Draft date: 11/4/26

2026 Fall National Meeting
Dallas, Texas

REGULATORY FRAMEWORK (B) TASK FORCE
Monday, November 16, 2026
3:00 – 4:00 p.m.
Convention Center—Texas D456—Level 3

ROLL CALL

NAIC Member	Representative	State/Territory
Marie Grant, Chair	Marie Grant	Maryland
Erin K. Hunter, Vice Chair	Joylynn Fix	West Virginia
Mark Fowler	Dusty Smith	Alabama
Heather Carpenter	Jeanne Murray	Alaska
Peter M. Fuimaono	Elizabeth Perri	American Samoa
Charles Bassett	Fausto Burruel	Arizona
Michael Conway	Debra Judy/Lila Cummings	Colorado
Joshua Hershman	Tricia Davé	Connecticut
Trinidad Navarro	Jessica R. Luff	Delaware
Karima M. Woods	Howard Liebers	District of Columbia
Michael Yaworsky	Alexis Bakofsky	Florida
John F. King	John F. King	Georgia
Dean L. Cameron	Dean L. Cameron	Idaho
Ann Gillespie	Ann Gillespie	Illinois
Holly W. Lambert	Alex Peck	Indiana
Doug Ommen	Julie Pearce	Iowa
Vicki Schmidt	Craig Van Aalst	Kansas
Sharon P. Clark	Shaun Orme	Kentucky
Michael T. Caljouw	Christopher Joyce	Massachusetts
Julia Dreier	Julia Dreier	Minnesota
Angela L. Nelson	Melissa Panettiere	Missouri
Eric Dunning	Martin Swanson	Nebraska
Ned Gaines	Ned Gaines	Nevada
Susan Ochs	Michael Fahncke	New Jersey
Remedio C. Mafnas	Remedio C. Mafnas	Northern Mariana Islands
Judith L. French	Laura Miller	Ohio
Glen Mulready	Mike Rhoads	Oklahoma
TK Keen	TK Keen	Oregon
Michael Humphreys	Richard L. Hendrickson	Pennsylvania
Larry D. Deiter	Jill Kruger	South Dakota
Amanda Crawford	Rachel Bowden	Texas

Jon Pike	Tanji J. Northrup	Utah
Scott A. White	Julie Blauvelt	Virginia
Patty Kuderer	Ingrid Ulrey/Todd Lovshin	Washington
Nathan Houdek	Coral Manning	Wisconsin

NAIC Committee Support: Jolie H. Matthews/Jennifer R. Cook/Joe Touschner

AGENDA

1. Consider Adoption of its Oct 29, Aug. 31, and Summer National Meeting Minutes—*Commissioner Marie Grant (MD)* — Attachment One, Attachment Two, Attachment Three

2. Consider Adoption of the Reports of its Working Groups —*Commissioner Marie Grant (MD)*
   A. Employee Retirement Income Security Act (ERISA) and Alternative Health Coverage (B) Working Group—*Martin Swanson (NE)*
   B. Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group—*Chrystal Bartuska (ND)*
   C. Prescription Drug Coverage (B) Working Group—*Joylynn Fix (WV)*

3. Discuss Claims Coding Issues—*Luke Chalker (Blue Cross and Blue Shield Association—BCBSA), Jennifer Holloman (American Hospital Association—AHA), and Eric Ellsworth (Consumers' Checkbook/Center for the Study of Services)*

4. Discuss its Next Steps on Prior Authorization (PA) —*Commissioner Marie Grant (MD)*

5. Discuss Any Other Matters Brought Before the Task Force —*Commissioner Marie Grant (MD)*

6. Adjournment

Agenda Item #1

Consider Adoption of its Oct. 29, Aug. 31, and Summer National Meeting Minutes
—Commissioner Marie Grant (MD)

Draft: 11/3/26

Regulatory Framework (B) Task Force
Virtual Meeting
October 29, 2026

The Regulatory Framework (B) Task Force met Oct. 29, 2026. The following Task Force members participated: Marie Grant, Chair (MD); Erin K. Hunter, Vice Chair, represented by Joylynn Fix (WV); Heather Carpenter represented by Jeanne Murray and Sarah Bailey (AK); Mark Fowler represented by Anthony L. Williams (AL); Charles Bassett represented by Alejandro Valenzuela (AZ); Joshua Hershman represented by Eleanor Manfredi (CT); Karima M. Woods represented by Howard Liebers and Tina Ching (DC); Trinidad Navarro represented by Jessica R. Luff (DE); Michael Yaworsky represented by Mike Milnes (FL); John F. King represented by Paula Shamburger (GA); Doug Ommen represented by Paula Wallin (IA); Dean L. Cameron represented by Randy Pipal (ID); Ann Gillespie represented by Kaitlyn Edicola (IL); Holly W. Lambert represented by Alex Peck (IN); Vicki Schmidt represented by Kenneth Scott (KS); Sharon P. Clark represented by Shaun Orme (KY); Michael T. Caljouw represented by Cara Libman and Rebecca Butler (MA); Julia Dreier (MN); Angela L. Nelson represented by Melissa Panettiere (MO); Eric Dunning represented by Maggie Reinert (NE); Susan Ochs represented by David Wolf (NJ); Ned Gaines (NV); Judith L. French represented by Laura Miller (OH); Glen Mulready represented by Rebecca Ross (OK); TK Keen represented by Jesse O'Brien (OR); Michael Humphreys (PA); Larry D. Deiter represented by Lisa Harmon and Gretchen Brodkorb (SD); Amanda Crawford represented by Rachel Bowden (TX); Jon Pike represented by Tanji J. Northrup (UT); Scott A. White represented by Julie Blauvelt (VA); Patty Kuderer represented by Rocky Patterson (WA); and Nathan Houdek represented by Coral Manning (WI).

1. Adopted its 2027 Proposed Charges

Commissioner Grant said two documents had been distributed for the Task Force's consideration. She explained that the first document, the Task Force's 2027 proposed charges, makes no substantive changes to the 2026 charges of the Task Force or its working groups. She said the document includes only nonsubstantive clarifying changes, shown in tracked changes. The one exception is the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group. Two completed Working Group charges are being proposed for deletion. Commissioner Grant said the second document contains suggested revisions the NAIC consumer representatives submitted in September. The revisions address many of the charges of the Health Insurance and Managed Care (B) Committee's groups, including the Task Force and some of its working groups.

Lucy Culp (Blood Cancer United) said the NAIC consumer representatives appreciate the time and attention the Task Force has devoted over the past year to prior authorization (PA) and related barriers for consumers. She said they hope this work continues and want to take part in future discussions, including through any additional working groups or other avenues. For 2027, she said the NAIC consumer representatives suggest adding a Task Force charge on nondiscrimination. Culp said the charge would assess how nondiscrimination protections exist today in health insurance and care delivery and would improve state insurance regulators' knowledge and enforcement of those protections. She said they also suggested a charge related to PA. For the Employee Retirement Income Security Act (ERISA) and Alternative Health Coverage (B) Working Group, Culp said the NAIC consumer representatives recommended a similar charge on how nondiscrimination protections apply to alternative health coverage, such as short-term plans, and other types of coverage now under the Working Group's purview.

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Silvia Yee (Disability Rights Education and Defense Fund—DREDF) said nondiscrimination is sometimes viewed as an expense that will be costly to companies, but a fair system works better for everyone, including consumers. She said recognizing the importance of a fair system across the charges helps consumers feel comfortable, know where to send complaints, and understand how they can help improve the system. She said consumers can serve as eyes and ears for state insurance regulators as they work to enforce a fair system. For this reason, she said the consumer representatives want nondiscrimination to play a visible, known part in the charges.

Yee also noted the NAIC consumer representatives' recommendation related to long-term care (LTC). She said the U.S. Senate Finance Committee has issued a call examining LTC and long-term services and supports (LTSS). She said states have always served as laboratories for innovation and know what is happening on the ground. She said the ability of states to recognize and respond to the LTC and insurance needs of consumers is irreplaceable.

Commissioner Grant said the Task Force will set aside the PA-related recommendations because it plans to hold a broader discussion on PA at its meeting at the Fall National Meeting. For the remaining recommendations, she noted that the Task Force has an ongoing charge to examine regulatory factors contributing to disparities in coverage and to recommend appropriate steps to reduce those disparities. Commissioner Grant said she believes this charge already encompasses some of the specific language the NAIC consumer representatives have recommended. She suggested that the Task Force continue this discussion at the Fall National Meeting, including how to make the recommendations more concrete and add them to its 2027 charges. She said there would be an opportunity to update the 2027 charges after that discussion.

Culp said she had no concerns with this approach. She acknowledged that the recommendations could be covered to some degree under the existing charge and welcomed the additional discussion. Yee agreed with the approach. She said disparities are a critical component and can arise from discrimination. She said the average consumer might not recognize that he or she belongs to a group that experiences disparities but will know if he or she has not been treated fairly.

Commissioner Grant said the Task Force will continue its discussion of the NAIC consumer representatives' recommended changes when it meets at the Fall National Meeting.

Fix made a motion, seconded by Manning, to adopt the Task Force's 2027 proposed charges, including its working group charges (Attachment One-A). The motion passed unanimously.

Having no further business, the Regulatory Framework (B) Task Force adjourned.

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Regulatory Framework (B) Task Force
Virtual Meeting
August 31, 2026

The Regulatory Framework (B) Task Force met Aug. 31, 2026. The following Task Force members participated: Marie Grant, Chair (MD); Erin K. Hunter, Vice Chair, represented by Joylynn Fix (WV); Heather Carpenter represented by Jeanne Murray (AK); Mark Fowler represented by Yada Horace (AL); Charles Bassett (AZ); Michael Conway represented by Debra Judy (CO); Joshua Hershman represented by Tricia Davé (CT); Karima M. Woods represented by Howard Liebers and Tina Ching (DC); Michael Yaworsky represented by Alexis Bakofsky (FL); John F. King (GA); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron (ID); Ann Gilespie (IL); Holly W. Lambert represented by Teresa Tetrick (IN); Vicki Schmidt represented by Craig Van Aalst (KS); Sharon P. Clark (KY); Michael T. Caljouw represented by Christoper Joyce (MA); Julia Dreier (MN); Angela L. Nelson (MO); Eric Dunning (NE); Susan Ochs represented by Aileen Egan (NJ); Ned Gaines represented by Jack Childress (NV); Judith L. French represented by Laura Miller (OH); Glen Mulready (OK); TK Keen represented by Jesse O'Brien (OR); Michael Humphreys (PA); Larry D. Deiter represented by Candy Holbrook (SD); Amanda Crawford represented by Rachel Bowden (TX); Jon Pike represented by Tanji J. Northrup (UT); Scott A. White represented by Julie Blauvelt (VA); Patty Kuderer represented by John Kelcher and Delika Steele (WA); and Nathan Houdek (WI).

1. Held a Question-and-Answer Session with the June 29 Speakers and Panelists

Commissioner Grant said the Task Force scheduled this meeting as a follow-up to its June 29 meeting to provide additional time for questions from Task Force members for the June 29 speakers and panelists from AHIP, the Blue Cross Blue Shield Association (BCBSA), and individual health plans, followed by presentations on prior authorization (PA) reform from NAIC consumer representatives, the American Hospital Association (AHA), and the American Medical Association (AMA).

David Merritt (BCBSA) said that just over a year ago, the country's largest plans issued a multi-year set of commitments to improve the PA process. He said the vast majority of claims—close to three billion each year—are covered without PA, which is typically reserved for high-risk, high-cost care decisions or cases where clinical evidence is lacking. He recapped progress reported earlier in the year, including a reduction in how often PA is used, with 6.5 million fewer PA requests this year than last, an 11% reduction generally concentrated in high-volume services such as imaging, ear, nose, and throat, radiology, and cardiology. He said continuity-of-care improvements allow patients with a current PA to carry approvals to new coverage in a standardized, secure way, and that plans have trained customer service teams to communicate more clearly and to explain how members can appeal a decision. He said all non-approved requests for clinical reasons continue to be reviewed by medical professionals. He noted that about half of PAs are still submitted by phone, fax, or mail and that the comprehensive approach of reducing, standardizing, and automating would be implemented over the next year and a half. He introduced Dr. Tim Law (Highmark), Dr. Ravi Kavasery (Blue Shield of California), and Katerina Guerraz (Aetna).

Commissioner Grant asked what carriers changed in their analysis that led to fewer services requiring PA. Law said Highmark previously reviewed every code on its PA list once a year through a determination process weighing medical necessity, patient safety, and fiscal responsibility, but now uses a dedicated team that reviews the list on a rolling basis, examining utilization, approval and denial rates, cost per unit, geographic variation, and the reasons for denials. He said Highmark had removed roughly 200 codes over the past six months and that the principal

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difference is the greater frequency of review. Kavasery said Blue Shield of California, a nonprofit California-based plan, had removed many codes before industry-level reform and emphasized that transparency and shared data across plans drive improvement, noting that a plan cannot improve what it does not measure. He said that regularly reviewing the data and adopting industry-wide reforms produced the six million and 11% reductions. Guerraz said Aetna's PA list is about 40% smaller than some peer plans' lists, that Aetna had removed codes with consistently high approval rates or where evidence-based medicine had evolved without affecting patient safety, and that a priority is approving appropriate PAs as quickly as possible.

Commissioner King said he had heard from the Medical Association of Georgia (MAG) that providers are not experiencing the improvements described. He asked whether there are plans to publish the list of services removed from PA and share it with state regulators. Law compared the situation to a commute with 10 traffic lights, in which a driver who hits nine green lights still complains about the one red light, and said Highmark publishes its PA list on its provider resource center and requires vendors to be as transparent as possible, though some treat their criteria as proprietary. He said anyone can access Highmark's list and compare it to the list from six months earlier. Guerraz said providers will not yet feel the effect of the new clinical standards because plans are in early-adopter implementation, and that consistent standards across health systems will reduce friction caused by missing information. Law said interoperability improvements are expected around Jan. 1, 2027. Commissioner King said the Georgia legislature convenes in January and would pass legislation if the industry does not act quickly. Guerraz said plans can move only as fast as their provider partners are willing to work with them. She said that currently, there are 12 health systems across the country working with them, but that they need more willing to implement these standards.

Fix asked what carriers have done to streamline PA for patients with chronic, incurable conditions who must renew PAs and referrals annually, even though their medications are not changing. Kavasery said a large part of the work involves real-time exchange of clinical data between providers and payers to reduce administrative burden and noted that chronic conditions do not always require the same treatment year after year because treatments are adjusted based on the patient's clinical picture. Guerraz said Aetna is reducing repetitive volume by bundling PAs—for example, combining the four to eight PAs often required for standard cancer treatment into one, and doing the same for fertility treatment—and is working with pharmacy benefit managers (PBMs) to streamline authorizations so patients are not required to obtain annual PAs for medications they will take for life, such as after a transplant. In response to a question from Fix about timing, Guerraz said the PBM work began in the past month. She explained that it is a cross-industry effort setting goals for 2027 and 2028, and that specific goals would be shared later in the year. Fix said the Prescription Drug Coverage (B) Working Group, which she chairs, would partner on the effort, noting that about 90% of the complaints received are pharmacy-related.

Commissioner Humphreys asked how long it would take for carriers to commit to a single uniform PA request form for use with providers, comparing the effort to Pennsylvania's work with insurers and hospital systems to standardize the data inputs required for provider directories. Jeanette Thornton (AHIP) said there needs to be more consistency in the data plans request and that the industry's Jan. 1, 2027, set of commitments includes standard document lists and standard questions for an initial 66 commonly prior-authorized medical services, applicable whether a PA is submitted by fax, portal, or electronic data exchange. She said a preview would be available in the coming days, but that each plan would still decide whether to approve a particular PA, so the medical criteria would not be standardized across plans. She also said standardized documentation would significantly reduce administrative denials for missing information. Commissioner Humphreys said carriers have leverage to require their vendors to deliver services consistently. Thornton said plans use a variety of vendors and that the standards are being shared with the vendor community. Guerraz said the standards are complete, that

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health plans decide whether to adopt them, and that a group of plans is moving forward with 12 health systems in early implementation before a broader rollout ahead of Jan. 1, 2027.

Commissioner Grant asked what carriers have done to help consumers navigate treatment options when a PA request is denied. She also asked the panelists to address communication with providers and consumers, including concerns that providers sometimes cannot reach a real person or reach staff located offshore. Guerraz said Aetna communicates a recommended course of action both digitally and in letters—for example, recommending less invasive treatment before orthopedic surgery where clinically appropriate—and makes plan medical directors available to speak with physicians and members, noting that its physicians are onshore, licensed, and board certified. Law said that for Highmark, any offshore staffing would occur on the customer service side rather than the medical side. He said Highmark's physicians are onshore and board-certified, and that peer-to-peer conversations between physicians can result in a denial being changed to an approval. He also said that Highmark's member letters direct plan members to discuss options with their own physician to avoid the corporate practice of medicine (COPM). Kavasery said the peer-to-peer process allows physician-to-physician discussion of the clinical criteria applied and the alternatives and appeal options available, and that independent review—including internal appeals, expedited appeals, and independent medical review—is one of the strongest consumer protections. Law said Highmark would, within about a month, add a cover letter to its denial letters that presents only the pertinent information a member needs, written at a seventh-grade reading level, comparing the current difficulty of locating that information to finding a needle in a haystack.

Fix asked how plans work with third-party vendors on utilization management (UM) criteria and what checks and balances exist, noting that state insurance regulators frequently hear plans attribute problems to their vendors. Law said Highmark no longer uses the vendor as an excuse. It is required to meet annually with vendors that have medical policy involvement under the National Committee for Quality Assurance (NCQA)'s UM accreditation requirements. It now meets with them quarterly to discuss clinical questions, evidence, and policy changes. He said one issue is that vendors publish medical policy updates only once a year, which can delay adoption of new criteria by up to 18 months, and that Highmark now reviews vendor policy changes to convert affected items to automatic approvals rather than making providers and members wait. He said Highmark created a dedicated team that works live with providers experiencing portal or Availity access problems, resulting in a process that is about 70% better than it was six months earlier. Fix said the improvement in West Virginia was about 80%. Guerraz said Aetna also relies on service-level agreements and is pushing UM vendors and electronic health record companies, such as Epic, to share multi-year technology roadmaps and capital investment plans. Thornton said the commitments reflect plans to take responsibility to partner with vendors and providers, with each party having a role. Fix said regulators cannot allow plans to delegate their compliance to a vendor. Commissioner Grant concluded the discussion, and the Task Force moved to its next agenda item.

2. Heard Additional Presentations on PA Reform

A. NAIC Consumer Representatives

Carl Schmid (HIV+Hepatitis Policy Institute), Harry Ting (Consumer Advocate), and Wayne Turner (National Health Law Program—NHeLP) presented on behalf of the NAIC consumer representatives. Schmid cited a Kaiser Family Foundation (KFF) survey finding that, after cost, 34% of insured people identified PA as the biggest hurdle to health care, and an additional 37% called it a minor burden. He also cited federal data on federal Affordable Care Act (ACA) marketplace plans showing 18% of PA requests were denied, ranging from 3% to 25% across plans. He said denials are rarely appealed but that 43% are overturned when appealed, ranging from 16% to 54%. Schmid

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expressed support for the carriers' voluntary commitments and the reduction in PA volume but urged more specific and public data, including lists of the services removed. He questioned whether continuity of care applies when a patient switches insurers and suggested a 90-day continuity period. Schmid said the voluntary commitments lack enforcement mechanisms, penalties, and standardized reporting requirements, and do not address prescription drugs.

Ting said making data accessible to consumers is the best way for states to hold voluntary efforts and the federal government accountable, and that states can do this most efficiently through regulation. He said meaningful PA reporting requires states to specify what data is reported and how ratios are calculated, noting that federal requirements are not adequately defined and that some 2025 Medicare Advantage (MA) data included incomplete cases or services not covered. He recommended that the Task Force develop PA data reporting specifications. Ting said data should be consolidated on state department of insurance (DOI) web pages or prominently linked on health plan homepages. He said PA metrics should be broken down by major service category, like Colorado, because combining non-pharmacy PA cases primarily measures diagnostic testing and imaging, which dominate volume.

Turner discussed opportunities for state DOIs regarding PA reform. He said state insurance regulators should require carriers to use up-to-date, evidence-based clinical criteria that reflect generally accepted standards of care and should ensure that any artificial intelligence (AI) tools apply those criteria properly. He said the Big Data and Artificial Intelligence (H) Working Group had taken the position that proprietary criteria used in the business of insurance should be subject to state regulatory authority, and that regulators' access to criteria could be built into contracts between carriers and third-party entities. Turner emphasized the importance of transparency of the criteria for enrollees and potential enrollees. He advocated for individualized written notices explaining the basis for an adverse determination, the clinical criteria, and appeal and grievance rights. He also said such notices need to be consumer-tested and written in plain language. Turner raised concerns about gold carding and its potential for adverse selection affecting people with chronic conditions. He also urged a review of whether PA is appropriate for a given service. He urged that data be searchable, user-friendly, and kept in one place.

Schmid said the NAIC consumer representatives recommend that the Task Force: 1) establish a new PA working group; 2) develop a NAIC model law or regulation on PA; 3) improve data reporting and transparency; 4) develop a market conduct examination chapter for PA, as was done for PBMs; and 5) continue to work with other NAIC groups on AI-related issues.

B. AHA

Terrence Cunningham (AHA) said PA is one of the only plan activities that can directly interfere with patient care, leading to delays, denials that should have been approved, and care abandonment when patients become frustrated. He cited a U.S. Department of Health and Human Services (HHS) Office of Inspector General report finding that up to 20% of PA requests denied by MA plans should have been approved. He described administrative burdens created by inconsistent submission methods—fax, phone, and plan-specific portals—and a lack of transparency regarding required documentation and medical-necessity criteria. Cunningham discussed the requirements of the interoperability and PA final rule, effective Jan. 1, 2027, and noted that it has the potential to be transformative. He said the carrier PA reform pledge is significant because it applies across plan types, including commercial lines, and that reform works only if it is standardized across plans. He raised concerns that the plan commitments could reflect compliance rather than true reform, saying physician reviewers need the independence to overturn preset rules, and there needs to be appropriate expertise, which should be identified

by National Provider Identifier (NPI) and taxonomy code. Cunningham said that reported reductions in codes subject to PA do not necessarily reduce actual PA volume if the removed codes are rarely used. He noted that this may also be offset by increased post-service UM or prepayment audits. He also said that the electronic standard must deliver true automation rather than simply links to forms. Cunningham said the AHA recommends that PA reform include: 1) clinician reviewer identification; 2) standardization of clinical criteria; 3) measurement of actual volume; 4) tracking of processing times; and 5) more granular, service-specific metric reporting.

C. AMA

Emily Carroll (AMA) said the AMA appreciates the health plans' pledge but based on past experience, it is concerned that pledges without accountability may not produce meaningful change. She cited a 2018 consensus statement on PA reform that did not lead to sufficient progress. Heather McComas (AMA) shared results from the AMA's December 2025 survey of 1,000 practicing physicians, conducted before many of the commitments took full effect. The survey results included findings that: 1) 95% of those surveyed said PA delays care; 2) more than a quarter surveyed said PA had led to a serious adverse event for a patient; 3) nearly three-quarters surveyed said denials had increased in recent years; and 4) 60% were concerned AI would increase denials. Carroll said that to address these concerns, the AMA recommends that: 1) PA reforms should address medical services, prescription drugs, and devices; 2) PA programs should be right-sized by exempting low-cost, high-value services such as primary care, cancer care, and autoimmune disease treatment; 3) data reporting should be granular by service or drug and by health plan product; 4) clinical criteria should be evidence-based, noting that more than a third of physicians report the criteria are rarely or never evidence-based and that automating faulty criteria only produces wrong answers faster; and 5) plan reviewers should be qualified, meaning a physician licensed in the state with the same specialty and experience treating the patient's condition should make decisions at the initial review level. She recommended that state DOIs implement regulatory changes, enforce existing reforms, educate stakeholders, and develop best practices for data collection and reporting. Carroll also recommended that the Task Force establish a PA working group.

Commissioner Grant said that, given the breadth of the discussion, the Task Force will consider holding a follow-up meeting to consider the recommendations in greater detail and will invite the presenters back. Fix agreed that the Task Force should continue its work on the issue.

Having no further business, the Regulatory Framework (B) Task Force adjourned.

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Draft Pending Adoption

Draft: 8/17/26

Regulatory Framework (B) Task Force
Columbus, Ohio
August 13, 2026

The Regulatory Framework (B) Task Force met in Columbus, OH, Aug. 13, 2026. The following Task Force members participated: Marie Grant, Chair (MD); Erin K. Hunter, Vice Chair, and Joylynn Fix (WV); Heather Carpenter represented by Sarah Bailey (AK); Mark Fowler represented by Kelli Littlejohn Newman (AL); Charles Bassett represented by Fausto Burruel (AZ); Michael Conway represented by Debra Judy (CO); Joshua Hershman represented by Tricia Davé (CT); Karima M. Woods represented by Howard Liebers and Tina Ching (DC); Trinidad Navarro represented by Jessica R. Luff (DE); John F. King represented by Paula Shamburger (GA); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Shannon Hohl (ID); Holly W. Lambert represented by Alex Peck (IN); Vicki Schmidt represented by Josh Carlson and Julie Holmes (KS); Sharon P. Clark represented by Shaun Orme (KY); Michael T. Caljouw represented by Kevin P. Beagan (MA); Angela L. Nelson (MO); Eric Dunning represented by Martin Swanson and Maggie Reinert (NE); Ned Gaines represented by Diana Branciforte (NV); Judith L. French represented by Kristin Cly (OH); Glen Mulready represented by Rebecca Ross (OK); TK Keen represented by Cassie Soucy (OR); Michael Humphreys (PA); Larry D. Deiter represented by Jill Kruger (SD); Amanda Crawford represented by Rachel Bowden (TX); Jon Pike represented by Tanji J. Northrup (UT); Scott A. White represented by Julie Fairbanks and Julie Blauvelt (VA); Patty Kuderer represented by Ingrid Ulrey (WA); and Nathan Houdek represented by Darcy Paskey and Jamie Adams (WI). Also participating was: Chrystal Bartuska (ND).

1. Adopted its June 29 and Spring National Meeting Minutes

The Task Force met June 29. During this meeting, the Task Force heard an update from the Blue Cross Blue Shield Association (BCBSA), AHIP, and a panel of plan representatives on the progress related to the industry's prior authorization (PA) reform initiative announced last year. The Task Force plans to hold a follow-up meeting on Aug. 31 to hear presentations on the issue from other stakeholders and hold a question-and-answer (Q&A) session.

Hohl made a motion, seconded by Swanson, to adopt the Task Force's June 29 minutes (Attachment One) and March 24 minutes (*see NAIC Proceedings – Spring 2026, Regulatory Framework (B) Task Force*). The motion passed unanimously.

2. Adopted the Reports of its Working Groups

Prior to asking for a motion to adopt the Task Force's working group reports, Commissioner Grant said that in adopting the report of the Employee Retirement Income Security Act (ERISA) and Alternative Health Coverage (B) Working Group, the Task Force is not adopting the *Guidance Document—ERISA Preemption and State PBM Laws* (Guidance Document). The Task Force will consider its adoption as the next meeting agenda item.

Hohl made a motion, seconded by Commissioner Hunter, to adopt the reports of the ERISA and Alternative Health Coverage (B) Working Group (Attachment Two); and the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group and the Prescription Drug Coverage (B) Working Group, which met in joint session Aug. 12 (Attachment Three). The motion passed unanimously.

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3. Adopted the Guidance Document

Seip said the ERISA and Alternative Health Coverage (B) Working Group adopted the Guidance Document during its July 22 meeting. She said the purpose of the Guidance Document is to provide information to state department of insurance (DOI) regulators and other state government officials related to ERISA preemption of state pharmacy benefit manager (PBM) laws. The Guidance Document considers the different types of state PBM laws and how appellate courts have applied the reasoning of the U.S. Supreme Court case *Rutledge v. Pharmaceutical Care Management Association (PCMA)*, to those laws. Seip said the Guidance Document does not analyze cases that were still being litigated as of July 22, which is the date the ERISA and Alternative Health Coverage (B) Working Group adopted the it. She noted, however, that recognizing the ongoing legal activity in this area, the Guidance Document includes an addendum summarizing ongoing cases involving ERISA preemption of state PBM laws.

Swanson made a motion, seconded by Hohl, to adopt the *Guidance Document—ERISA Preemption and State PBM Laws* (*see NAIC Proceedings – Summer 2026, Health Insurance and Managed Care (B) Committee, Attachment Four*). The motion passed unanimously.

4. Heard an Update from the RWJF on ICHRAs

Katherine Hempstead (Robert Wood Johnson Foundation—RWJF) updated the Task Force on individual coverage health reimbursement arrangements (ICHRAs). She said that while there has been rapid growth in ICHRA plan enrollment recently, it remains below the initial projections made in 2019. She also discussed the difficulty in tracking enrollment due to the lack of comprehensive data. Hempstead explained that about 80% of ICHRA plan enrollment is off the Affordable Care Act (ACA) exchange (ACA exchange), with a significant increase in ICHRA-tailored plan offerings in 2026. She said ICHRA plans are marketed by platform companies such as PeopleKeep. In addition, some insurers, such as Oscar, also market them. Hempstead said ICHRAs are being offered and marketed to mostly small employers: 1) as an antidote to high premium increases; 2) a promise of predictability; and 3) as the "401k of health benefits." She discussed the key findings of a July 2026 survey of about 1,000 employers conducted by the Employee Benefit Research Institute (EBRI) in partnership with Morgan Health. In assessing interest in ICHRAs, the survey's key findings indicate that just over one-third of evaluated employers are looking at ICHRAs. Companies with 100 or more workers show the highest interest, with 62% saying they are likely to adopt an ICHRA within two years. However, the study's key findings also found caveats to employer adoption, such as cost, plan quality, and network adequacy. Hempstead said that policy support for ICHRAs exists from both state and federal regulators, but labor unions remain skeptical. She noted that the "ICHRA-haters" have faded. Looking to the future, Hempstead said that at the macro-level, there is the potential for ICHRAs to reshape the coverage ecosystem, but risks remain if the individual market weakens.

Commissioner Grant asked if Hempstead had any recommendations or thoughts about how state insurance regulators can obtain a better understanding of the number of employers enrolling in ICHRAs for their employees. Hempstead reiterated the difficulty in obtaining the data. She said that because most ICHRA enrollments are off the ACA exchange, it makes it more difficult. Hempstead said she believes that the federal Centers for Medicare & Medicaid (CMS) is trying to measure this as part of ACA enrollment, but right now, she does not have any recommendations to offer, even though it is an important issue.

Commissioner Humphreys noted the difficulty in obtaining ICHRA plan enrollment data. He said, however, that when the Pennsylvania DOI asked insurers for enrollment data, the data they provided was pretty accurate based on what it had obtained from HealthSherpa. HealthSherpa is an official enhanced direct enrollment (EDE) partner with the federal government for the ACA exchanges. He asked Hempstead about administrative fees charged for operating an ICHRA platform because he was told by a provider group in western Pennsylvania that the fees that if they enrolled in an ICHRA plan, the fees they could see could be as high as $43 per member per month (PMPM). Commissioner Humphreys said that in contrast, Pennsylvania's ACA exchange user fee would be $11 to $13

PMPM. Hempstead said that the potential higher administrative fee costs for ICHRA plans are not surprising to her, given some of the complexities inherent with these types of plans.

5. Heard an Update from the CCIIO on EHBs Activities and the Pre-Enrollment Verification Process

Jeff Wu (federal Center for Consumer Information and Insurance Oversight—CCIIO) updated the Task Force on upcoming changes mandated by a provision in the One Big Beautiful Bill Act (OBBBA) H.R. 1, requiring pre-verification of eligibility for financial assistance before enrollment. He discussed the CMS' work in developing regulations implementing this requirement, including introducing a new concept of a pre-open enrollment verification period to help spread workload and improve timing.

Wu also discussed the status of the state essential health benefits (EHB) benchmark plan review process. He said the EHB benchmark plan review process remains paused while the review and stakeholder engagement continue. He noted that the CMS recently issued a request for information (RFI) titled *Comprehensive Review of the Essential Health Benefits Framework and Typical Employer Plan Standard* to obtain and engage stakeholders on the topic. Wu said there is no timeline for when the review process will resume. He also discussed the defrayal policy, which the CMS is enforcing more strictly than in the past. He noted, however, that the CMS is willing to work with the states on mandate clarifications. Wu discussed the CCIIO's priorities, which include fraud prevention, price transparency, and continued support for ICHRA innovation. He also mentioned that the CMS is working to resolve issues related to the stay of certain provisions of the 2027 Notice of Benefit and Payment Parameters (NBPP) Final Rule pursuant to *City of Columbus v. Kennedy*, *et al.* (Columbus II) No. 1:26-cv-02215.

Swanson asked Wu whether the CMS is truly wedded to enforcing the defrayal requirements outlined in the ACA rather than to its prior enforcement approach. Wu confirmed that the CMS is serious about enforcing the requirements as outlined in the law. Burruel asked Wu the purpose of the language regarding the defrayal requirement, which applies regardless of whether the benefit is embedded in the state's EHB benchmark plan. He discussed Arizona's previous actions and approach on the subject. Burruel said that with this new language, Arizona's legislature and its governor are concerned that the CMS will find that in clarifying some of its coverages, which are already embedded in its EHB benchmark plan, Arizona will be subject to the defrayal requirement. Wu agreed with Burruel that state EHB benchmark plans are broad, which complicates determining whether any updates and/or clarifications related to them would be subject to the defrayal requirement. He reiterated that the CMS is willing to work with the states on clarifying mandates as related to the defrayal requirements.

Commissioner Grant asked Wu if he had a timeline for when the CMS would promulgate the regulations implementing the pre-verification of eligibility for the financial assistance provision. Wu explained that it will not be a tri-agency regulation, with the CMS, the U.S. Department of Labor (DOL), and the Internal Revenue Service (IRS) all involved in its promulgation. However, because of some of the tax elements involved in developing the rule, which complicate it, he said the CMS currently has no specific timeline, but it is working as quickly as possible.

Having no further business, the Regulatory Framework (B) Task Force adjourned.

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Agenda Item #2

Consider Adoption of its Working Group Reports—*Commissioner Marie Grant (MD)*

- *Employee Retirement Income Security Act (ERISA) and Alternative Health Coverage (B) Working Group—Martin Swanson (NE)*
- *Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group —Chrystal Bartuska (ND)*
- *Prescription Drug Coverage (B) Working Group—Joylynn Fix (WV)*

2026 Fall National Meeting
Dallas, Texas

PRESCRIPTION DRUG COVERAGE (B) WORKING GROUP
Sunday, November 15, 2026
8:00 – 9:00 a.m.

Meeting Summary Report

The Prescription Drug Coverage (B) Working Group met Nov. 15, 2026. During this meeting, the Working Group:

1. Adopted its Summer National Meeting minutes, during which it met in joint session with the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group (*see NAIC Proceedings – Summer 2026, Regulatory Framework (B) Task Force, Attachment Three*).

2. Adopted its Oct. 5 minutes. During this meeting, the Working Group took the following action:
   A. Heard presentations on prior authorization (PA) for prescription drugs from the pharmacy benefit perspective, the plan perspective, and the consumer perspective. Each presenter discussed from their perspective how PA integrates with their work and the differences between medical and pharmacy benefits. The goal of the presentations was to help state insurance regulators identify opportunities to reduce friction and improve patient access in the PA process for prescription drugs through reforms, technology, or regulatory alignment.

3. Heard presentations from the Pharmaceutical Research and Manufacturers of America (PhRMA) and Texas Star Healthcare Consulting on group purchasing organizations (GPOs). The presentations defined GPOs and described how pharmaceutical manufacturers and other entities in the prescription drug distribution system work with GPOs.

4. Discussed updating a chart on state pharmacy benefit manager (PBM) licensing and registration laws. The Working Group chair requested that Working Group members and interested regulators review the chart and send any updates to NAIC committee support.

Agenda Item #3

Discuss Claims Coding Issues—*Luke Chalker (Blue Cross and Blue Shield Association—BCBSA), Jennifer Holloman (American Hospital Association—AHA), and Eric Ellsworth (Consumers' Checkbook/Center for the Study of Services)*

BlueCross BlueShield Association

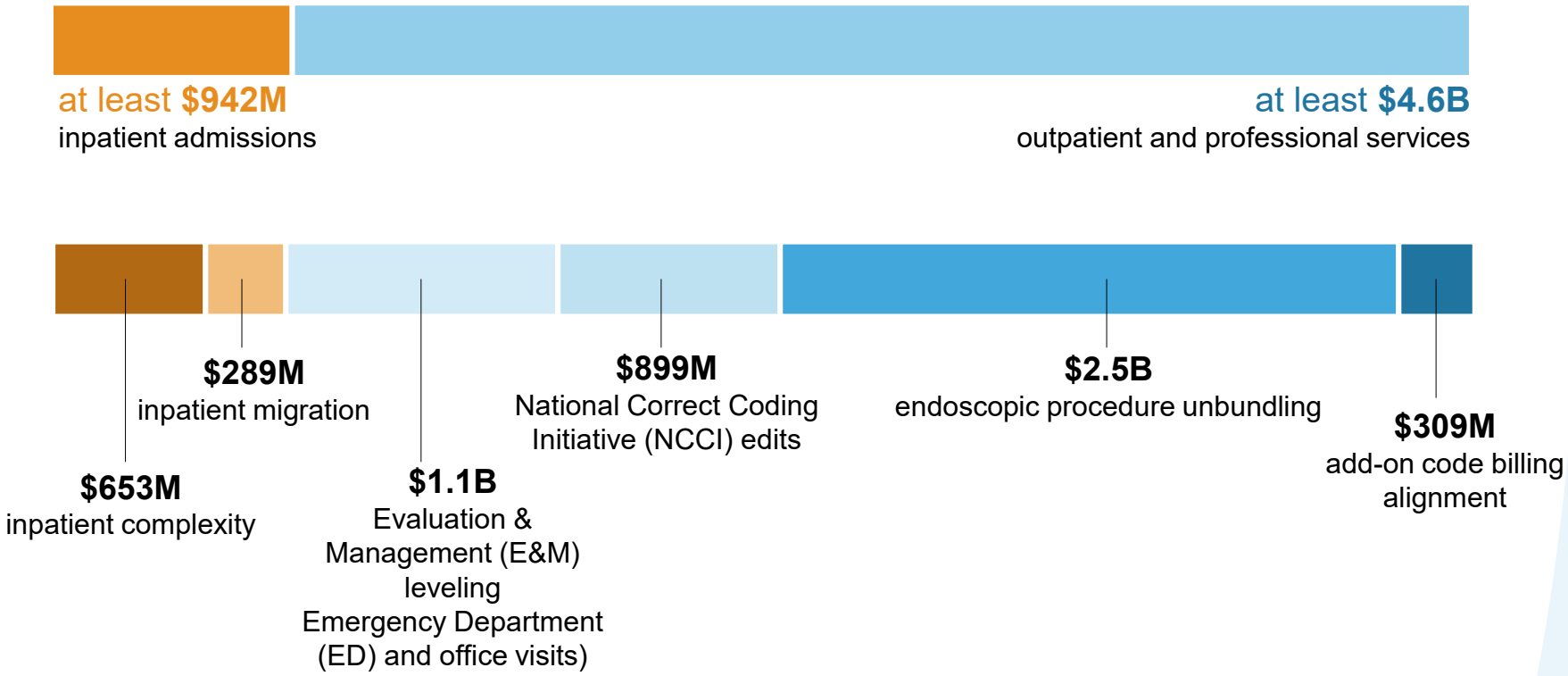
The Impact of AI Technologies on Coding Intensity and Healthcare Costs

Luke Chalker, SVP, Product and Data Science
Blue Cross Blue Shield Association

PROPRIETARY AND CONFIDENTIAL FOR BLUE PLAN USE ONLY
Blue Cross Blue Shield Association is an association of Independent Blue Cross and Blue Shield Companies.

Extrapolated across the Blue Commercial landscape, coding intensity *increases costs for patients and employers by* at least $5.5B in 2025

2025 Commercial Impact



With an early focus on identifying coding patterns, BCBSA is monitoring broader market shifts toward:

- Proactive surveillance
- Empowered local decision making
- More “real-time” interventions beyond retrospective analytics through claims-level clinical evidence

How it works

In the age of revenue maximization, AI tools assist providers to instantly harvests the content needed from the patient record to justify the highest possible reimbursement diagnosis related groups (DRG), as illustrated in the coding migration example below:

Inpatient Treatment

Treatment consistent with Respiratory Infection

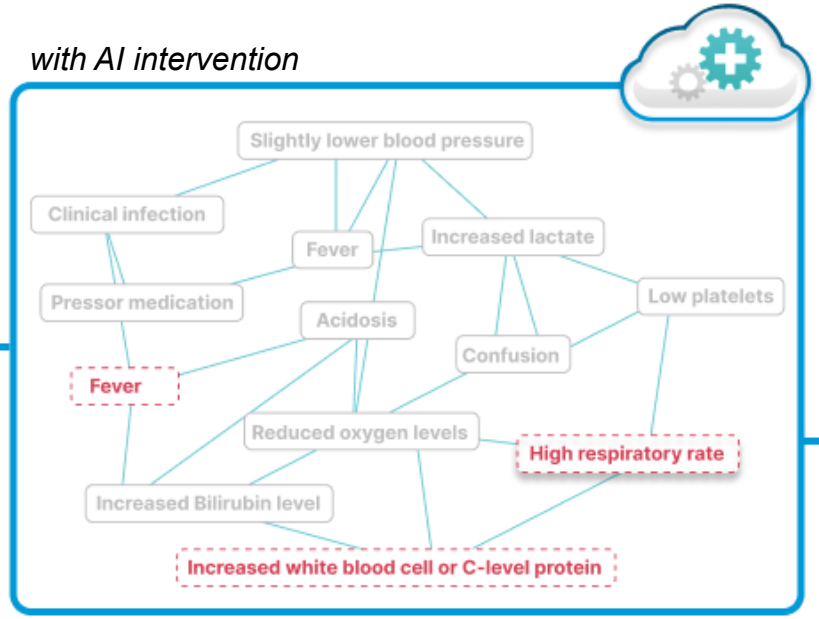
without AI intervention

0.755 DRG weight

$20,000

Typical Respiratory Infection admission (DRG 179)

with AI intervention



AI evaluates alternative ICD-10 codes and DRG assignments to optimize case weight and reimbursement

1.0233 DRG weight

$33,000

With the GenAI-uncovered evidence of sepsis (DRG 872)

GenAI tools scan patient medical records looking for lab values and key words that in combination, could provide evidence of sepsis

Looking at national Blue System data comparing 2025 to 2023, analysis showed:



at least **$942M**
inpatient admissions

Claims are shifting from lower-complexity DRGs into higher-severity DRGs without a corresponding increase in clinical care.

This shift is driving an estimated **$942M** in incremental Blue System costs.

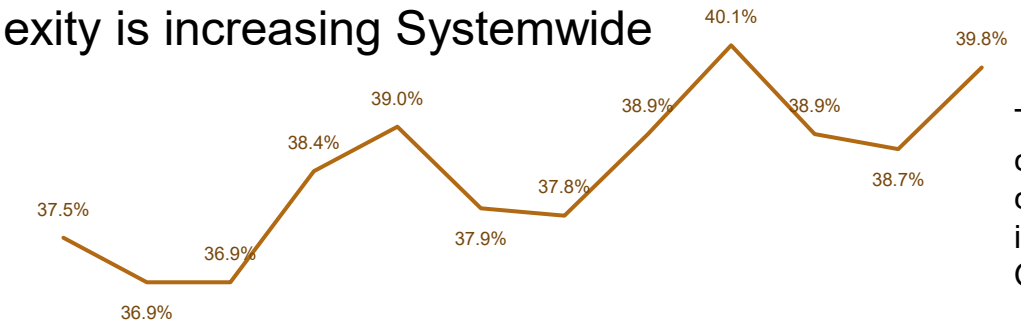


$289M
inpatient migration

$653M
inpatient complexity

55,158 cases that may not have been coded as complex under 2023 baseline rates

Complexity is increasing Systemwide



The rate of complications and comorbidities/major complications and comorbidities (CC/MCC) coding has increased steadily from Q1 ‘23 through Q4 ’25

Major bowel procedures demonstrate this trend

DRGs 329-331

Bowel procedures shift toward higher-coded complexity

Major bowel procedures coded at the highest complexity level rose from **20.2% to 22.7%** between 2023 and 2025, adding an estimated **$60.8 million** in costs.

Coding growth is concentrated in a subset of hospitals

Hospitals with the fastest coding growth classified **76% of cases as complex**, compared with **65%** at other hospitals.

These hospitals show similar or lower treatment intensity

Intensive Care Unit (ICU) use and transfusion rates were ***lower***, and median hospital stays were the same.

Anemia highlights the gap between coding and care

Hospitals with the fastest coding growth recorded **38% more acute posthemorrhagic anemia diagnoses**, yet a smaller share of those patients received transfusions (**16.9% vs. 19.3%** at other hospitals).

What moves a case into a higher complexity category?

"Bump codes" are secondary diagnosis codes that can move a hospital stay into a higher-paying billing category.

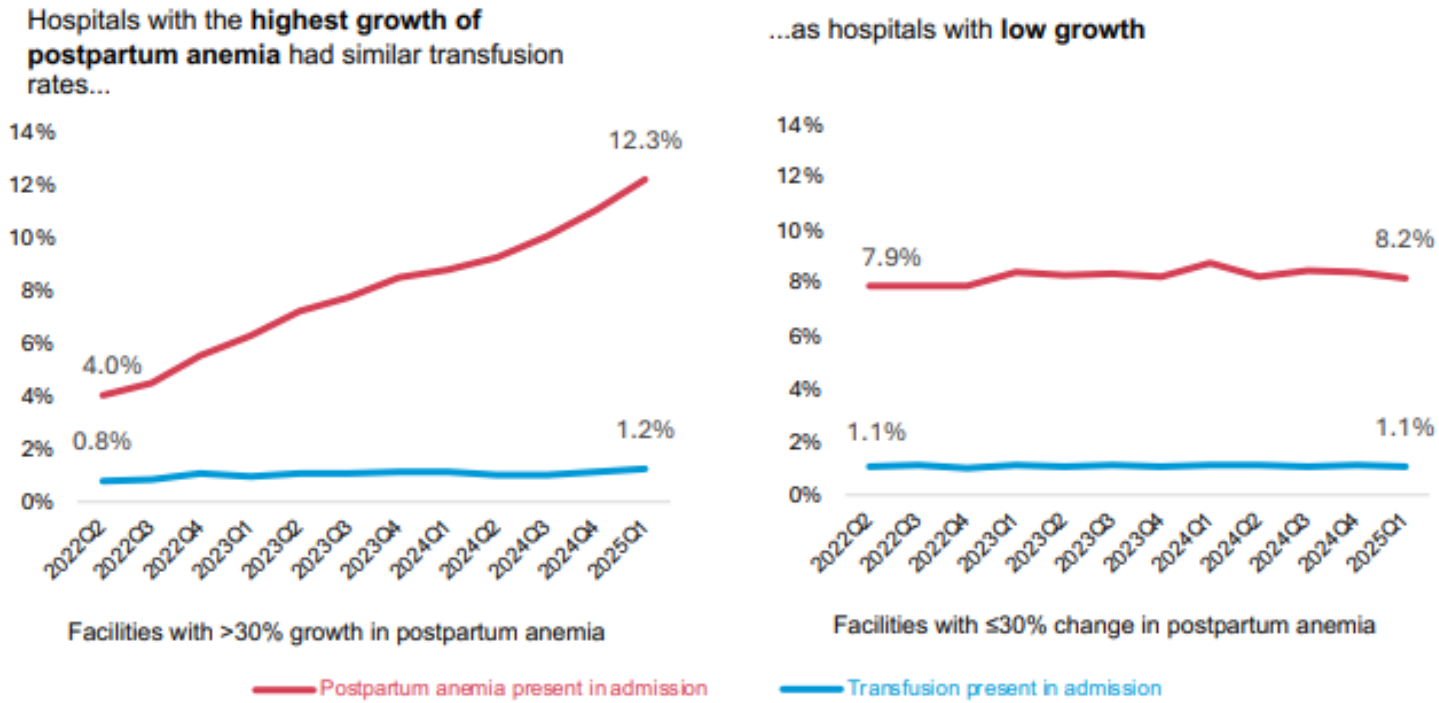
Fastest-growing bump codes for major bowel procedures included Acidosis, unspecified (E87.20); Hypo-osmolality and hyponatremia (E87.1); and Acute posthemorrhagic anemia (D62).

Metric	Top 25% Hospital with Fastest Coding Growth	Other
% Complex (MCC + CC)	**75.6%**	**65.0%**
% ICU Utilization	11.5%	13.2%
% Transfusion	3.6%	3.9%
% Reoperation	1.7%	1.5%
Median Length of Stay (LOS) (days)	4.0	4.0

Period: 2025

We also see this trend nationally for acute posthemorrhagic anemia in maternity cases

Across the Blue System, coding for acute posthemorrhagic anemia (D62) drove **+$22M** in additional maternity admission costs without a rise in related care, and it came from a small group of facilities



There is an unequal distribution of coding changes nationally

D62 coding in maternity care is rising faster than clinical treatment patterns, indicating potential documentation-driven inflation

Resources and Contact

BCBSA March 2026 Issue Brief:
Rising Coding Intensity and Its Impact on Health Care Affordability

BCBSA Sept. 2026 Whitepaper:
Hospital Coding Intensity Analysis: Major Bowel Procedures

Randi Chapman
BCBSA, State Affairs
Randi.chapman@bcbsa.com

American Hospital Association™

Advancing Health in America

AI and Claims Coding

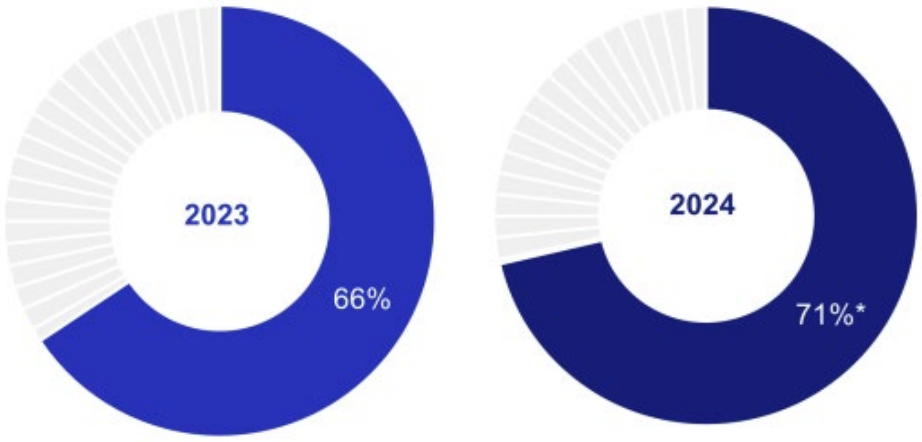
NAIC Regulatory Framework (B) Task Force Meeting

November 16, 2026

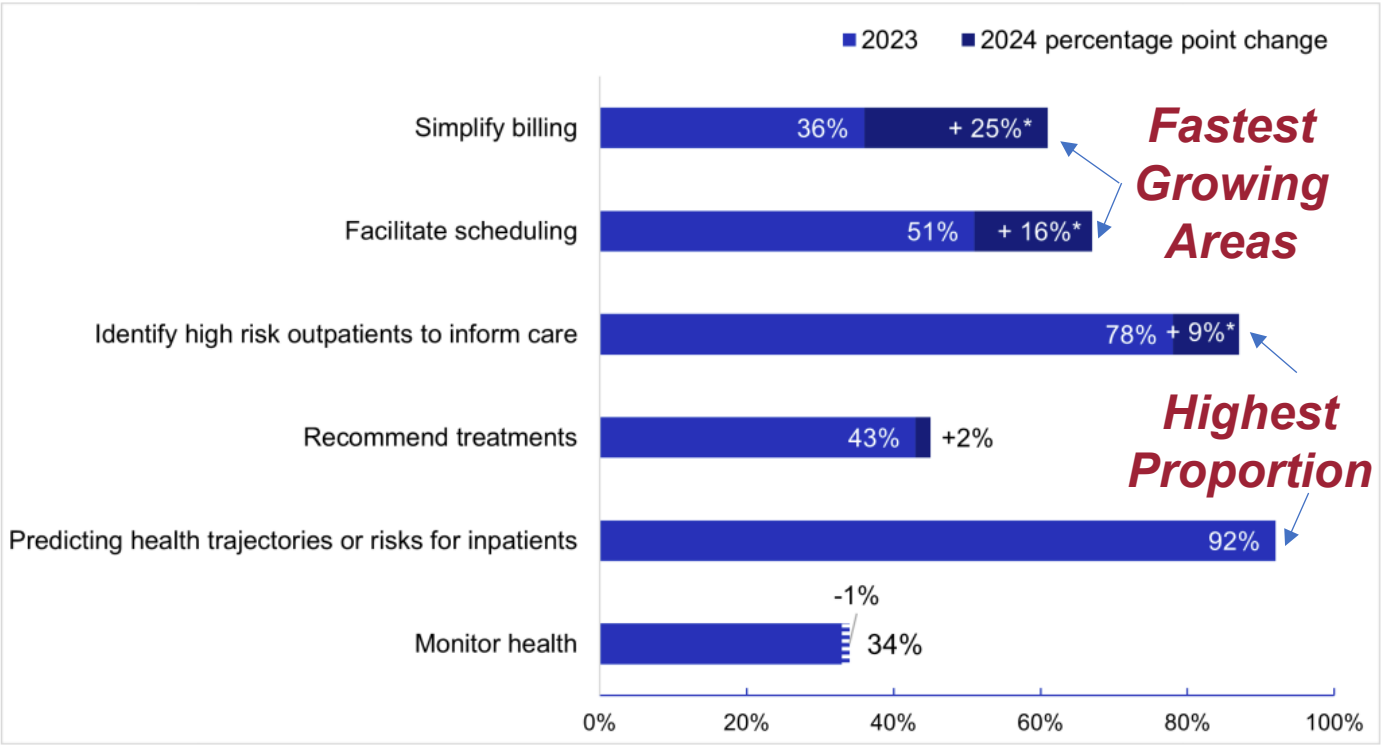
Hospital AI Use Continues to Grow

AHA has a supplemental Health Information Technology Supplemental survey that we issue in coordination with the Office of the National Coordinator

Non-federal acute care hospitals' adoption of predictive AI, 2023-2024



Predictive AI use cases among non-federal acute care hospitals that used any predictive AI, 2023-2024



SOURCE: https://healthit.gov/data/data-briefs/hospital-trends-use-evaluation-and-governance-predictive-ai-2023-2024/

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What problems are we trying to solve?

Workforce Shortages

Rising Costs



Projected physician shortage by 2036

Driver of shortages and costs

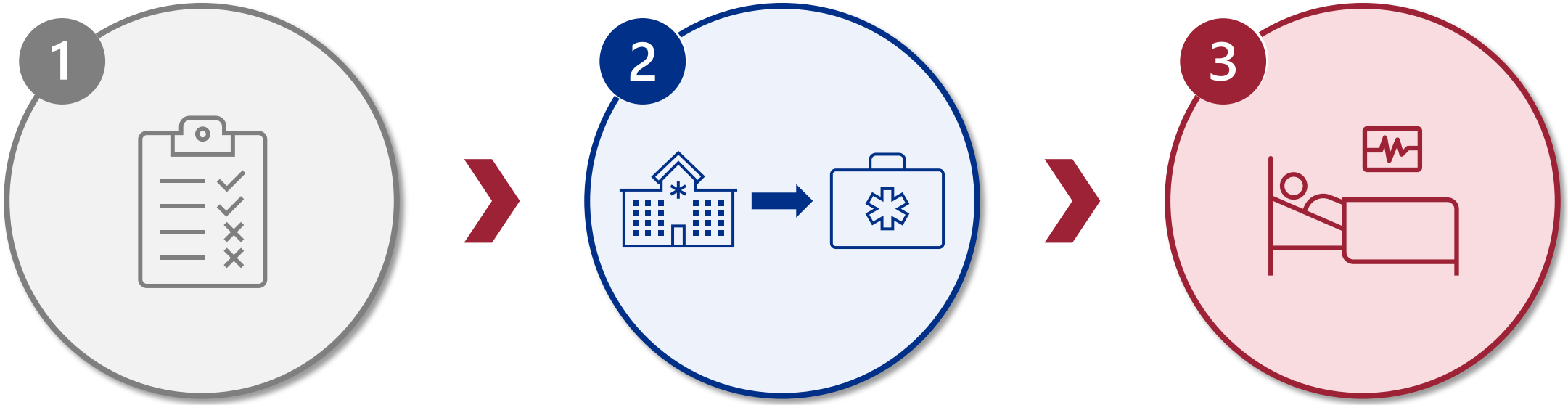
Percentage of GDP attributed to healthcare spending

While ensuring coding integrity, regulatory compliance and accurate representation of patient complexity

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AI and Coding



Complete and Accurate Documentation Supports Quality Care

Lower-Acuity Care Continues to Shift to Outpatient Settings

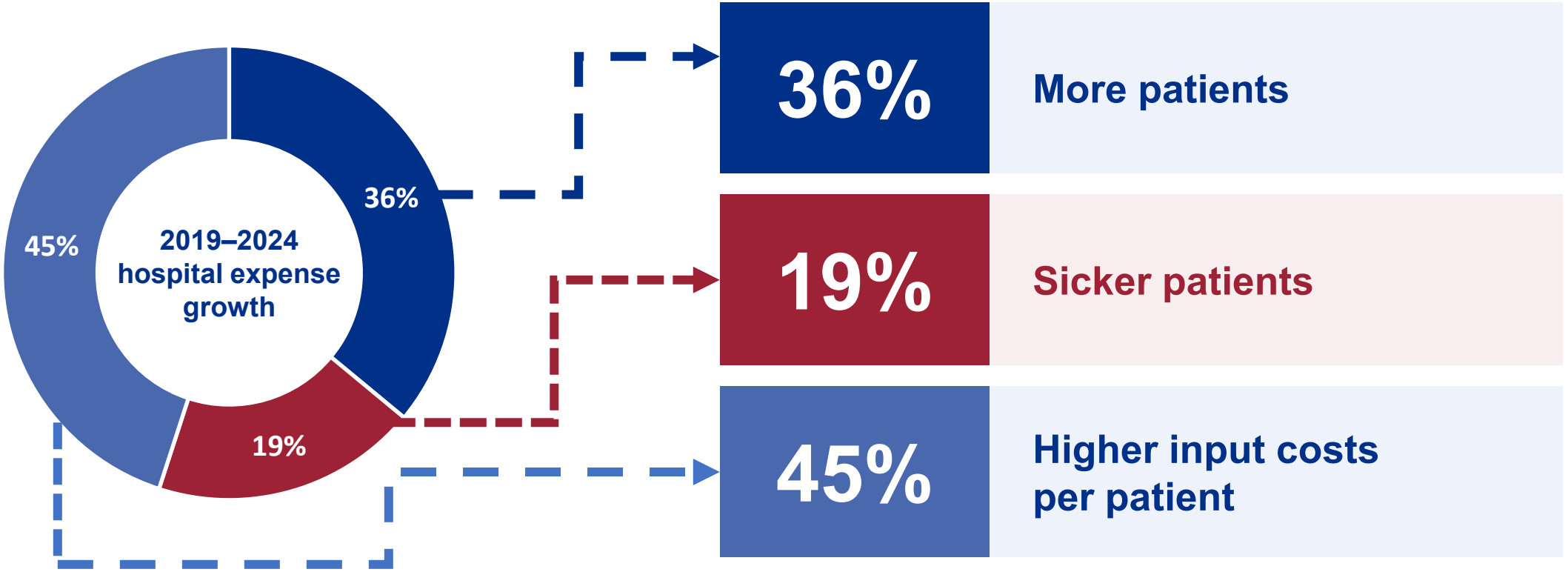
The Healthcare Ecosystem is Supporting an Aging, Sicker Beneficiary Population

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Sicker Patient Population

What's Driving Hospital Cost Growth in Hospitals' Costs of Caring for Patients?



Note: Estimates are based on a decomposition of total expense growth for IPPS hospitals from 2019–2024 using AHA data on adjusted admissions and total hospital expenses, combined with Medicare case-mix index values from the CMS IPPS Impact Files (FY 2020–2025).

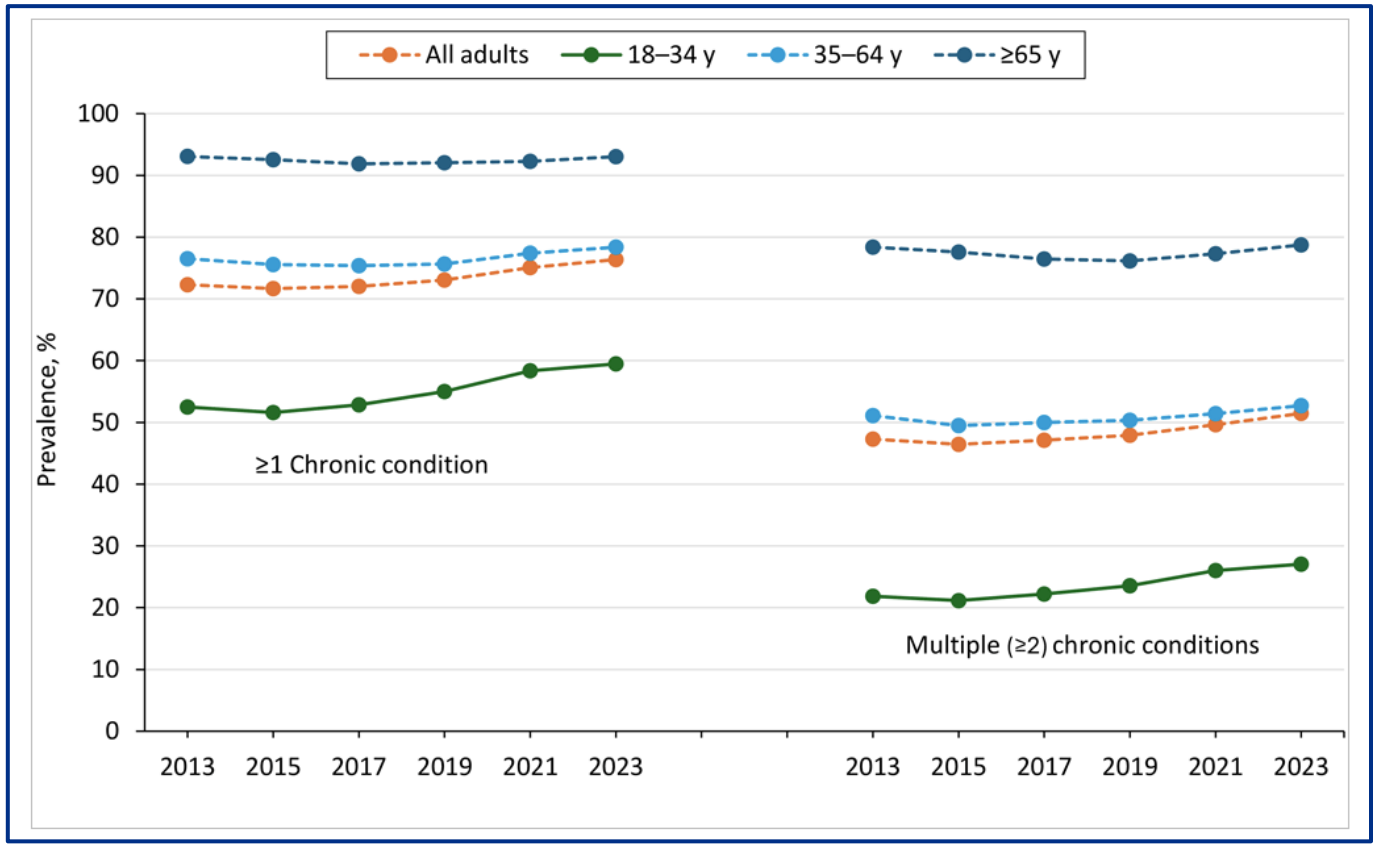
SOURCE: https://www.aha.org/system/files/media/file/2026/03/Costs-of-Caring-2026.pdf

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Sicker Patient Population

Trends in Multiple Chronic Conditions Among US Adults, By Life Stage, Behavioral Risk Factor Surveillance System, 2013–2023



90%+

Adults ≥65 Highest Prevalence
Older adults have the highest prevalence of 1+ and 2+ chronic conditions.

18–34

Younger Adults Increasing
Trends in prevalence of 1+ and 2+ chronic conditions among younger adults has worsened.

≈50%

Multiple conditions are common
Roughly half of adults ages 35–64 and of all adults have 2+ chronic conditions.

Note: Overall and age-specific trends in the prevalence in 1 or more chronic conditions or multiple (2 or more) chronic conditions of 12 selected chronic conditions among US adults, Behavioral Risk Factor Surveillance System, 2013–2023.

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SOURCE: https://www.cdc.gov/pcd/issues/2025/24_0539.htm

Conclusion

- Correctly assessing the clinical status of a patient is imperative to delivering high-quality care.
- Hospitals and health systems have legal, ethical and contractual obligations to ensure appropriate coding.
- Patients today are older and more clinically complex.
- New artificial intelligence tools are helping providers appropriately capture their patients' conditions to aid in care planning.
- Clinical documentation should drive discussion on diagnostic capture.

RESOURCES:

- https://www.aha.org/fact-sheets/2026-07-31-fact-sheet-artificial-intelligence-and-coding-intensity
- https://www.aha.org/costsofcaring
- https://www.aha.org/news/blog/2026-10-05-better-information-better-care-how-coding-supports-todays-complex-patients

AI in Claims Processing: Effects on Consumers and Potential Policy Reponses

Eric Ellsworth

Consumers' Checkbook / Center for the Study of Services

November 16, 2026

CHECKBOOK HEALTH

Increasing Use of AI in Claims Submission

- Provider organizations have adopted AI in key functions, notably:
  - Ambient scribes – documenting patient's narrative
  - Charge capture – reading the patient's chart to code claims
- Seems to be driving higher coding intensity
  - Information from ambient scribes can support additional and higher acuity diagnoses
  - AI in coding process finds more information supporting higher intensity coding
- Potential "battle of the bots"
  - AI Cannot Change System Incentives, Increases Their Scale and Speed
    Why AI Will Accelerate Health Care Inflation (Brailer, Health Affairs Forefront 2026)

CHECKBOOK HEALTH

Potential Insurer Reponses

- Additional coding rules and/or claims edits
- Automatic downcoding (potentially using AI)
- Require physician review and approval of AI-coded claims
- More frequent or detailed chart audits
- Tracking of utilization patterns from a provider to find and flag "additive diagnoses" or "overly intensive coding"
- More prior auth requirements
  - Especially on tests/studies that may lead to higher coding intensity
- Raise premiums

CHECKBOOK HEALTH

Potential Effects on Consumers

- Higher premiums
- Increased cost-sharing
  - As billed costs increase, these costs pass through deductibles and coinsurance
  - Insurers may also increase copays, out-of-pocket limits, etc.
- Potential increase in bills for denied claims
  - Providers back-end billing systems may not be fully aligned with other AI RCM tools
  - This can increase the likelihood that patients are billed over coding disputes
- Greater difficulty understanding what is happening with claims, EOBs, and bills
  - Especially if AI or claims edits apply in more subtle ways
- Provider may lack clarity on what was documented or billed

CHECKBOOK HEALTH

Oversight Needs

- Robust oversight of both insurer denials and provider billing
  - Denial reporting – collect X12 codes in denial reporting to drill in on coding issues
  - Strong enforcement of both “prompt pay” and “hold harmless”/balance billing laws
- Ensure that consumers can understand and take appropriate action on denials and balance bills
  - Ensure DOI consumer assistance can help consumers appropriate direct questions to insurers or providers as needed
  - Ensure that EOBs and bills clearly show what has and hasn’t been paid and clearly show what amounts should or should not be billed to consumers.
  - API approaches like Patient Access API can allow apps to translate details for consumers
  - Advanced Explanation of Benefits could provide clarity and accountability
    - Binding estimate required under No Suprises, not yet fully implemented
    - Pre-adjudicates the claim, enabling visibility into what will happen

CHECKBOOK HEALTH

Policy Options

- Require reporting of when and how AI is used in claims adjudication
  - Recent JAMA opinion suggest a national registry of uses of AI in provider organizations.
  - Similar approach could be taken for insurers
- Guard rails around use of AI in claims edits/downcoding
  - Transparency in Downcoding Act (IL Public Act 104-0568)
    - Requires human review and approval of downcoding
    - Payers must use appropriate X12 codes to indicate the reason for downcoding
  - Require insurers to request further information before paying lower code
    - MD DOI Bulletin 26-9
- Standardize coding rules as much possible
  - NCCI, CO Clean Medical Claims Initiative, VT 18 V.S.A. § 9418[a]
  - Consider standardized edits for specific coding intensity problems

CHECKBOOK HEALTH

September 2026

BlueCross BlueShield Association

Authors:
Chris Birkmeyer
David Wennberg, MD, MPH
Keith Kamons
Luke Chalker

ANALYSIS PERIOD
Q1 2023 - Q4 2025

Hospital Coding Intensity Analysis:
Major Bowel Procedures

Evidence of secondary diagnosis growth driving DRG coding intensity

EXECUTIVE SUMMARY

Hospitals are increasingly billing inpatient stays as more medically complex than they did a few years ago. That shift means higher payments to hospitals and higher costs across the healthcare system. We estimate the added cost to the Blue System at about $942 million over two years.

What is notable is how it happens. It is not more surgeries or more procedures. It is more secondary diagnoses added to a claim, conditions like low sodium or anemia, that move the claim into a higher-paying category. Many of these can be identified from a single lab result. The rise coincides with hospitals adopting new AI-assisted billing software that scans records and lab data for anything that can be coded.

To separate real changes in illness from changes in coding, this analysis looks for clinical discordance — cases where a diagnosis is added to the claim but the treatment you would expect for that diagnosis is not there. A condition that raises the payment but does not change the care a patient receives is the pattern the study focuses on.

The trend is steady and widespread. The share of cases billed as complex rose from roughly 37% in early 2023 to about 40% by late 2025. In one closely studied area, major bowel procedures, the most complex claims went up while the simplest ones fell, even though the associated treatments themselves did not change. The added complexity is concentrated in a subset of hospitals within peer groups (e.g., within teaching hospitals), which points to differences in coding practices more than a broad change in how sick patients are.

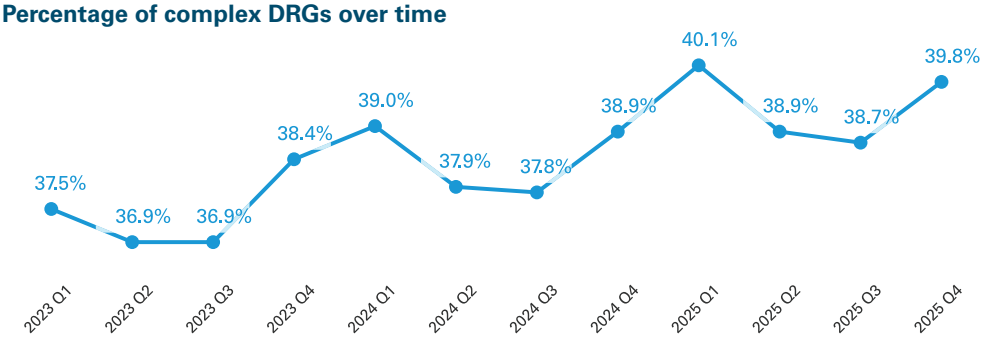
OVERVIEW

Hospital inpatient coding intensity — the increasing use of diagnoses that place patients into more medically complex and higher-paying billing categories — has increased materially over the past two years. We estimate that this trend is generating approximately $942 million in incremental claims costs for the Blue Cross and Blue Shield (Blue) System alone. Our analysis of over 55,000 excess complex cases found that hospitals are systematically adding secondary diagnoses that bump claims into higher-severity, higher-reimbursement diagnosis-related groups (DRGs) without a corresponding increase in clinical care. These shifts account for 70% of the incremental inpatient coding intensity costs to the Blue System.

SYSTEM-LEVEL ESCALATION

The rate of complication or comorbidity (CC) and major complication or comorbidity (MCC) coding has increased steadily from Q1 2023 through Q4 2025. Compared with 2023 baseline rates, hospitals classified 55,158 additional cases as complex. Those cases generated $653 million in incremental reimbursements at an average of $11,800 per excess complex case.

Percentage of complex DRGs over time



BOWEL PROCEDURE COMPLEXITY

Insights on Complexification

A deep dive into a specific DRG family illustrates what is driving increased complexity and reveals the fingerprints of the AI-enabled revenue cycle management (RCM) technologies. This also allows one to investigate clinical discordance — claims where the diagnosis is present, but expected treatment for this diagnosis is absent. The insights from these specific DRG families are consistent with broader patterns of increasing complexity across inpatient hospital claims.

Major bowel procedures (DRGs 329-331) are comprised of surgical procedures that are primarily used to treat colon cancer or diverticular disease. Over half of these procedures are endoscopy-based. Between 2023 and 2025, claims at the highest level of complexity (MCC claims) increased from 20.2% to 22.7%, while non-complex cases declined from 36.6% to 32.8%. This DRG family alone accounts for $60.8 million in incremental claims costs, as patients were moved into higher-severity, higher-reimbursement categories.

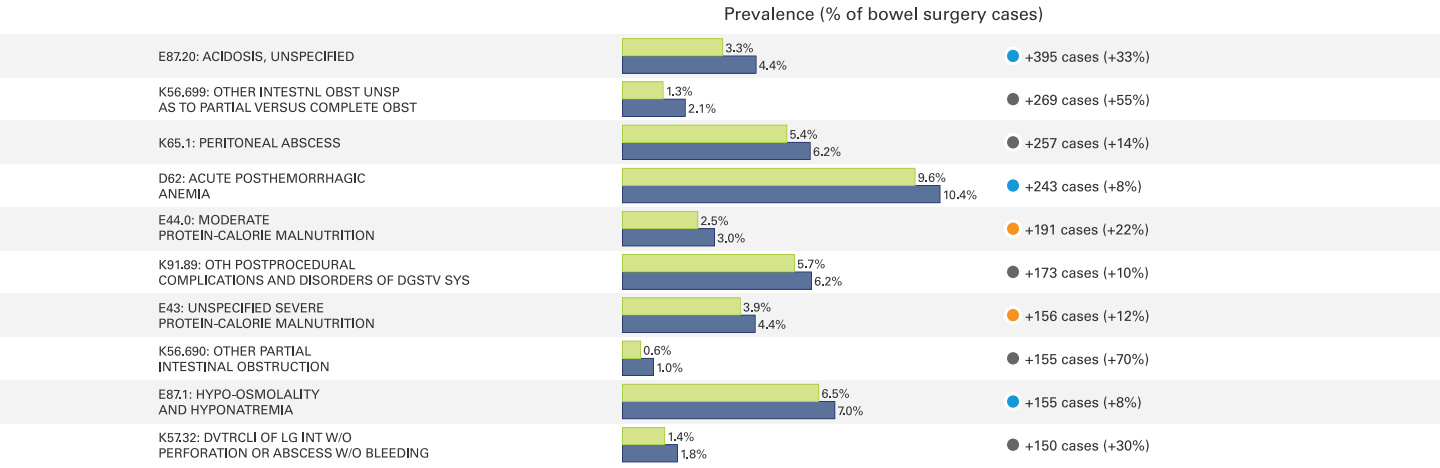
DIAGNOSIS DRIVERS

For major bowel procedures, evaluation of secondary diagnoses reveals specific documented diagnoses driving severity escalation, or "bump codes." The fastest-growing bump codes include lab-derived diagnoses such as unspecified acidosis (E87.20), hypo-osmolality and hyponatremia (E87.1) and acute posthemorrhagic anemia (D62), alongside documentation of malnutrition, abdominal abscess and intestinal obstruction diagnoses. Many of these diagnoses can be derived from single laboratory values or routine observations, making them particularly well-suited for detection by modern RCM technology. Technologies including ambient listening for observation codes and laboratory data mining appear to be contributing to this coding growth.

Top 10 Secondary Diagnoses Driving DRG Complexity Growth

Major Bowel Procedures (DRG 329-331) | 2023 vs. 2025

Labs: Laboratory-derived Diagnoses • **Ambient Listening:** AI Observation-based Codes • **Other:** Other Documentation Sources

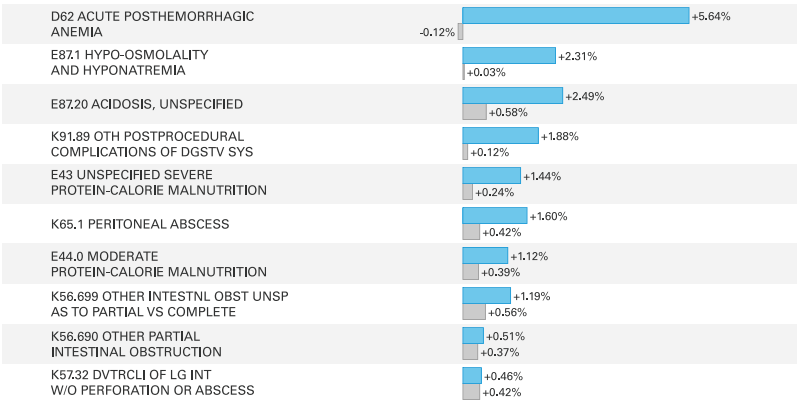


FACILITY CONCENTRATION

These new RCM technologies are being adopted at different rates across healthcare systems. Hospitals in the top 25% of complexity growth show significantly larger increases in secondary bump codes prevalence compared to other facilities. This difference is most pronounced for lab-derived conditions, suggesting these changes are driven by targeted technology-supported coding initiatives rather than shifts in patient illness.

Diagnosis Growth by Hospital Cohort for Major Bowel Procedures

2023 to 2025 | Top 25% Hospitals Other Hospitals



Clinical Discordance

One of the hallmarks of diagnosis-driven complexity is identifying treatment-diagnosis discordance. Hospitals with the highest coding growth show lower treatment intensity overall than peer facilities, where claims include diagnoses that are not accompanied by treatment one would expect for those conditions. Hospitals with the highest coding growth classify 76% of bowel procedures as complex, compared with 65% at other hospitals. However, these hospitals have similar or lower intensity of services (e.g., ICU use).

Period: 2025 — **Bowel Procedures (DRGs 329-331)**

Metric	Top 25%	Other
% Complex (MCC + CC)	75.6%	65.0%
% ICU Utilization	11.5%	13.2%
% Transfusion	3.6%	3.9%
% Reoperation	1.7%	1.5%
Median LOS (days)	4.0	4.0

Validating Diagnosis-Treatment Concordance: Anemia

Further evidence of treatment-diagnosis discordance can be found by examining posthemorrhagic anemia as a common bump code. Posthemorrhagic anemia refers to low hemoglobin levels in the setting of blood loss (hemorrhage), which often occurs during major surgical procedures.

When AI is used to identify abnormal tests, it may be set to flag *all* tests that have results outside of the normal range, even though clinicians typically do not treat mild anemias. **In top growth hospitals, the rate of anemia diagnosis is 38% higher than that of peer hospitals. However, their transfusion rate *among* patients diagnosed with anemia is much lower: 16.9% transfusion rate compared to 19.3% at peer facilities.** This diagnosis-treatment discordance suggests that the higher rate of anemia is a result of AI-driven coding. Consistent with this finding is the fact that the overall rate of transfusion is similar across all cases (above).

Period: 2025	Top 25%	Other
Anemia rate	13.7%	9.9%
Transfusion rate for claims with anemia diagnosis	16.9%	19.3%

The consistent inverse relationship between diagnosis-based complexity and both aggregate resource utilization and diagnosis-specific procedural intervention is the strongest indicator that coding escalation reflects documentation practice changes rather than actual patient acuity shifts.

CONCLUSION

Systematic use of AI-enabled RCM tools by healthcare systems may be linked to over $650 million in excess hospital reimbursement related to coding complexity optimization alone. This represents incremental hospital reimbursement from complexity growth for inpatient stays, independent of utilization or case mix changes. Critically, this growth hasn't stopped, nor is it limited to inpatient care. As more healthcare facilities adopt AI-enabled capabilities to optimize coding, increases in medical trend will continue. Using the Blue System's unique data assets, the Blue Cross Blue Shield Association has the unprecedented ability to identify these patterns, measure impact and proactively address cost drivers across the healthcare system.

BlueCross BlueShield Association

Agenda Item #4

Discuss its Next Steps on Prior Authorization (PA)—*Commissioner Marie Grant (MD)*

Regulatory Framework Task Force Prior Authorization Work and Possible Next Steps

Date	Activity
2025 Spring National Meeting (March 25, 2025)	Prior to beginning work on its prior authorization white paper, as directed by the B Committee, at its meeting at the 2025 Spring National Meeting, the Task Force received an overview of state PA laws and heard on the issue from the provider, consumer and patient, and insurer perspectives.
Virtual Interim Meeting Sept. 22, 2025	The Task Force discussed the comments received on the initial PA White Paper draft. The initial draft was developed by a drafting subgroup and forwarded to the Task Force for public distribution for comment.
2025 Summer National Meeting (August 12. 2025)	The Task Force heard an update from the BCBSA and AHIP on health plans' commitment to streamlining and simplifying PA stemming from the AHIP and BCBSA letter to the NAIC in July 2025 outlining the commitments of about 60 health insurance plans across the country to join this initiative.
2025 Fall National Meeting (December 10, 2025)	The Task Force and the B Committee adopted the PA White Paper at the 2025 Fall National Meeting.
Virtual Interim Meeting June 29, 2026	The Task Force heard an update on industry progress on its PA reform initiative. AHIP, BCBSA, and key representatives from major health insurance plans, including Aetna, Blue Shield of California, Cigna, Elevance Health, and Highmark, provided updates on their commitments to reform the prior authorization (PA) process.
Virtual Interim Meeting Aug. 31, 2026	The Task Force continued discussion of industry progress on its PA reform initiative as a follow up to its June 29 meeting to provide an opportunity for questions Task Force members and interested regulators might have based on the industry's update on its progress they provided during that meeting. The Task Force also heard presentations from other stakeholders
Virtual Interim Meeting Prescription Drug Coverage WG Oct. 5, 2026	The Prescription Drug Coverage Working Group heard presentations on prior authorization (PA) and prescription drugs from a pharmacy benefit perspective, health plan perspective, and consumer perspective as a follow-up to recent Regulatory Framework (B) Task Force meetings (June 29 and Aug. 31) on PA. The focus of the presentations was on how PA integrates with their work and the differences between medical and pharmacy benefits.

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Possible Next Steps	
Adopted PA White Paper Takeaways (Recommendations)	State regulators should work within the broader NAIC to develop PA standards or best practices. In addition, the following best practices should be helpful to states considering PA reforms. • <u>Take advantage of data calls</u> Make use of targeted data calls while in the legislative process to understand the state-specific market conditions. This data will prove invaluable to mold future legislation that will benefit the entire healthcare ecosphere. • <u>Incorporating flexibility in legislation</u> Any new processes in legislation, while well-intentioned, may cause unintended consequences for consumers. insurers, and providers. New processes, such as ePA, can cause unneeded delays if systems crash unless there are alternate methods permitted. • <u>Build relationships with state partners</u> In all conversations with providers, regulators, insurers, and consumer organizations, stay patient focused. The ultimate goal is to get patients the necessary care they need in the shortest amount of time. • <u>Implementation processes</u> As with any health care legislation, prior authorization changes to law can require significant effort to implement. It is important for state agencies to understand their roles with any changes, and to have mechanisms in law or processes in place to communicate how actions or decisions by one agency may impact the work of other agencies. In addition, many of the changes to facilitate faster processing time require IT updates at both the insurer and provider levels, taking both time and a financial commitment to achieve. • <u>Develop provider and consumer education</u> States may pursue public awareness campaigns so that health insurance consumers and their physicians become familiar with PA processes and the attendant appeal rights. States may also highlight rules currently in effect designed to significantly increase transparency of health insurer processes. Bringing more focus to the health insurance consumer experience with PA will greatly benefit those depending on the coverage they purchased to help navigate and address complex health concerns. • <u>Create structure for enforcement</u> New PA requirements can have complicated enforcement mechanisms, and some may require additional

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Possible Next Steps	
	staff expertise or investment in training. The Regulatory Framework (B) Task Force will evaluate the need for an ad hoc or other group to support regulators newly embarking on PA enforcement.
Stakeholder Suggestions	NAIC Consumer representatives: Establish a Prior Authorization WG. American Medical Association (AMA): Establish a Prior Authorization WG that could focus on:1) recommendations included in the final PA white paper *(see above)*; 2) aggregating states' experiences with implementation of prior authorization reforms; and 3) identifying best practices for addressing implementation and enforcement challenges. Additionally, a working group could consider model prior authorization legislation.
Potential Options	1. Establish a Prior Authorization Workgroup – Under B OR under Reg Framework Task Force – to track industry initiatives, make recommendations on data collection, and share best practices. 2. Monitor prior authorization efforts and continue discussions under existing B Committee structures.

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Agenda Item #5

Discuss Any Other Matters Brought Before the Task Force
—Commissioner Marie Grant (MD)