Wyoming Insurance Topics

Presented by the Wyoming Department of Insurance

June 3, 2015

To: Joint Corporations, Elections and Political Subdivisions Interim Committee
From: Wyoming Department of Insurance
Date: June 3, 2015
Re: Insurance Interim Topics

Table of Contents

Wyoming Department of Insurance Overview

The agency has 26 employees. The 2015-2016 biennium administrative budget of the Department is $5,549,315 which does not include general funds. The 1,100+ insurance companies licensed in Wyoming are each assessed annually an equal amount which funds the Department's budget. The Department oversees the budgets of the Board of Insurance Agents Examiners ($11,962 for the 2015-2016 biennium) and the Wyoming Health Insurance Pool ($29,122,277 for the 2015-2016 biennium). The Wyoming Health Insurance Pool budget includes $5,760,000 in general fund monies for the 2015-2016 biennium. The Departments also oversees the budget of the Wyoming Small Employer Health Reinsurance Program ($26,801,280 for the 2015-2016 biennium).

The primary function of the Department is regulation of the insurance industry in Wyoming. This includes:

Consumer Assistance – providing assistance to consumers to ensure that state laws are being followed regarding insurance claims and other areas of insurance. In 2014, our two consumer specialist handled 380 complaints.

Examinations – conducting examination of domestic insurers, producers (agents), and pre-need funeral and cemetery trust funds to determine financial solvency and compliance with the Wyoming Insurance Code. It is vitally important that the Department maintains its accreditation from the National Association of Insurance Commissioners (NAIC).

Licensing – requiring insurers, producers and others licensed by the Department meet the minimum standards contained in the Insurance Code. There are approximately 91,000 producers licensed to sell insurance in Wyoming. The licensing department handles applications, continuing education, renewals, name & address changes etc. Given the large volume of work and new personnel, this department is currently experiencing a back log in this area.

Enforcement – taking enforcement action when necessary to ensure compliance with the Insurance Code.

Oversight – providing administrative oversight of insurance programs created under Wyoming law. These include the Board of Insurance Agents Examiners, the Wyoming Health Insurance Pool, and the Wyoming Small Employer Health Reinsurance Program.

Policy Form Review – reviewing policy form filings to assure that insurance companies are following state statutes and regulations before approving the forms and filings for use in Wyoming. In 2014, 4,305 policy form filings were reviewed.

Public Service Announcements (PSA)
Wyo. Stat. §26-3-126

In 2013, Wyo. Stat. §26-3-126 was amended and eliminated the requirement for insurance companies to publish their financial summaries in Wyoming newspapers. In lieu of this requirement, the Department of Insurance now develops six (6) to twelve (12) public service announcements (PSAs) per year to inform consumers about various insurance topics. Each PSA contains a description of how citizens may access information about licensed insurance companies on the official Department website. As per statute, the PSA cost is spread equally among all licensed insurers. In the past, companies often complained about the disparate and costly publications that seemed to have very low readership. The Department uses the Wyoming Press Association as its agent to administer the PSA distribution and to invoice the Wyoming insurers. The amended statute requires the Department to present a report to this joint interim committee concerning any public response to the PSAs on or before July 1, 2015.
See Attachment 1.

Data Points
Newspapers in state: 41
Newspaper subscriptions: 155,516 (as of April 1, 2015)

Department Website
A computer analytics program indicates there were **156,000** "hits" on the Department homepage between July 2013 and May 1, 2015. The monthly PSAs are prominently displayed on this homepage; however, it is not possible to determine whether homepage viewers read the PSA or advanced to another page within the website.

Costs
Cost range prior to PSA Legislation: $240.00- $1800.00 per insurer
Cost after PSA Legislation:
Average Cost per Insurer 2014: $311.76
Average Cost per Insurer 2015: $317.45
Average Cost per Insurer 2016: $336.29 (anticipated)

Anecdotal comments prior to PSA legislation: (obtained from emails sent to the Department**)**
"rates are too high"
"Wyoming is the most expensive state for them [the insurance company] to publish"
"ridiculous rates"
"ridiculous rates and company has no say in choosing the publisher"
"How can we verify that it was published and where???"
"Really? Is this bona fide?"

Anecdotal comments after PSA legislation: (obtained from phone calls and e-mails to the Department)
"great information—thanks"
"helpful"
"The ACA information was so straightforward."

"I used the small business information to help me plan which plan to buy."

Indexed Annuities

Equity indexed annuities are a type of fixed annuity that earns interest based on changes in a market index, which measures how the market or part of the market performs. Some indexes are measures of how the overall financial markets perform (such as the S&P 500 Index or Dow Jones Industrial Average) during a set period of time (called the index term). Others measure how a specific financial market performs (such as the NASDAQ) during the term. When you buy an indexed annuity, you aren't investing directly in the market or the index; the interest rate earned is based on the index performance. Some indexed annuities offer you more than one index choice. Many indexed annuities also offer the choice to put part of your money in a fixed interest rate account, with a rate that won't change for a set period.

The interest rate is guaranteed to never be less than zero, even if the market goes down. The insurance company uses a formula to determine how a change in the index affects the amount of interest to add to your annuity at the end of each index term. Once interest is added to your annuity for an index term, those earnings usually are locked in and changes in the index in the next index term don't affect them. If you take money from an indexed annuity before an index term ends, the annuity may not add all of the index-linked interest for that term to your account.

Insurance companies use different formulas to calculate the interest to add to an annuity. They look at changes in the index over a period of time. The formulas insurance companies use often means that interest added to your annuity is based on only part of a change in an index over a set period of time. Participation rates, cap rates, and spread rates (sometimes called margin or asset fees) are all terms that describe ways the amount of interest added to your annuity may not reflect the full change in the index. But if the index goes down over that period, zero interest is added to your annuity, and the annuity value won't go down as long as you don't withdraw the money.

Equity indexed annuities are financial vehicles that can be sold only by insurance companies, and therefore regulated by state insurance departments. Because an equity indexed annuity does not invest directly in securities such as stocks, bonds, or mutual funds, it is not considered to be a financial product. Basically, an annuity is a contract between a consumer and an insurance company, which promises to pay you a future income in exchange for the lump-sum payment or premiums that you pay, thus "insuring" you have income in retirement.

Equity indexed annuities are regulated by the Department in the same manner as fixed annuities, and are subject to the following statutes and rules:

W.S. 26-15-101 et al. **See Attachment 2.**
W.S. 26-16-101 et al. **See Attachment 2.**
Wyoming Department of Insurance Rules, Chapter 12, Replacement of Life Insurance and Annuities
Wyoming Department of Insurance Rules, Chapter 64, Suitability and Annuity Transactions

The Department also requires that a Disclosure Notice must be provided to the consumer describing the key components of the contract. These components include, but are not limited to, the index, the index calculation method, whether the contract uses averaging or not, participation rate and caps. The descriptions must be simple, understandable to a typical reader and not misleading. The consumer and the producer selling the product must sign the Notice at the time of sale. The Department also reviews all advertising materials produced by the insurance company for any misleading or confusing information. Attached is a checklist that explains the provisions and documents the Department requires when an insurance company files a policy for review and approval before it can be sold to the public. **See Attachment 2.**

The Department received fewer than five formal complaints regarding equity indexed annuities during the period of 1/1/10 through 1/1/15, and of these complaints, there have not been any discernible trends. A consumer may contact the Department for assistance or education regarding an equity annuity policy, however this information is not tracked nor does it constitute a formal complaint. A typical complaint usually stems from a consumer feeling they were misinformed or confused about the interest rates they would earn, or the surrender charges that were assessed by withdrawing money early from the annuity.

Additional NAIC model rules are available, which provide standards for the disclosure of certain minimum information about annuity contracts to protect consumers and foster consumer education. The regulation specifies the minimum information which must be disclosed, the method for disclosing it and the use and content of illustrations with the sale of annuity contracts. The goal of this regulation is to ensure that purchasers of annuity contracts understand certain basic features of annuity contracts.

In conclusion, the Department of Insurance regulates and applies all applicable statutes and rules to equity indexed annuities, the same as traditional fixed annuities. Although additional NAIC model rules are available, the Department has been requiring insurers to provide the same information contained in these models. The Department also adopted rules governing suitability in annuities effective September 9, 2014. This rule requires an insurer or insurance producer who recommends a sale or transactions involving annuity products to appropriately address the insurance needs and financial objectives of the consumer. Given the small number of complaints regarding these types of annuities, we do not feel additional statutes or regulations are necessary.

National Association of Insurance Commissioner's Accreditation

In order for the Department to maintain its accreditation with the National Association of Insurance Commissioners (NAIC), the Department will need to implement the Corporate Governance Annual Disclosure Model Act and update the existing Annual Audited Financial Reports Law. These items will need to be effective by January 1, 2020, in order for the Department to maintain its accreditation; however, early adoption is encouraged.

In addition to being accreditation standards, these items are also important tools to help protect Wyoming consumers by ensuring that the insurance companies are employing sound corporate governance practices in order to adequately protect their policyholders.

I. Corporate Governance Annual Disclosure Model Act (proposed law)

The Corporate Governance Annual Disclosure Model Act was developed by the NAIC in response to the 2008 financial crisis and international regulatory standards known as Insurance Core Principles (ICPs).

The model was finalized by the NAIC in November 2014 and requires all domestic insurance companies, regardless of size, to submit a "Corporate Governance Annual Disclosure" to the Commissioner each year on June 1st. The insurer will need to disclose its corporate governance practices in the disclosure and will need to include the signature of the CEO or Corporate Secretary attesting to the fact that the insurer has implemented the corporate governance practices and that a copy of the disclosure has been given to the insurer's board or appropriate committee thereof. The model also provides for this information to be kept confidential. **See Attachment 3 &4.**

Some background about why this is needed:
Historically, the two largest causes of insurance company failures have been deficient loss reserves and rapid growth combined with inadequate pricing. However, the reserves and premium rates do not set themselves, there is a human component involved, so that's why we need to make sure that the companies have good corporate governance practices in place in order to remain financially solvent.

Good corporate governance practices include items such as: succession planning, ethics policies, codes of conduct, independent board members, and making sure people in key positions within the company possess an appropriate background, experience and integrity.

As a result of the 2009 U.S. Financial Sector Assessment Program (FSAP) review, recommendations were made for U.S. regulators to improve upon current corporate governance oversight practices in order to be more consistent with other countries. The U.S. regulatory system needs to be equivalent to the other countries so U.S. companies are allowed to do business around the globe.

II. Annual Audited Financial Reports Law (amendment to existing law)

In relation to the Corporate Governance Annual Disclosure Model Act, U.S. insurance regulators also determined that it was important to update the Annual Audited Financial Reports model law to require large insurance companies writing more than $500 million or insurance groups writing

more than $1 billion in annual premiums to maintain an internal audit function providing independent, objective and reasonable assurance to the company's audit committee and management regarding the insurer's governance, risk management and internal controls.

Currently, Wyoming does not have any domestic insurance companies that meet the $500 million threshold, so they would not be subject to this requirement at this time. However, we still need to have the law in place in case any large companies would redomesticate to Wyoming. *(Side note: BCBS is the largest with over $296 million in annual premiums).*

The update to this model will help make sure that the U.S. regulatory system is in compliance with Insurance Core Principle (ICP) #8 relating to risk management and internal controls. The update to this model will also help protect policyholders by making sure their insurance company is employing sound internal control practices. **See Attachment 6.**

III. Miscellaneous Updates (amendments to existing law)

During the Department's routine oversight of our domestic insurance companies, we have noted that some of the regulatory tools in the Insurance Code do not apply to all types of insurance companies. Therefore, the Department would like to make some minor updates to the Insurance Code, so that we can apply the same standards to all of our companies.

Specific Statutes to Address:

- Apply Hazardous Financial Condition law in W.S. §26-3-116 and W.S. §26-3-132 to HMOs (Chapter 34) and fraternals (Chapter 29).
- Apply home office/principal place of business and assets requirement in W.S. §26-24-129 to domestic HMOs.
- Apply supporting documentation requirement for expenses of $25.00 or more in W.S. §26-24-130 to HMOS.
- Apply W.S. §26-24-127 prohibiting pecuniary interests of officers or directors to HMOs.
- Apply timely claims payment requirement in W.S. §26-15-124 to HMOs.
- Apply the audit requirements in W.S. §26-3-301 to W.S. §26-3-317 to fraternals.
- Consider applying the entire Holding Company Act in Chapter 44 to HMOs. Currently, only the provision requiring our approval for an acquisition of a domestic HMO applies per W.S. §26-34-132. *(Note: May need to review language in W.S. §26-34-129 for conflicts in confidentiality language regarding certain confidential documents that are required in Chapter 44)*
- Although W.S. §33-16-529 gives the Department authority to regulate the sale of pre-need funeral contracts, add specific language to W.S. §26-32-101 regarding authority to license and provide regulations regarding all issues relating to pre-need funeral contracts.

IV. Pre-Need Funeral Contracts

Wyoming Statute §33-16-529(c) of the Funeral Service Practitioner's Act, W.S. provides that any person who is licensed pursuant to title 26 may sell insurance or pre-need funeral contracts authorized by that license. There are two ways that a pre-need funeral contract may be funded. The first is through the sale of a life insurance policy. In this case, the seller is required to have a license to sell life insurance under W.S. §26-32-201. The second is through direct payment from consumer to the seller. In this case, W.S. §26-32-101(a) provides the commissioner the authority to supervise and audit the funds. Unfortunately, there is no specific reference to licensing under title 26.

Having strong protections in place for pre-need contracts is imperative, given that performance of the contract is only required after the death of the contract beneficiary. Licensing requirements would give the commissioner the ability to ensure those selling pre-need contracts with direct payments are of good character, are financially responsible, and have general knowledge regarding contracts. In the event that an individual fails or refuses to abide by the statutory requirements or the Regulations of the Insurance Department regarding pre-need contracts, licensure would provide the commissioner additional enforcement mechanisms by revocation or suspension of the license pursuant to W.S. §26-9-211.

All but a couple of states regulate the sale of pre-needs funeral contracts. Although the method of regulation varies from state to state, it is clear that regulation of pre-needs funeral contracts by way of license or registration is important to protect the public interest. The Department of Insurance has historically required a license for the sale of pre-need contracts and would like to avoid any future confusions.

The Department recommends clarifying the statute by amending W.S. §26-32-101 to include the following language:

"(b) All persons selling pre-paid or pre-arranged funeral contracts must be licensed by the Department of Insurance."

Pharmacy Benefit Managers (PBM) Program

I. Overview of PMB Services

The National Association of Boards of Pharmacy defines pharmacy benefit manager (PBM) as a person that administers the prescription drug or device portion of health insurance plans on behalf of insurers,[1] and that engages in or directs the practice of pharmacy.[2] PBMs are basically third

[1] These include employers, HMOs and insurance carriers.

[2] Report of the Task Force on the Regulation of Pharmacy Benefit Managers—retrieved from http://www.nabp.net/system/rich/rich_files/rich_files/000/000/230/original/pbm-tf-report.pdf

party administrators responsible for managing prescription plans for a substantial percentage of Americans with prescription drug coverage.[3]

PBMs are sometimes referred to as the middlemen in the prescription drug market because they act as intermediaries between health plan sponsors and drug manufacturers and pharmacies. PBMs are able to use the promise of steering large quantities of business to network pharmacies in order to obtain favorable pricing on prescription drugs.

In addition to negotiating rebates with drug manufacturers, PBMs also negotiate with retail pharmacies to obtain various discounts on prescription drug prices. Additionally, PBMs try to assure adequate access for patients enrolled in the various health plans to obtain their prescription drugs. A PBM may also be responsible for the development and management of a drug formulary, which is a list of drugs that a health plan uses to make reimbursement decisions.

Some PBMs also operate their own mail order, specialty drug, and retail pharmacies. In these cases, PBMs negotiate directly with pharmaceutical manufacturers to purchase prescription drugs, and in some cases receive rebates from the manufacturers. Again, PBMs use their size and purchasing power as leverage to obtain discounted pricing on drugs, agreeing to include certain drugs in the formularies they offer to employee benefit plans.

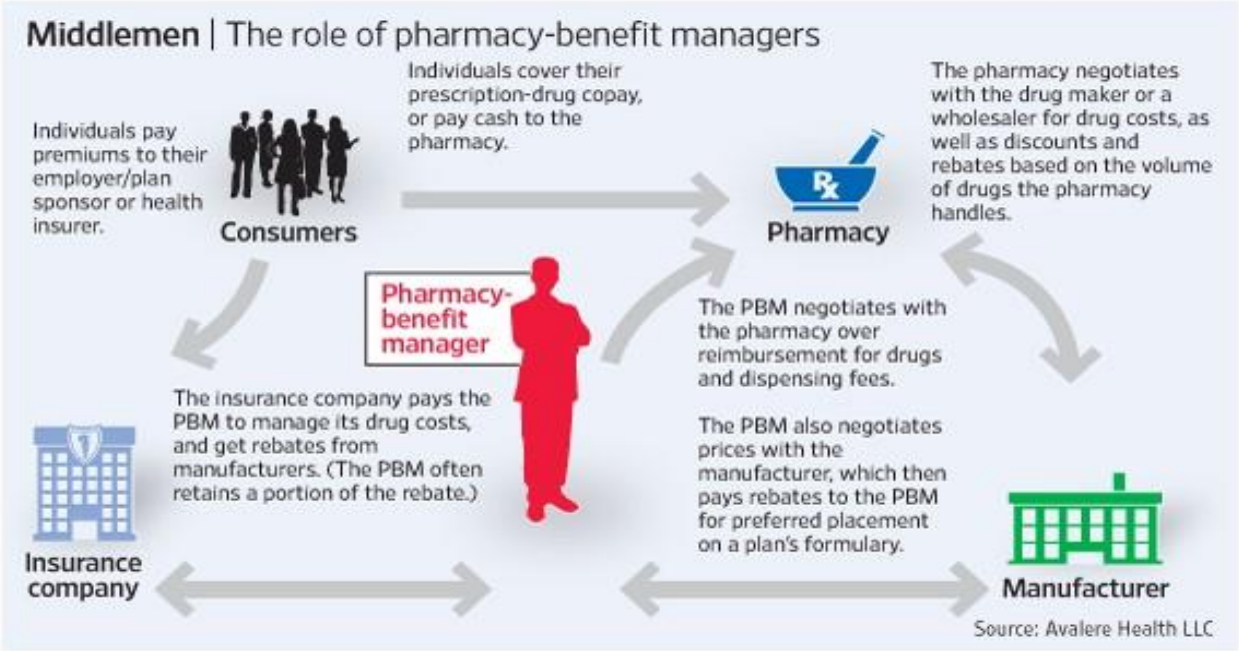
PBMs provide other administrative services to employee benefit drug programs, including general recordkeeping of drug purchases and usage, creation and maintenance of drug formularies, pharmaceutical utilization review, adjudication of drug claims, participant communications, and other services.[4]

In a typical situation where a benefit plan participant seeks to fill a drug prescription, the role of the PBM is illustrated as follows: The participant visits a network pharmacy, the pharmacy checks with the PBM to confirm participant eligibility, coverage and copayment information; the participant pays the copayment and purchases the drug, the PBM then reimburses the pharmacy at the negotiated network rate less the copayment, and the PBM then bills the plan at the rate negotiated for that drug. However, where a participant purchases the drug directly from the PBM as part of a mail order program, the pharmacy and wholesaler may not be involved at all.

Contracts between a PBM and health plan sponsors specify how much the health plan sponsors will pay PBMs for brand name and generic drugs. These prices are typically set as a discount off the average wholesale price (AWP)[5] for brand-name drugs and at the maximum-allowable cost (MAC)[6] for generic drugs (and sometimes brand drugs that have generic versions), plus a dispensing fee.

[3] Estimated at 95% of Americans with drug coverage.
[4] PBM Compensation and Fee Disclosure: Retrieved from United States DOL, http://www.dol.gov/ebsa/publications/2014ACreport1.html#cite-21
[5] AWP is the average price that manufacturers recommend wholesalers sell to physicians, pharmacies and others, such as hospitals.
[6] MAC is a price set for generic drugs and is the maximum amount that the plan sponsor will pay for a specific drug.

Table 1: The Role of PBMs



II. Potential Conflict of Interest in Current PBM Compensation System

Various sources of conflict of interest have been alleged against PBMs, especially those that own mail-order pharmacies that compete with retail pharmacies.

Retention of rebates by PBMs allegedly leads to conflict of interest, specifically, the PBM has incentives to encourage members to take a drug with a higher net cost to the plan sponsor because the PBM receives a larger rebate.[7] Because PBMs typically receive rebates on brand-name drugs, they are not incentivized to encourage the use of a less-expensive generic version. PBMs typically do not pass the rebated savings back to the plan sponsor.

There have been allegations that PBMs frequently require patients to switch drugs— so that they have to take a drug on which the PBM has negotiated a greater rebate—increasing the profit to the PBM.

Another potential conflict arises from the fact that the PBM's retail spread is usually a fixed percentage of the drug's list price. In theory, this implies that PBMs have little incentive to control the rate of increase in drug prices or to prefer drugs with lower list prices, as the PBM margin increases as drug prices increase. In large part, the plan sponsor has no knowledge about the rebate deals the PBM negotiates with the manufacturers and has no knowledge of the "spread" or the

[7] A 2004 case accused Medco of switching patients from the cholesterol treatment Lipitor to similar, but higher cost, Zocor, in order to gain higher rebate revenue on Zocor. The resulting settlement deemed it illegal for a PBM to incentivize a patient to switch to a drug that is more expensive for the plan sponsor.

difference between what the PBM pays the pharmacy and what the PBM charges them for the same drug.

A potential conflict of interest may also arise from the ability of PBMs to set reimbursement rates for both competitor retail pharmacies and mail-order pharmacies, and to steer utilization between the two. It has been argued that large PBMs artificially keep retail pharmacy reimbursements for generic drugs high in order to protect margins in their mail order business, which is the more profitable channel for PBMs.

Federal and State Regulations of PBMs

A. PBM Transparency Reporting for Medicare Part D and ACA Qualified Plans

The Patient Protection and Affordable Care Act (ACA) a includes provision requiring greater transparency in PBM contracts with Medicare Part D plans and plans on healthcare exchanges. The final rule requires Part D plans and their PBMs to make available to contracted pharmacies the reimbursement rates for drugs under Maximum Allowable Cost pricing standards.[8]

The ACA requires PBMs to provide the following information: (1) percentage of all prescriptions that were provided through retail versus mail order pharmacies and the percentage of prescriptions for which a generic drug was available and dispensed that is paid by the health plan; (2) the aggregate amount, type of rebates, discounts, or price concessions that the PBM negotiates that are attributable to patient utilization, and the aggregate amount that are passed through to the plan sponsor, and the total number of prescriptions that were dispensed;[9] and (3) the aggregate amount of the difference that the health plan pays the PBM and the amount the PBM pays the retail pharmacies, the mail order pharmacies, and the total number of prescriptions that were dispensed.

These required disclosures are in aggregate, so the PBM is not required to provide information on specific manufacturer contracts or pricing for specific customers or products. The PBM is required to make these disclosures to CMS and to the health plan sponsor, which is required to maintain confidentiality. Failure by the PBMs to timely or accurately disclose the requisite information will subject the PBM to penalties.[10]

While PBMs are also subject to other federal laws governing businesses, such as the False Claims Act, the Federal Trade Commission Act, and the Anti-Kickback Act, no federal agency or law is responsible for regulating the PBM industry. Likewise, at the state level, the majority of states do not regulate PBMs. The states that do regulate PBMs vary as to the aspect of PBM activities they regulate and to the extent they impose regulations.

B. State Regulatory Activities

1. Registration and Licensure Regulations

Pharmacies and pharmacists in Wyoming are regulated under the Wyoming Pharmacy Act in W.S. §33-24-101 to §33-24-301. The Board of Pharmacy created under this chapter regulates the

[8] This requirement will be effective beginning with contract year 2016.
[9] 42 U.S. Code, §1320b-23(b).
[10] Section 1320b-23(c).

practice of pharmacy in the State of Wyoming. This includes licensing of pharmacists, resident and nonresident pharmacies. The Board licenses/registers all manufacturers, distributors, and wholesalers that ship prescription drugs into, out of, or within the State of Wyoming. The Board also has the authority to promulgate Rules and Regulations, as authorized under the Wyoming Pharmacy Act. The Board however, does not regulate PBMs in Wyoming.

Currently, PBMs are not subject to any regulation in Wyoming, although they are subject to different regulatory requirements in a number of states. Some of these regulations include registration, requirement to be licensed as a third party administrator, and the requirement to be licensed as a PBM. **See Attachment 5.**

2. Audit Restrictions and Rights

Another area of state PBM regulation has to do with fair auditing regulations. Of the states that regulate PBMs, most address fair auditing provisions of pharmacies.[11] Fair auditing regulations impose restrictions and establish requirements on PBMs that audit pharmacies. States passed these regulations in response to concerns from pharmacists and pharmacy owners about PBM requirements for pharmacy audits.

Legitimate auditing practices are generally carried out by PBMs as a means of ensuring that patients are receiving the medications ordered by the physicians and paid by the employer, insurer or the government payer. PBM audits enables employers to root out wasteful spending on prescription drugs.

The National Community Pharmacists Association (NCAP) says that it supports legitimate auditing practices undertaken by PBMs to uncover true fraud and abuse. However, an NCPA survey conducted last fall indicated that almost 80% of independent pharmacies reported that PBMs apply inconsistent auditing standards across various plans. More than 80% reported that PBM auditors "always" or "often" required recordkeeping above and beyond the requirements of state and federal law.

Most state regulations include a requirement that PBMs provide "notice" to pharmacies before conducting an audit, with notice ranging from seven to fourteen days.[12] These regulations also require PBMs to allow pharmacies an opportunity to appeal audit results, generally within a thirty-day timeframe. States have also set limitations on what PBMs can audit. For example, states may limit the number of claims a PBM may audit or limit the period covered by a PBM audit between one to two years.

A number of states give plan sponsors a right to information the PBM may otherwise deem proprietary. Historically, PBMs have claimed many critical components of a PBM contract, such as claims data or rebate information, as proprietary information and refused to share this

[11] See Ark. Code Ann. § 17-92-1201 (West 2013); Fla. Stat. § 465.188 (2013); Ga. Code Ann. § 26-4-118; Ind. Code § 25-26-22-1; Md. Code. Ann., Ins. § 15- 1629; Miss. Code Ann. § 73-21-183; Mo. Ann. Stat. § 338.600; N.M. Stat. Ann. § 61-11-18.2; Okla. Stat. Ann. tit. 59 § 8; Tenn. Code Ann. § 56- 7-3103.
[12] Ark. Code Ann. § 17-92-1201; Miss. Code Ann. § 73-21-183.

information with the plan sponsor. These states give plan sponsors a statutory right to information that PBMs might not have granted to plan sponsors.

For example, in South Dakota, plan sponsors have a right to request information from the PBM.[13] Under the law, plan sponsors may request information on all rebate revenues and other remuneration from pharmaceutical manufacturers. Additionally, plan sponsors are given a legal right to audit the PBM's books with an independent auditor.

North Dakota requires that PBM-plan sponsor contracts include a provision granting plan sponsors the right to audit "manager's books, accounts, and records, including de-identified utilization information, as necessary …" to confirm the PBM is only retaining the money as entitled to under contract.[14] Similarly in Vermont, PBMs must allow plan sponsors periodic access to any information necessary to verify the plan's pricing arrangement with an independent auditor.[15] Vermont also allows plan sponsors to request all financial and utilization data relating to a prescription plan.[16]

3. Fee Arrangement Rights

Some states require a PBM to offer plan sponsors different options for the PBM's payment structure. Regulations addressing payment structure are designed to ensure plan sponsors pay appropriate fees in relation to the agreed pricing arrangement. For example, in North Dakota, the payment options that PBMs provide plan sponsors specify whether payment will be primarily through transaction fees.[17] In Vermont, PBMs may only charge plan sponsors a reasonable fee, "which represents a competitive pharmacy benefit manager profit."[18]

4. Drug Pricing Requirements

PBM drug pricing is another area that some states have regulated in response to concerns that PBMs were not passing all potential savings to plan sponsors. Some of these state regulations are designed to help prevent "price spreading," which allows PBMs to charge a plan sponsor for a drug, but pay a lower amount to the pharmacy that dispenses the drug and keep the difference. North Dakota requires PBMs to give plan sponsors the option of deciding between paying the PBM under three different payment structures, including an option for payment with pass-through pricing.[19]

Other state regulations focus on the reimbursement rates to pharmacies. Many different pricing formulas are available for PBMs to use when reimbursing pharmacies for drugs. The pricing standard the PBM uses may make it difficult for a plan sponsor to determine whether the calculated

[13] S.D. Codified Laws § 58-29E-4.
[14] N.D. Cent. Code § 26.1- 27.1-05(2).
[15] Vt. Stat. Ann. tit. 18, § 9421(c).
[16] Id. at § 9472(c)(1).
[17] N.D. Cent. Code § 26.1- 27.1-05(1).
[18] Vt. Stat. Ann. tit. 18, § 9421(b).
[19] N.D. Cent. Code § 26.1- 27.1-05(1).

price accurately reflects the cost of the drug.[20] For plan sponsors with contracts requiring pass-through pricing, regulations that control pharmacy reimbursement rates can help plan sponsors understand drug pricing. For example, Alabama prohibits agreements between PBMs and pharmacies to establish reimbursement rates or procedures for members under a prescription plan that would be less than the "usual and customary rate" a non-member customer would pay for the same or similar service.[21] Mississippi requires PBMs to use a nationally recognized reference in calculating pricing when reimbursing pharmacies.[22] It also requires the PBM to update the reference every three days.

5. Formulary and Interchange Restrictions

Some state regulations include provisions addressing formulary and interchange requirements for PBMs contracting with plan sponsors. These regulations either place restrictions on establishing and making changes to the preferred list of drugs on a prescription plan, or set limitations on when and how PBMs can require drug substitutions. These regulations attempt to contain the costs of prescriptions and to prevent PBMs from failing to pass on drug savings to plan sponsors.

For example, South Dakota's regulation limits the ability of PBMs to require drug substitutions.[23] Under the regulation, PBMs may only request a drug substitution if the product is therapeutically equivalent and less expensive. Substitutions that are more expensive must only be for medical reasons.

Vermont allows a PBM to substitute a drug with one that is more costly; however, requires the PBM to disclose to the plan sponsor the cost of both drugs, and to disclose any financial benefit the PBM received as a result of the substitution.[24] Additionally, Vermont requires PBMs to disclose to plan sponsors any arrangements for remuneration received from drug manufacturers relating to the formulary and drug-switch programs.

C. 15 LSO-0152

15 LSO-0152 is a draft bill related to regulating PBMs. **See Attachment 7.** The bill was ultimately not introduced during the 2015 session. There were preliminary discussion concerning the draft bill between the bill's sponsor, Representative Kirkbride, Chris Brown (Wyoming Retail Association) and the Department of Insurance.

At that time, the Department of Insurance expressed concerns regarding the bill. While regulating PBMs may be a good idea, the Department did not believe that it had sufficient manning or expertise to oversee any regulation of PBMs. Specifically, the expertise required to deal with

[20] Medicaid Pharmacy Admin. Ass'n & Nat'l Ass'n of Medicaid Dirs., Executive Summary and White Paper: Post AWP Pharmacy Pricing and Reimbursement (Jun. 2010), retrieved from http://hsd.aphsa.org/home/doc/SummaryofWhitePaper.pdf.
[21] Ala. Code § 34-23-115.
[22] Miss. Code § 73-21-155(1).
[23] S.D. Codified Laws § 58-29E-8.
[24] Vt. Stat. Ann. tit. 18, § 9472(c)(3).

technical pharmacological issues (such as disputes as to whether one generic is equivalent to another) is not found within the Department.

Approximately 18 states have passed various types of legislation to deal with PBMs. Some states require full licensing of PBMs while other states require the PBM to register with the state. 15 LSO-0152 is somewhat similar to the Iowa model whereby the PBM is registered with the Department of Insurance.

Attachment #1

The following table shows the approximate publication date and title of the PSAs to date.

Date*	**PSA Article Title**
5/1/2013	Preparing for Dangerous Weather Events and Storms
5/29/2013	Travel Insurance
6/12/2013	Understanding Your Insurance Policy
8/14/2013	College Students – Renters, Health Auto, and Identity Theft
9/25/2013	ACA Information - Marketplace
10/16/2013	ACA Information
11/13/2013	Medicare Open Enrollment
12/18/2013	Guaranty Association
1/15/2014	ACA
2/19/2014	ACA Open Enrollment
2/26/2014	Winter Fires
3/19/2014	Flood Insurance
5/21/2014	Spring/summer Weather and Storms Alert
6/25/2014	Personal/Home Inventory
7/23/2014	Summertime Travel Tips – Travel Insurance
8/27/2014	Back to School – college students insurance information
10/15/2014	Medicare Open Enrollment
11/12/2014	ACA – Open Enrollment
12/18/2014	Fire Safety – Winter Fires
1/21/2015	Review Your Policies & coverages – “Are You Prepared for 2015?”
2/20/2015	Health Care Insurance and Tax Returns
3/24/2015	Home-Based Businesses
4/22/2015	Storm Preparedness
5/20/2015	Annuities

* Publication dates may vary slightly as some newspapers are daily publications whereas others are weekly.

Attachment #2

Wyoming Insurance Department

Policy, Rate & Form Filing Requirements

Individual Equity Indexed Annuities

Contact Information:
Peter Greff
Insurance Standards Consultant
106 East 6th Avenue
Cheyenne, WY 82001
(307) 777-2448
(307) 777-2446 (fax)
peter.greff@wyo.gov

For **ALL** filings, the Wyoming Insurance Department requires the following document to be completed: Wyoming Uniform Filing Procedure for All Regulated Insurance Coverage Certification Form.

Updated 9/1/14

Wyoming Insurance Department	Statutes	http://legisweb.state.wy.us/statutes/sub26.htm
Wyoming Insurance Department	Rules and Regulations	http://soswy.state.wy.us
Wyoming Insurance Department	Memoranda of Dept. Position	August 6, 1997 Equity Indexed Annuity Requirements
REVIEW REQUIREMENTS	**REFERENCE**	**COMMENTS**
SERFF/Transmittal Letter	Wyoming Uniform Filing Procedure	All filings shall:
		Contain the company's name, address, NAIC number and company phone number.
		Have a "SUBJECT" line briefly describing filing type.
		Contain an itemized listing of each policy form and endorsement, including form number.
		Contain the name of individual responsible for the preparation of the filing.

		Contain a Certification of Compliance signed by an officer of the company, attorney or actuary.
"Red-Line" Documents	Department Position	Any filing that replaces or changes previously approved forms requires a "red-line" version of the document highlighting the proposed changes. "Red-Line documents are also required if changes are made due to Department objections to the filing.
Actuarial Memorandum	W.S. §26-15-111	Shall certify rates are reasonable in relation to the benefits provided.
Forms		
Wyoming Life & Health Guaranty Association Notice	W.S.§ 26-42-116	No insurer may deliver a policy or contract unless a copy of the Wyoming Life and Health Guaranty Association Notice is given to the policyholder or contract holder prior to or at the time of delivery. Please include a copy of the Notice you intend to use.
Replacement Question Requirement	Chapter 12, Section 7 of the Wyoming Insurance Department Regulations	Where a replacement is involved, a copy of the Replacement Notice shall be completed and the applicant be given a copy explaining replacement considerations. Please include a copy of the Notice you intend to use.
Free Look on Replaced Policies	Chapter 12, Section 7 of the Wyoming Insurance Department Regulations	The applicant shall have a right to an unconditional refund of all premiums paid, which right may be exercised within a period of a least thirty (30) days commencing from the date of delivery of the policy.
Grace Period	W.S.§ 26-16-103	There shall be a grace period of one (1) month, but not less than thirty (30) days, for the payment of any premium due after the first. The policy shall remain in force during the grace period. The insurer may impose an interest charge not to exceed six (6) percent per annum for the number of days of grace elapsing before the payment is received.
Incontestability	W.S.§ 26-16-104	The policy shall be incontestable after the policy is in force during the insured's lifetime for a period of two (2) years from its date of issue.
Entire Contract	W.S.§ 26-16-105	The policy and application, constitutes the entire contract between the parties and statements contained in the application, in the absence of fraud, are representations and not warranties.

Misstatement of Age	W.S.§ 26-16-106	If the age of the insured or any other person whose age is considered in determining the premium or benefit is misstated, any amount payable or benefit accruing under the policy shall be in an amount as the premium would purchase at the correct age.
Dividends	W.S.§ 26-16-107	In a participating policy there shall be a provision that the insurer shall annually ascertain and apportion any divisible surplus accruing on the contract.
Policy Loan	W.S.§ 26-16-108	The policy shall provide for a loan provision. The policy shall contain the conditions of the loan. The insurer reserves the right to defer the payment of any loan for six (6) months after application. The interest rate shall be at a maximum of eight (8) percent or a different rate previously approved by the commissioner.
Settlement of Death Benefit	W.S.§ 26-16-112	The death benefit, if any, shall include interest from the date of death until the date of payment. The interest rate shall be not less than the rate of interest payable on death proceeds left on deposit with the insurer. However, in no circumstances shall the payment exceed forty-five (45) days.
Nonforfeiture Value	W.S.§ 26-16-404	A signed actuarial memorandum describing the contract, values, reserves and surrender charges and demonstrate the compliance of policy values with the standard nonforfeiture law for individual deferred annuities.
Advertising	Department Position	All advertising, marketing materials and/or illustrations will be presented to the policyholder prior to and/or during the sale of any equity indexed product shall be submitted. All advertising materials must be submitted with the product before the product is offered for sale. Therefore, do not file the product until the advertising and marketing material is fully developed and ready for review.
Face Page Disclosure	Department Position	The face page must contain a disclosure statement that clearly labels the product as an equity indexed product.
Annual Report	Department Position	A sample of the annual report that will be given to the policy owner.
Minimum Value Illustration	Department Position	A copy of a minimum value illustration that must be provided which will simply and accurately demonstrate sample surrender values.

Product Summary Disclosure Document	Department Position	A copy of a narrative summary disclosure document describing the key components of the contract. These components include, but are not limited to, the index, the index calculation method, whether the contract uses averaging or not, participation rate and caps. The descriptions must be simple, understandable to a typical reader and not misleading.
Disclosure Acknowledgment Statement	Department Position	An acknowledgment statement signed by the applicant and company representative shall be enclosed verifying: That the applicant has received a copy of the disclosure document and understands the content within and that any concerns have been answered by the insurance company representative; That the agent has presented the disclosure document and a signed copy was provided to the applicant; That the company representative has not made statements which differ from the disclosure document and that no promises or assurances have been made about the future equity values of the contract. Please let us know if your disclosure notice is company prepared or one compiled by the NAIC.
Proceeds Under Annuity Contracts	W.S.§ 26-15-132	The benefits, rights, privileges and options which under any annuity contract issued are due or prospectively due the annuitant, are not subject to execution nor is the annuitant compelled to exercise any such rights powers or options. Creditors are not allowed to interfere with or terminate the contract, other than under specific exceptions.
Surrender/Withdrawal-Deferral of Payment	W.S.§26-16-403	If a contract provides for a lump sum settlement at maturity, or at any other time, that upon surrender of the contract at or prior to the commencement of any annuity payments, the company shall pay instead of any paid-up annuity benefit a cash surrender benefit in an amount as is specified in W.S. 26-16-405, 26-16-406, 26-16-408 and 26-16-409, provided the company may reserve the right to defer the payment of the cash surrender benefit for a period not to exceed six (6) months after demand therefore with surrender of the contract and after making written request and receiving the written approval of the commissioner. The request shall address the necessity and equitability to all policyholders of the deferral;

Attachment #3

CORPORATE GOVERNANCE ANNUAL DISCLOSURE MODEL ACT

Table of Contents

Section 1. Purpose and Scope.

A. The purpose of this Act is to:

1. Provide the Insurance Commissioner a summary of an insurer or insurance group's corporate governance structure, policies and practices to permit the Commissioner to gain and maintain an understanding of the insurer's corporate governance framework.

2. Outline the requirements for completing a corporate governance annual disclosure with the Insurance Commissioner.

3. Provide for the confidential treatment of the corporate governance annual disclosure and related information that will contain confidential and sensitive information related to an insurer or insurance group's internal operations and proprietary and trade secret information which, if made public, could potentially cause the insurer or insurance group competitive harm or disadvantage.

B. Nothing in this act shall be construed to prescribe or impose corporate governance standards and internal procedures beyond that which is required under applicable state corporate law. Notwithstanding the foregoing, nothing in this act shall be construed to limit the Commissioner's authority, or the rights or obligations of third parties, under [INSERT EXAMINATION CITATION]

C. The requirements of this Act shall apply to all insurers domiciled in this state.

Drafting Note: The requirements of this Act are intended to apply to all commercial risk bearing entities subject to oversight by state insurance departments. Therefore, modifications may be necessary to ensure that all entities intended to be subject to the Act, but not meeting the state's legal definition of "insurer," are appropriately referenced.

Section 2. Definitions.

A. "Commissioner." The Insurance Commissioner of the State.

B. "Corporate Governance Annual Disclosure (CGAD)." A Corporate Governance Annual Disclosure shall mean a confidential report filed by the insurer or insurance group made in accordance with the requirements of this Act.

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C. "Insurance group." For the purpose of this Act, the term "insurance group" shall mean those insurers and affiliates included within an insurance holding company system as defined in [insert state law equivalent to the model Insurance Holding Company System Regulatory Act.]

D. "Insurer." The term "insurer" shall have the same meaning as set forth in Section [insert applicable section] of this Chapter, except that it shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

E. "ORSA Summary Report." The term "ORSA Summary Report" shall mean the report filed in accordance with [insert applicable statutory reference to the Risk Management and Own Risk and Solvency Assessment Model Act.]

Section 3. Disclosure Requirement.

A. An insurer, or the insurance group of which the insurer is a member, shall, no later than June 1 of each calendar year, submit to the Commissioner a Corporate Governance Annual Disclosure (CGAD) that contains the information described in Section 5B below. Notwithstanding any request from the Commissioner made pursuant to Subsection C, if the insurer is a member of an insurance group, the insurer shall submit the report required by this Section to the Commissioner of the lead state for the insurance group, in accordance with the laws of the lead state, as determined by the procedures outlined in the most recent Financial Analysis Handbook adopted by the NAIC.

B. The CGAD must include a signature of the insurer or insurance group's chief executive officer or corporate secretary attesting to the best of that individual's belief and knowledge that the insurer has implemented the corporate governance practices and that a copy of the disclosure has been provided to the insurer's board of directors or the appropriate committee thereof.

C. An insurer not required to submit a CGAD under this section shall do so upon the Commissioner's request.

D. For purposes of completing the CGAD, the insurer or insurance group may provide information regarding corporate governance at the ultimate controlling parent level, an intermediate holding company level and/or the individual legal entity level, depending upon how the insurer or insurance group has structured its system of corporate governance. The insurer or insurance group is encouraged to make the CGAD disclosures at the level at which the insurer's or insurance group's risk appetite is determined, or at which the earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively and at which the supervision of those factors are coordinated and exercised, or the level at which legal liability for failure of general corporate governance duties would be placed. If the insurer or insurance group determines the level of reporting based on these criteria, it shall indicate which of the three criteria was used to determine the level of reporting and explain any subsequent changes in level of reporting.

E. The review of the CGAD and any additional requests for information shall be made through the lead state as determined by the procedures within the most recent Financial Analysis Handbook referenced in Paragraph A of this section.

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F. Insurers providing information substantially similar to the information required by this Act in other documents provided to the Commissioner, including proxy statements filed in conjunction with Form B requirements, or other state or federal filings provided to this Department shall not be required to duplicate that information in the CGAD, but shall only be required to cross reference the document in which the information is included.

Section 4. Rules and Regulations

The Commissioner may, upon notice and opportunity for all interested persons to be heard, issue such rules, regulations and orders as shall be necessary to carry out the provisions of this Act.

Section 5. Contents of Corporate Governance Annual Disclosure.

A. The insurer or insurance group shall have discretion over the responses to the CGAD inquiries, provided the CGAD shall contain the material information necessary to permit the Commissioner to gain an understanding of the insurer's or group's corporate governance structure, policies, and practices. The Commissioner may request additional information that he or she deems material and necessary to provide the Commissioner with a clear understanding of the corporate governance policies, the reporting or information system or controls implementing those policies.

B. Notwithstanding Subsection A of this section, the CGAD shall be prepared consistent with the Corporate Governance Annual Disclosure Model Regulation [INSERT CITATION]. Documentation and supporting information shall be maintained and made available upon examination or upon request of the Commissioner.

Section 6. Confidentiality.

A. Documents, materials or other information including the CGAD, in the possession or control of the Department of Insurance that are obtained by, created by or disclosed to the Commissioner or any other person under this Act, are recognized by this state as being proprietary and to contain trade secrets. All such documents, materials or other information shall be confidential by law and privileged, shall not be subject to [insert open records, freedom of information, sunshine or other appropriate phrase], shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the Commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's official duties. The Commissioner shall not otherwise make the documents, materials or other information public without the prior written consent of the insurer. Nothing in this section shall be construed to require written consent of the insurer before the Commissioner may share or receive confidential documents, materials or other CGAD-related information pursuant to Subsection C below to assist in the performance of the Commissioner's regular duties.

Drafting Note: States should consider whether to specifically invoke their examination statute as applicable additional confidentiality protection for documents submitted pursuant to this Model Act.

B. Neither the Commissioner nor any person who received documents, materials or other CGAD-related information, through examination or otherwise, while acting under the authority of the Commissioner, or with whom such documents, materials or other information are shared pursuant to this Act shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to Subsection A.

C. In order to assist in the performance of the Commissioner's regulatory duties, the Commissioner:

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1. May, upon request, share documents, materials or other CGAD-related information including the confidential and privileged documents, materials or information subject to Subsection A, including proprietary and trade secret documents and materials with other state, federal and international financial regulatory agencies, including members of any supervisory college as defined in the [insert cross-reference to appropriate section of Insurance Holding Company System Regulatory Act, as amended], with the NAIC, and with third party consultants pursuant to Section 7, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the CGAD-related documents, material or other information and has verified in writing the legal authority to maintain confidentiality; and

2. May receive documents, materials or other CGAD-related information, including otherwise confidential and privileged documents, materials or information, including proprietary and trade-secret information or documents, from regulatory officials of other state, federal and international financial regulatory agencies, including members of any supervisory college as defined in the [insert cross-reference to appropriate section of Insurance Holding Company System Regulatory Act, as amended], and from the NAIC, and shall maintain as confidential or privileged any documents, materials or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information.

D. The sharing of information and documents by the Commissioner pursuant to this Act shall not constitute a delegation of regulatory authority or rulemaking, and the Commissioner is solely responsible for the administration, execution and enforcement of the provisions of this Act.

E. No waiver of any applicable privilege or claim of confidentiality in the documents, proprietary and trade-secret materials or other CGAD-related information shall occur as a result of disclosure of such CGAD-related information or documents to the Commissioner under this section or as a result of sharing as authorized in this Act.

Section 7. NAIC and Third-party Consultants

A. The Commissioner may retain, at the insurer's expense, third-party consultants, including attorneys, actuaries, accountants and other experts not otherwise a part of the Commissioner's staff as may be reasonably necessary to assist the Commissioner in reviewing the CGAD and related information or the insurer's compliance with this Act.

B. Any persons retained under Subsection A shall be under the direction and control of the Commissioner and shall act in a purely advisory capacity.

C. The NAIC and third-party consultants shall be subject to the same confidentiality standards and requirements as the Commissioner.

D. As part of the retention process, a third-party consultant shall verify to the Commissioner, with notice to the insurer, that it is free of a conflict of interest and that it has internal procedures in place to monitor compliance with a conflict and to comply with the confidentiality standards and requirements of this Act.

E. A written agreement with the NAIC and/or a third-party consultant governing sharing and use of information provided pursuant to this Act shall contain the following provisions and

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expressly require the written consent of the insurer prior to making public information provided under this Act:

1. Specific procedures and protocols for maintaining the confidentiality and security of CGAD-related information shared with the NAIC or a third-party consultant pursuant to this Act.

2. Procedures and protocols for sharing by the NAIC only with other state regulators from states in which the insurance group has domiciled insurers. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the CGAD-related documents, materials or other information and has verified in writing the legal authority to maintain confidentiality.

3. A provision specifying that ownership of the CGAD-related information shared with the NAIC or a third-party consultant remains with the Department of Insurance and the NAIC's or third-party consultant's use of the information is subject to the direction of the Commissioner;

4. A provision that prohibits the NAIC or a third-party consultant from storing the information shared pursuant to this Act in a permanent database after the underlying analysis is completed;

5. A provision requiring the NAIC or third-party consultant to provide prompt notice to the Commissioner and to the insurer or insurance group regarding any subpoena, request for disclosure, or request for production of the insurer's CGAD-related information; and

6. A requirement that the NAIC or a third-party consultant to consent to intervention by an insurer in any judicial or administrative action in which the NAIC or a third-party consultant may be required to disclose confidential information about the insurer shared with the NAIC or a third-party consultant pursuant to this Act.

Section 8. Sanctions.

Any insurer failing, without just cause, to timely file the CGAD as required in this Act shall be required, after notice and hearing, to pay a penalty of $[insert amount] for each day's delay, to be recovered by the Commissioner and the penalty so recovered shall be paid into the General Revenue Fund of this state. The maximum penalty under this section is $[insert amount]. The Commissioner may reduce the penalty if the insurer demonstrates to the Commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

Section 9. Severability Clause.

If any provision of this Act other than Section 6, or the application thereof to any person or circumstance, is held invalid, such determination shall not affect the provisions or applications of this Act which can be given effect without the invalid provision or application, and to that end the provisions of this Act, with the exception of Section 6, are severable.

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Section 10. Effective Date.

The requirements of this Act shall become effective on January 1, 2016. The first filing of the CGAD shall be in 2016.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

Adopted by Executive/Plenary Committee at 2014 Fall National Meeting

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Attachment #4

CORPORATE GOVERNANCE ANNUAL DISCLOSURE MODEL REGULATION

Table of Contents

Section 1. Authority

These regulations are promulgated pursuant to the authority granted by Sections [insert applicable sections] and [insert applicable section] of the Insurance Law.

Section 2. Purpose

The purpose of these regulations is to set forth the procedures for filing and the required contents of the Corporate Governance Annual Disclosure (CGAD), deemed necessary by the [Commissioner] to carry out the provisions of [insert reference to Corporate Governance Annual Disclosure Model Act].

Section 3. Definitions.

A. "Commissioner." The Insurance Commissioner of the State.

B. "Insurance group." For the purpose of this Act, the term "insurance group" shall mean those insurers and affiliates included within an insurance holding company system as defined in [insert state law equivalent to the model Insurance Holding Company System Regulatory Act.]

C. "Insurer." The term "insurer" shall have the same meaning as set forth in Section [insert applicable section] of this Chapter, except that it shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

D. "Senior Management." The term "senior management" shall mean any corporate officer responsible for reporting information to the board of directors at regular intervals or providing this information to shareholders or regulators and shall include, for example and without limitation, the Chief Executive Officer ("CEO"), Chief Financial Officer ("CFO"), Chief Operations Officer ("COO"), Chief Procurement Officer ("CPO"), Chief Legal Officer ("CLO"), Chief Information Officer ("CIO"), Chief Technology Officer ("CTO"), Chief Revenue Officer ("CRO"), Chief Visionary Officer ("CVO"), or any other "C" level executive.

Section 4. Filing Procedures

A. An insurer, or the insurance group of which the insurer is a member, required to file a CGAD by the [insert reference to Corporate Governance Annual Disclosure Model Act], shall, no later than June 1 of each calendar year, submit to the Commissioner a CGAD that contains the information described in Section 5 of these regulations.

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B. The CGAD must include a signature of the insurer's or insurance group's chief executive officer or corporate secretary attesting to the best of that individual's belief and knowledge that the insurer or insurance group has implemented the corporate governance practices and that a copy of the CGAD has been provided to the insurer's or insurance group's Board of Directors (hereafter "Board") or the appropriate committee thereof.

C. The insurer or insurance group shall have discretion regarding the appropriate format for providing the information required by these regulations and is permitted to customize the CGAD to provide the most relevant information necessary to permit the Commissioner to gain an understanding of the corporate governance structure, policies and practices utilized by the insurer or insurance group.

D. For purposes of completing the CGAD, the insurer or insurance group may choose to provide information on governance activities that occur at the ultimate controlling parent level, an intermediate holding company level and/or the individual legal entity level, depending upon how the insurer or insurance group has structured its system of corporate governance. The insurer or insurance group is encouraged to make the CGAD disclosures at the level at which the insurer's or insurance group's risk appetite is determined, or at which the earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively and at which the supervision of those factors are coordinated and exercised, or the level at which legal liability for failure of general corporate governance duties would be placed. If the insurer or insurance group determines the level of reporting based on these criteria, it shall indicate which of the three criteria was used to determine the level of reporting and explain any subsequent changes in level of reporting.

E. Notwithstanding Subsection A of this Section, and as outlined in Section 3 of the Corporate Governance Annual Disclosure Model Act, if the CGAD is completed at the insurance group level, then it must be filed with the lead state of the group as determined by the procedures outlined in the most recent Financial Analysis Handbook adopted by the NAIC. In these instances, a copy of the CGAD must also be provided to the chief regulatory official of any state in which the insurance group has a domestic insurer, upon request.

F. An insurer or insurance group may comply with this section by referencing other existing documents (e.g., ORSA Summary Report, Holding Company Form B or F Filings, Securities and Exchange Commission (SEC) Proxy Statements, foreign regulatory reporting requirements, etc.) if the documents provide information that is comparable to the information described in Section 5. The insurer or insurance group shall clearly reference the location of the relevant information within the CGAD and attach the referenced document if it is not already filed or available to the regulator.

G. Each year following the initial filing of the CGAD, the insurer or insurance group shall file an amended version of the previously filed CGAD indicating where changes have been made. If no changes were made in the information or activities reported by the insurer or insurance group, the filing should so state.

Section 5. Contents of Corporate Governance Annual Disclosure

A. The insurer or insurance group shall be as descriptive as possible in completing the CGAD, with inclusion of attachments or example documents that are used in the governance process, since these may provide a means to demonstrate the strengths of their governance framework and practices.

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B. The CGAD shall describe the insurer's or insurance group's corporate governance framework and structure including consideration of the following.

(1) The Board and various committees thereof ultimately responsible for overseeing the insurer or insurance group and the level(s) at which that oversight occurs (e.g., ultimate control level, intermediate holding company, legal entity, etc.). The insurer or insurance group shall describe and discuss the rationale for the current Board size and structure; and

(2) The duties of the Board and each of its significant committees and how they are governed (e.g., bylaws, charters, informal mandates, etc.), as well as how the Board's leadership is structured, including a discussion of the roles of Chief Executive Officer (CEO) and Chairman of the Board within the organization.

C. The insurer or insurance group shall describe the policies and practices of the most senior governing entity and significant committees thereof, including a discussion of the following factors:

(1) How the qualifications, expertise and experience of each Board member meet the needs of the insurer or insurance group.

(2) How an appropriate amount of independence is maintained on the Board and its significant committees.

(3) The number of meetings held by the Board and its significant committees over the past year as well as information on director attendance.

(4) How the insurer or insurance group identifies, nominates and elects members to the Board and its committees. The discussion should include, for example:

(a) Whether a nomination committee is in place to identify and select individuals for consideration.

(b) Whether term limits are placed on directors.

(c) How the election and re-election processes function.

(d) Whether a Board diversity policy is in place and if so, how it functions.

(5) The processes in place for the Board to evaluate its performance and the performance of its committees, as well as any recent measures taken to improve performance (including any Board or committee training programs that have been put in place).

D. The insurer or insurance group shall describe the policies and practices for directing Senior Management, including a description of the following factors:

(1) Any processes or practices (i.e., suitability standards) to determine whether officers and key persons in control functions have the appropriate background, experience and integrity to fulfill their prospective roles, including:

(a) Identification of the specific positions for which suitability standards have been developed and a description of the standards employed.

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(b) Any changes in an officer's or key person's suitability as outlined by the insurer's or insurance group's standards and procedures to monitor and evaluate such changes.

(2) The insurer's or insurance group's code of business conduct and ethics, the discussion of which considers, for example:

(a) compliance with laws, rules, and regulations; and

(b) proactive reporting of any illegal or unethical behavior.

(3) The insurer's or insurance group's processes for performance evaluation, compensation and corrective action to ensure effective senior management throughout the organization, including a description of the general objectives of significant compensation programs and what the programs are designed to reward. The description shall include sufficient detail to allow the Commissioner to understand how the organization ensures that compensation programs do not encourage and/or reward excessive risk taking. Elements to be discussed may include, for example:

(a) The Board's role in overseeing management compensation programs and practices.

(b) The various elements of compensation awarded in the insurer's or insurance group's compensation programs and how the insurer or insurance group determines and calculates the amount of each element of compensation paid;

(c) How compensation programs are related to both company and individual performance over time;

(d) Whether compensation programs include risk adjustments and how those adjustments are incorporated into the programs for employees at different levels;

(e) Any clawback provisions built into the programs to recover awards or payments if the performance measures upon which they are based are restated or otherwise adjusted;

(f) Any other factors relevant in understanding how the insurer or insurance group monitors its compensation policies to determine whether its risk management objectives are met by incentivizing its employees.

(4) The insurer's or insurance group's plans for CEO and Senior Management succession.

E. The insurer or insurance group shall describe the processes by which the Board, its committees and Senior Management ensure an appropriate amount of oversight to the critical risk areas impacting the insurer's business activities, including a discussion of:

(1) How oversight and management responsibilities are delegated between the Board, its committees and Senior Management;

(2) How the Board is kept informed of the insurer's strategic plans, the associated risks, and steps that Senior Management is taking to monitor and manage those risks;

(3) How reporting responsibilities are organized for each critical risk area. The description should allow the Commissioner to understand the frequency at which

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information on each critical risk area is reported to and reviewed by Senior Management and the Board. This description may include, for example, the following critical risk areas of the insurer:

(a) Risk management processes (An ORSA Summary Report filer may refer to its ORSA Summary Report pursuant to the Risk Management and Own Risk and Solvency Assessment Model Act);

(b) Actuarial function;

(c) Investment decision-making processes;

(d) Reinsurance decision-making processes;

(e) Business strategy/finance decision-making processes;

(f) Compliance function;

(g) Financial reporting/internal auditing; and

(h) Market conduct decision-making processes.

Section 6. Severability Clause

If any provision of these regulations, or the application thereof to any person or circumstance, is held invalid, such determination shall not affect other provisions or applications of these regulations which can be given effect without the invalid provision or application, and to that end the provisions of these regulations are severable.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

Adopted by Executive/Plenary at 2014 Fall National Meeting
Technical Correction – January 2015

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Attachment #5

Table 2: State Regulatory Requirements for PBMs

States/Regulations	Registration Requirement	Licensing Requirements	Certificate of Registration
Iowa			Requires certification as a TPA
Louisiana		Requires PBMs to be licensed by the commissioner of insurance	
Massachusetts			Requires PBMs to obtain a certificate of registration from the insurance commissioner
New Mexico		Requires PBMs to become licensed by the superintendent of insurance	
North Dakota	Defines a PBM as an administrator and requires a PBM to be registered as an administrator		
Rhode Island	Includes PBMs in the definition of TPA and are regulated as such		
South Dakota		Requires any person or entity acting as PBM to obtain a valid license in order to operate as a TPA	
Texas			A PBM that collects premiums or contributions, or settles claims for Texas residents are required to hold TPA certificate of authority pursuant to the Texas insurance code
Utah	Requires a PBM to register with the division of corporations to do business in the state		

Washington	Requires registration with the Department of Revenue		
West Virginia		Entities meeting the definition of a PBM are required to licensed or registered as a TPA in order to operate	

ANNUAL FINANCIAL REPORTING MODEL REGULATION

Table of Contents

Section 1. Authority

This regulation is promulgated by the commissioner of insurance pursuant to Sections [insert applicable sections] of the [insert state] insurance law.

Section 2. Purpose and Scope

The purpose of this regulation is to improve the [insert state] Insurance Department's surveillance of the financial condition of insurers by requiring (1) an annual audit of financial statements reporting the financial position and the results of operations of insurers by independent certified public accountants, (2) Communication of Internal Control Related Matters Noted in an Audit, and (3) Management's Report of Internal Control over Financial Reporting.

Every insurer (as defined in Section 3) shall be subject to this regulation. Insurers having direct premiums written in this state of less than $1,000,000 in any calendar year and less than 1,000 policyholders or certificate holders of direct written policies nationwide at the end of the calendar year shall be exempt from this regulation for the year (unless the commissioner makes a specific finding that compliance is necessary for the commissioner to carry out statutory responsibilities) except that insurers having assumed premiums pursuant to contracts and/or treaties of reinsurance of $1,000,000 or more will not be so exempt.

Foreign or alien insurers filing the Audited financial report in another state, pursuant to that state's requirement for filing of Audited financial reports, which has been found by the commissioner to be substantially similar to the requirements herein, are exempt from Sections 4 through 13 of this regulation if:

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A. A copy of the Audited financial report, Communication of Internal Control Related Matters Noted in an Audit, and the Accountant's Letter of Qualifications that are filed with the other state are filed with the commissioner in accordance with the filing dates specified in Sections 4, 11 and 12, respectively (Canadian insurers may submit accountants' reports as filed with the Office of the Superintendent of Financial Institutions, Canada).

B. A copy of any Notification of Adverse Financial Condition Report filed with the other state is filed with the commissioner within the time specified in Section 10.

Foreign or alien insurers required to file Management's Report of Internal Control over Financial Reporting in another state are exempt from filing the Report in this state provided the other state has substantially similar reporting requirements and the Report is filed with the commissioner of the other state within the time specified.

This regulation shall not prohibit, preclude or in any way limit the commissioner of insurance from ordering or conducting or performing examinations of insurers under the rules and regulations of the [insert state] Department of Insurance and the practices and procedures of the [insert state] Department of Insurance.

Section 3. Definitions

The terms and definitions contained herein are intended to provide definitional guidance as the terms are used within this regulation.

A. "Accountant" or "independent certified public accountant" means an independent certified public accountant or accounting firm in good standing with the American Institute of Certified Public Accountants (AICPA) and in all states in which he or she is licensed to practice; for Canadian and British companies, it means a Canadian-chartered or British-chartered accountant.

B. An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

C. "Audit committee" means a committee (or equivalent body) established by the board of directors of an entity for the purpose of overseeing the accounting and financial reporting processes of an insurer or Group of insurers, the Internal audit function of an insurer or Group of insurers (if applicable), and external audits of financial statements of the insurer or Group of insurers. The Audit committee of any entity that controls a Group of insurers may be deemed to be the Audit committee for one or more of these controlled insurers solely for the purposes of this regulation at the election of the controlling person. Refer to Section 14E for exercising this election. If an Audit committee is not designated by the insurer, the insurer's entire board of directors shall constitute the Audit committee.

D. "Audited financial report" means and includes those items specified in Section 5 of this regulation.

E. "Indemnification" means an agreement of indemnity or a release from liability where the intent or effect is to shift or limit in any manner the potential liability of the person or firm for failure to adhere to applicable auditing or professional standards,

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whether or not resulting in part from knowing of other misrepresentations made by the insurer or its representatives.

F. "Independent board member" has the same meaning as described in Section 14C.

G. "Insurer" means a licensed insurer as defined in Sections [insert applicable sections] of the [insert state] insurance law or an authorized insurer as defined in Sections [insert applicable sections] of the [insert state] insurance law.

H. "Group of insurers" means those licensed insurers included in the reporting requirements of [insert state law equivalent of the model Insurance Holding Company System Regulatory Act], or a set of insurers as identified by management, for the purpose of assessing the effectiveness of Internal control over financial reporting.

I. "Internal audit function" means a person or persons that provide independent, objective and reasonable assurance designed to add value and improve an organization's operations and accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.

J. "Internal control over financial reporting" means a process effected by an entity's board of directors, management and other personnel designed to provide reasonable assurance regarding the reliability of the financial statements, i.e., those items specified in Section 5B through 5G of this regulation and includes those policies and procedures that:

(1) Pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of assets;

(2) Provide reasonable assurance that transactions are recorded as necessary to permit preparation of the financial statements, i.e., those items specified in Section 5B through 5G of this regulation and that receipts and expenditures are being made only in accordance with authorizations of management and directors; and

(3) Provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of assets that could have a material effect on the financial statements, i.e., those items specified in Section 5B through 5G of this regulation.

~~J~~K. "SEC" means the United States Securities and Exchange Commission.

~~K~~L. "Section 404" means Section 404 of the Sarbanes-Oxley Act of 2002 and the SEC's rules and regulations promulgated thereunder.

~~L~~M. "Section 404 Report" means management's report on "internal control over financial reporting" as defined by the SEC and the related attestation report of the independent certified public accountant as described in Section 3A.

~~M~~N. "SOX Compliant Entity" means an entity that either is required to be compliant with, or voluntarily is compliant with, all of the following provisions of the Sarbanes-Oxley Act of 2002: (i) the preapproval requirements of Section 201 (Section 10A(i) of the Securities Exchange Act of 1934); (ii) the Audit committee independence

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requirements of Section 301 (Section 10A(m)(3) of the Securities Exchange Act of 1934); and (iii) the Internal control over financial reporting requirements of Section 404 (Item 308 of SEC Regulation S-K).

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Section 14. Requirements for Audit Committees

This section shall not apply to foreign or alien insurers licensed in this state or an insurer that is a SOX Compliant Entity or a direct or indirect wholly-owned subsidiary of a SOX Compliant Entity.

A. The Audit committee shall be directly responsible for the appointment, compensation and oversight of the work of any accountant (including resolution of disagreements between management and the accountant regarding financial reporting) for the purpose of preparing or issuing the Audited financial report or related work pursuant to this regulation. Each accountant shall report directly to the Audit committee.

B. The Audit committee of an insurer or Group of insurers shall be responsible for overseeing the insurer's Internal audit function and granting the person or persons performing the function suitable authority and resources to fulfill their responsibilities if required by Section 15 of this Regulation.

C. Each member of the Audit committee shall be a member of the board of directors of the insurer or a member of the board of directors of an entity elected pursuant to Subsection ~~E~~ F and Section 3C.

D. In order to be considered independent for purposes of this section, a member of the Audit committee may not, other than in his or her capacity as a member of the Audit committee, the board of directors, or any other board committee, accept any consulting, advisory or other compensatory fee from the entity or be an affiliated person of the entity or any subsidiary thereof. However, if law requires board participation by otherwise non-independent members, that law shall prevail and such members may participate in the Audit committee and be designated as independent for Audit committee purposes, unless they are an officer or employee of the insurer or one of its affiliates.

~~D~~E. If a member of the Audit committee ceases to be independent for reasons outside the member's reasonable control, that person, with notice by the responsible entity to the state, may remain an Audit committee member of the responsible entity until the earlier of the next annual meeting of the responsible entity or one year from the occurrence of the event that caused the member to be no longer independent.

Drafting Note: In determining independence, the commissioner shall consider utilizing guidance provided in the SEC's Final Rule No. 33-8220, *Standards Relating to Listed Company Audit Committees* adopted April 9, 2003.

~~E~~F. To exercise the election of the controlling person to designate the Audit committee for purposes of this regulation, the ultimate controlling person shall provide written notice to the commissioners of the affected insurers. Notification shall be made timely prior to the issuance of the statutory audit report and include a description of the basis for the election. The election can be changed through notice to the

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commissioner by the insurer, which shall include a description of the basis for the change. The election shall remain in effect for perpetuity, until rescinded.

GF. (1) The Audit committee shall require the accountant that performs for an insurer any audit required by this regulation to timely report to the Audit committee in accordance with the requirements of SAS 61, *Communication with Audit Committees*, or its replacement, including:

(a) All significant accounting policies and material permitted practices;

(b) All material alternative treatments of financial information within statutory accounting principles that have been discussed with management officials of the insurer, ramifications of the use of the alternative disclosures and treatments, and the treatment preferred by the accountant; and

(c) Other material written communications between the accountant and the management of the insurer, such as any management letter or schedule of unadjusted differences.

(2) If an insurer is a member of an insurance holding company system, the reports required by Subsection FG(1) may be provided to the Audit committee on an aggregate basis for insurers in the holding company system, provided that any substantial differences among insurers in the system are identified to the Audit committee.

GH. The proportion of independent Audit committee members shall meet or exceed the following criteria:

Prior Calendar Year Direct Written and Assumed Premiums		
$0 - $300,000,000	**Over $300,000,000 - $500,000,000**	**Over $500,000,000**
No minimum requirements. See also Note A and B.	Majority (50% or more) of members shall be independent. See also Note A and B.	Supermajority of members (75% or more) shall be independent. See also Note A.

Note A: The commissioner has authority afforded by state law to require the entity's board to enact improvements to the independence of the Audit committee membership if the insurer is in a RBC action level event, meets one or more of the standards of an insurer deemed to be in hazardous financial condition, or otherwise exhibits qualities of a troubled insurer.

Note B: All insurers with less than $500,000,000 in prior year direct written and assumed premiums are encouraged to structure their Audit committees with at least a supermajority of independent Audit committee members.

Note C: Prior calendar year direct written and assumed premiums shall be the combined total of direct premiums and assumed premiums from non-affiliates for the reporting entities.

HI. An insurer with direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $500,000,000 may make application to the commissioner for a waiver from

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the Section 14 requirements based upon hardship. The insurer shall file, with its annual statement filing, the approval for relief from Section 14 with the states that it is licensed in or doing business in and the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

Section 15. Internal Audit Function Requirements

A. Exemption – An insurer is exempt from the requirements of this section if:

(1) The insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $500,000,000; or,

(2) If the insurer is a member of a Group of insurers that has annual direct written and unaffiliated assumed premium including international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $1,000,000,000.

Note: An insurer or Group of insurers exempt from the requirements of this section is encouraged, but not required, to conduct a review of the insurer business type, sources of capital, and other risk factors to determine whether an Internal audit function is warranted. The potential benefits of an Internal audit function should be assessed and compared against the estimated costs.

B. Function – The insurer or Group of insurers shall establish an Internal audit function providing independent, objective and reasonable assurance to the Audit committee and insurer management regarding the insurer's governance, risk management and internal controls. This assurance shall be provided by performing general and specific audits, reviews and tests and by employing other techniques deemed necessary to protect assets, evaluate control effectiveness and efficiency, and evaluate compliance with policies and regulations.

C. Independence – In order to ensure that internal auditors remain objective, the Internal audit function must be organizationally independent. Specifically, the Internal audit function will not defer ultimate judgment on audit matters to others, and shall appoint an individual to head the Internal audit function who will have direct and unrestricted access to the board of directors. Organizational independence does not preclude dual-reporting relationships.

D. Reporting – The head of the Internal audit function shall report to the Audit committee regularly, but no less than annually, on the periodic audit plan, factors that may adversely impact the Internal audit function's independence or effectiveness, material findings from completed audits and the appropriateness of corrective actions implemented by management as a result of audit findings.

E. Additional Requirements – If an insurer is a member of an insurance holding company system or included in a Group of insurers, the insurer may satisfy the Internal audit function requirements set forth in this section at the ultimate controlling parent level, an intermediate holding company level or the individual legal entity level.

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Section 16. Conduct of Insurer in Connection with the Preparation of Required Reports and Documents

A. No director or officer of an insurer shall, directly or indirectly:

(1) Make or cause to be made a materially false or misleading statement to an accountant in connection with any audit, review or communication required under this regulation; or

(2) Omit to state, or cause another person to omit to state, any material fact necessary in order to make statements made, in light of the circumstances under which the statements were made, not misleading to an accountant in connection with any audit, review or communication required under this regulation.

B. No officer or director of an insurer, or any other person acting under the direction thereof, shall directly or indirectly take any action to coerce, manipulate, mislead or fraudulently influence any accountant engaged in the performance of an audit pursuant to this regulation if that person knew or should have known that the action, if successful, could result in rendering the insurer's financial statements materially misleading.

C. For purposes of Subsection B of this section, actions that, "if successful, could result in rendering the insurer's financial statements materially misleading" include, but are not limited to, actions taken at any time with respect to the professional engagement period to coerce, manipulate, mislead or fraudulently influence an accountant:

(1) To issue or reissue a report on an insurer's financial statements that is not warranted in the circumstances (due to material violations of statutory accounting principles prescribed by the commissioner, generally accepted auditing standards, or other professional or regulatory standards);

(2) Not to perform audit, review or other procedures required by generally accepted auditing standards or other professional standards;

(3) Not to withdraw an issued report; or

(4) Not to communicate matters to an insurer's Audit committee.

Drafting Note: In determining what types of sanctions or penalties could be assessed for violations of items included in Subsections A through C, each state should refer to its individual authority provided by state statutes.

Section ~~16~~17. Management's Report of Internal Control over Financial Reporting

A. Every insurer required to file an Audited financial report pursuant to this regulation that has annual direct written and assumed premiums, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of $500,000,000 or more shall prepare a report of the insurer's or Group of insurers' Internal control over financial reporting, as these terms are defined in Section 3. The report shall be filed with the commissioner along with the Communication of Internal Control Related Matters Noted in an Audit described under Section 11. Management's Report of Internal Control over Financial Reporting shall be as of December 31 immediately preceding.

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B. Notwithstanding the premium threshold in Subsection A, the commissioner may require an insurer to file Management's Report of Internal Control over Financial Reporting if the insurer is in any RBC level event, or meets any one or more of the standards of an insurer deemed to be in hazardous financial condition as defined in (include reference to Corrective Action statute).

C. An insurer or a Group of insurers that is

(1) directly subject to Section 404;

(2) part of a holding company system whose parent is directly subject to Section 404;

(3) not directly subject to Section 404 but is a SOX Compliant Entity; or

(4) a member of a holding company system whose parent is not directly subject to Section 404 but is a SOX Compliant Entity;

may file its or its parent's Section 404 Report and an addendum in satisfaction of this Section ~~16~~ 17 requirement provided that those internal controls of the insurer or Group of insurers having a material impact on the preparation of the insurer's or Group of insurers' audited statutory financial statements (those items included in Section 5B through 5G of this regulation) were included in the scope of the Section 404 Report. The addendum shall be a positive statement by management that there are no material processes with respect to the preparation of the insurer's or Group of insurers' audited statutory financial statements (those items included in Section 5B through 5G of this regulation) excluded from the Section 404 Report. If there are internal controls of the insurer or Group of insurers that have a material impact on the preparation of the insurer's or Group of insurers' audited statutory financial statements and those internal controls were not included in the scope of the Section 404 Report, the insurer or Group of insurers may either file (i) a Section ~~16~~ 17 report, or (ii) the Section 404 Report and a Section ~~16~~ 17 report for those internal controls that have a material impact on the preparation of the insurer's or Group of insurers' audited statutory financial statements not covered by the Section 404 Report.

D. Management's Report of Internal Control over Financial Reporting shall include:

(1) A statement that management is responsible for establishing and maintaining adequate Internal control over financial reporting;

(2) A statement that management has established Internal control over financial reporting and an assertion, to the best of management's knowledge and belief, after diligent inquiry, as to whether its Internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles;

(3) A statement that briefly describes the approach or processes by which management evaluated the effectiveness of its Internal control over financial reporting; and

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(4) A statement that briefly describes the scope of work that is included and whether any internal controls were excluded;

(5) Disclosure of any unremediated material weaknesses in the Internal control over financial reporting identified by management as of December 31 immediately preceding. Management is not permitted to conclude that the Internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles if there is one or more unremediated material weaknesses in its Internal control over financial reporting;

(6) A statement regarding the inherent limitations of internal control systems; and

(7) Signatures of the chief executive officer and the chief financial officer (or equivalent position/title).

E. Management shall document and make available upon financial condition examination the basis upon which its assertions, required in Subsection D above, are made. Management may base its assertions, in part, upon its review, monitoring and testing of internal controls undertaken in the normal course of its activities.

(1) Management shall have discretion as to the nature of the internal control framework used, and the nature and extent of documentation, in order to make its assertion in a cost effective manner and, as such, may include assembly of or reference to existing documentation.

(2) Management's Report on Internal Control over Financial Reporting, required by Subsection A above, and any documentation provided in support thereof during the course of a financial condition examination, shall be kept confidential by the state insurance department.

Drafting Note: It is the recommendation that the company officer responsible for financial reporting would not be a member of the Audit committee and that the independent committee members would meet periodically, with no management present, with the independent certified public accountant to discuss the strengths and weaknesses of the insurer's or Group of insurers' internal control environments.

Section ~~17~~18. Exemptions and Effective Dates

A. Upon written application of any insurer, the commissioner may grant an exemption from compliance with any and all provisions of this regulation if the commissioner finds, upon review of the application, that compliance with this regulation would constitute a financial or organizational hardship upon the insurer. An exemption may be granted at any time and from time to time for a specified period or periods. Within ten (10) days from a denial of an insurer's written request for an exemption from this regulation, the insurer may request in writing a hearing on its application for an exemption. The hearing shall be held in accordance with the regulations of the [insert state] Department of Insurance pertaining to administrative hearing procedures.

B. Domestic insurers retaining a certified public accountant on the effective date of this regulation who qualify as independent shall comply with this regulation for the year ending December 31, 20[ ] and each year thereafter unless the commissioner permits otherwise.

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C. Domestic insurers not retaining a certified public accountant on the effective date of this regulation who qualifies as independent may meet the following schedule for compliance unless the commissioner permits otherwise.

(1) As of December 31, 20[ ], file with the commissioner an Audited financial report

(2) For the year ending December 31, 20[ ] and each year thereafter, such insurers shall file with the commissioner all reports and communication required by this regulation.

D. Foreign insurers shall comply with this regulation for the year ending December 31, 20[ ] and each year thereafter, unless the commissioner permits otherwise.

E. The requirements of Section 7D shall be in effect for audits of the year beginning January 1, 2010 and thereafter.

F. The requirements of Section 14 are to be in effect January 1, 2010. An insurer or Group of insurers that is not required to have independent Audit committee members or only a majority of independent Audit committee members (as opposed to a supermajority) because the total written and assumed premium is below the threshold and subsequently becomes subject to one of the independence requirements due to changes in premium shall have one (1) year following the year the threshold is exceeded (but not earlier than January 1, 2010) to comply with the independence requirements. Likewise, an insurer that becomes subject to one of the independence requirements as a result of a business combination shall have one (1) calendar year following the date of acquisition or combination to comply with the independence requirements.

Drafting Note: Adoption of Section 14 is assumed to occur one year prior to the effective date of Section ~~16~~17.

G. The requirements of Section ~~16~~ 17 and other modified sections [identify modified sections], except for Section 14 covered above, are effective beginning with the reporting period ending December 31, 2010 and each year thereafter. An insurer or Group of insurers that is not required to file a report because the total written premium is below the threshold and subsequently becomes subject to the reporting requirements shall have two (2) years following the year the threshold is exceeded (but not earlier than December 31, 2010) to file a report. Likewise, an insurer acquired in a business combination shall have two (2) calendar years following the date of acquisition or combination to comply with the reporting requirements.

H. The requirements of Section 15 are to be in effect January 1, 2016. If an insurer or Group of insurers that is exempt from the Section 15 requirements no longer qualifies for that exemption, it shall have one year after the year the threshold is exceeded to comply with the requirements of this article.

Section ~~18~~19. Canadian and British Companies

A. In the case of Canadian and British insurers, the annual Audited financial report shall be defined as the annual statement of total business on the form filed by such companies with their supervision authority duly audited by an independent chartered accountant.

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B. For such insurers, the letter required in Section 6B shall state that the accountant is aware of the requirements relating to the annual Audited financial report filed with the commissioner pursuant to Section 4 and shall affirm that the opinion expressed is in conformity with those requirements.

Section ~~19~~20. Severability Provision

If any section or portion of a section of this regulation or its applicability to any person or circumstance is held invalid by a court, the remainder of the regulation or the applicability of the provision to other persons or circumstances shall not be affected.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1980 Proc. I 29, 37, 212, 262, 266-272 (adopted).
1991 Proc. I 9, 17, 225-226, 426, 428, 429-434 (amended and reprinted).
1998 Proc. 2nd Quarter 12, 13, 158, 226, 230, 231-232 (amended).
2001 Proc. 4th Quarter 6, 13-14, 531, 551, 561-563 (amended).
2003 Proc. 2nd Quarter 473, 489, 491 (amended and adopted by parent committee).
2003 Proc. 3rd Quarter 15 (adopted by Plenary).
2006 Proc. 2nd Quarter 779-793 (amended and adopted by Plenary).

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Attachment #7

DRAFT ONLY
NOT APPROVED FOR INTRODUCTION

HOUSE BILL NO. [Bill Number]

Pharmacy benefit manager-regulation.

Sponsored by: Representative(s) Kirkbride

A BILL

for

AN ACT relating to the Wyoming Pharmacy Act; providing for the registration of pharmacy benefit managers; regulating practices related to claims audits and approved drug lists by pharmacy benefit managers as specified; providing for appeal of claims payment decisions by pharmacy benefit managers; providing definitions and amending a definition; providing for applicability; and providing for an effective date.

Be It Enacted by the Legislature of the State of Wyoming:

Section 1. W.S. 33-24-401 through 33-24-410 are created to read:

ARTICLE 4

PHARMACY BENEFIT MANAGERS

33-24-401. Definitions.

(a) As used in this article:

(i) "Audit" means an on-site or remote review of the records of a pharmacy by or on behalf of an entity;

(ii) "Claim" means a request from a pharmacy or pharmacist to be reimbursed for the cost of filling or refilling a prescription for a drug or for providing a medical supply or service;

(iii) "Clerical error" means a minor error:

(A) In the keeping, recording or transcribing of records or documents or in the handling of electronic or hard copies of correspondence;

(B) That does not result in financial harm to an entity; and

(C) That does not involve dispensing an incorrect dose, amount or type of medication or dispensing a prescription drug to the wrong person.

(iv) "Entity" means:

(A) A pharmacy benefit manager;

(B) An insurer;

(C) A third party administrator;

(D) A state agency; or

(E) A person who represents or is employed by one of the entities described in this paragraph.

(v) "Fraud" means knowingly and willfully executing or attempting to execute a scheme, in connection with the delivery of or payment for health care benefits, items or services, that uses false or misleading pretenses, representations or promises to obtain any money or property owned by or under the custody or control of any person;

(vi) "Insurer" means as defined by W.S. 26-1-102(a)(xvi);

(vii) "Pharmacist" means an individual licensed as a pharmacist under this chapter;

(viii) "Pharmacy" means a pharmacy licensed under this chapter;

(ix) "Pharmacy benefit manager" means a person who contracts with pharmacies on behalf of an insurer, a third party administrator or the state to:

(A) Process claims for prescription drugs or medical supplies or provide retail network management for pharmacies or pharmacists;

(B) Pay pharmacies or pharmacists for prescription drugs or medical supplies; or

(C) Negotiate rebates with manufacturers for drugs paid for or procured as described in this paragraph.

(x) "This act" means W.S. 33-24-401 through 33-24-410.

33-24-402. Pharmacy benefit managers; registration.

(a) Commencing July 1, 2015, to conduct business in this state, a pharmacy benefit manager shall register with the state board of pharmacy and annually renew the registration.

(b) To register under this section, a pharmacy benefit manager shall:

(i) Submit an application to the board on a form prescribed by the board;

(ii) Pay an annual registration fee, not to exceed fifty dollars ($50.00).

33-24-403. Claims audits; requirements.

(a) An entity that audits claims or an independent third party that contracts with an entity to audit claims shall:

(i) Establish, in writing, a procedure for a pharmacy to appeal the entity's findings with respect to a claim and shall provide a pharmacy with a notice regarding the procedure, in writing or electronically, prior to conducting an audit of the pharmacy's claims;

(ii) Not conduct an audit of a claim more than twenty-four (24) months after the date the claim was adjudicated by the entity;

(iii) Give at least fifteen (15) days advance written notice of an on-site audit to the pharmacy or corporate headquarters of the pharmacy;

(iv) Not conduct an on-site audit during the first five (5) days of any month without the pharmacy's consent;

(v) Conduct the audit in consultation with a pharmacist who is licensed by this or another state if the audit involves clinical or professional judgment;

(vi) Not conduct an on-site audit of more than two hundred fifty (250) unique prescriptions of a pharmacy in any twelve (12) month period except in cases of alleged fraud;

(vii) Not conduct more than one (1) on-site audit of a pharmacy in any twelve (12) month period;

(viii) Audit each pharmacy under the same standards and parameters that the entity uses to audit other similarly situated pharmacies;

(ix) Pay any outstanding claims of a pharmacy no more than forty-five (45) days after the earlier of the date all appeals are concluded or the date a final report is issued under W.S. 33-24-407(d);

(x) Not include dispensing fees or interest in the amount of any overpayment assessed on a claim unless the overpaid claim was for a prescription that was not filled correctly;

(xi) Not recoup costs associated with:

(A) Clerical errors; or

(B) Other errors that do not result in financial harm to the entity or a consumer; and

(xii) Not charge a pharmacy for a denied or disputed claim until the audit and the appeals procedure established under paragraph (i) of this subsection are final.

33-24-404. Claims audits; prohibition of statistical sampling.

An entity's finding that a claim was incorrectly presented or paid shall be based on identified transactions and not based on probability sampling, extrapolation or other means that project an error using the number of patients served who have a similar diagnosis or the number of similar prescriptions or refills for similar drugs.

33-24-405. Claims audits; payment; confidentiality.

(a) An entity that contracts with an independent third party to conduct audits shall not:

(i) Agree to compensate the independent third party based on a percentage of the amount of overpayments recovered; or

(ii) Disclose information obtained during an audit except to the contracting entity, the pharmacy subject to the audit or the holder of the policy or certificate of insurance that paid the claim.

33-24-406. Claims audits; validation of claims.

(a) For purposes of this act, an entity or an independent third party that contracts with an entity to conduct audits, shall allow as evidence of validation of a claim:

(i) An electronic or physical copy of a prescription if the prescribed drug was, within fourteen (14) days of the dispensing date:

(A) Picked up by the patient or the patient's designee;

(B) Delivered by the pharmacy to the patient; or

(C) Sent by the pharmacy to the patient using the United States postal service or other common carrier.

(ii) Point of sale electronic register data showing purchase of the prescribed drug, medical supply or service by the patient or the patient's designee; or

(iii) Electronic records, including electronic beneficiary signature logs, electronically scanned and stored patient records maintained at or accessible to the audited pharmacy's central operations and any other reasonably clear and accurate electronic documentation that corresponds to a claim.

33-24-407. Claims audits; report; contest.

(a) After conducting an audit under this act, an entity shall provide the pharmacy that is the subject of the audit with a preliminary report of the audit. The preliminary report shall be received by the pharmacy no later than forty-five (45) days after the date on which the audit was completed and shall be sent:

(i) By mail or common carrier with a return receipt requested; or

(ii) Electronically with electronic receipt confirmation.

(b) The entity shall provide the pharmacy that received a preliminary report under this subsection no fewer than forty-five (45) days to contest the report or any findings in the report in accordance with the appeals procedure established under this act and to provide additional documentation in support of the claim. The entity shall consider a reasonable request for an extension of time to submit documentation to contest the report or any findings in the report.

(c) If an audit results in the dispute or denial of a claim, the entity conducting the audit shall allow the pharmacy to resubmit the claim using any commercially reasonable method, including facsimile, mail or electronic mail.

(d) The entity shall provide the pharmacy that is the subject of an audit with a final report of the audit no later than sixty (60) days after the later of the date the preliminary report was received or the date the pharmacy contested the report using the appeals procedure established under this act. The final report shall include a final accounting of all monies to be recovered by the entity.

(e) Recoupment of disputed funds from a pharmacy by an entity or repayment of funds to an entity by a pharmacy, unless otherwise agreed to by the entity and the pharmacy, shall occur after the audit and the appeals procedure established under this act are final. If the identified discrepancy for an individual audit exceeds forty thousand dollars ($40,000.00), any future payments to the pharmacy shall be withheld by the entity until the audit and the appeals procedure established under this act are final.

33-24-408. Other remedies.

(a) This act does not:

(i) Preclude an entity from instituting an action for fraud against a pharmacy;

(ii) Apply to an audit of pharmacy records when fraud or other intentional and willful misrepresentation is evidenced by physical review, review of claims data or statements or other investigative methods; or

(iii) Apply to a state agency that is conducting audits or a person who has contracted with a state agency to conduct audits of pharmacy records for prescription drugs paid for by the Medicaid program.

33-24-409. Pharmacy benefit managers; drug lists.

(a) As used in this section:

(i) "List" means the list of drugs for which maximum allowable costs have been established;

(ii) "Maximum allowable cost" means the maximum amount that a pharmacy benefit manager will reimburse a pharmacy for the cost of a drug;

(iii) "Multiple source drug" means a therapeutically equivalent drug that is available from at least two (2) manufacturers;

(iv) "Network pharmacy" means a retail drug outlet registered with the board that contracts with a pharmacy benefit manager;

(v) "Therapeutically equivalent" means as defined in W.S. 33-24-147(a)(v).

(b) A pharmacy benefit manager shall:

(i) Not place a drug on a list unless there are at least two (2) therapeutically equivalent, multiple source drugs, or at least one (1) generic drug available from only one (1) manufacturer, generally available for purchase by network pharmacies from national or regional wholesalers;

(ii) Ensure that all drugs on a list are generally available for purchase by pharmacies in this state from national or regional wholesalers;

(iii) Ensure that all drugs on a list are not obsolete;

(iv) Make available to each network pharmacy at the beginning of the term of a contract, and upon renewal of a contract, the sources utilized to determine the maximum allowable cost pricing of the pharmacy benefit manager;

(v) Make a list available to a network pharmacy upon request in a format that is readily accessible to and usable by the network pharmacy;

(vi) Update each list maintained by the pharmacy benefit manager every seven (7) business days and make the updated lists, including all changes in the price of drugs, available to network pharmacies in a readily accessible and usable format;

(vii) Ensure that dispensing fees are not included in the calculation of maximum allowable cost.

(c) A pharmacy benefit manager shall establish a process by which a network pharmacy may appeal its reimbursement for a drug subject to maximum allowable cost pricing. A network pharmacy may appeal a maximum allowable cost if the reimbursement for the drug is less than the net amount that the network pharmacy paid to the supplier of the drug. An appeal requested under this section shall be completed within thirty (30) calendar days of the pharmacy making the claim for which appeal has been requested.

(d) A pharmacy benefit manager shall provide as part of the appeals process established under subsection (c) of this section:

(i) A telephone number at which a network pharmacy may contact the pharmacy benefit manager and speak with an individual who is responsible for processing appeals;

(ii) A final response to an appeal of a maximum allowable cost within seven (7) business days; and

(iii) If the appeal is denied, the reason for the denial and the national drug code of a drug that may be purchased by similarly situated pharmacies at a price that is equal to or less than the maximum allowable cost.

(e) If an appeal is upheld under this section, the pharmacy benefit manager shall make an adjustment on the date that the pharmacy benefit manager makes the determination for the pharmacy that requested the appeal from and after the date of initial adjudication.

(f) This section does not apply to the Medicaid program.

33-24-410. Applicability of act.

This act shall apply to contracts between pharmacies and pharmacy benefit managers that are entered into, renewed or extended on or after July 1, 2015.

Section 2. W.S. 33-24-101(a) is amended to read:

33-24-101. Short title; definitions.

(a) This act means W.S. 33-24-101 through ~~33-24-301~~ 33-24-410 and shall be known as the "Wyoming Pharmacy Act".

Section 3. This act is effective July 1, 2015.

(END)