and that describe the carrier or employer group's oversight of the processes. Request the entire contract in an unredacted format.

Others Reviewed

_____ _____

_____ _____

Review Procedures and Criteria

Review all contracts between the PBM and pharmacies, including but not limited to, the provider manual, network reimbursement forms, maximum allowable cost list information, provider updates or manual amendments. Ensure all contractual language is transparent and sufficiently clear to enable the pharmacy to understand how the effective rate reconciliation process will be implemented prior to the PBM beginning the annual (or quarterly) reconciliation.

Request a listing of all network pharmacies or PSAOs that have an effective rate contract and all pharmacies or PSAOs that do not have one. Ensure the PBM is offering contracts to all similarly situated pharmacies and that it provides a reasonable explanation for why it does not offer an effective rate contract to any specific pharmacies or pharmacy types, such as independent pharmacies. Understanding which pharmacies have an effective rate contract will assist the regulator in ensuring the PBM is compliant with state laws. For example, if a state requires NADAC payment for each drug, the regulator will not expect to see any effective rate contracts in that state.

Assess how the PBM determines which claims will be part of the reconciliation process, including categories of claims that are included and excluded in accordance with contract language. Confirm the selection of the claims is communicated to the pharmacies in clear and concise language.

Review all documents and communications sent from the PBM to the pharmacy as part of the reconciliation process. This should include but not be limited to any reconciliation reports, any claims data that is provided or can be requested by the pharmacy, any emails or other correspondence between the PBM and the pharmacy. Ensure all communications from the PBM provide sufficient detail to enable the pharmacy to understand the process and that all questions are appropriately addressed.

- If PBM provides any reports or charts to the pharmacy, ensure the document explains all use of acronyms

and claims categories through use of a key.

- Review all documents describing the final reconciliation amount that may be owed to or from pharmacies or PSAOs. Does the PBM provide reasonably sufficient detail to ensure that pharmacies understand how and when they will receive payment or make payments, if applicable.
- Does the PBM provide pharmacies with the ability to inquire about or appeal the PBMs final determination? Is the process reasonable in that it enables pharmacies to provide information to the PBM that may change the outcome of the reconciliation amount? Consider requesting specific examples of correspondence to review.

Review a sample of (or all) claims to ensure the PBM follows its own policies and procedures regarding reconciliation process. Compare the original "discount" and price paid to the pharmacy to the reconciled "discount" and price to determine if the reconciled "discount" applied to each claim or batch of claims is within the contractually stated "discount" amounts. In addition to the PBM's own "discounts," other discounts may include drug copay discount program, copay accumulator or maximizer program, or any other discount/price adjustment.

Review contracts between the PBM and the carrier or employer group to determine whether the reconciliation process as described to pharmacies is consistent with the PBM's requirements described in the carrier or employer group's contract with the PBM.

Consider verifying the accuracy of all the data and reports sent from the PBM with the pharmacy or pharmacy group. For example, if the PBM provides an annual report of all reconciled claims, did the pharmacy receive the same version?

STANDARDS
PHARMACY BENEFIT MANAGERS
PBM PRICING AND METHODOLOGIES
(BETWEEN PBM AND PHARMACIES)

Standard 5
The PBM demonstrates it has transparent payment methodologies for the dispensing fees of all drugs that enable a pharmacy to determine the dispensing fee amount paid for each claim.

Apply to: All PBMs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Pharmacy contracts and manuals in an unredacted format.

_____ An index of all policies and procedures relating to pharmacy dispensing fees.

_____ All policies and procedures that are applicable to pharmacy dispensing fees being examined. Request documents in an unredacted format.

_____ PBM contracts with pharmacies in an unredacted format.

_____ All notices, amendments, updates, or other informative documents describing any changes to the PBM's dispensing fees that it sends to pharmacies.

_____ All documents provided to the pharmacy that support or describe the PBM's dispensing fee amounts to specific pharmacies including but not limited to retail, mail order, specialty, or affiliate pharmacies.

_____ Contracts with the PBM and the carrier or employer group that include any references to the requirements for PBM's payment of dispensing fees to pharmacies and that describe the insurer or employer group's oversight of the processes. Request the entire contract in an unredacted format.

_____ Request all claims data for a specified time period and in a standardized template to capture all required claims information that may include but not be limited to:

- Pharmacy information including but not limited to name, NPN, and address.
- Pharmacy network name associated with each claim.
- Chain, independent, mail order, LTC, 340B, and specialty drug pharmacy claims with clear indication of each category.
- The drug pricing source used for reimbursement of each claim at the time of adjudication.
- The percentage *and* actual amount of any 'discount' or other price reduction from the drug pricing source drug copay copay discount program, copay accumulator or maximizer program, or any other discount/price adjustment that the PBM applied as part of its payment to the pharmacy.
- The amount of any fees or amount of any other price reduction that is not related to the drug or dispensing fee. For example, any claims processing fee applied to the claim.
- The final ingredient cost reimbursement amount of each claim for the drug.
- The final reimbursement of any dispensing fee.
- The type of health coverage being reimbursed, for example, commercial vs. Medicare and self-

funded vs. fully insured.

- The status of the claim, for example paid, rejected, adjusted, under appeal, etc.
- The dates of when the claim was submitted (generally referred to as "Date of Service") and when the PBM reimbursed the pharmacy, to ensure the PBM is timely when paying clean claims.
- If the claim was rejected or is under appeal, provide reasons, including applicable rejection codes. *The regulator should verify the PBM provides a reasonable basis to pharmacies for the status of the claim.*

**This information may be pared down if the regulator is only looking at dispensing fees and not all claims data. However, pharmacy and network information is important to assess whether the PBM is reimbursing dispensing fees consistently across pharmacies in a network.*

Others Reviewed

_____ _____

_____ _____

Review Procedures and Criteria

Review all contracts between the PBM and pharmacies, including but not limited to, the provider manual, network reimbursement forms, maximum allowable cost lists, drug discount or manufacturer coupon contracts. Ensure all contractual language is transparent and sufficiently clear to enable the pharmacy to understand the dispensing fee payment prior to the pharmacy being paid.

Assess how the PBM determines the dispensing fee amount it pays for each drug type including generic, brand and specialty drugs. Confirm the dispensing fee amount is communicated to the pharmacies in clear and concise language.

Assess the PBM's ability to change the dispensing fee amount. Confirm the 'change' process is transparent & communicated to pharmacies in clear and concise language that is easily understandable and cannot be misinterpreted to mean more than the plane language. If the PBM contract language gives the PBM authority to change the dispensing fee amount, assess how that change occurs, how often it occurs, how and when it is communicated to the pharmacies, and whether the change can be done with or without the pharmacies' consent.

Review contracts between the PBM and the carrier or employer group to determine whether the payment of dispensing fees described to pharmacies is consistent with the PBM's requirements described in the carrier or employer group's contract with the PBM.

Review a sample of (or all) claims to ensure the PBM follows its own policies and procedures regarding dispensing fees paid to pharmacies. Review claims data to assess if there are differing standards based on the type of pharmacy: chain, retail, mail order, LTC, 340B, specialty or, if the pharmacy is affiliated or not affiliated with the PBM. Standards should be applied in a non-discriminatory manner such that PBM does not favor affiliate over non-affiliate pharmacies, for example. Payment of dispensing fees should be consistent across pharmacies within the same network.

C. Contracts

STANDARDS
PHARMACY BENEFIT MANAGERS
PROVIDER/PHARMACY RELATIONS
(BETWEEN PBMS AND PHARMACIES)

Standard 1
The PBM demonstrates that it exercises good faith and fair dealing in its contracting and contract negotiation processes with pharmacies.

Apply to: All PBMs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Pharmacy contracts and manuals in an unredacted format.

_____ An index of all policies and procedures for the pharmacy contracting and contract amendment and negotiation process.

_____ From the indices provided, request all policies and procedures that are applicable to contracting or the contract negotiation processes with pharmacies that are being examined. Request documents in an unredacted format.

_____ A listing of all pharmacies in the PBM's network. The listing should also require the PBM to provide a listing of all contracts (including provider manuals) and contract amendments the PBM has in place with each pharmacy. For each contract and amendment, request a listing of the effective dates and summaries of the content of each contractual document.

_____ All documentation and correspondence, including but not limited to emails and red-lined documents, between pharmacies and the PBM that pertain to the contact and contact amendments. The documentation should provide examples of pharmacies' requests to change or amend contract terms and should show the PBM's responses.

Others Reviewed

_____ _____

_____ _____

Review Procedures and Criteria

Review policies and procedures regarding PBM requirements for contracting and contract negotiations with pharmacies. Review criteria to assess if there are differing standards based on the type of pharmacy: chain, independent, mail order, LTC, 340B, specialty, or affiliate. Review all exclusionary criteria which may include but not be limited to, placing limits on the number of pharmacies in a geographic location. Standards should be applied in a non-discriminatory manner such that the PBM does not favor affiliate over non-affiliate pharmacies, for example.

Review policies and procedures for providing information to pharmacies about the contracting and contract negotiation processes. Examples include how the PBM informs pharmacies of required documentation, timeframes for submission of information, processes for submission of information such as who can submit the information and how i.e. via email, web portal or postal mail, any fees required. Ensure the PBM's contracting process is described to pharmacies in clear and concise language such that the pharmacies understand how to request changes to the contract terms.

Review policies and procedures for providing information to pharmacies about the PBM's documentation review process, timeframes for the PBM's review, how the PBM provides feedback to pharmacy negotiation requests, how pharmacy may request or provide additional information.

Review the documentation to assess whether the PBM is willing to negotiate contractual terms (or not) and whether there are any concerning trends in the PBM's dealings with pharmacies.

Review the PBM communications to pharmacies to assess the PBM's responses to pharmacy negotiation requests. Ensure the PBM provides sufficient information to support or deny the pharmacy's requests. Ensure PBM contracting process is not unilateral or one-sided to prevent pharmacies from negotiating.

Review the PBM's communications to pharmacies to assess if the PBM is following its own policies and procedures for contracting and contract negotiations with pharmacies. Determine whether the PBM appears to contract with certain pharmacy types and not others. For example, does the PBM frequently negotiate with chain pharmacies and rarely with independent pharmacies? If so, request the PBM to provide an explanation for such outcomes.

Assess how the PBM responds to pharmacy inquiries about the PBM's or the pharmacy's contractual obligations. For example, does the PBM have processes for pharmacies to initiate inquiries or obtain assistance from the PBM? Assess the PBM's responses to pharmacies during the inquiry process. Assess whether the PBM provides timely responses and provides reasonably sufficient responses to the pharmacy to justify the PBM's response or final determination. Review specific examples of inquiries and follow-up from the PBM.

STANDARDS
PHARMACY BENEFIT MANAGERS
PROVIDER/PHARMACY RELATIONS

Standard 2
The PBM demonstrates that it exercises good faith and fair dealing in implementing its contractual obligations with its vendors that work with its network pharmacies.

Apply to: All PBMs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Pharmacy contracts and manuals in an unredacted format.

_____ An index of all contracts with vendors that provide pharmacy benefits management services on behalf of the PBM and that interact with the pharmacy. The index should include a description of the services provided by each vendor and how the services impact pharmacies.

_____ From the index provided, review all policies and procedures that are applicable to the practices with the pharmacies being examined. Request documents in an unredacted format.

_____ Unredacted PBM contracts from vendors that provide pharmacy benefit management services on behalf of the PBM.

Others Reviewed

_____ _____

_____ _____

Review Procedures and Criteria

Review policies and procedures regarding PBM requirements for implementing the terms of its contracts with its vendors. Review to assess if there are differing standards for the vendor's conduct that may, for example, be based on the type of pharmacy: chain, independent, mail order, LTC, 340B, specialty, or affiliate. Standards should be applied in a non-discriminatory manner such that the PBM does permit the vendor to favor an affiliate over a non-affiliate pharmacy, for example.

Review policies and procedures for providing information to pharmacies about vendors with whom the PBM contracts to perform certain functions. Review all documentation to assess if the PBM provides reasonably sufficient information to pharmacies such that they would understand the exact function of the vendor and how the pharmacy is to interact with the vendor.

Review contracts between the PBM and its vendors to ensure the PBM does not permit its vendors to engage in activities that are prohibited under state law. For example, if state law prohibits a PBM from charging fees to a pharmacy, the PBM should not have a contract with a vendor that allows the vendor to charge the prohibited fees.

Assess whether the PBM effectively implements its own contractual obligations with its vendors and pharmacies that interact with the vendor. The PBM should implement requirements in a non-discriminatory manner that is

consistent with state law. For example, the PBM should not implement its contracts in a manner that favors its affiliate pharmacies over non-affiliated pharmacies.

STANDARDS
PHARMACY BENEFIT MANAGERS
PROVIDER/PHARMACY RELATIONS

Standard 3
The PBM demonstrates that it has a reasonable and easily accessible dispute resolution process for pharmacies to address matters of conflict with the PBM.

Apply to: All PBMs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Pharmacy contracts and manuals in an unredacted format.

_____ A data dictionary or list (and definitions) of all types of disputes that it considers "disputes." This may include but not be limited to complaints, independent third-party reviews, and arbitration.

_____ An index of all policies and procedures relating to the PBM's dispute resolution process for pharmacies.

_____ From the index provided, request all policies and procedures that are applicable to dispute resolution process being examined. Request documents in an unredacted format.

_____ PBM documentation showing how disputes are addressed and finalized. The PBM should provide examples of actual disputes and provide all documentation sent to or received by a pharmacy showing how the dispute was initiated, the correspondence between the PBM and pharmacy, any documentation that is exchanged, and documentation showing how the dispute is resolved.

Others Reviewed

_____ _____

_____ _____

Review Procedures and Criteria

Review policies and procedures regarding the PBM's dispute resolution process with pharmacies. Review criteria for the different types of disputes to assess whether the PBM has clear protocols, timeframes, and documentation requirements for addressing and resolving each type of dispute.

Review contracts and manuals for details provided to pharmacies about the dispute resolution process. Review how the PBM informs pharmacies of how disputes may be initiated, any required documentation, timeframes for submission of information, processes for submission of information (i.e. via email, web portal or postal mail, any fees required), the PBM's obligation to provide a justification for the final determination and timeframes for PBM response and resolution of the dispute.

Review contracts and manuals with details about the dispute resolution process to ensure the information provided to pharmacies is clear, concise, and easily understood.

Assess whether the PBM's requirements for pharmacies are convenient and accessible or whether the requirements

create such a burden to seemingly dissuade a pharmacy from initiating or following through with a dispute. Examples of requirements that may dissuade a pharmacy from initiating a dispute may include but are not limited to, requiring pharmacies to initiate disputes and send supporting documentation solely through postal mail or requiring exorbitant fee amounts to request or initiate a dispute resolution process.

Assess the PBM's responses to pharmacies during the dispute resolution process. Ensure the PBM provides timely responses and provides reasonably sufficient responses to the pharmacy to justify the PBM's final determination.

Ensure the PBM's policies and procedures and implementation of those policies and procedures are consistent with state law.

Assess whether the PBM has staffing models to effectively resolve disputes.

D. Pharmacy Claims

STANDARDS
PHARMACY BENEFIT MANAGERS
PHARMACY CLAIMS

Standard 1
The PBM demonstrates that it has timely and transparent claims submission and adjudication processes for pharmacy claims that enable pharmacies to understand the payment rate prior to claims submission.

Apply to: All PBMs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Pharmacy contracts and manuals in an unredacted format

_____ An index of all policies and procedures for pharmacies to submit *and* adjudicate claims to the PBM.

_____ An index of all policies and procedures for the pharmacies to inquire about or contest the PBM's adjudication of pharmacy claims.

_____ Based on information submitted with the indices provided, request all policies and procedures that are applicable to the PBM's practices with pharmacies that are being examined. Request documents in an unredacted format.

_____ Other than contracts and manuals, request all documents provided by the PBM to pharmacies relating to claims processes including but not limited to claims forms with instructions, bulletins, PBM newsletters, pharmacy updates, other mass communications and time stamped screenshots and URLs of the PBM's website showing where information concerning its claims submission and appeals processes are communicated to pharmacies. Request documents be provided in an unredacted format.

_____ All internal PBM reports used by management regarding claims and claims processing. Request documents be provided in an unredacted format.

_____ All contacts with carriers or employer groups in an unredacted format.

_____ Request all claims data for a specified time period and in a standardized template to capture all required claims information that may include but not be limited to:

- Pharmacy information including but not limited to name, NPI, and address.
- Pharmacy network name associated with each claim.
- Chain, independent, mail order, LTC, 340B, and specialty drug pharmacy claims.
- The drug pricing source used for reimbursement of each claim.
- The percentage *and* actual amount of any 'discount' or other price reduction from the drug pricing source that the PBM applied as part of its payment to the pharmacy.
- The amount of any fees or amount of any other price reduction that is not related to the drug or dispensing fee. For example, any claims processing fee applied to the claim.

- The final reimbursement amount of each claim for the drug.
- The final reimbursement of any dispensing fee.
- The type of health coverage being reimbursed, for example, commercial vs. Medicare and self-funded vs. fully insured.
- The status of the claim for example paid, rejected, adjusted, under appeal, etc.
- The dates of when the claim was submitted (generally referred to as "Date of Service") and when it was paid (if applicable) to ensure the PBM is timely when paying clean claims.
- If the claim was rejected or is under appeal, provide reasons. *The regulator should verify the PBM provides a reasonable basis to pharmacies for the status of the claim.*

_____ Regulatory actions

Others Reviewed

_____ _____

_____ _____

Review Procedures and Criteria

Review policies and procedures related to the requirements for pharmacies to submit claims that may include but are not limited to the following:

- Claims processing software requirements.
- Claims form information that must be submitted with the claim such as the prescriber identification number, claim codes, and reject codes.
- Any applicable NCPDP standards.

Review policies and procedures relating to the requirements for pharmacies to submit claims that may require additional information, for example claims that include but may not be limited to the following:

- Dispensed as written codes
- Over-the-counter products
- Multi-ingredient compound processing
- Override
- Coordination of benefits
- Reversals
- Submission timeframes

Review policies and procedures relating to the PBM's adjudication of the claims. The policies and procedures should include, but not be limited to, the following:

- The PBM should have clear criteria for how it arrives at the payment level and dispensing fee for each claim. This should include how it determines which drug pricing source is used and how it determines any "discount" the PBM may apply to reduce the reimbursement amount paid to the pharmacy
- The PBM should have clear criteria for claims approvals, denials or rejections at the point of sale.
- The PBM should have clear timeframes for claims adjudication either through payment or rejection of the claim.
- The PBM should have processes describing how it provides pharmacies with reasonably sufficient detail to justify any claim that is rejected, which may include providing reject codes that can be reviewed by the pharmacy.
- The PBM should have clear criteria, including timeframes, describing processes for pharmacies to submit inquiries or appeals for example, about any claims that are rejected or denied. *This would not include coverage appeals initiated by a consumer.*

Review all PBM policies and procedures to assess whether the PBM applies different standards to different types of claims such as self-funded, specialty drug, mail order, nonresident or discount card claims. Verify that any differing standards are consistent with state law.

Review all pharmacy contracts, including any Provider Manuals, to ensure the claims submission and adjudication processes are clearly and concisely described to pharmacies. The PBM should provide pharmacies with detailed information about:

- Each step necessary to submit a claim.
- The process and timeframe for the PBM to review and make a determination about whether a claim will be paid.
- How a pharmacy may submit an inquiry, appeal, or otherwise contest the PBM's response to a pharmacy's claim. Information should include timeframes for each step in the process and should describe an easily accessible process for the pharmacy.
- Ensure information describes how pharmacies are reimbursed in accordance with applicable laws that may dictate payment amount and applicable dispensing fees.

Review all documentation to assess whether the PBM provides reasonably sufficient information about its claims payment methodology to ensure that pharmacies understand what they will be paid prior to submitting claims. This should include but not be limited to:

- If the PBM publishes a Maximum Allowable Cost (MAC) list, the list is readily available and useful to pharmacies. Does the listing provide a "search" function to find a specific drug or is the list formatted in a way that requires the pharmacy to scroll through thousands of drugs to find a specific drug? The latter would not be reasonable.
- If the PBM applies a "discount" or other type of reimbursement reduction to the drug pricing source it uses to pay pharmacies, is that discount reasonably described in documentation to pharmacies such that pharmacies will understand the final payment amount prior to submitting a claim? Use of opaque language that does not expressly identify use of a "discount" and the applicable discount amount should not be allowed; the regulator should require the PBM make changes to any opaque language.
- If the PBM uses a third-party vendor for processing and/or payment of any claims, is that process clearly described to pharmacies? Does the PBM expressly describe the criteria for when a claim will be diverted to a third party? Does it describe which specific drugs will be run through a third-party? Can the pharmacy "opt-in" or "opt-out" of any such programs? Does the PBM provide reasonably sufficient information such that the pharmacy will know its reimbursement level prior to submitting the claim?

When requesting claims data, require the PBM to submit ***all*** claims being examined, including a specific description of the claims being requested, including distribution channels (chain, independent, mail-order, LTC, 340B, or specialty), as well as lines of business (e.g. fully insured, Medicare, Medicaid, self-insured—ERISA, self-insured non-ERISA, etc.). In addition, consider including the scope of claims in the description (e.g. all pharmacies with physical locations in the state, member claims filled in the state, claims filled for members covered by health plans situsued in the state, or some other criteria). Ensure the PBM clearly identifies the payment amount and assess whether it is consistent with any state law, such as requiring payment at the NADAC rate or a required amount of a dispensing fee. Ensure the PBM is compliant with any state law prohibiting fees or claw backs of clean claims.

Consider requesting the PBM provide a live demonstration of its claims adjudication process for a sample of each type of claim being examined which may include but not be limited to: claims that are approved, claims that are denied, claims that are rejected, claims that are mail order only, claims that are for self-funded employer groups, or claims that are for fully insured plans.

Review all, or a sample of PBM contracts with carriers/employer group to assess if the PBM is compliant with the claims payment requirements in those contracts and that those terms are consistent with in all messaging to pharmacies. For example, if pass-through pricing is required by the insurer contract, is that consistent with the payment method (and applicable description) to pharmacies?

E. Pharmaceutical Manufacturer Rebates

STANDARDS
PHARMACY BENEFIT MANAGERS
PHARMACEUTICAL MANUFACTURER REBATES

Standard 1
The PBM demonstrates all rebate payments provided by pharmaceutical manufacturers to PBMs (including rebates paid by or to aggregators, group purchasing organizations, or affiliated entities), administrative fees, credits, incentives and penalties are passed through to health plans, payors, patients, or covered entities as applicable to current statutes, rules and regulations.

Apply to: All PBMs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ An index of all policies and procedures relating to the PBM's rebates.

_____ An index of all training manuals relating to the PBM's rebate administration, accounting, and reporting processes.

_____ All policies and procedures related to rebate negotiation, rebate processing, rebate invoicing, rebate collection, rebate crediting at the point of sale, and rebate remittance to health plans, payors, or covered entities as well as other affiliated entities that may administer rebate negotiations on behalf of the health plan, payor, or covered entity. Request document in unredacted format.

_____ A listing of all manufacturers with which the PBM receives rebates or has received rebates (for the applicable examination period).

_____ A listing of all health plans, insurers, employer groups, or covered entities for which the PBM provided services in the state during the examination period.

_____ Complete and unredacted contracts between the PBM and pharmaceutical manufacturers, rebate aggregators, group purchasing organizations, or affiliated entities involved in rebate negotiation, administration, or collection.

_____ Complete and unredacted contracts between the PBM and all applicable health plans, insurers, employer groups, and covered entities. Contracts should include all rebate-related provisions, including but not limited to:

- Definitions of rebates, administrative fees, and other manufacturer remuneration;
- Pass-through or retention provisions;
- Reporting requirements; and
- Audit rights.

_____ An index of periodic reports, certifications, or real-time systems made available to health plans to monitor rebates, fees, and discounts received by the PBM and/or amounts remitted to health plans.

_____ All standard rebate reports provided to health plans during the examination period, including data dictionaries and field definitions.

_____ All claims data and rebate data for a specified time period in a standardized template sufficient to link:

- Pharmacy information including, but not limited to name, NPI, and address.
- Pharmacy network name associated with each claim.
- Chain, independent, mail order, LTC, 340B, and specialty drug pharmacy claims.
- The drug pricing source used for reimbursement of each claim.
- The percentage *and* actual amount of any "discount" or other price reduction from the drug pricing source, drug copay discount program, copay accumulator or maximizer program, or any other discount/price adjustment that the PBM applied as part of its payment to the pharmacy.
- The amount of any fees or amount of any other price reduction that is not related to the drug or dispensing fee. For example, any claims processing fee applied to the claim.
- The final reimbursement amount of each claim for the drug.
- The final reimbursement of any dispensing fee.
- The type of health coverage being reimbursed, for example, commercial vs. Medicare and self-funded vs. fully insured.
- The status of the claim, for example paid, rejected, adjusted, under appeal, etc.
- The dates of when the claim was submitted (generally referred to as "Date of Service") and when it was paid (if applicable) to ensure the PBM is timely when paying clean claims.
- The percentage *and* actual amount of any "discount" or other price reduction from the drug pricing source, drug copay discount program, copay accumulator or maximizer program, or any other discount/price adjustment that the PBM applied as part of its payment to the pharmacy.
- The amount of any fees or amount of any other price reduction that is not related to the drug or dispensing fee. For example, any claims processing fee applied to the claim.
- The final reimbursement amount of each claim for the drug.
- The final reimbursement of any dispensing fee.
- The NDC and units are integral parts of the rebate transaction and must be included in the data dictionary.
- The rebate eligibility of the claim/drug.
- The rebate amount invoiced of the drug/claim.
- The rebate amount collected of the drug/claim.
- The rebate amount retained by the PBM.
- The rebate amount remitted to the health plan.
- The timing of each rebate transaction (claim versus rebate invoicing versus collection).

Others Reviewed

_____ _____

_____ _____

Review Procedures and Criteria

Review the PBM's policies and procedures and training manuals to determine if internal standards regarding the forwarding of manufacturer rebates exist governing the identification, invoicing, collection, accounting, allocation, and remittance of manufacturer rebates, fees, and discounts, and whether those standards comply with state requirements.

Review contracts between the PBM and health plans, carriers, or employer groups to determine:

- Whether rebates are required to be passed through in full, in part, or retained by the PBM;
- If rebates are to be passed through in full or in part, are they allocated to the health plan, payor, and/or patient as authorized by law or contract;
- Whether administrative fees or other retained amounts are expressly permitted; and
- Whether spread pricing or other pricing methodologies are authorized under the contract.

Review contracts between the PBM and pharmaceutical manufacturers or rebate aggregators to determine the types of remuneration received, the methodology used to calculate rebate amounts, and the timing of rebate payments.

Assess whether the PBM's descriptions of rebate practices in its contracts with health plans are consistent with its contractual arrangements with pharmaceutical manufacturers and affiliated rebate entities.

Determine whether the PBM has established processes to ensure that all rebate-eligible claims are accurately identified and included in manufacturer rebate submissions. Evaluate whether the PBM maintains controls to prevent the omission or misclassification of rebate-eligible claims.

Review all rebate transactions and associated pharmacy claims to verify that:

- The units for each NDC is applied appropriately and rebates are invoiced timely and appropriately in accordance with contractual and statutory requirements;
- Rebate amounts invoiced to manufacturers are supported by underlying claims data;
- Rebate amounts collected from manufacturers are consistent with contractual terms; and
- Rebate amounts remitted to health plans are calculated and transmitted in accordance with contractual and statutory requirements.

Assess whether rebates are remitted to health plans within required contractual or statutory timeframes and whether any delays are supported by documented reconciliation or dispute processes.

Where spread pricing is permitted under the contract between the PBM and the health plan, review claims and rebate data to determine whether the PBM's retention of spread or rebate amounts is consistent with the express terms of the contract and is accurately disclosed in required reporting to the health plan.

Review claims payment, pharmacy reimbursement, and rebate data collectively to ensure that drug ingredient cost, dispensing fees, administrative fees, alternative payment programs, discounts, accumulators, maximizers, spread pricing (if applicable), and manufacturer rebates are applied and reported in a consistent and transparent manner across all PBM financial transactions associated with a claim.

Assess whether the PBM provides health plans with reasonably sufficient detail in its reporting to enable the health plan to independently verify rebate calculations, collections, and remittances. Reports should allow reconciliation from manufacturer payment to claim-level utilization.

Determine whether the PBM applies differing rebate allocation methodologies across lines of business (e.g., fully insured, self-funded, independent, chain, LTC, specialty pharmacy) and verify that any such differences are permitted under applicable contracts and law.

Evaluate whether 340B pharmacies are included in rebate allocation and determine if permitted under applicable contracts and law.

Evaluate whether any affiliated pharmacies, specialty pharmacies, or PBM-owned entities are treated differently in rebate attribution or allocation and verify that such practices are disclosed and permitted under contract.

Where point-of-sale rebate crediting is used, review system logic, claims adjudication rules, and financial settlement processes to verify that rebate amounts applied at the point of sale are accurately calculated and reflected in both

member cost sharing and health plan financial reporting.

Determine whether the PBM maintains adequate internal controls, audit trails, and reconciliation processes to ensure completeness and accuracy of rebate invoicing, collection, and remittance.

STANDARDS
PHARMACY BENEFIT MANAGERS
PHARMACEUTICAL MANUFACTURER REBATES

Standard 2
The PBM demonstrates all pharmaceutical manufacturer rebates are correctly reported to the commissioner/department as applicable to current statutes, rules and regulations.

Apply to: All PBMs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations.

_____ An index of all training manuals relating to the PBM's rebate administration, accounting, and reporting processes.

_____ All policies and procedures related to rebate negotiation, rebate processing, rebate invoicing, rebate collection, rebate crediting at the point of sale, and rebate remittance to health plans or covered entities as well as other affiliated entities that may administer rebate negotiations on behalf of the health plan, payor, or covered entity. Request documents in unredacted format.

_____ A listing of all manufacturers with which the PBM receives rebates or has received rebates (for the applicable examination period).

_____ A listing of all health plans, insurers, employer groups, or covered entities for which the PBM provided services in the state during the examination period.

_____ Complete and unredacted contracts between the PBM and pharmaceutical manufacturers, rebate aggregators, group purchasing organizations, or affiliated entities involved in rebate negotiation, administration, or collection.

_____Complete and unredacted contracts between the PBM and all applicable health plans, insurers, employer groups, and covered entities. Contracts should include all rebate-related provisions, including but not limited to:

- Definitions of rebates, administrative fees, and other manufacturer remuneration;
- Pass-through or retention provisions;
- Reporting requirements; and
- Audit rights.

_____ An index of periodic reports, certifications, or real-time systems made available to health plans to monitor rebates, fees, and discounts received by the PBM and/or amounts remitted to health plans.

_____ All standard rebate reports provided to health plans during the examination period, including data dictionaries and field definitions.

_____ All claims data and rebate data for a specified time period in a standardized template sufficient to link:

- National Drug Code (NDC);
- Claim identifier;
- Dispensing date;

- Rebate eligibility;
- Rebate amount invoiced;
- Rebate amount collected;
- Rebate amount retained by the PBM;
- Rebate amount remitted to the health plan; and
- Timing of each rebate transaction.

Others Reviewed

_____ _____

_____ _____

Review Procedures and Criteria

Review the PBM's policies and procedures and training manuals to determine if internal standards regarding the preparation of statutorily required reports exist and whether those standards comply with state requirements.

Determine if applicable policies and procedures were actually communicated to employees responsible for the preparation of statutorily required reports.

Determine if the statutorily required reports to the regulator were complete, accurate, and timely filed.

F. Pharmacy Network Adequacy

STANDARDS
PHARMACY BENEFIT MANAGERS
PHARMACY NETWORK ADEQUACY

Standard 1
The PBM demonstrates its credentialling process for all pharmacies in its network and is able to demonstrate its credentially criteria from the beginning of the process to the end.

Apply to: All PBMs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Pharmacy contracts and manuals in an unredacted format.

_____ Pharmacy contracts and manuals with the PBM's language relating to credentialing.

_____ An index of all internal policies and procedures for the credentialing process.

_____ All policies and procedures that are applicable to credentialing practices being examined. Request documents in an unredacted format.

_____ Any complaints from the network enrollment/credentialing Department.

Others Reviewed

_____ _____

_____ _____

Review Procedures and Criteria

Review policies and procedures regarding PBM requirements for assessing licenses, credentials, accreditations, provider ID (including but not limited to NPI and NCPDP) and other qualifications for all pharmacies and pharmacy staff including but not limited to the pharmacist in charge (designated in different states as Supervising Pharmacist or Pharmacy Manager, etc), staff pharmacists, nationally certified and non-certified pharmacy technicians, and any customer service representatives/pharmacy clerks. Scope of practice and licensure are governed by the laws and regulations of each State Board of Pharmacy and should be reviewed as it pertains to that particular state. Review all exclusionary criteria such as requirements that pharmacists cannot be excluded or revoked by any licensing board.

Review any requirements for other personnel including but not limited to pharmacy owners, officers or directors. Review all exclusionary criteria that may apply.

Review all requirements for pharmacies including but not limited to application documents, insurance requirements such as professional liability coverage, any required minimum stock of drugs, and technological capabilities such as claims submission platforms.

Review policies and procedures for providing information to pharmacies about the credentialing process, including how the PBM informs pharmacies of required documentation, timeframes for submission of information, processes for submission of information such as via email, web portal or postal mail, and any credentialing fees required.

Review policies and procedures for providing information to pharmacies about the PBM's documentation review process, timeframes for the PBM's review, how the PBM provides feedback to a pharmacy, how a pharmacy may correct deficiencies or provide additional information.

Review contracts and manuals for details provided to pharmacies about the credentialing process. The PBM should provide clear and concise information that is consistent with its own policies and procedures and should follow any applicable state or federal law for credentialing and recredentialing. Information provided to pharmacies should address all the requirements and steps for credentialing and should provide pharmacies with adequate time to provide all documentation and provide pharmacies with the ability to address any questions about the process.

Request a listing of all pharmacies and staff that went through the credentialing process during the examination period. Request the results of each process (i.e. was the pharmacy "approved" to be in the PBM's network or not). Request the reasoning for all approval or denials. Consider creating a spreadsheet to use to collect this information in a format that is helpful for the regulator.

Request *all correspondence* between the PBM and a pharmacy as part of the credentialing process. Consider whether to request information from all entities/persons or just a sample of those that went through the credentialing process. "Correspondence" may include but not be limited to, all documents sent by the PBM to the pharmacies, all documents sent by the pharmacies to the PBM, any emails, notes from phone conversations, and any other communications about the credentialing process that occurred between the PBM and the pharmacy. Require documents to be provided in an unredacted format. Ensure all correspondence from the PBM is clear and concise and provides reasonably sufficient information to pharmacies regarding the credentialing process and any decisions made by the PBM.

In any Summary of the PBM Network Adequacy that proceeds these standards, consider describing the difference between the *PBM's network* and *pharmacy networks*. The PBM's network encompasses all pharmacies with which it contracts in the state. The PBM may have multiple pharmacy networks that may be designed based on types of drugs dispensed, how drugs are dispensed (i.e. mail order or chain/independent), or geographic location and will likely have differing reimbursement levels.

STANDARDS
PHARMACY BENEFIT MANAGERS
PHARMACY NETWORK ADEQUACY

Standard 2
The PBM demonstrates compliance with state law (if any), insurer or employer contracts, or other reasonable criteria, that it creates and maintains a network of pharmacies in a transparent manner.

Apply to: All PBMs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations.

_____ PBM and pharmacy contracts and manuals. This should include all network contracts and forms. Request documents be provided in an unredacted format.

_____ An index of all policies and procedures relating to the PBM's network and its pharmacy networks. From the index, Examiners should request all relevant policies and procedures for areas being examined. Request documents be provided in an unredacted format, including requiring all pricing information be unredacted.

_____ PBM and insurer or employer plan contracts. Request the entire contract, including any amendments, in an unredacted format.

_____ A listing of all the pharmacies with which the PBM contracts. The listing should require the PBM to identify each pharmacy's location, pharmacy type (for example, chain, independent, mail-order, specialty, LTC, or 340B pharmacy), the types of business it serves (commercial, Medicaid or Medicare), the types of drugs it dispenses (generic, brand, specialty), the unique pharmacy network each pharmacy participates in, whether the pharmacy is an affiliate pharmacy or not, whether the pharmacies' network participation changed at any time during the examination period and the reason for such change (i.e. PBM changed terms, pharmacy opted out, carrier requested change). Consider creating a spreadsheet to use to collect this information in a format that is helpful for the regulator.

_____ A state map or geo-maps identifying the location of each pharmacy.

_____ A description of the differences in each unique pharmacy network. For each pharmacy network, the PBM should identify the types of drugs dispensed, consumer access (such as mail order or chain/independent), the reimbursement levels including any "discounts" applied and dispensing fees provided, any criteria for participation and any participation limits or restrictions. Standards should be applied in a non-discriminatory manner such that the PBM does not favor affiliate over non-affiliate pharmacies, for example.

_____ A list of all insurers and employer groups and each plan for the entity for which the PBM administers prescription drug benefits. Require the PBM to identify every network associated with each plan. Consider creating a spreadsheet to use to collect this information in a format that is helpful for the regulator.

_____ If required by state law, the PBM files with the department of insurance all required contract forms and any material changes to a contract proposed for use with its participating providers and intermediaries.

Others Reviewed

_____ _____

_____ _____

Review Procedures and Criteria

Review internal policies and procedures regarding PBM requirements for ensuring the PBM has appropriate number of pharmacies in applicable geographic areas to ensure network pharmacies provide appropriate access to consumers. Ensure the PBM is compliant with state law and any requirements within its contracts with insurers and employer groups.

Review the PBM's internal policies and procedures to assess how the PBM creates, maintains and changes pharmacy networks. Ensure the PBM has clear and concise requirements. The PBM internal requirements should include but not be limited to:

- Requirements for pharmacy location. This should include requirements to address pharmacy shortage areas (or pharmacy deserts) and describe how the PBM utilizes out-of-network pharmacies when necessary.
- Requirements for how the PBM may update or change network requirements or network participation for a pharmacy. This should include procedures for the PBM to provide *notice* of changes to the pharmacies and its carrier/employer group clients.
- Requirements for pharmacy network reimbursement levels. Ensure these are applied consistently among all pharmacies in each network.
- Conditions under which a pharmacy may be terminated, including requirements on how the pharmacy is notified of the termination and payment for all unpaid claims at the time of the termination.

Review contracts and manuals with pharmacies that describe all aspects of the pharmacy networks. Ensure information is provided in a manner that is clear, concise, and easily understandable. Areas to review include but are not limited to:

- Do contracts/manuals clearly describe the requirements for participation in each pharmacy network?
- How does the PBM change the terms of the pharmacy network requirements? Any changes should be made in a transparent manner and with timely notice to the pharmacies.
- Do the contracts/manuals clearly describe the reimbursement including dispensing fees for each network?

Review the pharmacy listing to assess how often the PBM made changes to the pharmacy network requirements and participation levels during the examination period. Ensure the specific reasons for such changes are reasonable. Request all correspondence with pharmacies impacted by any changes. Request all correspondence with insurers and employer groups about the network changes. Ensure the message conveyed to insurers and employer groups is consistent with the message provided to pharmacies.

Review the listing of pharmacies and description of pharmacy network differences to ensure compliance with state and federal requirements. Depending on the state's legal requirements, areas to consider include by are not limited to:

- Does the PBM have networks that are comprised solely of affiliate pharmacies?
- Does the PBM have networks that are comprised solely of mail order pharmacies?
- Are the reimbursement rates among the differing networks reasonable or do the rates show differing levels for affiliate only networks when compared to networks without affiliates?

In any Summary of the PBM Network Adequacy that proceeds these standards, consider reviewing the PBM's contracts and manuals with pharmacies as part of how to ask for specific information about "contracting."

STANDARDS
PHARMACY BENEFIT MANAGERS
PHARMACY NETWORK ADEQUACY

Standard 3
The PBM demonstrates compliance with state law (if any) or other reasonable criteria, that it maintains a network of pharmacies that is sufficient in number and types of pharmacies to ensure that all services to covered persons will be accessible without unreasonable delay.

Apply to: All PBMs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policies and procedures for providing information to covered persons about pharmacy directories.

_____ Policies and procedures for addressing inquiries or complaints from covered persons about pharmacy directories or access. This should include policies and procedures for how covered persons may access emergency pharmacy services when necessary.

_____ Documentation regarding how the PBM makes its provider directory (that lists all providers who participate in its network) available to covered persons and how it makes available, on a timely and reasonable basis, updates to its directory.

_____ All documentation to inform covered persons how and where they may fill their prescriptions. Documentation should provide details of how covered persons may contact the PBM with inquiries.

_____ A listing of all the pharmacies with which the PBM contracts. The listing should require the PBM to identify each pharmacy's location, pharmacy type (for example, chain, independent, mail-order, LTC, or 340B pharmacy), the types of business it serves (commercial, Medicaid or Medicare), the types of drugs it dispenses (generic, brand name, specialty), the unique pharmacy network each pharmacy participates in, and whether the pharmacy is an affiliate pharmacy or not.

_____ A state map or geo-maps identifying the location of each pharmacy in relation to consumers.

Others Reviewed

_____ _____

_____ _____

Review Procedures and Criteria

Ensure the PBM has established and will maintain adequate arrangements to ensure reasonable proximity of participating pharmacies to the business or personal residence of covered persons. In determining whether a PBM has complied with this provision, the regulator should consider the relative availability of pharmacies in the service area.

Review policies and procedures for providing information to covered persons about in-network pharmacies and emergency services.

Review all information provided to covered persons to ensure the information is provided in a clear and concise manner and updated regularly. PBMs should have clear information that describes how consumers may contact the PBM with any inquiries about pharmacy options.

Review all consumer complaints submitted to the PBM and the regulator to assess whether consumers have issues with pharmacy access.

G. Utilization Review

1. Purpose

The utilization review portion of the examination is designed to verify that insurers or payors and their designees, including PBMs, that provide or perform utilization review services comply with standards and criteria for the structure and operation of utilization review processes.

The areas to be considered in this kind of review include the insurer's or payor's utilization review policies and procedures, annual summary reports, timeliness in making utilization review decisions and handling appeals, communications with members about the program and oversight of delegated utilization review functions.

DUR is conducted in three primary forms: prospective, concurrent, and retrospective. Prospective DUR occurs prior to dispensing and is designed to identify potential issues such as drug–drug interactions, therapeutic duplication, or inappropriate dosing before the medication is provided to the patient. Concurrent DUR takes place during the course of treatment and is used to monitor ongoing therapy, such as reviewing refill patterns or emerging safety concerns while a patient is actively receiving a medication. Retrospective DUR is performed after dispensing and involves analyzing historical claims data to identify patterns of inappropriate prescribing, potential overutilization, or opportunities for provider or patient education.

2. Techniques

The analysis of utilization review activities should include an overview of the PBM's written utilization review policies, procedures and scripts, in addition to an overview of how utilization review activities are applied to individual cases. Utilization review issues may also surface during the examiners' inspection of claims, complaints and grievance procedures.

a. Examiners should request a written overview of the PBM's utilization review program. The overview should include the names and positions of individuals responsible for overseeing the program, along with the qualifications of the utilization review director and staff. The overview should also include if the PBM utilizes artificial intelligence (AI) in its utilization review, and if so, the extent of what is being reviewed by AI and what criteria determines that it moves from AI to PBM staff. Examiners may request an interview of appropriate personnel, to supplement information obtained in the written overview. During this process, examiners should also determine how the PBM maintains corporate oversight of the utilization review process. Where applicable, the examiner should obtain copies of any required utilization review licenses or certifications. Review the scope of the utilization review program. Utilization review functions for some specialized services are occasionally delegated to other entities. Examiners should request copies of applicable reports required for regulatory purposes.

b. Examiners should also obtain the program materials and scripts to ascertain the source of guidelines used, how frequently the materials are updated and whether they are supported by reliable sources of data and medical protocol. In addition, obtain standards used by applicable accreditation entities, if any. A review of the time guidelines for responding to utilization review and reconsideration requests should be conducted. An evaluation of the methods used to communicate utilization review decisions to medical providers, subscribers and other applicable divisions within the company should be completed.

c. Evaluate the availability of, and access to, the utilization review program to plan members or subscribers. Review adequacy of staffing and hours of operation.

d. Ascertain whether utilization review requirements are consistent with and supported by language the contractual agreement with the insurer and the insurer's policy, certificate of coverage and marketing materials.

e. Obtain listings of utilization review determinations, including approvals or certifications, denials, and requests for reconsideration. Using appropriate sampling methodology, select a representative sample of cases for detailed review. For each sampled case, obtain the clinical criteria and review guidelines applied in the determination and evaluate whether the PBM's actions were consistent with its written policies, clinical standards, and established review procedures. Ensure that the examiner assigned to this review possesses sufficient clinical expertise to interpret the applicable criteria, understand the clinical context of the request, and assess whether determinations were made in accordance with the PBM's documented guidelines and utilization review protocols.

f. Obtain annual reporting by the PBM of its utilization review. Minimum standards should include:
   - Number of requests by type (prior authorization, maximum unit, appeal, etc.).
   - Number approved of each type.
   - Number denied of each type.
   - Number appealed of each type.
   - Number approved after appeal of each type.
   - Timeframe of each response of each type.
   - Whether or not each of the above was derived from AI, clinical staff, or non-clinical staff.

3. Tests and Standards

The utilization review assessment includes, but is not limited to, the following standards related to the performance of utilization review activities by the PBM.

STANDARDS
PHARMACY BENEFIT MANAGERS
UTILIZATION REVIEW

Standard 1
The PBM operates its utilization review program in compliance with applicable statutes, rules and regulations.

Apply to: PBMs providing or performing utilization review services to an insurer or payor.

Priority: Essential

Documents to be Reviewed

_____Applicable statutes, rules and regulations, including those related to mandated benefits and services.

_____Utilization review policies and procedures.

_____Utilization review program or plan documentation.

_____Medical criteria used to make utilization review determinations.

_____Job description of the staff position functionally responsible for day-to-day management.

_____Minutes of the PBM's board of directors.

_____Minutes of the PBM's utilization review committee.

_____Documentation of clinical staff credentialing maintenance and education requirements.

_____Program assessment reports.

Others Reviewed
_____ _____

_____ _____

Review Procedures and Criteria

Verify that the PBM implements procedures to ensure effective corporate oversight of its utilization review program.

Verify that a PBM that requires a request for benefits under the covered person's health benefit plan to be subjected to utilization review, implements a written utilization review program that describes all review activities, both delegated and nondelegated for:

- The filing of benefit requests;

- The notification of utilization review and benefit determinations; and

- The review of adverse determinations in accordance with applicable state statutes,
- Verify that the PBM's written utilization review program document describes all the following:
    - Procedures to evaluate the medical necessity, appropriateness, efficacy or efficiency of pharmacy services;
    - Data sources and clinical review criteria used in decision-making;
    - Mechanisms to ensure consistent application of clinical review criteria and compatible decisions;
    - Data collection processes and analytical methods used in assessing utilization of pharmacy services;
    - Provisions for ensuring confidentiality of clinical and proprietary information;
    - If AI is used and in what capacity;
    - The organizational structure (e.g., utilization review committee, quality assurance or other committee) that periodically assesses utilization review activities and reports to the insurer's or payor's governing body; and
    - The staff position functionally responsible for day-to-day program management.

- Verify that the PBM ensures that appropriate personnel have operational responsibility for conducting the insurer's or payor's utilization review program.

STANDARDS
PHARMACY BENEFIT MANAGERS
UTILIZATION REVIEW

Standard 2
The PBM operates its utilization review program in compliance with applicable statutes, rules and regulations.

Apply to: PBMs providing or performing utilization review services to an insurer or payor.

Priority: Essential

Documents to be Reviewed

_____Applicable statutes, rules and regulations.

_____Utilization review policies and procedures.

_____Form letters.

_____Activity reports.

_____Provider manual.

_____Files with utilization review requests (Verify that all levels of authorized, appealed and disapproved requests are reviewed).

Others Reviewed
_____ _____

_____ _____

Review Procedures and Criteria

Verify that the PBM utilization review program uses documented clinical review criteria that are based generally accepted, independently-developed clinical standards published by the federal government or professional organizations and evaluated periodically to assure ongoing efficacy.

Note: The PBM may develop its own clinical review criteria or may purchase or license clinical review criteria from qualified vendors.

Verify that the PBM makes its clinical review criteria available upon request to authorized government agencies.

Verify that the PBM ensures that qualified pharmaceutical professionals administer the utilization review program and oversee review decisions. Verify that the PBM has appointed clinical peers to evaluate the clinical appropriateness of adverse determinations.

Verify that the PBM issues utilization review decisions and benefit determinations in a timely and efficient manner pursuant to the requirements set forth in applicable state statutes, rules and regulations.

Verify that the PBM has a process to ensure that utilization reviewers apply clinical review criteria in conducting utilization review consistently.

Verify that the PBM conducts routine assessments of the effectiveness and efficiency of its utilization review program.

Verify that the PBM's data systems are sufficient to support utilization review program activities and to generate management reports to enable the PBM to monitor and manage pharmacy services effectively.

If a PBM delegates any utilization review activities to a utilization review organization, verify that the PBM maintains adequate oversight, to include all the following:

- A written description of the utilization review organization's activities and responsibilities, including reporting requirements;
- Evidence of formal approval of the utilization review organization program by the PBM or respective insurer; and
- A process by which the PBM evaluates the performance of the utilization review organization.

If a PBM delegates any utilization review activities to AI, a AI program, or a AI vendor, verify that the PBM maintains adequate oversight, to include all the following:

- A written description of the AI/AI organization's activities and responsibilities, including reporting requirements;
- Evidence of formal approval of the AI program by the PBM or respective insurer; and
- A process by which the PBM evaluates the performance of the AI functionality.

Verify that the PBM coordinates its utilization review program activities with other medical management activity conducted by the insurer or payor, such as quality assurance, credentialing, provider contracting, data reporting, grievance procedures, claims adjudication, processes for assessing member satisfaction and risk management.

Verify that the PBM provides covered persons, or, if applicable, the covered person's authorized representatives and participating providers with access to its utilization review staff via a toll-free number or collect call telephone line.

Verify that the PBM, when conducting utilization review, collects only the information necessary, including pertinent clinical information, to make the utilization review or benefit determination.

Verify that PBM staff conducting each type of utilization review are qualified to make clinical determinations, i.e. non-clinical staff should not be making determinations on drug coverage based on detailed clinical criteria from information based on patient-specific laboratory or clinical findings when compared to national guidelines or predetermined criteria.

STANDARDS
PHARMACY BENEFIT MANAGERS
UTILIZATION REVIEW

Standard 3
The PBM discloses information about its utilization review and benefit determination procedures to covered persons, or, if applicable, the covered persons' authorized representative, in compliance with applicable statutes, rules and regulations.

Apply to: PBMs providing or performing utilization review services to an insurer or payor.

Priority: Essential

Documents to be Reviewed

_____Applicable statutes, rules and regulations.

_____Member materials.

Others Reviewed

_____ _____

_____ _____

Review Procedures and Criteria

Verify that the PBM provides a clear and accurate summary of its utilization review and benefit determination procedures to the covered person's authorized representative.

Determine whether the PBM makes its utilization review criteria publicly available, including whether such criteria are posted on a website or otherwise maintained in a manner that allows covered persons and providers to easily access and obtain them upon request.

Verify that the PBM provides a clear and comprehensive description of its utilization review procedures, including the procedures for obtaining adverse review determinations, and a statement of rights and responsibilities of covered persons.

STANDARDS
PHARMACY BENEFIT MANAGERS
UTILIZATION REVIEW

Standard 4
The PBM makes standard utilization review and benefit determinations in a timely manner and as required by applicable state statutes, rules and regulations, as well as the provisions of HIPAA.

Apply to: PBMs providing or performing utilization review services to an insurer or payor.

Priority: Essential

Documents to be Reviewed

_____Applicable statutes, rules and regulations.

_____Utilization review policies and procedures.

_____Form letters.

_____Activity reports.

_____Provider manual.

_____Files with utilization review requests (Verify that all levels of authorized, appealed and disapproved requests are reviewed).

Others Reviewed

_____ _____

_____ _____

Review Procedures and Criteria

Verify that the PBM maintains written procedures, pursuant to applicable state statutes, rules and regulations, for making standard utilization review and benefit determinations on requests submitted to the PBM by the covered person, or, if applicable, the covered person's authorized representative, for benefits and for notifying the covered person, and, if applicable, the covered person's authorized representative, of its determinations with respect to these requests within the specified time frames required pursuant to applicable state statutes, rules and regulations.

State and federal law may contain specific criteria outlining mandates related to communication from the PBM to the patient or prescriber, such as time limitations of response, manner of communication (written notice, portal, etc.), and may contain different criteria related to different types of insurers/payors. The evaluation should take all state and federal guidelines for any/all types of insurers/payors.

For prospective review determinations, verify that the PBM makes the determination and notifies the covered person, or, if applicable, the covered person's authorized representative, of the determination, whether the PBM certifies the provision of the benefit or not, within a reasonable period of time appropriate to the covered person's medical condition, but in no event later than the time as required by state or federal law after the date the PBM

receives the request.

Whenever the determination is an adverse determination, verify that the PBM makes the notification of the adverse determination in accordance with state or federal statutes, rules and regulations regarding procedures for standard utilization review and benefit determination.

Verify that if the PBM extends the time period for making a determination and notifying the covered person, or, if applicable, the covered person's authorized representative, of the determination one time for up to the time required by state or federal law pursuant to applicable state or federal statutes, rules and regulations, the PBM has:

- Determined that the extension was necessary due to matters beyond the PBM's control; and
- Notified the covered person, or, if applicable, the covered person's authorized representative, prior to the expiration of the initial time period as required by state or federal law, of the circumstances requiring the extension of time and the date by which the PBM expects to make a determination.

If the extension referenced above is necessary due to the failure of the covered person, or, if applicable, the covered person's authorized representative, to submit information necessary to reach a determination on the request, verify that the PBM issues a notice of extension that:

- Specifically describes the required information necessary to complete the request; and
- Gives the covered person, or, if applicable, the covered person's authorized representative, at least by the time as required by state or federal law from the date of receipt of the notice to provide the specified information.

Whenever the PBM receives a prospective review request from a covered person, or, if applicable, the covered person's authorized representative, that fails to meet the insurer's or payor's filing procedures, verify that the PBM notifies the covered person, or, if applicable, the covered person's authorized representative, of this failure and provides in the notice information on the proper procedures to be followed for filing a request.

Verify that the notice referenced in the previous paragraph is provided by the PBM as soon as possible, but in no event later than the time required by state or federal law following the date of the failure.

Verify that the PBM provides the notice orally or, if requested by the covered person, or, if applicable, the covered person's authorized representative, in writing.

Note: The provisions regarding the covered person's, or, if applicable, the covered person's authorized representative's, failure to meet the insurer's filing procedures apply only in the case of a failure that:

- Is a communication by a covered person, or, if applicable, the covered person's authorized representative, that is received by a person or organizational unit of the PBM responsible for handling benefit matters; and

- Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific pharmaceutical service, treatment, or provider for which certification is being requested.

For concurrent review determinations, if a PBM has certified an ongoing course of treatment to be provided over a period of time or number of treatments, examiners need to be aware that:

- Any reduction or termination by the PBM during the course of treatment before the end of the period or number of treatments, other than by health benefit plan amendment or termination of the health benefit plan, constitutes an adverse determination; and

- The PBM shall notify the covered person, or, if applicable, the covered person's authorized representative, of the adverse determination in accordance with applicable state or federal statutes, rules and regulations regarding

procedures for standard utilization review and benefit determination at a time sufficiently in advance of the reduction or termination to allow the covered person, or, if applicable, the covered person's authorized representative, to file a grievance to:

- Request a review of the adverse determination pursuant to state or federal statutes, rules and regulations; and
- Obtain a determination with respect to that review of the adverse determination before the benefit is reduced or terminated.

Verify that the pharmaceutical service or treatment that is the subject of the adverse determination is continued by the PBM without liability to the covered person with respect to the internal review request made pursuant to state statutes, rules and regulations.

For retrospective review determinations, verify that the PBM makes the determination within a reasonable period of time, but in no event later than the time as required by state or federal law after the date of receiving the benefit request.

If the retrospective review determination is an adverse determination, verify that the PBM provides notice of the adverse determination to the covered person, or, if applicable, the covered person's authorized representative, in accordance with applicable state statutes regarding procedures for standard utilization review and benefit PBM determination.

Verify that if the insurer extends the time period for making a determination and notifying the covered person, or, if applicable, the covered person's authorized representative, of the determination one time for up to the time as required by state or federal law pursuant to applicable state or federal statutes, rules and regulations, the insurer has:

- Determined that the extension was necessary due to matters beyond the PBM's control; and
- Notified the covered person, or, if applicable, the covered person's authorized representative, prior to the expiration of the initial time period as required by state or federal law, of the circumstances requiring the extension of time and the date by which the insurer expects to make a determination.

If the extension referenced above is necessary due to the failure of the covered person, or, if applicable, the covered person's authorized representative, to submit information necessary to reach a determination on the request, verify that the PBM issues a notice of extension that:

- Specifically describes the required information necessary to complete the request; and
- Gives the covered person, or, if applicable, the covered person's authorized representative, at least by the time as required by state or federal law from the date of receipt of the notice to provide the specified information.

Verify that the PBM calculates the time periods, within which a prospective or retrospective determination is required to be made pursuant to applicable state statutes, rules and regulations, to begin on the date the request is received by the PBM in accordance with the insurer's procedures established pursuant to applicable state or federal statutes, rules and regulations for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

If the time period for making a prospective or retrospective determination is extended due to the covered person's, or, if applicable, the covered person's authorized representative's, failure to submit the information necessary to make the determination, verify that the PBM calculates the time period for making the determination to begin on the date on which the PBM sends the notification of the extension to the covered person, or, if applicable, the covered person's authorized representative, until the earlier of:

- The date on which the covered person, or, if applicable, the covered person's authorized representative, responds to the request for additional information; or
- The date on which the specified information was to have been submitted.

STANDARDS
PHARMACY BENEFIT MANAGERS
UTILIZATION REVIEW

Standard 5
The PBM provides written notice of an adverse determination of standard utilization review and benefit determinations in compliance with applicable statutes, rules and regulations.

Apply to: PBMs providing or performing utilization review services to an insurer or payor.

Priority: Essential

Documents to Be Reviewed

_____Applicable statutes, rules and regulations.

_____Utilization review policies and procedures.

_____Form letters.

_____Utilization review files.

Others Reviewed

_____ _____

_____ _____

Review Procedures and Criteria

Verify that the PBM issues notification of an adverse determination, in a manner calculated to be understood by the covered person, to include all the following:

- The specific reason or reasons for the adverse determination;
- Reference to the specific plan provisions on which the determination is based;
- A description of any additional material or information necessary for the covered person, or, if applicable, the covered person's authorized representative, to perfect the benefit request, including an explanation of why the material or information is necessary to perfect the request;
- A description of the PBM's grievance procedures established pursuant to applicable state statutes, rules and regulations, including any time limits applicable to those procedures;
- If the PBM relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion, or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person, or, if applicable, the covered person's authorized representative, upon request;
- The PBM's policy on level of professional clinical license that is appropriate to conduct the adverse determination and if any secondary clinical staff was consulted prior to making an adverse determination;
- If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person, or, if applicable, the covered person's authorized representative, free of charge upon request;
- A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination;

- The written statement of the scientific or clinical rationale for the adverse determination; and
- A statement explaining the availability of and the right of the covered person, or, if applicable, the covered person's authorized representative, as appropriate, to contact the insurance commissioner's office at any time for assistance or, upon completion of the PBM's grievance procedure process as provided under state statutes, rules and regulation, to file a civil suit in a court of competent jurisdiction. The statement shall include contact information for the insurance commissioner's office.

Verify that the PBM provides the notice in writing or electronically, when required by state or federal law.

STANDARDS
PHARMACY BENEFIT MANAGERS
UTILIZATION REVIEW

Standard 6
The PBM conducts expedited utilization review and benefit determinations in a timely manner and in compliance with applicable statutes, rules and regulations.

Apply to: PBMs providing or performing utilization review services to an insurer or payor.

Priority: Essential

Documents to Be Reviewed

_____Applicable statutes, rules and regulations.

_____Utilization review policies and procedures.

_____Form letters.

_____Utilization review files.

Others Reviewed
_____ _____

_____ _____

Review Procedures and Criteria

Verify that the PBM has established written procedures pursuant to applicable state statutes, rules and regulations for receiving benefit requests from covered persons, or, if applicable, their authorized representatives, and for making and notifying the covered person, or, if applicable, the covered person's authorized representative, of expedited utilization review and benefit determinations with respect to urgent care requests.

Verify that the PBM, in the case of a failure by a covered person, or, if applicable, the covered person's authorized representative, to follow the PBM's procedures for filing an urgent care request, notifies the covered person, or, if applicable, the covered person's authorized representative, of the failure and the proper procedures to be followed for filing the request.

Verify that the PBM's notice regarding a covered person's, or, if applicable, the covered person's authorized representative's, failure to follow the PBM's procedures for filing an urgent care request:

- Is provided to the covered person, or, if applicable, the covered person's authorized representative, as appropriate, as soon as possible, but not later than the time as required by state law after receipt of the request; and
- May be oral, unless the covered person, or, if applicable, the covered person's authorized representative, requests the notice in writing.

Note: The provisions regarding the covered person's, or, if applicable, the covered person's authorized representative's, failure to follow the PBM's procedures for filing an urgent care request apply only in the case of a failure that:

- Is a communication by a covered person, or, if applicable, the covered person's authorized representative, that is received by a person or organizational unit of the PBM responsible for handling benefit matters; and
- Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific pharmaceutical service, treatment or provider for which approval is being requested.

For an urgent care request, unless the covered person, or, if applicable, the covered person's authorized representative, has failed to provide sufficient information for the PBM to determine whether, or to what extent, the benefits requested are covered benefits or payable under the insurer's or payor's health benefit plan, verify that the PBM notifies the covered person, or, if applicable, the covered person's authorized representative, of the PBM's determination with respect to the request, whether or not the determination is an adverse determination, as soon as possible, taking into account the medical condition of the covered person, but in no event later than the time as required by state or federal law after the receipt of the request by the PBM.

If the PBM's determination is an adverse determination, verify that the PBM provides notice of the adverse determination in accordance with applicable state statutes, rules and regulations regarding procedures for expedited utilization review and benefit determination.

If the covered person, or, if applicable, the covered person's authorized representative, has failed to provide sufficient information for the health carrier to make a determination, verify that the PBM notifies the covered person, or, if applicable, the covered person's authorized representative, either orally or, if requested by the covered person, or, if applicable, the covered person's authorized representative, in writing of this failure and states what specific information is needed as soon as possible, but in no event later than the time as required by state law after receipt of the request.

Verify that the PBM provides the covered person, or, if applicable, the covered person's authorized representative, a reasonable period of time to submit the necessary information, taking into account the circumstances, but in no event less than the time as required by state or federal law after notifying the covered person, or, if applicable, the covered person's authorized representative, of the failure to submit sufficient information, pursuant to applicable state statutes, rules and regulations.

Verify that the PBM notifies the covered person, or, if applicable, the covered person's authorized representative, of its determination with respect to the urgent care request as soon as possible, but in no event more than 48 hours after the earlier of:

- The PBM's receipt of the requested specified information; or
- The end of the period provided for the covered person, or, if applicable, the covered person's authorized representative, to submit the requested specified information.

If the PBM's determination is an adverse determination, verify that the PBM provides notice of the adverse determination accordance with applicable state statutes, rules and regulations regarding procedures for expedited utilization review and benefit determination.

For concurrent review urgent care requests involving a request by the covered person, or, if applicable, the covered person's authorized representative, to extend the course of treatment beyond the initial period of time or the number of treatments, if the request is made at least by the time as required by state law prior to the expiration of the prescribed period of time or number of treatments, verify that the PBM makes a determination with respect to the request and notifies the covered person, or, if applicable, the covered person's authorized representative, of the determination, whether it is an adverse determination or not, as soon as possible, taking into account the covered person's medical condition, but in no event more than the time as required by state or federal law after the PBM's receipt of the request.

If the PBM's determination is an adverse determination, the PBM shall provide notice of the adverse determination or coordinate with the carrier in accordance with applicable state or federal statutes, rules and regulations regarding procedures for expedited utilization review and benefit determination.

Verify that the PBM calculates the time period within which a determination is required to be made pursuant to applicable state or federal statutes, rules and regulations, to begin on the date the request is filed with the either the insurer or PBM in accordance with the insurer's procedures established pursuant to applicable state or federal statutes, rules and regulations for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

Verify that the PBM's notification of an adverse determination pursuant to an expedited utilization review and benefit determination is set forth in a manner calculated to be understood by the covered person, or, if applicable, the covered person's authorized representative, to include all the following:

- The specific reason(s) for the adverse determination;
- Reference to the specific plan provisions on which the determination is based;
- A description of any additional material or information necessary for the covered person, or, if applicable, the covered person's authorized representative, to complete the request, including an explanation of why the material or information is necessary to complete the request;
- A description of the insurer's internal review procedures established pursuant to applicable state or federal statutes, rules and regulations including any time limits applicable to those procedures;
- A description of the PBM expedited review procedures established pursuant to applicable state statutes, rules and regulations;
- If the PBM relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion, or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person, or, if applicable, the covered person's authorized representative upon request;
- If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person, or, if applicable, the covered person's authorized representative, free of charge upon request;
- If applicable, instructions for requesting:
  - A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination, as set forth in applicable state statutes, rules and regulations; or
  - The written statement of the scientific or clinical rationale for the adverse determination, as set forth in applicable state or federal statutes, rules and regulations; and
- A statement explaining the availability of and the right of the covered person, or, if applicable, the covered person's authorized representative, as appropriate, to contact the insurance commissioner's office at any time for assistance or, upon completion of the health carrier's grievance procedure process as provided under applicable state or federal statutes, rules and regulations to file a civil suit in a court of competent jurisdiction. The statement shall include contact information for the insurance commissioner's office.

Verify that the PBM provides the notice orally, in writing or electronically.

If the PBM provides the notice of adverse determination orally, verify that the PBM also provides written or electronic notice of the adverse determination within the time as required by state or federal law following the oral notification when required by state or federal law.

STANDARDS
PHARMACY BENEFIT MANAGERS
UTILIZATION REVIEW

Standard 7
The PBM monitors the activities of the utilization review organization or entity with which the PBM contracts and ensures that the contracting organization complies with applicable state and federal provisions and accompanying regulations.

Apply to: PBMs contracting out utilization review services.

Priority: Essential

Documents to Be Reviewed

_____Applicable statutes, rules and regulations.

_____Utilization review policies and procedures.

_____Contracts with organizations or entities.

_____Reports of entity reviews and audits (if any).

_____Periodic reports from the organization or entity.

_____Minutes of the PBM's board of directors

_____Minutes of the PBM's utilization review committee

_____Policies and procedures for oversight

Others Reviewed

_____ _____

_____ _____

Review Procedures and Criteria

Whenever a PBM contracts to have a utilization review organization or other entity perform the utilization review functions required by the *Utilization Review and Benefit Determination Model Act (#73)* or applicable state statutes, rules and regulations, the PBM is responsible for monitoring the activities of the utilization review organization or entity with which the PBM contracts and for ensuring that the requirements of the *Utilization Review and Benefit Determination Model Act (#73)* and applicable state statutes, rules and regulations are met.

Verify that the PBM has policies and procedures in place that ensure the utilization review programs of designees comply with all applicable state and federal laws establishing confidentiality and reporting requirements.

H. Drug Formulary, Placement, and Specialty Drug

The Drug Formulary, Placement and Specialty Drug review includes, but is not limited to, the following standards related to how the Formulary is managed and controlled by the PBM.

STANDARDS
PHARMACY BENEFIT MANAGERS
DRUG FORMULARY, PLACEMENT, AND SPECIALTY DRUG

Standard 1
The PBM establishes and maintains a formulary program in compliance with applicable statutes, rules and regulations.

Apply to: PBMs providing or maintaining formulary services to an insurer.

Priority: Essential

Documents to Be Reviewed

_____Applicable statutes, rules and regulations.

_____Formularies and formulary templates used during the examination period.

_____All (P&T Committee meeting minutes with identified P&T Committee members, including their affiliation and specialty.

_____A list of any other committee or group that makes drug placement suggestions or determinations.

Others Reviewed

_____ _____

_____ _____

Review Procedures and Criteria

Verify that all the PBM's formulary and drug placement-related systems utilized during the examination period are appropriate to all applicable state statutes, rules and regulations.

Verify that the PBM formularies utilized during the examination period are appropriate to all applicable state statutes, rules and regulations.

Verify that the PBM P&T Committee or other committee(s) decisions and statements are in compliance with all applicable state and federal statutes, rules and regulations.

STANDARDS
PHARMACY BENEFIT MANAGERS
DRUG FORMULARY, PLACEMENT, AND SPECIALTY DRUG

Standard 2
The PBM establishes and maintains a formulary program in compliance with applicable statutes, rules and regulations regarding access to medications.

Apply to: PBMs providing or maintaining formulary services to an insurer.

Priority: Essential

Documents to Be Reviewed

_____Applicable statutes, rules and regulations.

_____Formularies and formulary templates used during the examination period. Utilization review policies and procedures.

_____ All policies, procedures, and other documentation relevant to drug utilization management, including but not limited to, all fail-first policies including step-therapy protocols, prior authorization requirements, and medical necessity guidelines.

_____Any and all list(s) of medications included in and excluded from the mail order benefit.

_____Any and all list(s) of medications allowed for a 90-day supply, and those only allowed for 30-day supply or less, for both mail order and retail pharmacies.

Others Reviewed

_____ _____

_____ _____

Review Procedures and Criteria

Verify that all the PBM's formularies utilized during the examination period allow drugs to be dispensed at locations required and appropriate to comply with all applicable state and federal statutes, rules and regulations.

Verify that all the PBM's formularies utilized during the examination period do not restrict access to drugs to select pharmacies in violation of any required and applicable state and federal statutes, rules or regulations.

STANDARDS
PHARMACY BENEFIT MANAGERS
DRUG FORMULARY, PLACEMENT, AND SPECIALTY DRUG

Standard 3
The PBM defines and appropriately places any specialty drug on the formulary when a state has a specialty drug definition to comport with applicable statutes, rules and regulations.

Apply to: PBMs providing or maintaining formulary services to an insurer.

Priority: Essential

Documents to Be Reviewed

_____Applicable statutes, rules and regulations.

_____Formularies and formulary templates used during the examination period. Utilization review policies and procedures.

_____Specialty drug list(s)

_____All P&T Committee meeting minutes with identified P&T Committee members, including their affiliation and specialty.

_____A list of any other committee or group that makes drug placement suggestions or determinations.

Others Reviewed
_____ _____

_____ _____

Review Procedures and Criteria

Verify that all the PBM's formulary and drug placement-related systems utilized during the examination period use the applicable definition in accordance with all applicable state and federal statutes, rules and regulations.

Verify that the PBM formularies utilized during the examination period have any drug that meets the definition of specialty placed appropriately and further that any drug that does not meet the definition tiered appropriately in accordance with all applicable state statutes, rules and regulations.

Verify that the PBM P&T Committee or other Committees decisions and statements use and apply the correct definition of specialty drug in compliance with all applicable state statutes, rules and regulations.

I. Complaints, Grievances, and Appeals

1. Purpose

The purpose of complaints, grievances and appeals handling procedures is to provide a process for consumers or providers to address issues, and to evaluate how well a regulated entity complies with laws, resolves issues, and timely responds to dissatisfaction expressed by consumers or providers. This includes:

- Ensuring compliance with applicable statutes and/or regulations[1], including:
  - Determining whether complaints, grievances or appeals were resolved according to the laws in place;
  - Establishing whether violations were committed; and
  - Monitoring future conduct for compliance;

- Verifying that the entity has policies and processes in place to properly manage and timely resolve issues raised by consumers, providers, or pharmacies; and

- Identifying problem areas that may indicate broader operational issues.

All sections emphasize the importance of reviewing how concerns, whether classified as complaints, grievances, or appeals, are processed, documented, and used to improve consumer service.

2. Techniques

The examination approach for complaints, grievances, and appeals procedures include the following shared techniques:

- **Register Reconciliation:** Compare the entity's internal register of issues with those received by the insurance department.
- **Sampling:** Selecting a random sample of complaints, grievances, or appeals for detailed review.
- **Trend Analysis:** Identifying patterns or recurring issues to detect systemic problems.
- **Documentation Review:** Assessing written policies, procedures, contracts, provider manuals, and final resolutions to determine whether proper steps were taken.
- **Communication Verification:** Ensuring that members, consumers, providers, and pharmacies are informed of the procedures and their rights.

All procedures call for reviewing the frequency and nature of the issues raised and whether they were resolved in accordance with the applicable standards.

3. Tests and Standards

Key Standards for Complaints, Grievances and Appeals include:

- **Accurate Logging and Documentation:** Ensuring that all cases are properly recorded in a clear, accessible register and include sufficient detail (type of issue, dates, resolution).
- **Procedural Adequacy:** Verifying that the regulated entity has adequate written procedures for handling and resolving the issue, and that these are disclosed to consumers, providers, and pharmacies.
- **Timely Resolution:** Confirming that the regulated entity responds to concerns within the time frames established by law.
- **Compliance and Fairness:** Determine that responses:
  - Fully address the issue(s) that was raised.

[1] The term statutes and/or regulations refers to all legally binding statutes, rules, regulations, policies or other documents promulgated by an entity with said power.

- Include adequate supporting documentation.
- Are compliant with policy statutes and regulations.
- Provide appropriate remedies when necessary.

Complaints, Grievances, and Appeals stress maintaining records that are accessible to regulators and retaining them for appropriate time periods.

STANDARDS
PHARMACY BENEFIT MANAGERS
COMPLAINTS, GRIEVANCES, AND APPEALS

Standard 1
The PBM maintains a detailed, accessible register documenting each complaint, grievance, or appeal, in accordance with the applicable records retention schedule.

Apply to: All PBMs

Priority: Essential

Documents to Be Reviewed

_____Applicable statutes, rules and regulations.

_____Regulated entity register.

_____Insurance department records.

_____Direct consumer or pharmacy complaint, grievance, or appeal.

_____Member evidence of coverage.

Others Reviewed
_____ _____

_____ _____

Review Procedures and Criteria

Verify accurate logging of the issue, date received, review actions, and resolution.

Verify that the register includes enough detail to support regulatory review.

Verify that the PBM retains the register for at least 3 years, or in accordance with applicable state or federal law, whichever is longer.

STANDARDS
PHARMACY BENEFIT MANAGERS
COMPLAINTS, GRIEVANCES, AND APPEALS

Standard 2
The PBM has written procedures for handling complaints, grievances and appeals and communicates such procedures to consumers, contracted providers, and contracted pharmacies.

Apply to: All PBMs

Priority: Essential

Documents to Be Reviewed

_____Applicable statutes and regulations.

_____Complaint, grievance, and appeal procedure manuals, including manuals specific to the credentialing and/or auditing departments.

_____Member evidence of coverage.

Others Reviewed
_____ _____

_____ _____

Review Procedures and Criteria

Verify that the company maintains a complaint register.

Verify that the PBM included the complaint log and procedures that include the audit, credentialing, and network enrollment departments.

Verify that the PBM's procedures comply with applicable statutes and regulations.

Verify that the PBM's procedures are communicated to consumers and contracted providers

Verify that the PBM has filed procedures with the insurance commissioner where required.

STANDARDS
PHARMACY BENEFIT MANAGERS
COMPLAINTS, GRIEVANCES, AND APPEALS

Standard 3
The PBM must resolve and respond to complaints, grievances, and appeals within prescribed timeframes.

Apply to: All PBMs

Priority: Essential

Documents to Be Reviewed

_____Applicable statutes and regulations.

_____PBM register.

_____Test Sample.

_____Complaint, grievance, or appeal letter or email and PBM response.

_____Supporting documentation (claim files, extension requests, etc).

Others Reviewed
_____ _____

_____ _____

Review Procedures and Criteria

Review test sample to ensure the PBM is maintaining adequate documentation.

Determine if the PBM's response is timely in accordance with state and/or federal law. *Note:* Timing is measured from the date the issue is received.

STANDARDS
PHARMACY BENEFIT MANAGERS
COMPLAINTS, GRIEVANCES, AND APPEALS

Standard 4
The PBM actions taken in response to complaints, grievances, or appeals must comply with insurance laws, contracts, and regulations as well as address all identified concerns.

Apply to: All PBMs

Priority: Essential

Documents to Be Reviewed

_____Applicable statutes and regulations.

_____Contracts, including provider manuals.

_____PBM register.

_____Test Sample.

_____Complaint, grievance, or appeal letter or email and PBM response.

_____Supporting documentation (claim files, extension requests, etc).

Others Reviewed
_____ _____

_____ _____

Review Procedures and Criteria

Review documentation to determine if the PBM response fully addresses the issues raised. If the PBM did not properly address/resolve the complaint, the Examiner should ask the PBM what corrective action it intends to take.

For reviewing responses:
- Was the response timely.
- Was the response complete and responds to all issues raised.
- Does the response include adequate documentation to support the respondent's position.
- Were the respondent's actions appropriate from a business standpoint.
- Were the respondent's actions compliant with applicable statutes and regulations.
- Were the appropriate remedies for the consumer identified.

Document potential violations.

J. Pharmacy Audits

STANDARDS
PHARMACY BENEFIT MANAGERS
PHARMACY AUDITS

Standard 1
The PBM demonstrates that it has reasonable and uniform criteria and procedures for pharmacy audits and demonstrates that it follows those standards.

Apply to: All PBMs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations.

_____ Pharmacy contracts and manuals in an unredacted format.

_____ Index of all policies and procedures relating to the PBM's audits conducted on pharmacies.

_____ A listing of all types of audits that may include but not be limited to on-site, investigational, or desktop audits. (PBM should have policies and procedures for each audit type.)

_____ From the index and listing provided, all policies and procedures that are applicable to auditing process being examined. (Request documents in an unredacted format.)

_____ Documentation to pharmacies describing how audits are initiated, conducted and finalized. (Documentation should be provided in an unredacted format.)

_____ A listing of parties who perform pharmacy audits on behalf of the PBM, including third-party vendors and credentials of auditor staff.

_____ A listing of all audits initiated or that were ongoing during the examination period. (As part of this request, the timeline of when each audit was initiated, the reason for the audit, the type of audit (on-site, desktop, etc.), a copy of the draft audit report, verification and supporting documentation of when the draft audit report was sent to the pharmacy, whether the pharmacy provided additional information after the draft report, when the final report was sent to the pharmacy, whether the audit resulted in a corrective action plan for the pharmacy, whether the audit resulted in any recoupment from the pharmacy (including the amount), whether the audit resulted in any remittance to the pharmacy (including the amount), whether the pharmacy disputed or appealed the findings in the final audit report and the results of any dispute or appeal. Consider creating a spreadsheet to use to collect this information in a format that is helpful for the regulator.

_____ All correspondence between the PBM and a pharmacy as part of audits during the examination period. (Consider whether to request information from all audits or just a sampling of the audits. 'Correspondence' may include but not be limited to all documents sent by the PBM to the pharmacies, all documents sent by the pharmacies to the PBM, any emails, notes from phone conversations, and any other communications about the audit that occurred between the PBM and the pharmacy. Require

documents to be provided in an unredacted format.)

_____ Summary of any use of artificial intelligence (AI) that it may use as part of auditing a pharmacy.

_____Policies and procedures associated with the use of AI.

Others Reviewed

_____ _____

_____ _____

Review Procedures and Criteria

Review applicable state and federal law to ensure PBM policies and audits are compliant.

Review internal PBM policies and procedures regarding the PBM's audit process with pharmacies. Review criteria for the different types of audits to assess whether the PBM has clear protocols, timeframes, documentation collection and review processes, requirements for on-site audits including processes for documenting observations during the on-site audit, and requirements for addressing pharmacy questions. The PBM should have internal policies and procedures for all aspects of the audit, including but not limited to processes for initiating, conducting, and resolving each type of audit.

Review contracts and manuals with details about the audit process to ensure the information provided to pharmacies is clear, concise, and easily understood. While the details of the audit process are important, the information must be provided in a clear and concise manner that will be understood by pharmacies.

Review contracts and manuals for details provided to pharmacies about the audit process. Review how the PBM informs pharmacies of how audits are initiated, any required documentation, timeframes for submission of information, processes for submission of information (i.e. via email, web portal or postal mail), any fees required by the PBM that are outside the audit finding, how the pharmacy may address and rectify potential findings, the PBM's obligation to provide a justification for the draft audit report and final determination, timeframes for PBM responses to pharmacies throughout the audit, and timeframes for resolution of the audit.

Assess whether the PBM's requirements for pharmacies are reasonable and provide pharmacies with the following:

- The scope, frequency (including the maximum annual amount) and method of all audits.
- Detailed guidelines, including metrics and data, used during audits.
- Advanced notice of an upcoming audit, and the day of the month the audit began.
- Sufficient time to prepare and collect required information.
- Convenient and accessible methods for corresponding with the PBM during the audit, for example does the pharmacy have a point of contact to ask questions and obtain clarification on the PBM's expectations.
- Sufficient time to review and correct any audit findings prior to the PBM's final determination.
- Sufficient input into the implementation of a corrective action plan (if applicable) and sufficient time to comply with the requirements of a corrective action plan.
- An appropriate dispute resolution process that pharmacies may use to dispute audit findings. The process for pharmacies should be convenient and accessible and should not create such a burden to seemingly dissuade a pharmacy from initiating or following through with a dispute resolution process.

If the regulator feels the PBM's policies and procedures are reasonable, ensure the PBM also follows and implements its own policies and procedures. Review timeframe requirements, whether the PBM provides reasonable and concise information to pharmacies in response to any questions, and whether the PBM provides

appropriate justifications in the draft and final audit reports.

Review the results of all audits to determine if audits are conducted in a manner that appears reasonable for each of the individual pharmacies being audited and that there are no concerning trends with how the PBM conducts audits. For example, when conducting routine audits, are pharmacies selected randomly or does the PBM only audit non-affiliated, independent pharmacies? *The latter trend would be problematic.*

Verify that the PBM conducts pharmacy audits in compliance with applicable state laws and regulations. Ensure such methods are reasonable, utilized appropriately and consistent with any regulatory requirements (or prohibited if required by state law or regulation). For example, if use of auditing techniques such as extrapolation is prohibited by state law or regulation, the PBM should not apply the method in any audits.

Assess whether the PBM has staffing models to effectively initiate, conduct and finalize audits.

Assess the PBM's use of AI to ensure it is reasonable and that any results or findings from the use of AI are conveyed to the pharmacy in a clear and transparent manner.

Draft: 7/22/26

Speed to Market (D) Working Group
Virtual Meeting
July 13, 2026

The Speed to Market (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met July 13, 2026. The following Working Group members participated: Julie Fairbanks, Chair (VA); Maureen A. Motter, Vice Chair (OH); Jeff Varga (IL); Craig Van Aalst (KS); Tammy Lohmann (MN); Camille Anderson-Weddle (MO); LuAnne J. King (NH); Rob Lee (WA); Barry Haney (WI); and Lela D. Ladd (WY).

1. Considered Adoption of its June 17 Minutes

Fairbanks said the Working Group would hold its consideration of adopting the June 17 minutes (Attachment Nine-A) until the next meeting, as a quorum was not present.

2. Discussed the Suggestions Received on the PCM

Motter discussed the suggestions received on updates to the product coding matrix (PCM). She explained that the matrices were created to improve filing consistency, clarify coding guidance, and address product classifications that may have changed over time.

Motter said one suggestion was received regarding the property/casualty (P/C) matrix. She explained that the current PCM instructions indicate that flood endorsements should not be filed using the flood type of insurance (TOI), but rather under the applicable property insurance filing code. The suggestion was to add similar guidance for earthquake endorsements so that they would be filed under the appropriate property TOI rather than the earthquake TOI. She noted that the flood and earthquake TOIs would continue to apply to standalone policies, rather than endorsements.

Motter also noted that this filing instruction differs from annual statement instructions, which indicate that if an endorsement acts like a separate policy—with its own separate premium, deductible, and limit—it should be recorded on the annual statement line as if it were a standalone policy. Lohmann said Minnesota supported treating earthquake endorsements in the same manner as flood endorsements. No one opposed the suggested approach. Motter summarized that the Working Group appeared comfortable with updating the P/C wording and said the update would be put forward for confirmation, possibly by vote.

Motter then discussed life and health PCM suggestion B1, which proposed adding two additional sub-TOIs under NA01 Network Access Provider Contract for network adequacy reports: one for Affordable Care Act (ACA) products and one for non-ACA products. She said at least one state is using the System for Electronic Rates & Forms Filing (SERFF) to receive network adequacy reports and is seeking a better filing location for them.

Bridget Kieras (NAIC) explained that reports are not always product filings in the traditional sense, as they may not include forms or rates and may consist only of supporting documents. She said SERFF modernization is expected to include a specialty filing type for reports that would not require a TOI. She invited the state that submitted the suggestion to contact her for further discussion. Motter noted that some states receive such reports in paper and that Wyomingthe receives reports through SERFF using a filing type such as “inter report” or “annual form filing.” Fairbanks said Virginia does not receive those reports and that using a filing type made sense.

Jeremy Chance (NAIC) identified Colorado as the state that submitted the suggestion. Motter summarized that the Working Group's recommendation appeared to be for states to consider using a filing type and to hold off on adding additional insurance sub-types until the report feature expected through SERFF modernization is available.

Motter next discussed life and health PCM suggestion B2, which proposed adding a new TOI and sub-TOI for occupational accident coverage. She said the requester indicated that occupational accident filings are being submitted under H21, which makes them difficult to search. Motter said Ohio currently receives these filings under existing accident-only TOIs, such as H02G and H02I, and asked whether updating or refreshing the descriptions for existing TOIs might be preferable to creating a new TOI.

Kieras noted that if searching is the main concern, the SERFF labels feature may be useful. Motter said filer education and state filing descriptions are also useful tools. Ladd commented that educating filers, rather than changing the TOI list, would be preferable. Lohmann indicated that no additional TOIs were needed. Motter summarized that the Working Group's recommendation appeared to be to advise the requester to focus on filer education, use existing accident TOIs, and consider using filing labels if a state needs to identify occupational accident filings more specifically.

Motter then discussed the final suggestion, which concerned whether H16 should be inactivated for short-term, limited-duration products. She explained that in 2019, the Working Group created H15G and H15I for short-term, limited-duration products, with descriptions indicating that prior to Jan. 1, 2026 such products were filed under H16 and that H16 should not be used going forward. She said the requester suggested inactivating the H16 sub-TOIs because H15 had been created for those products.

Motter said the issue required further discussion because nearly every state has H16 enabled, while fewer states have enabled H15, and filings continue to be submitted under H16. She said Ohio's life and health staff had received only a few H15 filings and had rejected them, directing filers to use H16. Fairbanks said Virginia's team indicated that the discontinuation of H16 may not have been well communicated and that education may be needed.

Motter said her understanding was that when H15 was created, the intent may have been to exclude short-term products that were not ACA products from the ACA TOI structure because other H16 sub-TOIs were ACA-related. Kieras confirmed that, under SERFF modernization, ACA-related products are expected to be separated from other life and health products for implementation purposes. Motter said it would be helpful for states to determine whether short-term products are ACA products and whether they should move in the same implementation wave as ACA products.

Lohmann said Minnesota's health staff indicated that short-term products must be major medical and must comply with ACA requirements. Ladd also indicated that the products must comply with federal requirements. Fairbanks said Virginia's team considered short-term products to be major medical, but she noted that short-term, limited-duration products may be treated differently by different states. She said the issue should be sent to the Speed to Market (D) Working Group for further discussion.

Motter said the Working Group may need to determine whether states need both ACA and non-ACA short-term classifications and whether the descriptions should be revised so states can decide which TOIs to use based on their laws and product requirements. She said the current instruction stating that H16 should no longer be used is inaccurate and, at a minimum, should be revised. She suggested that H16 may remain appropriate for short-term policies that must comply with ACA requirements, while H15 may be appropriate for products that do not need to comply. Utah commented that it has at least some products that it does not consider major medical.

Fairbanks added that Virginia reviews out-of-state short-term, limited-duration filings and that the proper classification may depend on the laws of the state where the product is filed.

Motter said she would work with Chance and have further discussions with states to better understand whether they need both ACA and non-ACA short-term classifications, and to develop clearer descriptions of the relevant sub-TOIs. She summarized the Working Group's discussion as follows: the Working Group supported the P/C wording update; recommended use of a filing type for network adequacy reports rather than adding sub-TOIs; recommended use of existing TOIs and filer education for occupational accident filings; and agreed that further communication with states is needed regarding H15 and H16 short-term, limited-duration product classifications.

3. Heard an Update on the *Product Filing Review Handbook*

Fairbanks reported that she and Motter are reviewing substantive updates to the introduction, Chapter 1, and Chapter 2 of the *Product Filing Review Handbook*. She said the suggestions were received from Jessica Baggerley (VA) and Ladd. She said they are discussing draft revisions with Kieras before exposing the draft to the Working Group. Fairbanks said she hoped the drafts would be shared before or at the next meeting so the Working Group could discuss them.

4. Heard an Update from the Compact

Susan Ezalarab (Interstate Insurance Product Regulation Commission—Compact) introduced Sarah Neil, senior manager of regulatory affairs for the Compact, to provide the report.

Neil said the Compact adopted six new uniform standards during the previous year: three for group annuity products and three for group life products. She explained that the group annuity standards were part of the work to amend group standards to allow for non-employer groups. She said states retain authority to approve non-employer groups, while companies may file group products with the Compact for use with those groups, with the Compact approving the forms.

Neil said the Compact has continued member-state education and expanded into product training. She noted that the first training, for life insurance, is available on demand. She also said the Compact held two successful roundtables, which she described as listening and brainstorming sessions that help inform the Compact's strategic direction and practices.

Neil reported that the three group annuity standards adopted in 2025 became available for filing on April 6, following the 90-day seasoning period. She said the Compact has several uniform standards under active rulemaking, including updates to long-term care rate-filing standards, immediate and deferred income annuity standards, and accidental death benefit standards. She said the long-term care standards were scheduled for a public hearing on July 30, with tentative adoption planned for Aug. 13, depending on the hearing and comments received. She said the immediate and deferred income annuity standards were expected to follow the same schedule, and the accidental death benefit standards were scheduled for adoption on July 30. She also said the Product Standards Committee completed its review of the life insurance bonus benefit and that those standards would be exposed for public comment, with a meeting scheduled for Aug. 18 and notice expected that week.

Neil said the Compact established a monthly member call for department staff who handle rate and form filings. She said the calls generally occur on the third Thursday of each month and are used to discuss Compact filings, including filings involving pre-filing communications, questions about whether a filing falls within the uniform standards, and other filings of interest to Compact members. She encouraged states to identify filings they would like to discuss.

Neil also reported that the Compact has four NAIC Connect pages: one for the Product Standards Committee, one for the Adjunct Services Committee, one for the Rulemaking Committee, and a master Compact page that includes other member materials, including the life insurance training. She said the pages are closed groups but are available to Compact state regulators upon request. She also described the Compact's member coordinator approach, under which each member state has a dedicated regulatory affairs contact for questions involving filings, committee work, or other matters. She said the list of member states and assigned contacts is available on the Compact's Connect page.

Neil provided filing statistics through June 30, 2026. She said 248 insurers are actively registered to file with the Compact; the Compact has received 562 product filings year to date; filers include a median of 46 states per filing; the average turnaround time is 27 business days; the Compact has processed more than 1,700 SERFF transactions year to date; and 546 products have been approved to date.

Ladd asked how communication could be streamlined between the Compact and Compact states when filings are rejected or when issues arise, and companies then go directly to the states without the states being aware of the issue before the Compact. She also asked whether long-term care rate increases above 15% come through the Compact first or whether the 15% threshold is a hard stop. Neil said she would welcome an offline conversation with Ladd regarding the communication issue and possible use of NAIC Connect features. Regarding long-term care, Neil said the filing comes through the Compact first for Compact-approved products. She clarified that the Compact only reviews rates for Compact-approved products and that legacy work remains with the states. She said that for increases above the 15% threshold, the Compact issues an advisory opinion and walks member states through the filing before it ultimately goes to each participating state. For increases within the 15% threshold, the Compact has authority to approve the filing, but it still conducts outreach to ensure states have an opportunity to ask questions and are comfortable with the Compact's conclusion before approval.

5. Received an Update on SERFF Modernization

Kieras said the update focused on early-adopter progress, formulation of cohort two, and tips for industry users. She said SERFF is actively working with all 10 early adopter states and expects a significant push in the fourth quarter. She said the goal is to have half of the early adopter states in production by the end of 2026, with the remaining early adopter states and cohort two states moving in the first and second quarters of 2027. She said one early adopter state is expected to go live in September, with the state to be announced soon. She also said the Northern Mariana Islands will be implemented directly onto the new platform because it does not use the legacy platform, although timing is pending as the jurisdiction continues recovery efforts following the typhoon.

Kieras explained that each state will move to production on its own timeline, with data migration and staff preparedness as the main drivers. She said each implementation helps inform the broader implementation strategy, industry training, and platform improvements.

Kieras said cohort two is another smaller phase of states that will move to the new platform and help harden the platform and improve implementation practices. She said formal invitations were sent to states that had expressed interest and that the NAIC is waiting for states to confirm participation. She said cohort two is expected to include about 12 to 15 states and will include a mix of states moving across all lines and states moving by business or unit type. She said a series of calls with cohort two states will begin in August, and states interested in cohort two that did not receive an invitation should contact her as soon as possible.

Kieras encouraged industry users to attend SERFF Product Steering Committee meetings to stay current on program updates. She suggested that industry users review internal workflows, check and update user lists, and

run the user management report in the SERFF legacy platform to ensure users are active and have the correct roles. She noted that all users should be logging in with Okta credentials. She also said new training dates will be offered, with a greater focus on demonstrations than on hands-on training and supplemented by additional resources and an expanded training manual.

Kieras said the project team will continue outreach and training for cohort two and early adopter states. She said the NAIC will hold informational sessions for states that are not in cohort two to raise awareness and help them prepare at their own pace. She encouraged industry users to watch for training opportunities, SERFF alerts in the legacy system, and email communications. She said the NAIC will begin a communication push with tips, tricks, and ways for users to get engaged and prepared. She also said there are opportunities to participate in user acceptance testing for those who can devote time to it. Kieras reminded participants that the NAIC will provide 30 days' advance notice of state launch dates, state by state.

Having no further business, the Speed to Market (D) Working Group adjourned.

Draft: 6/30/26

Speed to Market (D) Working Group
Virtual Meeting
June 17, 2026

The Speed to Market (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met June 17, 2026. The following Working Group members participated: Julie Fairbanks, Chair (VA); Maureen A. Motter, Vice Chair (OH); Mary Grover (CO); Julie Rachford (IL); Kenneth Scott (KS); Tammy Lohmann (MN); Camille Anderson-Weddle (MO); LuAnne J. King (NH); Debra Diaz-Lara (TX); Rob Lee (WA); Barry Haney (WI); and Lela Ladd (WY). Also participating were: Matthew Eberhardt and Amber Thorvilson (MT).

1. Adopted its April 23 Minutes

The Working Group met April 23. During this meeting, it took the following action: 1) adopted its Oct. 8, 2025 minutes; 2) discussed its 2026 charges; 3) received an update on the System for Electronic Rates & Forms Filing (SERFF) modernization project and the Product Steering Committee (PSC); and 4) discussed the decommission of the Product Requirements Locator (PRL).

Ladd made a motion, seconded by King, to adopt its April 23 minutes (Attachment Nine-A1). The motion passed unanimously.

2. Received an Update on the *Product Filing Review Handbook*, Chapters 1 and 2

Fairbanks reported that volunteers from Wyoming and Virginia reviewed chapters 1 and 2 of the *Product Filing Review Handbook* and submitted revisions. She stated that the revisions are currently under review and will be compiled for presentation to the Working Group.

Fairbanks indicated that the Working Group anticipates reviewing the proposed revisions at its July 13 meeting, with a vote to occur at a later date. She invited additional volunteers to assist with reviewing chapters 1, 2, or subsequent chapters and asked interested parties to contact NAIC committee support to be included in future meetings.

3. Received an Update on the Decommissioning of the PRL

Fairbanks reported that progress has been made in transitioning information from the Product Requirements Locator (PRL), including coordination to move certain state data. She stated that the Working Group is prepared to proceed with decommissioning the PRL by the end of June 2026.

Bridget Kieras (NAIC) confirmed that the decommissioning remains on track and noted that a message has been posted to notify users accessing the platform that it will be retired.

4. Heard a Presentation on CLARA

Fairbanks invited Kieras to present on the Compliance Language Assistant for Regulatory Analysis (CLARA), an artificial intelligence (AI) tool designed to assist states in reviewing insurance filings.

Kieras provided an overview of CLARA, explaining that it uses natural language processing to evaluate insurance form language against regulatory standards and is designed as a standalone application accessible through the NAIC system. She described the onboarding process for states, the rule-based framework used for training CLARA, and how the tool produces pass/fail outputs with explanatory reasoning to assist reviewers.

Kieras noted that CLARA is currently in a pilot phase, with multiple states participating, and emphasized that the tool is optional for state use. She discussed ongoing efforts to expand functionality, improve performance, and potentially integrate CLARA more fully into filing systems.

Kieras demonstrated the tool and provided examples of how to create, test, and apply rules to filings. She also discussed the anticipated impact for regulators and the industry, including improved consistency and efficiency in filing reviews.

Eberhardt and Thorvilson provided remarks regarding Montana's experience implementing CLARA. Eberhardt described early efforts to build rule groups using statutory and checklist requirements and noted that the tool shows promise in improving consistency and efficiency while allowing reviewers to focus on higher-level analysis. He stated that a human reviewer will continue to make final determinations on compliance issues.

Kieras announced that a CLARA workshop will be held in conjunction with the Insurance Summit in October in Kansas City, MO, and invited interested states to participate.

Fairbanks facilitated discussion and questions from the Working Group. Topics included considerations related to the use of AI in filing review processes and potential communication to the industry.

5. Discussed Other Matters

Fairbanks referenced a recent inquiry from Colorado regarding the use of SERFF Tableau dashboards. She invited states to share whether they are using the dashboards, how they are being used, and whether there is interest in a future discussion or presentation on available reporting tools.

Kieras stated that documentation is available for each dashboard and offered to assist states seeking access. She noted that NAIC committee support welcome feedback to improve reporting tools and highlighted that SERFF data is accessible through additional platforms.

Fairbanks suggested a future presentation to further explore reporting capabilities and gather input from states.

Having no further business, the Speed to Market (D) Working Group adjourned.

Draft: 5/12/26

Speed to Market (D) Working Group
Virtual Meeting
April 23, 2026

The Speed to Market (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met April 23, 2026. The following Working Group members participated: Julie Fairbanks, Chair (VA); Maureen A. Motter, Vice Chair (OH); Crystal Phelps (AR); Susan Jennette (DE); Sharon Holston (ID); Julie Rachford (IL); Craig Van Aalst (KS); Tammy Lohmann (MN); Brandi Simmons (MO); LuAnne J. King (NH); Mark Worman (TX); Kelly Christensen (UT); Rob Lee (WA); Lela D. Ladd (WY); and Tim Sigman (WV).

1. Adopted its Oct. 8, 2025, Minutes

Fairbanks said the Working Group met Oct. 8, 2025, and took the following action: 1) adopted its Aug. 21, 2025, minutes; 2) received an update on the System for Electronic Rates & Forms Filing (SERFF) metrics report; 3) discussed the *Product Filing Review Handbook* annual review process; 4) heard a report on the SERFF modernization project and SERFF Product Steering Committee (PSC); and 5) received an update on the Interstate Insurance Product Regulation Commission (Compact).

Ladd made a motion, seconded by Jennette, to adopt the Working Group's Oct. 8, 2025, minutes *(see NAIC Proceedings – Fall 2025, Market Regulation and Consumer Affairs (D) Committee, Attachment Six)*. The motion passed unanimously.

2. Discussed its 2026 Charges

Fairbanks introduced herself as the new Working Group chair and provided an overview of her background. She noted Motter, the previous chair, will serve as vice chair and that she will rely on Motter's expertise, particularly on property/casualty (P/C)-specific issues. She invited Working Group members to provide feedback on the group's charges during the meeting, by email, or at future meetings.

Fairbanks noted the charge to consider the proposed SERFF features or functionality presented by the PSC and to review the PSC's periodic reports. She asked how the Working Group could be more active in partnering with SERFF to provide feedback on features and functionality. Bridget Kieras (NAIC) stated the SERFF team is happy to partner, particularly on major enhancements, and noted the PSC continues to meet monthly with 100 to 120 attendees. Fairbanks mentioned bringing a Compliance Language Assistant for Regulatory Analysis (Clara) presentation and use cases from other states to a future meeting.

Fairbanks highlighted the charge to provide a forum for gathering information from states and industry on tools, policies, and resolutions to address common filing issues. She explored opportunities for discussion and suggested creating a resource list of working groups and topics, considering regulator-only calls for certain product filing types, and inviting the industry to bring common filing issues to the Working Group. Kieras asked whether the Speed to Market (D) Working Group has a presence on NAIC Connect. Monique Rojas (NAIC) confirmed it does not. Kieras suggested creating one. Motter expressed support and cited a past example in which companies experienced difficulty filing products while simultaneously working on certificates of authority.

Fairbanks noted the Working Group began working last year on a filing metrics report for commissioners using SERFF Tableau reports. The report did not meet the Spring National Meeting deadline and remains in process.

Fairbanks noted the deadline for product coding matrix (PCM) and uniform transmittal document (UTD) change suggestions is April 30. Motter stated she would compile suggestions for a future meeting. Jeremy Chance (NAIC) confirmed no submissions had been received and offered to send additional communication. Baggerly asked whether the UTD maps to what users see in SERFF. Motter explained that the UTD is a holdover from pre-SERFF paper filings and that much of its content has been built into SERFF. She noted few UTD change requests have been received in recent years. Kieras asked whether the UTD might now be obsolete and could be retired given the modernization. Fairbanks stated she would add this to the agenda for a future meeting. Motter reminded the Working Group that PCM changes approved this year would become effective Jan. 1, 2027.

Fairbanks noted a significant overhaul of the *Product Filing Review Handbook* was completed a couple of years ago, with technical edits made by Petra Wallace (NAIC) last year. She asked for volunteers for a subgroup of two to three members to review the handbook and present recommendations. Motter asked members to flag any topics that have been missed or are known to be incorrect. Ladd volunteered for the subgroup. Fairbanks stated the group would aim to review a couple of chapters between meetings.

Fairbanks asked for suggestions on how the Working Group can better support the Compact. Ladd raised a gap between what is filed with the Compact and what is filed with the states. Fairbanks suggested setting time to discuss further and noted states should also bring filings to the Compact.

3. Heard a Report on the SERFF Modernization Project and SERFF PSC

Kieras provided an update on the PSC. The committee meets monthly with 100 to 120 attendees. Meetings include presentations, platform updates, demonstrations, and engagement activities. The Okta cutover is complete. Summaries, recordings, and future dates are available on the SERFF website.

Kieras reported the Compact went live on the new SERFF platform in March 2025. She explained the Compact was chosen as the first group because of its smaller footprint, close partnership with the NAIC, and willingness to undertake risk. She noted that this is the largest IT project the NAIC has ever undertaken, and that a phased rollout was selected to ensure high-quality support. The team has deployed improvements continuously since launch through daily to weekly releases. The Compact has been an exceptional partner in helping refine the platform for states.

Kieras highlighted features built into the new platform, including a modern interface, streamlined filing creation, the first AI implementation in the form schedule, consolidation of four filing update methods into one, document annotation with cross-filing comparison, enhanced review features using a task-based approach, email notifications, and tailored disposition of public access. She explained the team built a stable core first and is now adding features, focusing on usability and quality of life. Every legacy feature is rethought rather than simply replicated, drawing on decades of experience.

Kieras stated significant performance improvements were made in late 2025 and early 2026. The team is working with 10 early adopter states on application training, state-specific development, filer outreach, data migration, and change control. The target is for early adopters to begin moving to production in the second half of 2026, initially one state at a time. Data migration is the primary constraint: the Compact had approximately 12,000 filings, and migration took about a day and a half. Deployments will occur on weekends, and rollout will be staggered as confidence builds.

Kieras announced the formation of cohort two, the next group of states. Approximately 10 states have already expressed interest. Selection involves a mutual evaluation of state readiness and technical fit. Selection and announcement are planned for the end of the second quarter of 2026. After cohort two, the team expects 20 to

25 states to have completed the process, enabling faster progression. Plan management requirements gathering will begin in the late third or fourth quarter of 2026. Types of insurance integrated with plan management will remain in legacy, and all states will likely move to plan management at the same time.

Kieras explained that the original plan was to move all life, annuity, and credit business areas six months after the Compact. The team learned that moving all states at once created too much risk due to change management needs, state-specific configuration, and data migration complexity. State data is typically older and more complex than Compact data. The phased approach allows quality support, gradual industry training, and process maturation. During the coexistence period, states will have different transition dates, and many users will operate in both systems. Tools and messaging are being developed to guide users.

Kieras introduced Clara, an AI-powered compliance review tool that uses natural language processing to read forms and compare them to regulatory standards. She stated Clara was built by the NAIC within its infrastructure, uses AWS components and machine learning models, but does not train those models with user data, and uses single sign-on with Okta credentials. Clara is a lightweight, standalone application that sits outside both versions of SERFF, so states can use it even if they are not on the new platform.

Kieras explained that Clara learns individual rules through language, examples, and test cases. Rules are grouped into rule groups that function as checklists, with a many-to-many relationship allowing reuse across product types and review cycles. Clara provides pass/fail results with explanations, but reviewers always have final ownership. Integration will tighten over time, and eventually, Clara will be embedded in the review process.

Kieras stated Arizona, Connecticut, and Vermont are currently piloting Clara, as well as the Compact. Arkansas and the District of Columbia have signed on and will begin onboarding shortly. Future roadmap items include rule sharing between states and industry-facing features that would advise insurers of potential objections before submission.

Kieras clarified that Clara is independent of early adopter and cohort two status. Any state can sign up once ready. States must be willing to participate and may need to work through internal policy or governance decisions. Clara is not mandatory. Kieras stated that states need to use Clara themselves first to gain confidence, and the NAIC must build the necessary interfaces. Industry-facing features are not expected this year but are on the roadmap for next year.

4. Discussed Product Requirements Locator Decommission

Fairbanks stated that the Product Requirements Locator (PRL) is nearing the end of its life. She explained that the PRL was intended to allow companies to access state product filing requirements, but states have not been updating it, and the industry has not been using it. She noted that only a few states still have content.

Fairbanks asked states that still have requirements in the PRL to notify her or Rojas by May 1 regarding how much time they would need to copy or download information before decommissioning.

Kieras stated that if a state's content is out of date, the state should reach out to Brandy Woltkamp (NAIC) or Kieras for behind-the-scenes assistance rather than spending time copying and downloading.
Lohmann stated that Minnesota's PRL is up to date and contains extensive information used by the enforcement division on a regular basis. She expressed strong concern about losing the data and stated Minnesota had no prior opportunity to move the information and does not have the staff to do so.

Kieras reassured the Working Group that the NAIC would not decommission the PRL without adequate notice. She stated the NAIC wants to begin the process because of technical compliance work required to maintain the tool, and given the overall low usage, it does not appear to be a good use of developer time. She stated the NAIC will work with Minnesota to address the situation.

Fairbanks asked other states to reach out with concerns and stated the Working Group would follow up at the next meeting.

Having no further business, the Speed to Market (D) Working Group adjourned.