MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

Market Regulation and Consumer Affairs (D) Committee Dec. 11, 2025, Minutes
- Market Regulation and Consumer Affairs (D) Committee Nov. 21, 2025, Minutes (Attachment One)
- Market Analysis Procedures (D) Working Group Nov. 03, 2025, Minutes (Attachment Two)
- Market Conduct Annual Statement Blanks (D) Working Group Nov. 6, 2025, Minutes (Attachment Three)
  - Market Conduct Annual Statement Blanks (D) Working Group Oct. 2, 2025, Minutes (Attachment Three-A)
    - Market Conduct Annual Statement Blanks (D) Working Group Sept. 11, 2025, Minutes (Attachment Three-A1)
- Market Regulation Certification (D) Working Group Dec. 9, 2025, Minutes (Attachment Four)
  - Market Regulation Certification (D) Working Group Nov. 17, 2025, Minutes (Attachment Four-A)
  - Minimum Market Analysis Requirement (Attachment Four-B)
- Pharmacy Benefit Management (D) Working Group (Attachment Five)
  - Pharmacy Benefit Manager Licensure and Regulation Guidelines for Regulators (Attachment Five-A)
- Speed to Market (D) Working Group Oct. 8, 2025, Minutes (Attachment Six)
  - Speed to Market (D) Working Group Aug. 21, 2025, Minutes (Attachment Six-A)

Draft Pending Adoption

Draft: 12/15/25

Market Regulation and Consumer Affairs (D) Committee
Hollywood, Florida
December 11, 2025

The Market Regulation and Consumer Affairs (D) Committee met in Hollywood, FL, Dec. 11, 2025. The following Committee members participated: Dean L. Cameron, Chair (ID); Trinidad Navarro, Co-Vice Chair (DE); Holly W. Lambert, Co-Vice Chair, represented by Meggan Brumbaugh (IN); Sharon P. Clark (KY); Robert L. Carey represented by Timothy N. Schott (ME); Angela L. Nelson and Jo A. LeDuc (MO); Mike Causey represented by Jacqueline Obusek (NC); D.J. Bettencourt (NH); Ned Gaines (NV); Carter Lawrence (TN); Cassie Brown and Matthew Tarpley (TX); and Allan L. McVey and Joylynn Fix (WV). Also participating were: Sheryl Parker (FL); David Buono (PA); Brett Bache (RI); Larry D. Deiter (SD); and Bryan Stevens (WY).

1. Adopted its Nov. 21 and Summer National Meeting Minutes

The Committee conducted an e-vote that concluded Nov. 21 to adopt its 2026 proposed charges.

Commissioner Navarro made a motion, seconded by Commissioner Clark, to adopt the Committee's Nov. 21 (Attachment One) and Aug. 13 minutes (*see NAIC Proceedings – Summer 2025, Market Regulation and Consumer Affairs (D) Committee*). The motion passed unanimously.

2. Received an Update on the Development of Examination and Licensing PBMs

Fix said the Pharmacy Benefit Management (D) Working Group adopted the *Pharmacy Benefit Manager (PBM) Licensure and Regulation Guidelines for Regulators.* She said these guidelines provide guidance to states and territories on setting up licensure/registration processes based on the jurisdiction's legislative instructions. Fix also said the *Market Regulation Handbook* chapter on PBM examinations has been exposed for a public comment period ending Jan. 6, 2026. Fix said that the Working Group is also monitoring the work to enhance State Based Systems (SBS) to handle complaints regarding PBMs.

Director Cameron said that while the Committee will consider the adoption of the Working Group's report as part of agenda item 7, the Committee will not consider adoption of the *Pharmacy Benefit Manager (PBM) Licensure and Regulation Guidelines for Regulators*, which the Working Group adopted Dec. 9. He said this will allow the members an opportunity to review the work.

3. Received an Update on Marketplace Issues Discussed at the Market Actions (D) Working Group

Buono said he chairs the Market Actions (D) Working Group with the assistance of vice chair Pam O'Connell (CA). He said the Working Group consists of a diverse and geographically balanced membership of the top market conduct regulators in the country. The Working Group provides regulator-only forums where all jurisdictions can engage in the free exchange of market conduct information. Buono said that he and O'Connell have worked hard this year with the Working Group's members to create a collaborative environment that fosters robust information sharing.

Buono stated that the Working Group meets in regulator-to-regulator session due to the subject matter it discusses. Within the Working Group, insurance regulators discuss potential compliance problems with insurers and other entities engaged in the business of insurance. One of the Working Group's biggest responsibilities is to prudently review the information it receives. He stated that the information sometimes turns out to be true. He stated that insurance regulators cannot discuss market conduct investigations publicly unless an action is

completed with a document that requires publication (such as a regulatory settlement agreement). If Working Group meeting attendees prematurely speak publicly about something that turns out to be nothing, it could unfairly impact the reputation of the entity and also damage the credibility of state-based regulation.

Buono said that earlier this year, the Working Group acknowledged that some jurisdictions felt excluded from the Working Group's meetings and discussions. With the help of Director Cameron, the Working Group communicated that every jurisdiction's Collaborative Action Designee (CAD) is welcome and encouraged to participate in the Working Group's regularly scheduled monthly meetings and national meeting sessions. This knowledge has generated an increase in attendance and participation. Now, commissioners, superintendents, and directors should have access to information from their CADs about issues being discussed and ongoing collaborative actions (such as open exams and pending settlements).

Buono said the Working Group serves the important goal of enhancing state regulation by reducing duplicative efforts and identifying potential compliance problems that have multi-jurisdictional impact. He said an effective national analysis process is key to helping the Working Group meet these objectives; however, in recent years, the Working Group has set this activity aside while it considered how to make the most efficient use of NAIC and state resources for this purpose. He said that having CADs engaged in each jurisdiction will allow the Working Group to begin the revitalization of national analysis. He said the Working Group's vision is a phased approach beginning in 2026 with quarterly "on the spot" Chief Market Regulator Forum (CMRF) discussions presented by CADs to develop topics for review. What the Working Group hears from states and territories during these meetings will direct how it focuses its analysis project, including whether it is centered around emerging issues affecting multiple states, certain lines of business that are coming up, or specific entities that are generating concern. Buono said the Working Group will learn what CADs are seeing in their states/territories and engage in more in-depth analysis, which will inform the Working Group's decisions on appropriate next steps. As a longer-term goal, the Working Group intends to explore how more modern analysis techniques and newer technologies, such as data visualization tools, might help it improve its national analysis work.

Buono said that in 2025, the Working Group oversaw the completion of monitoring exam work required by the regulatory settlement agreements for two different matters. He said that the Working Group also saw great work completed by the Coordinated Market Investigations Subgroup (CMIS) led by Matthew Gendron (RI) and Dan Bumpus (VA). He stated that the CMIS is tasked with facilitating interstate communication and coordinating collaborative state regulatory activities involving non-traditional market actions. It focuses on concerns regarding unlicensed entities and how best to coordinate investigations and enforcement efforts. Gendron and Bumpus have navigated the complex world of insurance (or non-insurance) and provided states with guidance and steps on how to approach these issues.

Buono said that maintaining and improving the geographic balance of the Working Group's members has continued to be an area of focus for him and O'Connell. In the past year, the Working Group added Stevens, who is from the Western Zone. Buono said that he and O'Connell hope that as membership changes, they can continue to bring more geographic balance to the Working Group. He specifically mentioned their hope to add members from the Southeast Zone.

Buono stated that the Working Group is currently discussing topics like mental health parity, other health insurance-related matters, annuities/suitability/best interest, producer/agent items, and claims and underwriting topics, such as the use of aerial photos, property/casualty (P/C) claims payments, total losses, field inspection, and estimation processes. He said the Working Group's ultimate goal is to enhance state-based regulation by reducing duplicative efforts and promoting efficiencies that ensure market issues are adequately addressed when and where they occur.

4. Discussed the Draft Cybersecurity Incident Response Framework

Tarpley said that following the Summer National Meeting, the Committee delegated its 2026 priority to create a cybersecurity incident response framework to the Market Conduct Examinations Guidelines (D) Working Group. He said the framework will serve two purposes: 1) the framework will assist NAIC members in assessing the significance of cybersecurity events; and 2) the framework will include protocols for the multistate coordination after a cybersecurity event.

Tarpley said that to fulfill these purposes, the framework will develop criteria to assess the impact of a cybersecurity event, develop an appropriate threshold that would trigger the need for multistate coordination, develop procedures to identify the lead states for coordinating a response, and clarify the roles of the Market Actions (D) Working Group, Cybersecurity (D) Working Group, and Financial Analysis (E) Working Group. He said that this work will extend into 2026 due to its complexity and the need to include a broad base of regulators and interested parties.

Tarpley then highlighted three items. First, the Working Group formed a small group of subject matter experts (SMEs) to create an initial draft of a framework document. Second, the current Cyber Event Response Plan (CERP) developed by the Cybersecurity (H) Working Group will be leveraged. He said the CERP focuses on individual state responses, and there is no need to revisit this work. The response framework will either overlay or be merged with the CERP to address how states can coordinate a multistate response. This is why there is a need for input from market, cyber, and financial regulators as this work proceeds. Third, the Market Conduct Examinations Guidelines (D) Working Group will circulate the initial draft created by the SMEs for public comment. He anticipates an initial draft will be circulated in the first quarter of 2026.

5. Heard a Presentation from the IRES

Bache said he is the chair of the Insurance Regulatory Examiners Society (IRES) Membership & Benefits Committee and the co-chair of the Career Development Seminar Committee. He said he also serves on the IRES Executive Committee and Board of Directors.

Bache said IRES was established in 1987 and will be celebrating its 39th year in 2026. He said that it is a nonprofit organization run by volunteer members and has eight committees, each led by a chair. The committees have specific functions, such as: accreditation and ethics; budget and finance; career development seminar; education; market conduct management (MCM)/advanced MCM (AMCM); meeting and elections; membership and benefits; and publications. Bache stated that said IRES has a contract with Miller Wenhold to assist with the day-to-day administration of the organization.

Bache stated that aid IRES' purpose is to work with state, federal, and contracted insurance regulators to promote professionalism and integrity in their work. It achieves this goal through a variety of activities. He said members are mainly employees of state/territory and federal insurance regulatory agencies, and independent contractors that help those agencies, but memberships are also offered to industry members, and a number of firms and companies are represented as members.

Bache said that states and territories are the primary regulators of the insurance industry. However, with the passage of the Affordable Care Act (ACA) and other federal insurance laws, federal regulators have also become more active in certain insurance markets. He said that as the regulatory landscape becomes more complex, it is important that consumers know the regulators are professional and consistent whenever possible, especially in their interpretation and enforcement of the laws. This has been done over the decades through market analysis, market conduct examinations, and consumer complaint investigations.

Bache said that through activities such as the development of insurance regulatory webinars and designations, IRES helps to promote professionalism and integrity. Many of IRES' designations require continuing education (CE) to promote continuous learning, keeping IRES members informed on the latest regulatory practices and considerations. He said that the IRES also recognizes emerging training needs, such as those around the Mental Health Parity and Addiction Equity Act (MHPAEA), and works to create training or designations to fill the training void. -IRES offers the following designations: Accredited Insurance Examiner (AIE); Certified Insurance Examiner (CIE); MCM; AMCM; Certified Insurance Consumer Service Representative (CICSR); and its newest training program in development, Behavior Health Parity Auditor (BHPA).

Bache said IRES also offers opportunities for members to participate in four to six free-to-member webinars per year. These webinars dive into specific subject matter, such as market conduct supervision; PBM oversight and examinations; NAIC consumer liaisons; and auto and property insurance reform. He said IRES listens closely to what its membership wants to learn about and tailors its webinars to the feedback it receives.

Bache said IRES is broken down into state chapters, and each state has the opportunity to name a chair who serves as the connection between IRES and its members in each state. The state chairs meet monthly to talk about everything happening at IRES, get feedback from states, and keep communication lines open.

Bache said that because IRES members are from state insurance departments, consulting firms, and industry, regulators can interact with the industry through the various opportunities that IRES offers. It also allows regulators to build their own network and collaborate with one another. He said the IRES is supported, in part, by the IRES Foundation School. The IRES Foundation School is an annual event that allows for both state and federal regulators to present regulatory insurance education sessions to industry compliance personnel.

Bache said that starting out as a regular member of IRES, getting involved in many committees, and then taking on leadership roles has helped his career development as a market conduct regulator. The positives include the various connections he has made, the education and designations he has received, and the feeling of being a true part of market conduct regulation on a national scale. He said another big positive is that IRES awards several scholarships to state regulators each year: four to individuals who do not have to be an IRES member and one to an individual who does need to be an IRES member. These scholarships provide individuals with the opportunity to attend IRES events that they might not otherwise be able to attend and learn about IRES if they are not a member.

Bache said Rhode Island utilized IRES in the development of its market conduct team. When Rhode Island hires new market conduct examiners, they must immediately start working toward IRES designations. This helps them gain basic knowledge, and the designations are prerequisites for them to reach higher levels in the organization. Bache stated that the IRES has new hires get involved in the webinars and attend IRES CDS each year, and they make new contacts along the way. He said that not everyone in the Rhode Island department gets the chance to travel to a national meeting, so participating in the educational programs and opportunities that IRES offers is another way to achieve that.

Bache said IRES helps regulators keep up with the ever-changing insurance marketplace and fosters uniformity between regulators by responding to new products, technology, and AI-driven tools; supporting multistate regulatory consistency; updating its training as the markets evolve; and embedding ethics and transparency in regulatory work.

Fix noted that IRES has been given approval to develop a PBM education track.

6. Discussed Producer Licensing Issues

A. The Proposal for an NAIC Consumer Agent/Broker Search Tool

Director Cameron said that earlier in the year, the Committee heard a presentation from the Financial Industry Regulatory Authority (FINRA) on its Broker Check and from NAIC staff on the consumer agent/broker search tool it is developing. He stated that for states that have population centers located in two states, it is important that consumers can find information on regulatory actions from all states in which the brokers and agents operate. NAIC staff are continuing to develop an effective tool that displays all regulatory actions against brokers and agents. This tool may include links to each state's regulatory actions.

B. Implementation of Revised NAIC Uniform Producer Licensing Applications

Director Deiter stated that the National Insurance Producer Registry (NIPR) is continuing its work on implementing the uniform licensing application updates. The 2026 uniform application updates include: 1) clarified attestation language; 2) clarified background question language; 3) a citizenship question added to individual renewal applications; 4) FINRA Central Registration Depository (CRD) added to renewal applications; and 5) updated terminology and clearer instructions.

Director Deiter said that, along with implementing the adopted changes, NIPR is making minor technical edits to keep the applications consistent. He said that on Nov. 9, NIPR sent an early notification to states and territories about technical data adjustments required for updating their state back-office systems.

Director Deiter said that over the next four months, NIPR will work closely with regulators to ensure these updates are rolled out smoothly. He said NIPR's goal is to launch the application changes early in the second quarter of 2026.

C. Update on the Template for the 1033 Written Consent Process

Director Deiter said that while the Producer Licensing (D) Task Force adopted the template for the 1033 written consent process at the Summer National Meeting, the American Property Casualty Insurance Association (APCIA) recently submitted a comment regarding the definition of "conviction" and the drafting note that reads, "States may include in the definition of Conviction a plea in abeyance, a diversion, a sealed, or an expunged conviction." Director Deiter said the issue was discussed during the Task Force's meeting, and the general consensus from the members was that there is a need for further review of the APCIA's comments. This is why the template is not before the Committee for adoption. He said the Task Force will review the comments and potentially make amendments to the template. He said he anticipates that the template will be presented to the Committee for adoption at the 2026 Spring National Meeting.

D. NAIC PICS Alerts for the NIPR Attachment Warehouse

Tim Mullen (NAIC) said the NIPR's Attachment Warehouse is a tool used by states to electronically receive, store, and share licensing-related documents submitted by producers and applicants for licensure with other state insurance regulators. He said that when supporting documentation is uploaded to the Attachment Warehouse, states and territories are notified through a Personalized Information Capture System (PICS) alert.

Mullen said that to improve the PICS alerts for the Attachment Warehouse, the NAIC implemented an "Alert Manager Shared" inbox to proactively manage "bounce backs" for all NAIC alerts. This will allow the NAIC to identify individuals who have signed up for alerts but failed to receive them. This is an important improvement

that will allow NAIC staff to be more proactive in assisting states when there is a change in personnel that requires deactivating a state user account and adding a new state user account.

Mullen said that to complement these actions, NAIC staff compiled a list of regulators in each state receiving the Attachment Warehouse PICS alerts. The NAIC and NIPR are partnering to schedule a webinar on Jan. 13, 2026, to provide additional outreach and training to states regarding the Attachment Warehouse and the management and use of PICS alerts.

Mullen reminded everyone that NIPR surveyed current users and, as part of its three-year strategic plan, is enhancing the Attachment Warehouse to increase usability and create a better way for state and territory insurance regulators to review documents. He said that before starting this work, NIPR first needed to modernize its websites and upgrade the identity management capabilities to enhance the user experience. NIPR is on track to complete its modernization efforts in 2025 and will begin its work to modernize the Attachment Warehouse in 2026.

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

Director Cameron highlighted two matters for the attention of the Committee. He noted that the Market Regulation Certification (D) Working Group has adopted a new standard for the Voluntary Market Regulation Certification Program, and the Pharmacy Benefit Management (D) Working Group adopted the *Pharmacy Benefit Manager (PBM) Licensure and Regulation Guidelines for Regulators.* He said the Committee will consider both the new standard and the guidelines at the 2026 Spring National Meeting. He said he anticipates industry comments on the licensure and regulation guidelines. He invited comments with substantive suggestions.

A. Market Analysis Procedures (D) Working Group

LeDuc said the Market Analysis Procedures (D) Working Group met Nov. 3 and took the following action: 1) adopted a recommendation to request approval from the Market Regulation and Consumer Affairs (D) Committee to engage an external party to retool the prioritization tool for the private passenger auto (PPA) line of business using current technologies; and 2) reviewed its activities in its two prior meetings. The Working Group also met Oct. 6 and Aug. 25 in regulator-to-regulator session, pursuant to paragraph 6 of the NAIC Policy Statement on Open Meetings. LeDuc said that during these meetings, the Working Group discussed the specifics of an SME group's recommendations for improving the Market Analysis Prioritization Tool (MAPT), including the reasons supporting the recommendations, how jurisdictions could improve their baseline analysis, and the next steps for implementing the recommendations.

LeDuc said the MAPT is a tool that displays multiple data points by line of business for all companies in a state/territory. By using this side-by-side comparison of companies, market analysts can prioritize companies for more in-depth analysis. LeDuc said that after extensive discussion, the Working Group agreed to the SME group's recommended changes, which included additional data elements, such as data collected through the Market Conduct Annual Statement (MCAS). The SME group also recommended deleting some data elements not determined to be useful in the current MAPT. She said this work is in accordance with the Working Group's charge to assess currently available market analysis data to identify needed improvements in the effectiveness of the data for market analysis and the predictive abilities of the market scoring systems utilizing the data.

LeDuc said the Working Group believes the baseline analysis and prioritization of companies can be greatly enhanced using modern technology, such as artificial intelligence (AI) and machine learning (ML). The Working Group will work with NAIC staff to draft a project proposal for the Committee to consider by the Spring National Meeting.

LeDuc said that in accordance with its charge to consider new lines of business for MCAS, the Working Group considered adding home and auto warranty products to MCAS. She said this was declined due to a lack of authority over those lines in many states/territories.

Commissioner Clark made a motion, seconded by Commissioner Brown, to adopt the reports of the following task forces and working groups: 1) Antifraud (D) Task Force; 2) Producer Licensing (D) Task Force; 3) Market Analysis Procedures (D) Working Group (Attachment Two); 4) Market Conduct Annual Statement Blanks (D) Working Group (Attachment Three); 5) Market Examination Guidelines (D) Working Group; 6) Market Information Systems (D) Working Group; 7) Market Regulation Certification (D) Working Group (Attachment Four); 5) Pharmacy Benefit Management (D) Working Group (Attachment Five); and Speed to Market (D) Working Group (Attachment Six). The motion passed unanimously.

A. Discussed Other Matters

Parker said that this year, the Big Data and Artificial Intelligence (H) Working Group had a charge to develop an AI evaluation tool to help regulators conduct market or financial examinations and assess the controls and practices insurers have as it pertains to AI systems. She said the AI evaluation consists of four exhibits to: 1) help regulators quantify a regulated entity's use of AI; 2) support a regulator's understanding of a regulated entity's governance of AI; 3) help with assessing high-risk models; and 4) assess the AI systems model data.

Parker said the AI Systems Evaluation Tool was exposed for a 60-day public comment period, after which there was extensive discussion in November and consideration of suggested edits during this national meeting. She said there will be a pilot of the evaluation tool in the first quarter of 2026, and the Working Group will probably make a referral to the Committee for updates to the *Market Regulation Handbook* that incorporate the AI Systems Evaluation Tool.

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

SharePoint/Support Staff Hub/Committees/D CMTE/2025 Fall/_Final Minutes/12-D Min

Draft: 12/2/25

Market Regulation and Consumer Affairs (D) Committee
E-Vote
November 21, 2025

The Market Regulation and Consumer Affairs (D) Committee conducted an e-vote that concluded Nov. 21, 2025. The following Committee members participated: Dean L. Cameron, Chair (ID); Trinidad Navarro, Co-Vice Chair (DE); Holly W. Lambert (IN); Sharon P. Clark (KY); Robert L. Carey (ME); Mike Causey represented by Jackie Obusek (NC); D.J. Bettencourt (NH); Ned Gaines (NV); and Allan L. McVey (WV).

1. Adopted its 2026 Proposed Charges

The Committee conducted an e-vote to consider adoption of: 1) its 2026 proposed charges; 2) the Antifraud (D) Task Force charges; and 3) the Producer Licensing (D) Task Force charges.

A majority of the Committee members voted in favor of adopting the 2026 proposed charges (*see NAIC Proceedings – Fall 2025, Executive (EX) Committee, Attachment Three*). The motion passed.

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

Draft: 11/11/25

Market Analysis Procedures (D) Working Group
Virtual Meeting
November 3, 2025

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Nov. 3, 2025. The following Working Group members participated: Jo A. LeDuc, Chair (MO); Raymond A. Guzman, Vice Chair (MD); Molly Nollette and Chelsy Maller (AK); Teri Ann Mecca (AR); Cheryl Hawley and Tolanda McNeal (AZ); Don McKinley (CA); Isaac Nevole (CO); Steve DeAngelis (CT); Pratima Lele (DC); Susan Jennette (DE); Karen McGlynn (FL); Chris Heisler (IL); Lori Cunningham (KY); Lisa Fullington (LA); Timothy N. Schott (ME); Danielle Torres (MI); Robert McCullough (NE); Erin Porter (NJ); Peggy Willard-Ross (NV); Larry Wertel (NY); Guy Self (OH); Landon Hubbart (OK); Karen Veronikis (PA); Brett Bache (RI); Rachel Moore (SC); Tanji J. Northrup (UT); Melissa Gerachis (VA); Isabelle Turpin Keiser (VT); Sandy Ray (WA); and Rebecca Rebholz (WI). Also participating was: Bryan Stevens (WY).

1. Discussed its August and October Meetings

LeDuc said the Working Group met Oct. 6 and Aug. 25 in regulator-to-regulator session. She said the Working Group focused on recommendations for improving the Market Analysis Prioritization Tool (MAPT). The Working Group discussed reasons for including or excluding specific data elements and how jurisdictions might use an improved MAPT. She said the Working Group agreed to take a vote on the next steps in an open meeting.

2. Adopted Recommendations from the MAPT Recommendations Ad Hoc Group

LeDuc said the MAPT Recommendation Ad Hoc Group's recommendations are focused on the private passenger automobile (PPA) line of business, but have potential applicability to the homeowners line of business due to the similarity of certain data elements. The final recommendations included high-level categories of data elements, with the only new category being state producer licensing appointments, which are only applicable to states that collect such data.

LeDuc said the Ad Hoc Group's goal was to identify key data elements for prioritizing companies for more in-depth analysis. She said the Ad Hoc Group reviewed both internal and external data sources; however, it did not consider methods of using the data for prioritization. She said there are four options available for developing a prioritization process using the recommended data elements. The options include: 1) using a scoring system similar to the current MAPT; 2) using a system similar to the Market Conduct Annual Statement (MCAS)-MAPT; 3) using a scoring system that blends MAPT and the MCAS-MAPT; and 4) engaging an external party to retool the prioritization tool using current technologies. She said the Ad Hoc Group recommends the fourth option, which would include asking the Market Regulation and Consumer Affairs (D) Committee to approve resources to engage professional expertise for developing a revised system with enhanced predictive capabilities.

Schott made a motion, seconded by Jennette, to accept the recommendation to request approval from the Market Regulation and Consumer Affairs (D) Committee to engage an external party to retool the prioritization tool, for the PPA line of business only, using current technologies. The motion passed unanimously.

3. Heard a Report from the Market Regulation Certification (D) Working Group on the MARS Level 1 Requirement

LeDuc said the Market Analysis Procedures (D) Working Group requested that the Market Regulation Certification (D) Working Group consider a requirement for a minimum number of Market Analysis Review System (MARS) Level 1 reviews.

Stevens said the Market Regulation Certification (D) Working Group exposed a draft of a new definition of what would be considered "market analysis," which includes baseline, Level 1, Level 2, and certain continuum actions that involve market analysis. He said that once the Working Group agrees on what will be included in and counted as market analysis for purposes of the new requirement, it will discuss an appropriate number of analyses to meet the requirement. Stevens said the Working Group plans to meet Nov. 17.

Stevens said the requirement draft is attached to the Nov. 17 meeting invitation, and copies can be requested from Randy Helder (NAIC).

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

LeDuc said Arizona proposed adding warranty contracts for homes and automobiles to the MCAS. She said there were some questions as to how many state/territory departments of insurance have the authority to regulate this business. McNeal said Arizona posted the question to the market regulation bulletin board and that while some states have oversight, the number is insufficient for MCAS reporting. Arizona is analyzing responses to its survey of companies offering these products in Arizona and will share findings early next year.

5. Discussed the Lunch-and-Learn Schedule

LeDuc said the next lunch-and-learn session is scheduled for Nov. 10 and will feature demonstrations from Georgia on its automated baseline review using MAPT data and Vermont on its Power BI tool for MCAS outlier identification.

LeDuc said future sessions are planned for 2026, and all topic suggestions are welcome. Guzman said that Maryland may present on its MCAS investigation process at the first-quarter lunch-and-learn. He said it would focus on Maryland's framework for analyzing insurance company responses and integrating those findings into reviews.

6. Discussed Revisions to MARS Level Two Guidance

The Working Group continued to review and update the continuum activity guidance. The discussion included adding language encouraging state/territory analysts to reach out to other states/territories when reviewing continuum actions by other states. This could be added as a best practice.

The Working Group also began discussion on the examinations section of the Level 2 guidance and discussed inserting a link to the publicly posted examination reports for each state that posts them.

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

SharePoint/Member Meetings/D CMTE/2025 Fall National Meeting/MAPWG/0623/6-MAPWG T.docx

Draft: 11/26/25

Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
November 6, 2025

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Nov. 6, 2025. The following Working Group members participated: Joshua Guillory, Chair (LA); Tolanda McNeal, Vice Chair (AZ); Teri Ann Mecca (AR); Sheryl Parker (FL); Patrick Tallman (IL); Paula Shamburger (GA); Lori Cunningham (KY); Raymond A. Guzman (MD); Danielle Torres (MI); Jo A. LeDuc (MO); Robert McCullough (NE); Elouisa Macias (NM); Jonathan Wycoff (NV); Guy Self (OH); Spencer Peacock (OR); Karen Veronikis (PA); Rachel Moore (SC); Tony Dorschner (SD); Rhonda Bowling-Black (TN); and Rebecca Rebholz (WI). Also participating was: Sherry Manning (NC).

1. Adopted its Oct. 2 Minutes

The Working Group met Oct. 2 and took the following action: 1) adopted its Sept. 11 minutes; 2) adopted the draft clarification to health Market Conduct Annual Statement (MCAS) data call and definitions to address the handling of expatriate policies; 3) discussed the "required to file" procedures for MCAS filings; and 4) reviewed the long-term care (LTC) MCAS.

Rebholz made a motion, seconded by Guzman, to adopt its Oct. 2 minutes (Attachment Three-A). The motion passed unanimously.

2. Discussed the "Required to File" Procedures for MCAS Filings

Manning said the market analysis team confirmed their presence and provided overall comments. The team emphasized the importance of ensuring that all companies meeting filing requirements are properly flagged as required to file, especially when using in-house data sources. The team reiterated ongoing concerns that the current process functionally prevents states from approving filings, as noted in its written comments.

Peacock noted recurring issues during Level 1 reviews wherein insurers that were expected to report were missing from the required reporter list. He stated that the investigation showed this was often because companies either did not complete the MCAS premium exhibit form or completed it incorrectly, resulting in additional exception processing. Under the current opt-in process, Oregon feels it must conduct its own verification to ensure all required entities are identified. This would result in insurers receiving correspondence directly from multiple states rather than through a centralized system. Peacock expressed interest in shifting back toward an opt-out approach, with exceptions addressed on a line-by-line basis, where the previous method may not have worked.

Teresa Cooper (NAIC) gave a summary of options for determining "required to file" status. Her presentation included
a comprehensive list of potential options to help refine how insurers are identified as "required to file." However, she acknowledged that none of the options is perfect. The options include:

- Option one: Automatically mark all lines applicable to an insurer's financial statement type as required to file (i.e., the opt-out model). The advantages of this option are that it reduces missed filers and shifts responsibility to insurers. The disadvantage of this option is that it generates incorrect required-to-file marks that regulators must review.

- Option two: Use financial statement premium references (i.e., the original approach). The advantages of this option are that it is a familiar method and would require no major changes. The disadvantages are that definitions do not always match MCAST, it is missing travel premium, and it produces inaccurate indicators.

- Option three: Continue using the MCAST premium exhibit but add a required portable-premium amount. The advantages of this option are that it shows insurers reviewed applicability and provides cross-checks. The disadvantages are that it is still dependent on accurate reporting, adds workload, and may not improve accuracy.

- Option four: Require states to determine which companies must file. The advantage of this option is that it could increase accuracy. The disadvantage is that it would put a heavy resource burden on states.

- Option five: States consistently fine companies that fail to submit required filings. The advantage is that it may incentivize compliance. The disadvantage is that resource limitations may hinder enforcement.

- Option six: Assign review responsibilities to states and/or NAIC staff to identify missing filers. The advantage is that it would potentially improve accuracy. The disadvantage is that there are resource constraints at both the state and NAIC levels.

Cooper noted that any major process changes are unlikely to be implemented for the 2025 data year. She also highlighted that the move to a new NAIC data-reporting system may change how required-to-file indicators are generated.

Rodriguez said Wisconsin preferred the previous process, noting that waiver requests were manageable and clearly identified situations, such as credit and lender-placed products. The prior approach allowed the state to review premium amounts, verify companies' claims, and determine whether a waiver was appropriate. She emphasized that the earlier system gave regulators the ability to directly ensure required companies were filing, and she believes returning to that method would best serve the states.

Coker requested clarification on the fourth option (related to insurers reporting written premium and cross-referencing financial statement data). She asked whether this information would be vetted by the NAIC or simply made available within the specific document for regulators to review. Her main question focused on where the reported data would be visible and how it would be validated.

Cooper clarified that she proposed to continue using the existing MCAST premium exhibit but add a new column where insurers would report their MCAST-reportable premium, rather than only answering yes or no on filing requirements. This additional data would allow regulators to cross-check the reported premium against what appears in the financial statement. She noted that the current system cannot perform this validation on the front end; however, the NAIC could run queries on the back end and provide supporting analysis.

LeDuc followed up on Arizona's question regarding the fourth option. She recalled that this approach—adding a new schedule or blank for reporting premium—was part of the original proposal. LeDuc asked what had changed that would make the industry more receptive to this option now compared to when it was first proposed.

Guillory explained that the original proposal was scaled back because the industry opposed additional MCAST premium reporting requirements. However, states' recent feedback shows that many insurers are not completing the current schedule accurately, which is causing problems. Adding more detailed reporting could encourage insurers to be more careful and improve data quality. He clarified that it is not that the industry is now more

supportive, but rather that the current "experiment" has exposed issues, and this option may address them regardless of industry preference. Guillory then invited industry representatives to comment.

Joe Zolecki (Elevance Health) noted that earlier industry concerns, especially from the health sector, centered on timing and data differences between filings. Health financial statements and health MCAS filings occur at different times, meaning MCAS premium data may not be available when financial statements are filed.

He emphasized that health MCAS premium data differs from financial statement premium data, which could cause confusion if the numbers do not match. These timing and data-definition differences previously led to concerns about conflicting premium figures and potential misunderstandings. Due to these issues, the industry supported using the yes or no response on filing requirements rather than additional premium reporting.

Zach Palank (Oklahoma) acknowledged concerns raised by North Carolina and Oregon and agreed that more checks tied to the financial annual statement would be helpful. He proposed exploring whether waiver requests could be approved for multiple years, rather than annually. For companies that write only limited products (e.g., credit), a multi-year waiver, such as a five-year approval, could reduce the administrative burden on both states and insurers.

Guillory exposed the options for a 30-day public comment period ending December 6, 2025, with comments to be sent to Hal Marsh (NAIC).

3. Discussed the Review of the LTC MCAS

Guillory referenced a previous discussion about adding a new interrogatory for significant business events or strategies. NAIC staff found inconsistencies across MCAST lines of business, particularly for LTC. He suggested deferring decisions on this data element for LTC and considering a future review for consistency across all lines. He stated that comments or suggestions can be sent to Marsh for future discussion.

The Working Group then discussed the claimants and claimant requests activity section. Guillory reviewed the existing data elements: 1) number of claimants approved for benefits at the beginning of the period; 2) number of claimants with pending determinations at the beginning and end of the period; 3) number of new claimants during the period; 4) claimant requests denied or not paid, categorized by reasons (e.g., pre-existing condition, waiting period not met, service not covered, provider not qualified, benefit criteria not met); 5) other denied/closed requests; and 6) determinations by timeframe (0–30, 31–60, 61–90, and beyond 90 days). Guillory invited discussion on whether any existing buckets are unnecessary or if additional categories should be added.

Ayah Abedali (American Council of Life Insurers—ACLI) asked for clarification on questions 32, 33, and 30/30A. Specifically, a member asked whether the counts in question 33 include or exclude the counts from question 32. Guillory clarified that for questions 32 and 33, new claimants during the period whose requests were not completed by the end of the period would be counted in both buckets, pending claimant requests at the end of the period, and new claimants during the period. He invited corrections from others if his explanation was inaccurate.

Abedali asked about question 32 regarding pending claimant requests at year-end. Some requests initially classified as pending claimant determinations under question 34 may later be reclassified as non-claim requests in the following year. Abedali asked whether the beginning-of-year pending claimant count (question 32) should be adjusted to remove these reclassified requests or left unchanged to match the prior year-end count.

Cooper noted there is no formal guidance on whether to adjust the beginning-of-year pending claimant counts. She suggested that either approach is acceptable if accompanied by a comment explaining the rationale. She said the explanation could say, "If counts are adjusted, note why they no longer match year-end totals. If counts are left unchanged, note that some requests were later determined to be non-claim requests."

Guillory transitioned to benefit payment requests activity, starting at line 47. He opened the floor for discussion, but there were no comments. He explained the data elements being collected, including: 1) number of benefit payment requests pending at the beginning of the year, received during the period, or not paid during the period; 2) number of requests pending at the end of the period; and 3) payment timing buckets (0–30 days, 31–60 days, 61–90 days, and beyond 90 days). Similar buckets for requests that were denied or not paid during the period.

Abedali asked for clarification on question 49 regarding benefit payment requests denied or not paid. Specifically, whether companies still report the denied items separately, even though the overall claim was approved, if a monthly claim includes multiple itemized expenses and most are approved, but one or more are denied.

Regarding the next steps and lawsuit activity section, Guillory opened the discussion on clarifying guidance for reporting denied benefit payment requests (question 49), inviting companies and regulators to provide feedback via email for consideration at a future meeting. He transitioned to the lawsuit activity section, reviewing the current data elements: 1) number of lawsuits open at the beginning of the period, opened during the period, closed during the period, and total closed considering the consumer; and 2) number of lawsuits open at the end of the period.

Guillory asked for feedback on any additional items to collect, but received none. He summarized that the entire LTC MCAS blank has now been reviewed over the last two calls. Guillory said a 30-day public comment period will be set, and discussion will resume in December. He said the goal is to begin voting and making decisions on updates to the blank in January, if he remains chair.

Abedali asked for clarification on question 41 regarding claimant requests denied because benefit eligibility criteria were not met. She asked how companies should report cases where a claim is denied in one year but later overturned on appeal in the following year.

Randy Helder (NAIC) explained that if a claim is denied one year but later overturned and paid in a following year, then the claim would initially be reported as denied in the first year. In the following year, when reopened and paid, it would be reported as a new claimant request and not counted as a denial for that year.

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

SharePoint/NAIC Support Staff Hub/D Working Groups/MCAS Blanks WG (TES)/2025 MCAS Blanks WG

Draft: 10/14/25

Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
October 2, 2025

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Oct. 2, 2025. The following Working Group members participated: Joshua Guillory, Chair (LA); Tolanda McNeal, Vice Chair (AZ); Lori Plant (AR); Rachael Lozano (FL); Elizabeth Nunes (GA); Lori Cunningham (KY); Mary Lou Moran (MA); Raymond A. Guzman (MD); Jo A. LeDuc (MO); Jonathan Wycoff (NV); Ryan McConnell (OH); Karen Veronikis (PA); Tara Nixon (SC); Tony Dorschner (SD); Rhonda Bowling-Black (TN); Shelley Wiseman (UT); Darcy Paskey (WI); and Letha Tate (WV). Also participating were: Sherry Manning and John Curry (NC).

1. Adopted its Sept. 11 Minutes

The Working Group met Sept. 11 and took the following action: 1) adopted its Aug. 7 minutes; 2) discussed the handling of expatriate policies on the health Market Conduct Annual Statement (MCAS); and 3) discussed the formation of a subject matter expert (SME) group to begin work on the long-term care (LTC) MCAS.

Wycoff made a motion, seconded by Guzman, to adopt the Working Group's Sept. 11 minutes (Attachment Three-A1). The motion passed unanimously.

2. Adopted the Draft Clarification to Health MCAS Data Call and Definitions to Address the Handling of Expatriate Policies

Guillory explained that the proposed addition serves as a clarification rather than a substantive change. Therefore, if the Working Group approves it, the note can be incorporated without following the full revision timeline. The clarification would be added to the 2025 health MCAS data call and definitions, along with a note indicating that the Working Group reviewed and approved it.

Guillory then opened the floor for questions or comments from Working Group members or state regulators regarding the draft clarification.

Moran thanked the Working Group for its efforts in addressing this matter, noting that Massachusetts appreciated the work and was primarily focused on ensuring consistency across reporting. She expressed gratitude to everyone involved for clarifying the language.

Guillory thanked Moran for her comments and reiterated that the clarification was valuable in ensuring shared understanding among states. He added that it is always beneficial to make sure the intent is clear for both current and future reference.

Hearing no further discussion or comments from Working Group members or interested parties, Guillory moved to proceed with formal action.

LeDuc made a motion, seconded by Moran, to approve the draft clarification. The motion passed unanimously.

Guillory confirmed that the approved clarification will be added to the health MCAS data call and definitions.

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

Teresa Cooper (NAIC) explained the background of the required-to-file process. She said that when the NAIC started collecting MCAS data centrally, the team needed a consistent method to determine which companies were expected to file. At that time, MCAS included only four lines of business: private passenger auto (PPA), homeowners, individual life, and individual annuity.

Cooper stated that the NAIC identified premium references within the financial statements that could be used to determine whether a company met the threshold for filing. However, this approach presented challenges. For example, some companies reported homeowners premium under a different line of business or had PPA premium associated with other types of coverage not included in MCAS. These inconsistencies resulted in inaccurate required-to-file indicators, forcing companies to submit waiver requests each year that states then had to review. As MCAS expanded to additional lines of business, including several health-related lines, the process became increasingly complex. It became difficult to find consistent financial statement references that applied across all 13 lines of business, leading to programming and data accuracy challenges.

Cooper said that to improve consistency, the NAIC developed the MCAS premium exhibit, a supplement to the financial statement. The original intent was for this exhibit to include actual MCAS premium data. However, after discussions with industry, the reporting requirement was reduced to a "yes" or "no" response, indicating whether a company had MCAS-reportable premium in a given state and line of business. This change was proposed to and approved by the Financial Analysis Solvency Tools (E) Working Group and subsequently implemented.

Cooper stated that, in the current process, companies submit their financial statements and the MCAS premium exhibit by March 1. The exhibit responses determine whether a company is marked as required-to-file within the MCAS application. Regulators then use this information to identify expected filings.

Cooper acknowledged that this process still presents challenges. Some companies leave responses blank or incorrectly report their filing status due to internal miscommunication between financial and market data staff. As a result, some companies that should file are incorrectly excluded, while others may incorrectly appear as required. This creates gaps in the data and requires additional follow-up by state regulators. She added that there is no perfect solution for determining the required-to-file status. Both the original and current approaches have weaknesses that lead to inaccurate indicators. Cooper emphasized the importance of finding a process that best serves regulators while remaining manageable for companies.

Cooper also noted that the NAIC is in the process of modernizing its Financial Data Repository (FDR), which will affect MCAS data handling. Depending on the direction the Working Group decides to take, the implementation of any revised required-to-file procedures will need to be incorporated into that new system. Cooper concluded her remarks by offering to answer any questions.

Manning explained that North Carolina has concerns with the current required-to-file process. Under the existing system, if a company answers "no" to the MCAS premium exhibit question on page 101 of the financial statement, it is not placed in required-to-file status. Manning noted that this can lead to situations where companies either forget to make a selection or make an incorrect selection, unintentionally excluding themselves from the waiver determination process. She explained that this process creates additional work for states, which must query data after the filing period to identify missing filings and contact companies directly to ensure compliance. Additionally, companies that should have been allowed to request a waiver but left the exhibit question blank cannot access the MCAS filing portal to do so, since they are not flagged as required-to-file. As a result, North Carolina's analysts have had to manually track and reconcile filings outside the system, which is time-consuming and inefficient.

Sherry emphasized that prior to this change, all waiver requests were handled within the portal, and the new process places an unnecessary burden on state analysts.

Guillory proposed allowing a two-week comment period for members to gather feedback and provide written input. He encouraged regulators to review the issue internally and send comments or concerns to Hal Marsh (NAIC), who would compile the responses.

4. Reviewed the LTC MCAS

A. Data Availability for Lines of Business

Guillory asked if companies have data to report for standalone LTC, life hybrid, and annuity hybrid.

Nunes asked about the ability to add explanations for "yes" and "no" responses. Cooper responded that comments are optional and can be used to explain warnings during submission.

B. Significant Events or Business Strategy Changes

LeDuc noted potential duplication of existing questions on significant events or business strategy changes.

Wycoff suggested adding a standalone question on significant rate increases.

C. Suggested Standalone Question: Significant Rate Increases

McNeal proposed including "substantial rate increases that resulted in benefit selection changes" as a standalone question. Guillory confirmed this could be considered as a separate question in future meetings. LeDuc recommended separating that question from the "data anomaly" question to avoid overlap.

Paskey suggested defining "significant rate change" if it is added as a standalone question.

McNeal referenced model language linking substantial rate increases to benefit disclosure.

Kirsten Wolfford (American Council of Life Insurers—ACLI) cautioned that narrative context questions could create a reporting burden and inconsistency.

D. Other Interrogatory Questions

Regarding the active writing of policies at year-end, Guzman supported adding the "yes" or "no" question. McNeal agreed that "yes" and "no" answers are preferable from an industry perspective. LeDuc said she preferred breaking down by each line of business for consistency.

Regarding the number of class action lawsuits, Jennette and McNeal supported moving the question to the lawsuit section for clarity and analysis. Guzman noted the potential duplication if the question is left in the interrogatories; he recommended bifurcation.

Regarding the use of managing general agents (MGAs)/third-party administrators (TPAs), LeDuc opposed requiring the list of names and stated support for only "yes" and "no" responses. Jennette and Guzman agreed, stating that detailed names are not typically needed for company selection.

E. General Information Section (Questions 19–30)

Guillory reviewed the metrics on policies/contracts in force, new business, lapses, rescissions, replacements, and complaints.

Wolfford raised the issue of complaints received via social media. Cooper clarified that the guidance on complaints received via social media is that they count if the consumer reasonably expects a response.

Curry suggested capturing lapses initiated by consumers separately from natural lapses to monitor potential loss of consumer protections. Curry confirmed this would be considered in future discussions.

Guillory outlined the Working Group's next steps: 1) continue reviewing LTC MCAS sections in future meetings; and 2) defer decisions on additions/changes to votes at later meetings. He encouraged participants to submit additional feedback via email to Marsh for inclusion in the Working Group's next agenda.

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

SharePoint/NAIC Support Staff Hub/D Working Groups/MCAS Blanks WG (TES)/2025 MCAS Blanks WG

Draft: 9/29/25

Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
September 11, 2025

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Sept. 11, 2025. The following Working Group members participated: Joshua Guillory, Chair (LA); Tolanda McNeal, Vice Chair (AZ); Rachael Lozano (FL); Elizabeth Nunes and Paula Shamburger (GA); Chris Heisler (IL); Lori Cunningham (KY); Mary Lou Moran (MA); Raymond A. Guzman (MD); Amy Bonito (MI); Jo A. LeDuc (MO); Martin Swanson (NE); Jonathan Wycoff (NV); Guy Self (OH); August Hall (PA); Rachel Moore (SC); Nneka LaBon (TN); Shelley Wiseman (UT); Melissa Gerachis (VA); Theresa Miller (WV); and Mary Kay Rodriguez (WI).

1. Adopted its Aug. 7 Minutes

The Working Group met Aug. 7 and took the following action: 1) adopted its July 10 minutes; 2) discussed how to care for discretionary groups on the other health Market Conduct Annual Statement (MCAS); 3) adopted the proposal form to address clarification of blanket policy reporting on the other health MCAS; 4) discussed the handling of expatriate policies in the health MCAS; and 5) discussed the formation of a subject matter expert (SME) group to begin work on the long-term care (LTC) MCAS.

Wiseman made a motion, seconded by LeDuc, to adopt its Aug. 7 minutes *(see NAIC Proceedings – Summer 2025, Market Conduct Annual Statement Blanks (D) Working Group, Attachment Two)*. The motion passed unanimously.

2. Discussed the Handling of Expatriate Policies on the Health MCAS

Guillory re-introduced the discussion on expatriate policies in the health MCAS, a topic Mary Lou Moran (MA) raised at the Working Group's July 10 meeting. As Moran was not present, Guillory provided background, noting the lack of clear guidance on how states are handling expatriate policies.

Guillory presented the NAIC's findings from a review of the 2024 Supplemental Health Care Exhibit. Seven companies were found that reported expatriate premiums, which are less than 1% of the market share. While the total expatriate premiums are a small percentage of the market share, for a company, expatriate premiums can be a large percentage of its health premiums.

In order to provide the direction Massachusetts is asking for, Guillory presented the following three options: 1) allow each state to make its own choice on whether or not it wants expatriate business reported as part of health care premiums; 2) exclude expatriate business from health care premiums; and 3) include expatriate business in health care premiums.

LeDuc made a motion, seconded by Gerachis, to exclude expatriate business from health care premiums. The motion passed unanimously.

Guillory asked Teresa Cooper (NAIC) what updates are needed to reflect that expatriate business would not be reported on the health MCAS. Cooper responded that the NAIC would provide a draft and share it with the Working Group for its approval.

3. Discussed the Formation of an SME Group to Begin Work on the LTC MCAS

Guillory identified that the formation of an SME group to review the LTC MCAS reporting blank and data call and definitions would not happen, as no volunteers from state regulators or the industry came forward. He reminded participants that review of the LTC blank and data call and definitions is in line with a Working Group charge to review data elements in effect for more than three years. Guillory stated that the full Working Group will conduct the review during regular calls.

To begin the LTC review discussions, Guillory discussed the current LTC blank data elements in each reporting section. He noted some data elements present in other MCAS lines of business, identified by NAIC staff, that could be considered for addition to the LTC blank. Guillory said a listing of possible data elements would be provided as an attachment for the next Working Group meeting. He asked participants to be prepared to discuss this further at the October meeting.

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

SharePoint/NAIC Support Staff Hub/D Working Groups/MCAS Blanks WG (TES)/2025 MCAS Blanks WG

Draft: 12/9/25

Market Regulation Certification (D) Working Group
Hollywood, Florida
December 9, 2025

The Market Regulation Certification (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met in Hollywood, FL, Dec. 9, 2025. The following Working Group members participated: Bryan Stevens, Chair (WY); T.J. Patton, Vice Chair (MN); Lori Plant (AR); Daniel Mathis (IA); Mary Kwei (MD); Jo A. LeDuc (MO); Charles Whitehead and Tracy Biehn (NC); Ralph Boeckman (NJ); Sahar M. Hassanin (NM); Rodney Beetch (OH); Landon Hubbart (OK); Rachel Moore (SC); Tanji J. Northrup (UT); Andrea Baytop and Julie Fairbanks (VA); Karla Nuissl (VT); Sandy Ray (WA); and Michael Malone (WV). Also participating were: Danielle Torres (MI); and Elizabeth Nunes (GA).

1. Adopted its Nov. 17 Minutes

Stevens said the Working Group met Nov. 17 and took the following action: 1) discussed a draft proposal for a market analysis standard to be added to the Voluntary Market Regulation Certification Program; and 2) discussed the implementation of the full certification phase of the Voluntary Market Regulation Certification Program.

LeDuc made a motion, seconded by Patton, to adopt the Working Group's Nov. 17 minutes (Attachment Four-A). The motion passed unanimously.

2. Adopted a Market Analysis Standard for the Voluntary Market Regulation Certification Program

Stevens said that after the Working Group's Nov. 17 meeting, the subject matter expert (SME) group met and revised the draft market analysis standard's wording to reflect the Working Group's conversation.

Patton said the new definition of market analysis broadens what counts toward market analysis to include baseline, Market Analysis Review System (MARS) Level 1, Level 2, and certain continuum actions that involve market analysis. He said the proposed standard now includes a minimum of 30 reviews based on the broadened definition. He stated that during the Nov. 17 meeting, there was a lot of discussion on the appropriate number of reviews. The consensus seemed to be that 30 was a good "stretch goal" for jurisdictions, but some departments with fewer resources expressed concerns that 30 reviews could be undoable.

Patton said that to address those concerns, the proposal is that this standard will not be mandatory, but rather coded yellow. An additional checklist question was proposed, asking jurisdictions whether they have a strategy in place for completing 30 reviews if they did not do 30 reviews.

Stevens said completing 30 reviews sounds like a lot, but with the broadened definition, they can be done. He said he is the only one in his state doing market analysis, and he thinks he can reach 30 reviews.

LeDuc made a motion, seconded by Baytop, to adopt the proposed Requirement 12—Department Market Analysis Activity with a primary (not mandatory) requirement of 30 market analysis activities (Attachment Four-B). The motion passed unanimously.

Stevens said the Market Regulation and Consumer Affairs (D) Committee will vote on the standard at the Spring National Meeting.

3. Discussed the Implementation Plan for Full Certification

Stevens stated that the Voluntary Market Regulation Certification Program is currently in the first step of the implementation plan. Last year and this year, the Working Group received 22 applications for provisional certification. He said that per the program's implementation plan, each jurisdiction that submits a self-certification is automatically provisionally certified. Each of the 22 jurisdictions that have submitted self-certifications has received an acknowledgement, and the appointed peer review group is currently doing assessments of the jurisdictions' self-certifications.

Stevens said that the second step of the implementation plan is to develop a mechanism for implementing the Full Certification Program. Once in place, jurisdictions will have the option to continue self-certifying or to apply for full certification.

Stevens said the plan calls for the formation of a market regulation standards and certification working group. He said he believed that would be this current Working Group, with one difference: the new Working Group's members would be appointed annually.

Additionally, Stevens said that to be fully certified, the jurisdiction's application would be reviewed by an NAIC review team constructed like the financial accreditation review team. He said he thought the current peer review group could transform into this review team. He said the Working Group needs to discuss how the reviews would be conducted (e.g., via Webex, in person, or a combination of both).

Stevens said requests for full certification must be submitted before the Spring National Meeting each year, and no more than 12 applications per year would be accepted for review. This would allow for a five-year cycle of 12 jurisdictions per year. At the Fall National Meeting each year, the recommendations for full certification will be provided to the Working Group for decisions.

Stevens said that fully certified jurisdictions will submit a self-certification in the third year and renew their full certification every five years. He said any fully certified jurisdiction can exit full certification at any time and choose to just be provisionally certified or not participate at all.

Stevens said the first questions to be answered are the composition and methods of the review team and the annually appointed working group.

Patton said the program currently has 22 provisionally certified states, and it is important to maintain the momentum. Stevens agreed and said that it is important to learn from what other states are doing in their market regulation programs. He said that, for example, he would like to know if Missouri is conducting an examination on a Wyoming domestic company so that he can know the processes they are using and trust the work that Missouri is doing when he does his own analysis of the company.

LeDuc said it would help to get more states if the program and checklist were simplified and easier to complete. Randy Helder (NAIC) said the NAIC publications team is working on improving the format and look of the program and is using Missouri's template for the checklist due to its user-friendliness and clarity.

Patton and Nuissl asked if the Working Group was ready to begin reviewing applications for full certification. Stevens said it would be better to start after the Spring National Meeting, when the new requirement will be considered by the Market Regulation and Consumer Affairs (D) Committee. LeDuc said it would be useful to first

get the peer review team assessments of the self-certification back to the provisionally certified states and receive their feedback.

Stevens asked why states that have not submitted self-certifications have yet to do so. Kwei said that Maryland had some struggles with replacing some market regulation leadership. She said she thought Maryland would be ready in 2026. LeDuc said the peer review group is available to assist, and Baytop said the initial assessments will be sent to the provisionally certified states soon. She said it would be helpful to get their feedback to understand what changes could be made to make the checklist and measurements clearer.

Torres said Michigan is provisionally certified but has some concerns regarding some of the statutory authorities referenced in the certification program. She said the feedback from the peer review group will be helpful in working with their legislature to get model acts adopted. Stevens agreed. He said Wyoming does not have some of the referenced market regulation statutes, but its examination statutes are broad enough to allow them to accomplish what is addressed in the referenced market regulation statutes.

Stevens reminded the Working Group that self-certification applications can still be sent to Helder, and all self-certifications will be acknowledged with provisional certification. He stated that if a department of insurance (DOI) can get them submitted prior to the Market Regulation and Consumer Affairs (D) Committee's Dec. 11 meeting, he will be able to report the total number of provisionally certified states to the Committee. He stated that at this time, he plans to report that the program has 22 provisionally certified states, but he will add any that arrive before the Committee's meeting.

Nunes stated that she does the market analysis for Georgia, and the state also uses contractors. It is difficult for Georgia to calculate the full-time equivalent (FTE) number of analysts and examiners. Stevens said most states use contractors to some extent. LeDuc said it is still important to know how many in-house staff are being used for market analysis, as well as counting the hours of the contractors. Baytop said Virginia did not use a complicated formula for FTE. If an examiner also did some analysis, they would be counted as half an analyst. Stevens suggested that a compilation of the types and methods of answers that were provided by the provisionally certified states for each checklist question could be useful for states that are still working on their self-assessments. He said that the compilation will be ready before the 2026 Spring National Meeting.

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

SharePoint/NAIC Support Staff Hub/Member Meetings/D Cmte/2025 Fall/MRCWG/Fall

Draft: 11/20/25

Market Regulation Certification (D) Working Group
Virtual Meeting
November 17, 2025

The Market Regulation Certification (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Nov. 17, 2025. The following Working Group members participated: Bryan Stevens, Chair (WY); T.J. Patton, Vice Chair (MN); Chelsy Maller (AK); Teri Ann Mecca (AR); Daniel Mathis (IA); Mary Kwei (MD); Jo A. LeDuc and Teresa Kroll (MO); Shane Quinlan (NC); Martin Swanson (NE); Erin Porter (NJ); Elouisa Macias (NM); Rodney Beetch (OH); Landon Hubbart (OK); Cassie Soucy (OR); Gary Jones (PA); Rachel Moore (SC); Tanji J. Northrup (UT); Andrea Baytop and Julie Fairbanks (VA); Isabelle Turpin Keiser (VT); Sandy Ray (WA); and Allan L. McVey (WV). Also participating were: Tolanda McNeal (AZ); Pam O'Connell (CA); Victoria Hastings (IN); Danielle Torres (MI); Hermoliva Abejar (NV); Matthew Gendron (RI); Stacie Parker (TX); and Darcy Paskey (WI).

1. Adopted Aug. 6 Minutes

The Working Group met Aug. 6 and took the following action: 1) adopted its May 21 minutes; and 2) discussed the proposed market analysis certification requirement.

Commissioner McVey made a motion, seconded by Ray, to adopt the Working Group's Aug. 6 minutes *(see NAIC Proceedings – Summer 2025, Market Regulation and Consumer Affairs (D) Committee, Attachment Three)*. The motion passed unanimously.

2. Discussed Voluntary Market Regulation Certification Program Implementation Plan and Certification Applications

Stevens said that in 2024 and 2025, the Working Group received 22 applications for provisional certification. He said this was in accordance with step one of the adopted implementation plan. According to the program's implementation plan, each jurisdiction that submits a self-certification will automatically be provisionally certified. He said each of the 22 jurisdictions that submitted self-certifications has received an acknowledgement, and the appointed peer review group is currently doing assessments of the jurisdictions' self-certifications.

Stevens stated that, after the initial self-certification, the implementation plan requires the provisionally certified jurisdiction to submit a self-certification report annually. While the Working Group continues to receive some new self-certifications, it has not, to date, received any of the annual self-certifications from the jurisdictions that have already been provisionally certified. He stated that, as this is the first year that the Working Group has been receiving and assessing the self-certification applications, the annual requirement will not be enforced this year.

Stevens reminded attendees that self-certification applications can still be sent to Randy Helder (NAIC), and all applications will be acknowledged with provisional certification. He said that if a state/territory can submit its self-certification prior to the Market Regulation and Consumer Affairs (D) Committee's Dec. 11 meeting at the Fall National Meeting, he will be able to report to the Committee the total number of provisionally certified states. This report will include all 22 submitted self-certifications plus any new submissions. He said he would like to have 25 applications by the Fall National Meeting and 35 by the end of next year.

Stevens said the Working Group will meet Dec. 9 at the Fall National Meeting to begin discussions on developing the mechanisms for implementing full certification. He asked Helder to send the implementation plan to all

interested regulators and interested parties so the Working Group can prepare to discuss how to proceed during the Fall National Meeting.

Torres asked how long it takes to get the assessment for the peer review group. Stevens said the self-certifications are being reviewed in order, and not all 22 have been reviewed yet. He believes there is one more meeting planned for the review group.

Hastings asked whether it is expected that the self-certifications have the state's or territory's policies and procedures attached to the checklist or if only the checklist is required. Stevens said that if a state/territory is comfortable with submitting its policies and procedures, that is helpful to the review team. Hastings asked what type of feedback a state should expect to see. Stevens said it varies but mostly consists of requests for clarification. He said that clarification is sometimes needed because the checklist formatting is off and the answer is unclear. At other times, it may be a request for the policies and procedures once they are drafted by the state.

O'Connell asked who comprises the review panel. Stevens said the review panel consists of Patton, Baytop, Soucy, LeDuc, Jones, and himself.

Gendron asked if there is an appeals process if a state disagrees with an assessment. Stevens said there is not. He said everyone is just trying to get on the same page right now, and the review panel is willing to talk about any disagreements. He said this is a collaborative effort.

3. Discussed the Proposed Draft of a New Market Analysis Certification Requirement

Stevens said that prior to this meeting, the Working Group exposed a draft of a new definition of what would be considered market analysis. He said the new definition broadens what counts as market analysis to include baseline, Market Analysis Review System (MARS) Level 1, MARS Level 2, and certain continuum actions that involve market analysis. He said that if the Working Group agrees on what would be included in and counted as market analysis for purposes of the new requirement, it can then decide what an appropriate number of analyses would be needed to meet the requirement.

Patton thanked the drafting group for its work on the proposal. He stated that the drafting group is working on a proposed requirement focused on two topics, and two considerations were taken into account for each topic. The first topic is developing a definition of what counts as market analysis. Once a consensus is reached on the definition, the second topic is to determine a sufficient amount of market analysis to meet the requirement. He said that for each topic, the drafting group is considering the resources available to each state/territory and ensuring that the analysis done by jurisdictions is analysis that other jurisdictions can obtain and utilize.

Patton said the market analysis definition was broadened to include baselines, MARS Level 1, MARS Level 2, and general market analysis projects. The definition also provides some examples of what would qualify as a general market analysis project. He said the list includes special data calls, market-wide surveys, and interrogatories, but the examples are not all-inclusive. Other types of activities could also qualify. He said the drafting group took into account the Working Group's discussion on how different jurisdictions conducted market analysis. He said that for an analysis to be counted, it had to be performed during the calendar year.

Stevens thanked the drafting group for its work on the proposal. He said the value of the requirement is for other jurisdictions to be able to share their analyses and not duplicate each other's work.

Gendron said this is a good list of market analysis activities. He said Rhode Island will do projects on topics such as title insurance or annuities and conduct between six and 20 Level 1 or Level 2 analyses on different companies prior to issuing a public report on the topic.

Paskey said Wisconsin just conducted a survey of 164 private passenger automobile (PPA) companies. She asked if the expectation was that Wisconsin would have to do a Level 1 analysis on each of the 164 companies to get credit for the national analysis. LeDuc said the general market analysis category is a way for a state to count activities that it has done that are outside of the routine baseline, Level 1, or Level 2 reviews. She said it is not the expectation that all these are input into MARS. She said it is great that Rhode Island does that because it helps inform other states, but it is not part of the requirement. The definition attempts to encompass all the things states report that do not fall into the standardized systems.

Moore said she is the only person doing market analysis in South Carolina, and her state uses State Based Systems (SBS). She asked if analyses in SBS would be considered and counted. Patton said they would.

Helder said North Carolina submitted a question regarding the way the definition was worded. It was unclear whether the requirement was for the analyses to be done in the same calendar year as the data. He said this will be clarified, but the intention is that the requirement is to count the number of market analyses conducted in the calendar year, not the number of analyses by data year. Quinlan said that answered North Carolina's question.

Patton asked if a vote needed to be taken on the definition of the market analysis prior to moving into a discussion on the appropriate number of analyses to be done by the state per year. Helder said the vote can wait until the entire requirement is drafted with the analysis definition, the quantity of market analyses to be conducted, and whether the requirement is a mandatory or secondary requirement.

Patton asked whether the current Market Analysis Procedures (D) Working Group requirement of 30 analyses is workable for jurisdictions, given the broadened definition. Quinlan said 30 can be a start. Stevens said that just as South Carolina only has one market analyst, he is the only market analyst in Wyoming. He said that Wyoming was planning for 20 reviews in 2026. While 30 is not unreasonable, he would prefer 20 reviews as the baseline. Soucy agreed with Stevens and said that it would be a good floor for smaller states with fewer resources.

Gendron said he liked the goal of conducting 30 reviews. He said it is unlikely a jurisdiction would lose its certification if it only did 26 reviews. He said that often states use the financial accreditation program standards to argue for sufficient staffing. He said he thinks the standards should be a little higher.

Stevens asked if the proposed requirement would be mandatory or secondary. LeDuc said the drafting group did not discuss that, but she thought initially it could be a secondary requirement. Patton and Stevens agreed that it should initially be secondary, but wondered if that would lead some states not to be concerned with meeting the requirement. LeDuc said it would not always have to be secondary.

Turpin Keiser asked whether 30 is too low a number for larger states with more resources. Stevens said states like California have a large staff, but in the last meeting, they indicated that most of the staff is composed of examiners with very few analysts. Parker noted that Texas is similar to California in terms of the number of examiners versus analysts. LeDuc said that if the requirement was to be scalable by the size of the staff, it would be necessary to tighten the definition around what constitutes an analyst and how to count the number of analysts.

Baytop said the requirement should be secondary since it has just been added to the certification program. She said maybe in the future, it can be changed to a mandatory requirement, and consideration can be given to scaling it per the full-time-equivalent number of analysts.

Patton asked if states that wanted 20 analyses as the minimum would be comfortable with 30 if it were a secondary requirement. Moore, Soucy, and Stevens all agreed that they would be comfortable with 30 analyses. Abejar said that regardless of the number, the prioritization of the companies to be reviewed is more important. Stevens agreed that it is important for states with limited resources to use their time wisely, but at the same time, it is good to have a stretch goal. He said a jurisdiction will not be told it is not certified because it fell short of 30 analyses. LeDuc said that if a state does not meet enough secondary requirements, it could mean that it is not certified. Stevens agreed that would be the case with full certification, but the state would still be provisionally certified.

Patton said the drafting group will meet again to put together a requirement that the Working Group can vote on. Stevens said the Working Group can consider adoption of the proposed requirement at the Fall National Meeting. Stevens said the Fall National Meeting will be used to wrap up the work of the Working Group for 2025 and plan for 2026. He said he would like to have 25 states provisionally certified by the end of 2025 and 35 by the end of 2026.

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

SharePoint/Member Meetings/D CMTE/2025 Fall National Meeting/MRCWG/1117/11-MRCWG T.docx

Minimum Market Analysis Requirement

Contents

SME Group Proposal

Requirement 12 – Department Market Analysis Activity

The jurisdiction or department must demonstrate proactive oversight of its market by engaging in a minimum level of market analysis activity.

Objective

This requirement's objective is to ensure the department conducts systematic market analysis to proactively and effectively identify and address potentially unfair or harmful market practices by insurers.

Measurement

To successfully meet this requirement, the jurisdiction must conduct thirty (30) or more market analysis activities in order to answer "Yes" to checklist item 12b.

Each jurisdiction will decide which line(s) of business and type(s) of analysis to conduct, but priority should be given to the lines of business and issues that have the highest potential for significant consumer harm involving either domestic carriers or foreign carriers.

Guidelines

The department should conduct market analysis in a systematic way to identify potential issues. It should routinely collect and analyze data to understand the normal operating patterns within a market and identify companies whose practices deviate significantly from the market norm and may pose a risk to consumers.

Each jurisdiction will decide which line(s) of business and type(s) of analysis to conduct, but priority will be given to the lines of business and issues that have the highest potential for significant consumer harm.

To determine the number of market analysis activities,

- the market analysis activity must be entered into the NAIC MARS Level 1, MARS Level 2 or MATS databases and completed during the calendar year. Each entry counts as one market analysis activity.

- each line of business reviewed per carrier will count as a market analysis activity. For example, if an analyst reviews both the homeowner and private passenger auto lines of business for a particular carrier, it would count as two market analysis activities.

When assessing whether the department has achieved the minimum level of market analysis activities, the following activities are regarded as fulfilling an activity for the purpose of satisfying this requirement.

- Baseline Analysis
- Level 1 Review
- Level 2 Review
- General Market Analysis Projects

Baseline analysis

Baseline analysis utilized data as a benchmark from which deviations and comparisons are measured. It should be a systematic process whereby basic parameters are used to evaluate the entire marketplace for a specific line of business in order to identify those companies that may require a more detailed and thorough review.

It is to be conducted using the NAIC's Market Analysis Prioritization Tool and/or the MCAS-Market Analysis Prioritization Tool as the basis for the review. A baseline analysis that incorporates either of the MAPT tools into a jurisdiction's proprietary process/tool would also count as a baseline analysis.

Each baseline analysis is counted in the year it is completed. Each line of business reviewed will count as one review regardless of the number of companies included in the baseline review. In the absence of a business reason, reviews should be conducted using the most current data year available when the data is downloaded.

Level 1/Level 2 Reviews

Level 1 or Level 2 Reviews can be Level 1, Level 2 or a combination of both. The review must be entered into the NAIC MARS database and is counted in the year in which it is completed.

Each line of business reviewed per insurer will count as one review. For example, if a review includes both Homeowner and Private Passenger Auto for a particular insurer, it counts as two reviews. A review that included three lines of business would count as three reviews.

In the absence of a business reason, reviews should be conducted using the most current data year available when the review was created in MARS.

General Market Analysis Projects

General market analysis projects include departmental analysis activities that involve analyzing general market conditions but are outside the scope of Baseline Analysis, Level 1 Reviews or Level 2 Reviews.

These could take many forms and may include special projects or studies undertaken at the request of senior management to understand a specific market practice and/or to identify potential outliers. Examples of special market analysis projects include, but are not limited to:

- Special data calls and studies related to current and emerging issues.
- Market-wide survey designed to gather information for the purpose of understanding a specific market practice
- Interrogatories sent to significant portions of a market to collect/analyze information regarding certain practices
- Market reviews regarding the industry's implementation of new laws.
- Studies of emerging issues

To be counted, the market analysis project must be completed during the calendar year being evaluated. It may be a one-time project or a periodically recurring initiative.

Checklist

Market Analysis

12a. Did the department perform market analysis activities during the current year?

12b. Did the department complete thirty (30) or more market analysis activities during the current year?

12c. If the answer to 12(b) is "no", has the department developed a strategy for completing thirty (30) or more market analysis activities during future years? If yes, describe it.

12d. Indicate below the number of market analysis activities for which market analysis was performed in the prior review period. Market analysis means a formal review of a jurisdiction's market and/or individual companies through existing processes (e.g., baseline analysis, Level 1 reviews, Level 2 Reviews, general market analysis, and/or special analysis projects).

	Total Activities Reported in MARS	Total Activities Reported in MATS
Current Year (CY)		
CY-1		
CY-2		

Current Requirement

Market Analysis Review System (MARS)

Minimum Annual Number of Reviews

The Market Analysis Procedures (D) Working Group (MAP) was asked by the Market Regulation Accreditation (D) Working Group to consider minimum MARS review counts for each state. This document outlines the minimum MARS reviews by state, as adopted by MAP.

A phase in period is provided to allow for training and resources.

NOTES:

1. The term "REVIEWS" can be Level 1, Level 2 or a combination of both.
2. To "count", the review must be entered into the NAIC MARS database and completed during the calendar year.
3. Each line of business reviewed per carrier will count as a MARS review. For example, if an analyst reviews both Homeowner and Private Passenger Auto for a particular carrier, it would count as two MARS reviews.
4. The number of reviews completed by each state will be reported to MAP quarterly, and posted on MyNAIC.

Year 1 (2017):

Each state conducts a minimum of ten (10) reviews. The line of business and type of carrier reviewed will be at the discretion of each state, but priority given to domestic carriers or foreign carriers involved in issues that are potentially significant to the state.

Year 2 (2018):

Each state conducts a minimum of fifteen (15) reviews. The line of business and type of carrier reviewed will be at the discretion of each state, but priority given to domestic carriers or foreign carriers involved in issues that are potentially significant to the state.

Year 3 (2019):

Each state conducts a minimum of twenty (20) reviews. The line of business and type of carrier reviewed will be at the discretion of each state, but priority given to domestic carriers or foreign carriers involved in issues that are potentially significant to the state.

Year 4 (2020):

Each state conducts a minimum of twenty-five (25) reviews. The line of business and type of carrier reviewed will be at the discretion of each state, but priority given to domestic carriers or foreign carriers involved in issues that are potentially significant to the state.

Year 5 (2021) and beyond:

Each state conducts a minimum of thirty (30) reviews. The line of business and type of carrier reviewed will be at the discretion of each state, but priority given to domestic carriers or foreign carriers involved in issues that are potentially significant to the state.

SME Group Summary

The SME Group began by discussing the purpose and reasons for creating and implementing the requirement. It offers the following background to set the stage for its revised proposal.

Background

The requirement for completing a minimum number of reviews came about at a time when state regulators were being criticized for not having uniform standards to identify market issues, leading to inconsistent responses to market conduct problems. During this time, the Government Accountability Office (GAO) also conducted a study. The primary recommendation coming out of the study was that states should develop standardized procedures for conducting market analysis and coordinating their efforts.

In response to the criticism and the GAO study, the current systematic approach to conducting market analysis was developed. This new system represented a shift away from resource-intensive, on-site market conduct examinations to a structure that allowed regulators to identify potential issues and seek corrective action before problems became widespread. The intent was to provide a data-driven process to more efficiently identify which companies and practices posed the most significant risk to consumers, helping regulators prioritize their resources.

To achieve a more systematic proactive approach to market regulation, the following were created:

- Market Conduct Annual Statement
- Baseline Analysis
- Level 1 Reviews
- Standardized Level 2 Reviews

To enhance consistency and coordination, the NAIC developed and implemented tools like MAPT, MARS, and MATS. However, creating the processes and tools was only half of the response to the criticisms. The other half was to encourage the adoption of the new ‘modernized’ analysis process and demonstrate that jurisdictions were utilizing it. The demonstration involved each jurisdiction completing a minimum number of Level 1 Reviews.

The initial number of reviews was established using a combination of factors intended to consider the size of each jurisdiction's market. Over the years, the initial benchmarks have been reviewed periodically. Unfortunately, the documentation showing how the minimum number of reviews was determined was not retained. Efforts to recreate were not successful, and the formula was eventually abandoned in favor of the current benchmark, which was adopted by the Market Analysis Procedures Working Group on January 28, 2016.

In discussing the issue, the SME generally agreed that the pressures that existed leading up to and resulting in the development of the current structured market analysis approach are still valid. And that failure to maintain and encourage the use of a more proactive and systematic approach to the identification of market conduct issues would not be in our best interest. As such, the SME agreed that

the initial primary purpose of establishing a minimum number of reviews, geared toward demonstrating our commitment to conducting proactive data-driven analysis, is still relevant and should continue to be the goal for establishing a minimum requirement.

The SME also recognized that the requirement, as it currently exists, is not flexible enough to accommodate the various processes used by jurisdictions in monitoring their market.

As such, the **SME recommends that a new requirement be added** to the Certification program that:

- Establishes **a minimum level of required activity** that is directly related to the market size of the individual jurisdiction.
- Not be expanded to include all regulatory actions on the continuum but remains **limited to only those activities associated with market analysis**.
- **Expands the types of market analysis activities**, beyond Level 1 and Level 2 Reviews, that count toward meeting the minimum requirement.

The SME felt that adding a new requirement would be the best approach in the long run, as none of the existing requirements address minimum performance standards. Rather, they focus on core items such as department authority, staffing resources/qualifications, and other process-related items and therefore do not provide a logical place for inserting a minimum performance standard. A new, standalone requirement, on the other hand, would allow for maximum flexibility and create an extendable structure, allowing for future growth in terms of minimum performance requirements.

Requirement 12		Mandatory Condition Met	(Primary)	(Secondary)		
12a	Did the department perform market analysis activities during the current year?					
12b	Did the department complete thirty (30) or more market analysis activities during the current year?					
12c	If the answer to 12(b) is "no", has the department developed a strategy for completing thirty (30) or more market analysis activities during future years? If yes, describe it.					
12d	Indicate below the number of market analysis activities for which market analysis was performed in the prior review period. Market analysis means a formal review of a jurisdiction's market and/or individual companies through existing processes (e.g., baseline analysis, Level 1 reviews, Level 2 Reviews, general market analysis, and/or special analysis projects).					
Certification Score Total						
Total Points Possible						
Score						
Pass/NoPass						
Points needed to pass			0			

29 THIS SCORE SHOULD BE THE TOTAL OF MANDATORY ITEMS IDENTIFIED IN THE CHART ABOVE -- its not necessary to assign a score value for meeting expectations	18 The PRIMARY GOALS should be given a scorable point basis that is weighted by the total of primary goals inside each REQUIREMENT; this would include the requirements needed of any secondary goals == this would achieve the 100% assigned overall points to each REQUIREMENT;	20 Secondary goals that are "working toward" meeting the requirements of the Red Mandatory or Yellow Primary goals should be partial point values that equal up to 75% of the total score value that is assessed for the primary goals in this REQUIREMENT AREA. (All other green tagged secondary goals are designed to be supportive of requirements to meet red and yellow -- so those would not be given a partial score value at all when used to support only)

1st assessment	all mandatory must be met
1st 5-year re-assessment	50% of remaining available points
2nd 5-year re-assessment	90% of remaining available points

Draft: 12/15/25

Pharmacy Benefit Management (D) Working Group
Hollywood, Florida
December 9, 2025

The Pharmacy Benefit Management (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met in Hollywood, FL, Dec. 9, 2025. The following Working Group members participated: Joylynn Fix, Chair (WV); Susan Jennette, Co-Vice Chair (DE); Ashley Scott, Co-Vice Chair (OK); Kayla Erickson (AK); Tolanda McNeal (AZ); Sophie Thomas and Lila Cummings (CO); Kurt Swan (CT); Sheryl Parker (FL); Paula Shamburger and Elizabeth Nunes (GA); Andria Seip (IA); Shannon Hohl, Weston Trexler, and Tia Nichols (ID); Jack Engle and Chris Heisler (IL); Victoria Hastings and Grant Lindman (IN); Ben Miller-Coleman (KS); Shaun Orme (KY); Frank Opelka, Kallie Ruggiero Somme, and Lisa Fullington (LA); Mary Lou Moran and Kevin P. Beagan (MA); Joe Stoddard (MI); T.J. Patton and Norman Barrett (MN); David Dachs (MT); Robert Croom (NC); John Arnold (ND); Cheryl Wolff (NE); Ralph Boeckman (NJ); Jonathan Wycoff (NV); Alice McKenney (NY); Kristin Cly (OH); David Buono and Joesph Handline (PA); Jud Jones (TN); Tanji J. Northrup (UT); Sebastian Arduengo and Karla Nuissl (VT); Sandy Ray (WA); Lori Luder and Darcy Paskey (WI); and Lauren White and Jill Reinking (WY). Also participating were: Marti Hooper (ME); and Alejandro Amparan (NM).

1. Adopted its Summer National Meeting Minutes

Parker made a motion, seconded by Buono, to adopt the Working Group's Aug. 11 minutes (*see NAIC Proceedings – Summer 2025, Market Regulation and Consumer Affairs (D) Committee, Attachment Four*). The motion passed unanimously.

2. Heard a Presentation from Pharmacy Marketplace on the Proposed Automated Complaint Tool

Kris Rhea (Pharmacy Marketplace) discussed the Pharmacy Marketplace's proposed automated pharmacy complaint tool. He highlighted the findings from the Pharmacy Marketplace's audit of pharmacy complaint processes in all 50 states. Rhea discussed how the proposed tool would address current issues with invalid pharmacy complaints and smooth out the appeals process. He provided a demonstration of the proposed tool.

Rhea provided these key takeaways: 1) pharmacy benefit manager (PBM) fragmentation and fatigue lead to frustrated pharmacies and pharmacists that file invalid complaints if they file at all; 2) collaboration among all stakeholders is the key to reform; and 3) technology, together with collaboration, can declutter enforcement and expose true patterns.

3. Adopted the *Pharmacy Benefit Manager Licensure and Regulation Guidelines for Regulators* Document

Fix said that after the Working Group completed its review of the initial draft of the *Pharmacy Benefit Manager Licensure and Regulation Guidelines for Regulators* document the drafting group developed, the Working Group distributed it for a public comment period that ended Dec. 1. She explained that the document is truly a guidance document intended to assist state insurance regulators, who may be considering licensing PBMs, to use as an example when discussing such legislation. Fix emphasized that the document is not a model law, but rather reflects what states have already done.

In response to its request for comments, the Working Group received eight comment letters: the Blue Cross Blue Shield Association (BCBSA), NAIC consumer representatives, the Michigan Department of Insurance and Financial

Services (DIFS), the National Association of Chain Drug Stores (NACDS), the National Community Pharmacists Association (NCPA), the Pharmaceutical Care Management Association (PCMA), the Pharmaceutical Research and Manufacturers of America (PhRMA), and URAC. Scott asked for comments from Working Group members and interested regulators.

Seip expressed appreciation for the work on the draft. She said she supports incorporating the Michigan DIFS-suggested revisions in the draft. She also suggested a revision to the definition of "health benefit plan" in Section 3E to add the words "or other entity."

Chris Petersen (Arbor Strategies LLC), speaking on behalf of the PCMA, expressed concerns about the format and substance of the draft. He said that although the document is intended to be a guideline, it looks like an NAIC model, which could cause confusion. Tyler Hoblitzell (BCBSA) said the BCBSA appreciates the Working Group's work, but it has concerns about the guidelines' scope and applicability. He said the BCBSA also has questions about how states would use the guidelines. Franca D'Agostino (Cigna Healthcare) said Cigna Healthcare appreciates the Working Group's efforts, but it does not believe that the guidelines are consistent with the Working Group's charges to provide clear standards for PBM licensure. Mollie Zito (UnitedHealthcare) expressed support for the comments on concerns with the draft guidelines expressed by previous commenters. Leanne Gassaway (CVS Health) said CVS Health wants a document that will be useful. She said CVS Health does not believe the draft guidelines will be helpful because all 50 states currently have PBM licensure or registration laws. Christine Cappiello (Elevance Health) also expressed support for the comments on concerns with the draft guidelines expressed by previous commenters. She said Elevance Health believes the guidelines require further refinement and stands ready to assist in that process.

Seip made a motion, seconded by Jennette, to adopt the *Pharmacy Benefit Manager Licensure and Regulation Guidelines for Regulators* document with the Michigan DIFS-suggested revisions and her suggested revision for the definition of "health benefit plan" in Section 3E (Attachment Five-A). The motion passed unanimously. Fix said the adopted guidelines will be forwarded to the Market Regulation and Consumer Affairs (D) Committee for its consideration.

4. Discussed the Draft PBM Examination Chapter

Fix said the Working Group exposed an initial draft of a PBM examination chapter on Nov. 25 for a public comment period ending Jan. 16, 2026. She said the Working Group plans to meet to discuss the comments received in late January or early February. Fix invited stakeholders to discuss any initial comments they have on the draft. No one had any initial comments to provide.

5. Heard an Update on Necessary Changes to SBS to Better Handle PBM Complaints

Jennette provided an update on the work to develop changes to State Based Systems (SBS) to better handle PBM complaints. She said that following the Summer National Meeting, she worked with Iowa, Oregon, Vermont, and West Virginia to design an SBS PBM module and finalize the necessary fields. She said the next step is to finalize the SBS codes necessary for reporting. Jennette said she has been working with the SBS team to ensure it understands what the Working Group wants and to be ready to move forward as quickly as possible after the Working Group receives the necessary approval for this project from the NAIC. She said that over the next few months, she will be working with Iowa, Oregon, Vermont, and West Virginia on naming the fields to collect the appropriate data and develop the online complaint forms for initial complaints and appeals.

Jennette explained that the SBS includes a combination of the market regulation consumer complaint module and the external health care appeal module. The new PBM module will be for complaints from providers, pharmacists, or pharmacies, and pharmacy services administrative organizations (PSAOs) against PBMs. Jennette said she hopes to have this work complete and available to those states that want to use it by June 2026.

6. Discussed Other Matters

Fix said that, as many people are aware, data breaches and ransomware attacks have become a significant issue. They are happening more and more frequently. Some of these data breaches have involved PBMs. Fix urged PBMs and other related entities to report data breaches and any data integrity issues to state insurance regulators in a timely manner.

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

SharePoint/NAIC Support Staff Hub/Member Meetings/D CMTE/PBMWG/PBMWG MtgMin 12-9-25.docx

Adopted by the Pharmacy Benefit Management (D) Working Group, Dec. 9, 2025

Draft 12/9/25

PHARMACY BENEFIT MANAGER LICENSURE AND REGULATION GUIDELINES FOR REGULATORS

Table of Contents

Section 1. Short Title

This best practice document shall be known and may be cited as the Pharmacy Benefit Manager Licensure and Regulations Guidelines for Regulators.

Section 2. Purpose

A. This document establishes the standards and criteria for the licensure and regulation of pharmacy benefit managers providing claims processing services or other prescription drug or device services for health benefit plans.

B. The purpose of this document is to:

(1) Promote, preserve, and protect the public health, safety and welfare through effective regulation and licensure of pharmacy benefit managers;

(2) Promote the solvency of the commercial health insurance industry, the regulation of which is reserved to the states by the McCarran-Ferguson Act (15 U.S.C. §§ 1011 – 1015), as well as provide for consumer savings, and fairness in prescription drug benefits;

(3) Provide for powers and duties of the commissioner; and

(4) Prescribe penalties and fines for violations.

Section 3. Definitions

Drafting Note: States should review and modify the definitions below, if needed, for consistency with their state laws or regulations.

A. "Claims processing services" means the administrative services performed in connection with the processing and adjudicating of claims relating to pharmacist services that include:

(1) Receiving payments for pharmacist services;

(2) Making payments to pharmacists or pharmacies for pharmacist services; or

(3) Both paragraphs (1) and (2).

B. "Commissioner" means the Commissioner of Insurance.

Drafting Note: Use of the title of the chief insurance regulatory officer wherever the term "commissioner" appears.

C. "Covered person" means a member, policyholder, subscriber, enrollee, beneficiary, dependent or other individual participating in a health benefit plan.

D. "Data calls" generally means a request for specific information or datasets from various sources, such as organizations, departments, or individuals. It often serves as a crucial step in gathering and consolidating data for analysis, reporting, or decision-making.

E. "Health benefit plan" means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier or other entity to provide, deliver, arrange for, pay for or reimburse any of the costs of [physical, mental or behavioral] health care services.

F. "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract or enters into an agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health insurance company, a health maintenance organization, a hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services.

Drafting Note: States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

G. "Other prescription drug or device services" means services other than claims processing services, provided directly or indirectly, whether in connection with or separate from claims processing services, including, but not limited to:

(1) Negotiating rebates, discounts or other financial incentives and arrangements with drug companies;

(2) Disbursing or distributing rebates;

(3) Managing or participating in incentive programs or arrangements for pharmacist services;

(4) Negotiating or entering into contractual arrangements with pharmacists or pharmacies, or both;

(5) Developing and maintaining formularies;

(6) Designing prescription benefit programs; or

(7) Advertising or promoting services.

H. "Pharmacist" means an individual licensed as a pharmacist by the [state] Board of Pharmacy.

I. "Pharmacist services" means products, goods, and services or any combination of products, goods and services, provided as a part of the practice of pharmacy.

J. "Pharmacy" means the place licensed by the [state] Board of Pharmacy in which drugs, chemicals, medicines, prescriptions and poisons are compounded, dispensed or sold at retail.

K. (1) "Pharmacy benefit manager" means a person, business or entity, including a wholly or partially owned or controlled subsidiary of a pharmacy benefit manager, that provides claims processing services or other prescription drug or device services, or both, to covered persons who are residents of this state, for health benefit plans.

(2) Pharmacy benefit manager does not include:

(a) A health care facility licensed in this state;

(b) A health care professional licensed in this state;

(c) A consultant who only provides advice as to the selection or performance of a pharmacy benefit manager; or

(d) A health carrier to the extent that it performs any claims processing and other prescription drug or device services exclusively for its enrollees.

Section 4. Applicability

A. This document shall apply to a contract or health benefit plan issued, renewed, recredentialed, amended or extended on or after the effective date of any regulatory changes as prescribed by the commissioner including any health carrier that performs claims processing or other prescription drug or device services through a third party. The commissioner shall establish a timeline for compliance.

B. As a condition of licensure, any contract in existence on the date the pharmacy benefit manager receives its license to do business in this state shall comply with the guidelines of this document.

C. Nothing in this document is intended or shall be construed to conflict with existing relevant federal law.

Section 5. Licensing Requirement

A. A person may not establish or operate as a pharmacy benefit manager in this state for health benefit plans without first obtaining a license from the commissioner.

B. The commissioner may adopt regulations establishing the licensing application, financial and reporting requirements for pharmacy benefit managers.

C. A person applying for a pharmacy benefit manager license shall submit an application for licensure in the form and manner prescribed by the commissioner with the following documents and forms:

(1) Articles of Incorporation or other entity formation documents which contain stamps or certification of filing with the Secretary of State of the domicile state;

(2) Organizational Chart detailing entity structure of officers;

(3) Provide names, business and mailing address, email addresses and phone number for individuals responsible for regulatory compliance and complaints;

(4) Certificate of Good Standing or other documentation verifying registration in the applying state;

(5) Completed Biographical Affidavit UCAA Form 11 or state form as prescribed by the commissioner for all officers and managing owners with more than 10% ownership in the entity;

(6) Surety Bond in the amount prescribed by the commissioner and all applicable state laws and regulations;

(7) Errors & Omissions Coverage in the amount prescribed by the commissioner and all applicable state laws and regulations;

(8) Audited Financials or other approved financial statement form approved by the commissioner showing financial viability;

(9) List of all affiliations of a health insurer, health care center, hospital service corporation, medical service corporation, sub-contractors with noted duties pursuant to agreements between parties, or fraternal benefit society licensed in the state of application attested to by an officer of the applying pharmacy benefit manager entity; and

(10) Any other state specific documents deemed necessary by the commissioner.

.

D. A person submitting an application for a pharmacy benefit manager license shall file representative copies of its standard pharmacy network/provider participation agreement, standard health carrier/client services agreement, and any material subcontracting or delegation agreements as part of the license application.

E. If any facilities, personnel, services, or networks are provided or held by an entity other than the person submitting the application, including a parent company, subsidiary, or affiliate, person submitting the application shall maintain and submit an arm's length agreement establishing the perosn's legal right of access to and use of those resources in accordance with good corporate governance.

F. (1) A person submitting an application for a pharmacy benefit manager license shall demonstrate, as part of the license application, that it has adequate digital infrastructure, personnel, systems, and processes to securely process claims, safeguard records, and implement reasonable cybersecurity and breach-reporting measures.

(2) Applicants shall provide documentation sufficient to demonstrate operational readiness and information security controls, including:

(a) A written attestation from a responsible officer confirming the existence of policies, personnel, and systems designed to protect data and ensure secure claim processing;

(b) A summary description of digital infrastructure and cybersecurity measures, including data encryption, access control, and backup protocols;

(c) Copies or summaries of the applicant's cybersecurity and incident response policies; and

(d) Representative copies of any third-party or affiliate service agreements governing digital systems, data access, or hosting arrangements, which must include provisions ensuring confidentiality, breach notification, and legal right of access.

(3) Licensees shall maintain such infrastructure, controls, and documentation on an ongoing basis throughout the term of licensure and make them available to the commissioner upon request.

G. A person submitting an application for a pharmacy benefit manager license shall include with the application a non-refundable application fee as prescribed by the commissioner and applicable state laws and regulations.

H. The commissioner may refuse to issue or renew a license if the commissioner determines that the applicant or any individual responsible for the conduct of affairs of the applicant is not competent, trustworthy, financially responsible or of good personal and business reputation or has been found to have violated the insurance laws of this state or any other jurisdiction, or has had an insurance or other certificate of authority or license denied or revoked for cause by any jurisdiction.

I. Renewal requirements.

(1) Unless surrendered, suspended or revoked by the commissioner, a license issued under this section shall remain valid as long as the pharmacy benefit manager continues to do business in this state and remains in compliance with the provisions of this act and any applicable rules and regulations, including the payment of an annual license renewal fee as prescribed by the commissioner and applicable state laws and regulations and completion of a renewal application on a form prescribed by the commissioner.

(2) Such renewal fee and application shall be received by the commissioner on or before designated renewal date or the anniversary of the effective date of the pharmacy benefit manager's initial or most recent license as prescribed by the commissioner and applicable state laws and regulations.

(3) The renewal application shall include:

(a) An attestation by an officer of the pharmacy benefit manager whether or not in the previous year, the licensee or any contracted health plan engaged in the practice of steering or imposed point of sale or retroactive fees in connection with its health plans and insureds;

(b) Audited financials or other financial statement form approved by the commissioner showing

financial solvency as determined by the commissioner; and

(c) Proof of continuation of previously submitted bonds or newly executed surety and error and omissions bonds.

J. Requirements after approval of license in the form and process prescribed by the commissioner and all applicable state laws and regulations.

(1) Provide the National Average Drug Acquisition Cost (NADAC) established by the federal Centers for Medicare & Medicaid (CMS) report:

(a) For the months of January through April, no later than June 15;

(b) For the months of May through August, no later than October 15; and

(c) For the months of September through December, no later than February 15 of the following year.

(2) On or before March 1 of each year, provide the website domain and uniform resource locator (URL) for public access to the pharmacy benefit manager's NADAC reports.

(3) Report all rebates and other payments received in the preceding year from pharmaceutical manufacturers on behalf of each health plan the pharmacy benefit manager is contracted with on a form or process as prescribed by the commissioner.

(4) Proof of Network Adequacy Requirements and Reporting.

(a) A pharmacy benefit manager's network shall be reasonably adequate, shall provide for convenient patient access to pharmacies within a reasonable distance from a patient's residence and shall not be comprised only of mail order pharmacy benefits but have a mix of mail order and physical stores in this state.

(b) A pharmacy benefit manager shall provide a network report describing the pharmacy benefit manager's network and the mix of mail-order to physical stores in this state in a time and manner required as prescribed by the commissioner. A pharmacy benefit manager's network shall include a detailed description of any separate, sub-networks for specialty drugs.

(c) Failure to provide a timely report or meet the network adequacy standards provided in subparagraph (a) of this paragraph may result in the suspension, revocation, or denial of a pharmacy benefit manager's license by the commissioner.

(d) A pharmacy benefit manager may not require a pharmacy or pharmacist, as a condition for participating in the pharmacy benefit manager's network, to obtain or maintain accreditation, or credentialing that is inconsistent with, more stringent than, or in addition to state requirements for licensure or other relevant federal or state standards.

Drafting Note: States may not be able to include mail order to meet network adequacy or other standards to meet regulatory reporting standards.

Drafting Note: States may consider adding a waiver provision for applicants and licensees unable to meet the network adequacy requirements under this subsection.

K. Requirements After Inactivation of License.

(1) The pharmacy benefit manager shall maintain a surety and errors and omissions bonds for a period of at least one year immediately following the surrender, non-renewal or revocation of the license.

(2) All data calls and reporting shall be required for the months the pharmacy benefit manager was actively licensed and conducting business in the state.

Section 6. Gag Clauses and Other Pharmacy Benefit Manager Prohibited Practices

A. In any participation contracts between a pharmacy benefit manager and pharmacists or pharmacies providing prescription drug coverage for health benefit plans, no pharmacy or pharmacist may be prohibited, restricted or penalized in any way from disclosing to any covered person any healthcare information that the pharmacy or pharmacist deems appropriate regarding:

(1) The nature of treatment, risks or alternative thereto;

(2) The availability of alternate therapies, consultations, or tests;

(3) The decision of utilization reviewers or similar persons to authorize or deny services;

(4) The process that is used to authorize or deny healthcare services or benefits; or

(5) Information on financial incentives and structures used by the insurer.

B. A pharmacy benefit manager may not prohibit a pharmacy or pharmacist from discussing information regarding the total cost for pharmacist services for a prescription drug or from selling a more affordable alternative to the covered person if a more affordable alternative is available.

C. A pharmacy benefit manager contract with a participating pharmacist or pharmacy may not prohibit, restrict, or limit disclosure of information to the commissioner, law enforcement or state and federal governmental officials, provided that:

(1) The recipient of the information represents it has the authority, to the extent provided by state or federal law, to maintain proprietary information as confidential; and

(2) Prior to disclosure of information designated as confidential the pharmacist or pharmacy:

(a) Marks as confidential any document in which the information appears; or

(b) Requests confidential treatment for any oral communication of the information.

D. A pharmacy benefit manager may not terminate the contract of or penalize a pharmacist or pharmacy due to a pharmacist or pharmacy:

(1) Disclosing information about pharmacy benefit manager practices, except for information determined to be a trade secret, as determined by state law or the commissioner; or

(2) Sharing any portion of the pharmacy benefit manager contract with the commissioner pursuant to a complaint or a query regarding whether the contract is in compliance.

E. (1) A pharmacy benefit manager may not require a covered person purchasing a covered prescription drug to pay an amount greater than the lesser of the covered person's cost-sharing amount under the terms of the health benefit plan or the amount the covered person would pay for the drug if the covered person were paying the cash price.

(2) Any amount paid by a covered person under this subsection shall be attributable toward any deductible or, to the extent consistent with section 2707 of the Public Health Service Act, the annual out-of-pocket maximums under the covered person's health benefit plan.

Section 7. Enforcement

A. The commissioner shall enforce compliance with all applicable laws and regulations of the state.

B. Regulatory Examinations.

(1) The commissioner may examine or audit the books and records of a pharmacy benefit manager providing claims processing services or other prescription drug or device services for a health benefit plan to determine compliance with all state laws and regulations.

(2) All pharmacy benefit managers operating in this state shall provide to the commissioner or their designee convenient and free access, at all reasonable office hours, to all books and records relating to the business affairs.

(3) The cost of the examination shall be the responsibility of the pharmacy benefit manager. The state should refer to the *Model law on Examinations* (#390) for additional guidance. It can be considered that if the examination was the result of a complaint filed and it is determined that the complaint was not justified, the commissioner can consider not requiring payment from the pharmacy benefit manager.

(4) The information or data acquired during an examination under paragraph (1) is:

(a) Considered proprietary and confidential;

(b) Not subject to the [Freedom of Information Act] of this state;

(c) Not subject to subpoena; and

(d) Not subject to discovery or admissible in evidence in any private civil action.

C. The commissioner may use any document or information provided during the regulatory examination to determine compliance with all state laws and regulations.

D. The commissioner may impose a penalty on a pharmacy benefit manager or the health carrier with which it is contracted, or both, for any violation of state laws and regulations.

E. An appeals process for any administrative action or fine should be provided to the pharmacy benefit manager in accordance with state laws and regulations.

Section 8. Regulations

The commissioner may promulgate regulations relating to pharmacy benefit managers that are not inconsistent with this document.

Section 9. Effective Date

A person doing business in this state as a pharmacy benefit manager on or before the effective date of any changes in state laws or regulations shall have six (6) months to come into compliance.

Drafting Note: States laws or regulations may vary on when a change in state law or regulation is effective. As such, states should review their laws and regulations and modify the language in this section accordingly.

Draft: 10/14/25

Speed to Market (D) Working Group
Virtual Meeting
October 8, 2025

The Speed to Market (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Oct. 8, 2025. The following Working Group members participated: Maureen A. Motter, Chair (OH); Julie Fairbanks, Vice Chair (VA); Austin Childs (AK); Jimmy Gunn (AL); Susan Jennette (DE); Stephanie Clayton (ID; Julie Rachford (IL); Cathy Abbott (KS); Tammy Lohmann (MN); Camille Anderson-Weddle (MO); LuAnne J. King (NH); Tanji J. Northrup (UT); Todd C. Merkley (WA); Mary Kay Rodriguez (WI); and Tana Howard (WY). Also participating was: Nour Benchaaboun (MD).

1. Adopted its Aug. 21 Minutes

Motter said that the Working Group met Aug. 21 and took the following action: 1) adopted its June 24 minutes; 2) approved a product coding matrix (PCM) revision regarding Affordable Care Act (ACA)-related dental products; 3) discussed the survey for System for Electronic Rates & Forms Filing (SERFF) Tableau dashboards, metrics, and reporting; 4) received an update on the *Product Filing Review Handbook*; 5) heard a report on the SERFF modernization project and SERFF Product Steering Committee (PSC); and 6) received an update on the Interstate Insurance Product Regulation Commission (Compact).

Northrup made a motion, seconded by Fairbanks, to adopt its Aug. 21 minutes (Attachment Six-A). The motion passed unanimously.

2. Received an Update on the SERFF Metrics Report

Motter provided background on a recent request from Director Cameron to reinstate the type of metrics report that directors and commissioners had historically received at national meetings. She explained that such reports had not been distributed for approximately five years. Previously, they included data such as the number of filings submitted through SERFF, turnaround times for those filings, and the extent to which states were adopting and using market regulation tools, including the SERFF system, the Product Requirements Locator, and review checklists. To address this renewed request, a small subgroup met with Director Cameron's staff to clarify what information should be included in the reports and how that information compares to past reporting. The group also met with members of the SERFF team to discuss the scope and format of the proposed metrics. The SERFF team is expected to provide sample reports in the coming weeks. Once available, those samples will be shared with the Working Group for review and approval before being distributed to directors and commissioners.

Motter explained that the intent is to provide the report on an annual basis using year-end data, with the first report anticipated for presentation at the 2026 Spring National Meeting. Each commissioner or director will receive a state-specific report summarizing activity by system instance (for example, property/casualty [P/C] and life and health) and comparing 2024 to 2025 data. Reports will include monthly filing and closure counts, five-year trend data, turnaround times, and product-specific details for several key TOIs, including personal auto, homeowners, and long-term care. The report will focus solely on individual states and will not include state-to-state comparisons.

Motter added that commissioners and directors will be encouraged to collaborate with their state staff for more detailed or granular analysis using existing reporting tools. She emphasized that transparency is a primary goal

and that the data provided should be easily reproducible by state staff so they can explain figures confidently to their leadership.

Motter confirmed that Compact data would not be part of the report and that it would reflect only filings submitted directly to the states. Nour also noted that Maryland uses the "Life Other" and "Annuity Other" types of insurance (TOIs) to capture long-term care hybrid products and suggested that those categories be included in the reporting for completeness.

Fairbanks commented that isolating long-term care (LTC) TOIs may prove more complex than initially anticipated. She suggested that, once sample reports are developed, the group may wish to seek additional input on the best approach for capturing that data.

Motter noted that the subgroup would continue refining the proposed report before bringing it back to the Working Group for review. She reiterated that the ultimate goal is to provide transparent, replicable information to commissioners and directors, ensuring consistency and clarity in how SERFF metrics are reported.

3. Received an Update on the *Product Filing Review Handbook*

Motter explained that the *Product Filing Review Handbook* is reviewed on a two-year cycle. Petra Wallace (NAIC) recently conducted a technical review of the document. This review included verifying the accuracy of URLs, correcting grammar and punctuation errors, and ensuring overall consistency and clarity. The updated handbook carries the 2024 publication year on its cover and was officially published to the publications section of the NAIC website on July 29, following completion of the technical review.

Maureen noted that although the handbook has just been refreshed and published, the MCAS Working Group will soon begin assessing whether any substantive updates are needed. She invited Working Group members to share any recommendations for additions, deletions, or edits to the handbook. Members were encouraged to contact her or committee support with specific suggestions to ensure the document remains accurate and useful for regulators and industry stakeholders.

4. Received a Report on the SERFF Modernization Project and SERFF PSC

Brandy Woltkamp (NAIC) provided an update on the ongoing SERFF modernization project, which has been progressing steadily since its launch in March. The project focuses on three primary areas: 1) improving usability; 2) enhancing user support; and 3) optimizing system performance. Based on user feedback, several process and feature improvements have been made to increase usability, and subsequent feedback has been positive. To strengthen user support, the project team has involved Tier 2 staff as well as business analysts, including Bridget Kieras (NAIC), Lauren Bandle (NAIC) (the product owner for the Appian team), and others. This collaborative approach ensures that users receive comprehensive assistance during the transition to the modernized platform.

Woltkamp explained that system performance has been a particular area of focus. The initial launch, originally planned for November, was delayed until March to address performance issues. Since then, ongoing improvements have been implemented, resulting in measurable gains in performance and overall user satisfaction. The team continues to monitor and refine performance as additional phases of the project roll out, recognizing that a large number of users will be transitioning to the new platform.

Woltkamp then described the updated implementation approach. Rather than moving all business areas and jurisdictions to the new platform simultaneously, the project has transitioned to a "wave" approach, designating a group of 10 early adopter states. These states were selected based on engagement and other criteria, with a mix of large and small jurisdictions included to ensure diverse feedback. Not all business areas will move for each early adopter state—some will transition only P/C, while others will move only life, accident, and health. One consistent rule, however, is that health-related filings (those under PCM beginning with "H" and "NA" for network adequacy) will remain in the legacy system. Woltkamp explained that this is due to existing connections between those filings and federal plan management requirements, including relationships with binders and the Unified Rate Review Template, which necessitate maintaining those filings in the legacy environment.

The decision to shift to a phased adoption model was made to avoid overwhelming both users and support staff. Transitioning all 53 jurisdictions at once was deemed impractical given the data volume and resource demands. The wave-based strategy allows the team to refine processes as they go, provide individualized support, and ensure a smooth transition. The modernization is not simply a rebuild of the legacy system; it represents a new platform with updated terminology, design, and workflows, requiring careful onboarding and user training. During the initial coexistence phase, early adopter states will operate in both the legacy and new systems. Some filings, such as health and network adequacy filings, will remain in legacy, while other types will move to the new platform. This will result in a bifurcated experience for both regulators and industry filers. To minimize confusion, system messaging and tools are being developed to clearly indicate which platform should be used for each filing type and state. The transition will begin with one state at a time, allowing the team to refine the data migration process before expanding to larger groups of states.

Several backend adjustments have also been made in preparation for the transition. The legacy system has been updated under a feature flag, so users will not see changes until their state moves to the new platform. For example, the filing wizard in legacy will notify filers if their selected state has moved to the new platform and will redirect them accordingly, with a note that health and network adequacy filings should still be submitted in legacy. For filings that have been transferred, legacy versions will become read-only, allowing users to view but not edit them. In contrast, filings that remain in legacy will continue to function normally.

Woltkamp shared several lessons learned from the Compact migration process, including maintaining the state dropdown for easier file searches and ensuring that legacy reporting remains available for historical filings. However, it was noted that open or "in-flight" filings moved to the new platform will appear as permanently open in legacy reports, since the systems will not exchange updates once migration occurs. The team is working to finalize these legacy adjustments in advance of the next Appian release and the data migration for early adopter states.

Motter opened the floor for questions from Working Group members, interested regulators, and interested parties. She asked a clarifying question regarding the handling of closed filings that are transferred from the legacy system to the new platform, specifically whether closed filings could be reopened if a company later needed to make corrections.

Woltkamp confirmed that closed filings transferred to the new platform could be reopened and reclosed as needed. The functionality would mirror what is currently available in the legacy system, allowing full review and completion capabilities within the new platform.

Having no further business, the Speed to Market (D) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Committees/D CMTE/2025 Summer/S2M WG/October 8 2025

Draft: 9/9/25

Speed to Market (D) Working Group
Virtual Meeting
August 21, 2025

The Speed to Market (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Aug. 21, 2025. The following Working Group members participated: Maureen A. Motter, Chair (OH); Julie Fairbanks, Vice Chair (AK); Mary Grover (CO); Susan Jennette (DE); Stephanie Clayton (ID); Julie Rachford (IL); Kenneth Scott (KS); Tammy Lohmann (MN); Camille Anderson-Weddle (MO); Ted Hamby (NC); LuAnne J. King (NH); Joshua Blakey (OR); Tanji J. Northrup (UT); Todd C. Merkley and Gail Jones (WA); and Lela D. Ladd (WY). Also participating was: John DiBlasi (MD).

1. Adopted its June 24 Minutes

The Working Group met June 24 and took the following action: 1) discussed suggestions received on the product coding matrix (PCM) and the uniform transmittal document (UTD); 2) heard a report on the System for Electronic Rates & Forms Filing (SERFF) modernization project and SERFF Product Steering Committee (PSC); and 3) received an update on the Interstate Insurance Product Regulation Commission (Compact).

Lohmann made a motion, seconded by Jennette, to adopt the Working Group's June 24 minutes *(see NAIC Proceedings – Summer 2025, Market Regulation and Consumer Affairs (D) Committee, Attachment One-E)*. The motion passed unanimously.

2. Approved a PCM Revision Regarding ACA-Related Dental Products

Motter stated that the Working Group reviewed potential updates to the PCM regarding Affordable Care Act (ACA)-related dental products. A survey was distributed for feedback, but responses were limited. The proposed change would not create new types of insurance (TOIs) or sub-TOIs but would clarify the description to provide filers with better direction. Motter stated that the options discussed included: 1) updating the description to state that all ACA-related dental products should use this code; 2) updating the description to state that all ACA-related dental products should use this code unless otherwise instructed by the state; and 3) leaving the description unchanged.

Motter stated that feedback indicated mixed preferences. Some survey participants supported the first option, a few favored the second option, and a couple preferred no change. Further comments from the Working Group were invited. Motter opened the floor for comments from Working Group members, other regulators, and interested parties; no comments were offered.

Motter invited motions regarding the proposed description changes, with the following three choices: 1) no change; 2) updating the description for all ACA-related dental products; and 3) updating the description with allowance for state-specific instruction. No motions were made.

Grover confirmed that Colorado has had issues with filers misclassifying products, assuming that only pediatric dental applies. She stated that Colorado is working to improve communication with industry and supports organizing the options more clearly. She indicated a preference for using the sub-TOI for all ACA-related dental.

Rachford reported that Illinois voted for no change on the survey. She asked if only one state was experiencing issues and whether broad changes were necessary without a strong consensus. She opposed a motion.

Motter noted that at least one state (Colorado) is confused. She explained that the intent of updating the description is to clarify filer direction, not impact queries. She emphasized the need for closure on the suggestion and clarified motion implications.

DiBlasi stated that he did not support the first option, which included updating the description to state that all ACA-related dental products should use this code.

Jones stated that Washington does not use the Health Organization (HORG) code for dental. She explained that Washington instructs filers directly through filing instructions. She said pediatric and family dentists are directed to use specific codes. Washington would not use HORG for dental.

Lohmann made a motion, seconded by Grover, to approve the second option, which includes updating the description to state that ACA-related dental should use this code unless states instruct otherwise. The motion passed, with Illinois opposed.

Rachford and Grover asked for clarification. It was confirmed that states could issue their own instructions if they did not want the new description applied. IL opposed final vote.

Jeremy Chance (NAIC) clarified that the update would be limited to the PCM reference document, not system changes. He confirmed that the updated PCM would be posted Jan. 1, 2026.

Motter confirmed that Lohmann's motion passed. She noted that opposing states could provide separate filing instructions.

Randy Helder (NAIC) acknowledged the outcome and thanked participants.

Chance will update the PCM descriptions for the three relevant sub-TOIs. The new PCM will be effective Jan. 1, 2026. States may issue separate filing instructions if they do not adopt the change.

3. Discussed SERFF Tableau Dashboards, Metrics, and Reporting

Motter explained that years ago, NAIC staff presented adoption and turnaround reports to commissioners at national meetings. These reports stopped around 2021, when states gained access to similar reporting in SERFF. Some commissioners have since asked what happened to those reports. Motter stated that a survey was conducted to see if states provide any reports directly to their management teams and to gauge interest in using new reporting tools (including Tableau reports available in SERFF). The survey received more than nine responses.

Motter suggested pivoting the charge to educate commissioners on available reports and to ensure state point persons are also aware, so they can provide the information when asked. Motter proposed a two-pronged approach that would include educating commissioners and state staff who would generate and provide reports. She invited volunteers to help identify the right state contacts and work with the SERFF team on education.

Jones shared Washington's practice. She said Washington DOI began reporting turnaround times to its chief financial officer (CFO) after receiving SERFF growth charts at a commissioner meeting. She said the CFO uses the state turnaround report to pull the number of filings and the percentage of turnaround for property/casualty (P/C), life, and health. Data is plugged into a state-developed weighted spreadsheet to produce a single average turnaround number. Jones said these reports are quarterly, and their results support staffing needs. Jones stressed the importance of retaining the state turnaround report for continued reporting.

Anderson-Weddle said she worked with Jones to develop the reporting approach for Washington and confirmed the use of a weighted calculation.

Motter said she liked Washington's approach and noted that staffing implications are an important angle. She suggested that there is potential to enhance Tableau tools for broader use. She shared her state's method, which includes using SERFF data for monthly reporting (e.g., filings received/closed, pending, average turnaround), then comparing year-to-date (YTD) and prior year results. Motter stressed the goal of minimizing "data massaging" by providing better tools. She said she will discuss Tableau reporting with Director Dean L. Cameron (ID) and explore commissioners' interest in standard outputs. She encouraged states to share ad hoc solutions for potential broader development.

Fairbanks confirmed that Virginia reports turnaround time to its commissioner. She asked whether Washington alters SERFF data or just re-presents it. Jones clarified that Washington runs SERFF reports for each line (P/C, life, health), then combines them in a weighted spreadsheet to produce a cumulative number.

Motter noted that Wyoming and Colorado expressed interest in participating. She requested that Washington share the reporting approach with the Working Group. She stressed the importance of working with the SERFF team to identify appropriate state contacts.

4. Received an Update on the *Product Filing Review Handbook*

Motter announced the completion of the updated *Product Filing Review Handbook*. She confirmed the plan for a two-year review cycle: this year's focus is limited to technical edits (e.g., URLs, grammar, punctuation), while next year's review will evaluate chapter content for potential substantive updates. Motter asked Working Group members if any chapters stood out as needing review next year or if they had preferences for structuring the biennial review approach. No comments were offered. Motter stated she will propose a review order (e.g., starting with Chapter 1 or Chapter 4) and circulate it to the Working Group for feedback in preparation for the next cycle.

5. Received a Report on the SERFF Modernization Project and SERFF PSC

Lauren Bandle (NAIC) provided a comprehensive update on SERFF modernization progress. She said the project began with an assessment in 2020. A pilot request for proposal (RFP) was issued in November 2020, and the modernization officially launched in March 2022. The first production release (Compact filings) was in March 2025. Bandle said the focus since the launch has been on: 1) improving usability through enhancements and defect fixes; 2) providing high-touch customer service with rapid defect resolution; and 3) addressing performance, with system response times reduced by around 50%.

Bandle also announced a pivot in the rollout strategy from moving directly into life/annuity and credit to using an "early adopters" model. Ten states will transition next, some with both P/C and life and health, others with one line first. She said the reasons for the pivot include maintaining high-quality support, careful data migration, tailoring features to specific state needs, and allowing for incremental learning and refinement.

Bandle outlined the following fourth quarter priorities: 1) the launch of a zip PDF feature; 2) enhancements to searching/reporting; 3) improved notifications and access controls; 4) continued performance improvements; 5) single state filing creation (user interface [UI] and application programming interface [API]); 6) expanded state fee calculations; and 7) ongoing AI form review feature development.

Bandle also gave an update on the SERFF PSC, noting strong engagement, with about 225 attendees per monthly meeting. Meeting topics include the Compact warranty period, new features, the Okta single sign-on (SSO) transition, and early adopters. She stated that engagement activities with question and answer (Q&A) and feedback tools have been successful. She said feature-specific calls with Compact filers have also been well received and will continue.

Motter noted that the next SERFF PSC call is scheduled for next week. She asked how interested parties can get added to the distribution list. Bandle confirmed the date of the SERFF PSC call and said it would include a presentation from the Summer National Meeting. She said interested parties can contact her directly or email serffmodernizationquestions@naic.org to be added to the PSC list.

6. Received an Update on the Compact

Dan Bradford (Compact) provided an update from the Compact Commission's Aug. 12 meeting (held during the Summer National Meeting). He said Commissioner Marie Grant (MD) was appointed Treasurer. He said six new uniform standards were adopted for group product lines, and an amendment to the rulemaking process was exposed to expedite non-controversial adoptions. Bradford said the adjunct services committee announced the pilot of a new consultation and advisory services office to support collaboration on products within the Compact's authority but outside current uniform standards. Bradford said the Compact remains at 48 members, including 46 states, the District of Columbia, and Puerto Rico. Regarding filing statistics as of June 30, Bradford said the Compact reviewed product filing volume and average turnaround times.

Bradford also gave a summary of the Compact's 2025 highlights. He said 19 amended group life standards (including non-employer groups) have been adopted, and group disability income standards have been amended. He also noted the launch of the NAIC Member Connect pages for committees. Bradford stated that the new group annuity and group life standards adopted Aug. 12 will become effective for filing Dec. 1 or Dec. 21.

Bradford said the product standards committee is working on the 2026 prioritization list. He said the committee held a public call Aug. 5, and its next call is scheduled for Oct. 7 to receive feedback before making a recommendation to the management committee. Bradford said the Compact's website offers organized information by audience, including dockets for developing standards and records for adopted standards. He said the website also provides additional materials on the rulemaking/adoption process and contact information for the Compact's regulatory affairs team.

Having no further business, the Speed to Market (D) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Committees/D CMTE/2025 Summer/S2M WG/August 21 2025

