MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

Draft Pending Adoption

Draft: 3/31/26

Market Regulation and Consumer Affairs (D) Committee
San Diego, California
March 25, 2026

The Market Regulation and Consumer Affairs (D) Committee met in San Diego, CA, March 25, 2026. The following Committee members participated: Ann Gillespie, Chair (IL); Angela L. Nelson, Vice Chair (MO); Heather Carpenter (AK); Jimmy Harris (AR); Charles Bassett (AZ); Trinidad Navarro represented by Susan Jennette (DE); Dean L. Cameron (ID); Holly W. Lambert represented by Meggan Brumbaugh (IN); Sharon P. Clark represented by Shawn Boggs (KY); D.J. Bettencourt (NH); Ned Gaines represented by Diana Branciforte (NV); Michael Humphreys and David Buono (PA); and Allan L. McVey and Joylynn Fix (WV). Also participating were: Doug Ommen (IA); Danielle Torres (MI); and Mary Block (VT).

1. Adopted its 2025 Fall National Meeting Minutes

Commissioner Humphreys made a motion, seconded by Director Nelson, to adopt the Committee's Dec. 11, 2025, minutes (*see NAIC Proceedings – Fall 2025, Market Regulation and Consumer Affairs (D) Committee*). The motion passed unanimously.

2. Appointed the Market Conduct Regulation Modernization (D) Working Group and Adopted its Charges

Director Gillespie said a new Committee priority is to consider the future of market regulation, which will be accomplished through the formation of the Market Conduct Regulation Modernization (D) Working Group. The Working Group's charges include: 1) assess with input from NAIC members and interested stakeholders the current state of the market regulatory framework and the need for changes in response to changing markets, business models, and consumer expectations; and 2) provide recommendations for the improvement and modernization of the market conduct regulatory framework.

Director Gillespie said Committee members did preliminary work during the Commissioners' Conference in February and earlier in March. She said the new Working Group will meet bi-weekly to consider: 1) the collection and analysis of market conduct data; 2) interstate collaboration; 3) the *Market Regulation Handbook* and examination approaches; 4) NAIC support and systems; 5) training; and 6) the oversight of other entities, such as third-party vendors. She said that during its first year, the Working Group will be fact-finding and gathering input from members and stakeholders. The Working Group will develop recommendations to be considered for adoption at the Fall National Meeting. The Working Group's second year will be devoted to the implementation of the recommendations. Director Gillespie stated that the Working Group's discussions will be intensive, and she is looking for full participation.

Director Cameron noted this was a very tight timeline for the new Working Group to come up with recommendations on such a big project. He said it is good to stay focused on the six areas of exploration.

Commissioner Ommen said the Life and Annuity (A) Committee is working on the topic of annuity and life illustrations and looks forward to coordinating with the new Working Group on the issues of data collection and analysis. He said he also spoke with Commissioner Clark, who is looking forward to working with the Working Group on training issues.

Lucy Culp (Blood Cancer United) said the NAIC consumer representatives look forward to assisting in the work and asked whether the Working Group's meetings would be open. She also asked how the consumer representatives

could be the most helpful. Director Gillespie said the Working Group will coordinate with the Consumer Board of Trustees. She said the Working Group's calls will be closed, but stakeholders will be invited per topic discussed.

Director Nelson made a motion, seconded by Commissioner McVey, to appoint the Market Conduct Regulation Modernization (D) Working Group and adopt its charges. The motion passed unanimously.

3. Adopted the *PBM Licensure and Regulation Guidance for Regulators*

Fix said the Pharmacy Benefit Management (D) Working Group adopted the *Pharmacy Benefit Manager (PBM) Licensure and Regulation Guidelines for Regulators* on Dec. 9, 2025. She said the guidelines before the Committee include additional industry and consumer representative input. Director Gillespie noted that a lot of input was received, and work based on that input has been completed since the 2025 Fall National Meeting. Director Carpenter said she appreciated the exposure process for the guidelines and agreed with the revisions. Director Cameron said the Working Group drafted a good product, took additional input, and improved the product.

Carl Schmid (HIV+Hepatitis Policy Institute) urged the Committee to adopt the guidelines. He said he appreciated the work and compromises that went into the document. He said more attention could be paid to group purchasing and rebates, but he understood this was a compromise document.

Commissioner McVey made a motion, seconded by Jennette, to adopt the *PBM Licensure and Regulation Guidance for Regulators* (Attachment One). The motion passed unanimously.

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

Torres said the Committee assigned the task of developing a cybersecurity coordination framework to the Market Conduct Examinations (D) Working Group. She said the Working Group is in the early stages of the discussions. She said a group of subject matter experts (SMEs) will draft an initial framework, which will be subject to stakeholder input via comment periods.

Torres said the framework will be a resource with extensive topical overlap to the Cybersecurity Event Response Plan (CERP). She said there is already authority that supports a state insurance regulator's role in responding to an event, but state insurance regulators lack guidance on how to respond collaboratively when appropriate. This framework will allow state departments of insurance (DOIs) to coordinate effectively.

Torres said the Working Group discussed several initial concepts during its March 12 meeting. She said the Working Group must decide: 1) the proper role of a lead state; 2) whether there is a role for any NAIC working group to support the lead state; and 3) thresholds to be met since the framework will only apply to the most significant cybersecurity events.

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

Director Gillespie said the Committee's working groups will continue their work, and the Committee members should ensure their work is consistent with the strategic direction to be established by the new Market Conduct Regulation (D) Modernization Working Group. Director Gillespie noted, for example, that the Market Analysis Procedures (D) Working Group plans to request the Committee's approval to retain a consultant to assist in enhancing the Market Analysis Prioritization Tool (MAPT) with new technology, such as artificial intelligence (AI). She also noted that the Market Regulation Certification (D) Working Group is continuing to receive and review states' self-certifications. The Working Group also plans to present a proposed draft of a new market analysis certification requirement for states to conduct at least 30 market analysis activities, which are recorded in the Market Analysis Review System (MARS) or Market Action Tracking System (MATS). She said Committee members

will want to explore these requests and leverage the work in conjunction with the discussion of the new Market Conduct Regulation Modernization (D) Working Group.

Buono said the Market Actions (D) Working Group is currently accepting applications for six open Working Group spots. Applications will be accepted through April 9. Buono also said that during its March 22 meeting, the Working Group heard that when several smaller states have requested follow-up examinations of a company, they have threatened to leave the market in their state. He said this is unacceptable behavior, and he has asked states to let the Market Actions (D) Working Group know if they receive this threat.

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

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

Block said the Big Data and Artificial Intelligence (H) Working Group is finalizing a draft of the AI systems evaluation tool through a pilot program. Block said a pilot of the tool began in March, and the pilot states are meeting weekly to share their insights and to train on using the tool. The states are deciding which companies to evaluate and engaging with the domestic states of the companies. She said there will be one to 10 companies per participating state, and there will be more property/casualty (P/C) companies and a mix of market conduct and financial analysts. As part of the pilot, the Working Group will request feedback from the companies involved.

Director Gillespie said the increasing use of AI is one of the main drivers for modernizing market conduct regulation.

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

SharePoint/Support Staff Hub/Committees/D CMTE/2026 Spring/_Final Minutes/3-D Min

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Adopted by the Market Regulation and Consumer Affairs (D) Committee March 25, 2026

PHARMACY BENEFIT MANAGER LICENSURE AND REGULATION GUIDANCE FOR REGULATORS

Maintained by the Pharmacy Benefit Management (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee

The NAIC has prepared this publication to assist state insurance regulators that are considering licensure or regulation of pharmacy benefit managers (PBMs). It is not a model law and, as such, is not intended to represent a uniform standard for all state insurance regulators.

A regulator using these guidelines should refer to the laws adopted by their state when determining its requirements for licensure, registration, or regulation of pharmacy benefit managers.

Table of Contents

SECTION 1: INTRODUCTION

The purpose of this document is to serve as a guide for state insurance regulators that are considering pharmacy benefit manager licensure or regulation. It includes sample standards and criteria for the licensure of pharmacy benefit managers and their operations as defined in state law.

State insurance regulators may wish to license PBMs to:

(1) Promote, preserve, and protect the public health, safety and welfare; and

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

PBM licensing best practices include:

(1) Providing for powers and duties of the commissioner; and

(2) Prescribing enforcement standards and appeals processes for violations of state law.

The document includes the following sections:

1. Core licensing guidelines for PBMs – This section provides core licensing standards for licensing PBMs.
2. Illustrative operational requirements under license – This section goes beyond core licensing standards and addresses additional PBM operational requirements under the license for consideration. Some states have enacted or proposed laws establishing these operational standards. The examples provided here reflect standards that certain legislatures have adopted or considered as part of broader regulation tied to a PBM's license to operate in the state.
3. Additional policy resources - This section details additional NAIC resources for states that wish to consider further regulation of a PBM's operations or the pharmacy benefit, and a brief illustrative list of additional PBM regulations some states have proposed or enacted into law.

SECTION 2: CORE LICENSING GUIDELINES FOR PBMS

The following section reflects core licensing standards for states that wish to begin licensing pharmacy benefit managers (PBMs).

Definitions

States should ensure that key terms are clearly defined in state law when establishing licensing standards for PBMs. Definitions of terms such as covered person, health plan, health carrier, pharmacist, and pharmacy used in the licensure of PBMs should be consistent with their existing state laws or regulations to maintain uniformity and avoid introducing new interpretations of currently defined terms.

For new licensure standards, the only essential term to define is "pharmacy benefit manager," as all other terms necessary for licensing should already be addressed in a state's insurance or pharmacy statutes and regulations.

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

A. (1) "Pharmacy benefit manager" means a person or entity that administers or processes prescription drug benefits on behalf of a health plan that is issued, delivered, or renewed in this state, is subject to state insurance regulation, and provides coverage to residents of this state, unless defined differently in state law.

(2) Pharmacy benefit manager does not include:

(a) A health care facility, pharmacist, or pharmacy licensed in this state;

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

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

(d) A health carrier to the extent that it administers or processes prescription drug benefits exclusively for its enrollees.

Applicability & Scope

When establishing new standards, a state's statutes should clarify the applicability to PBMs currently operating in the state and to in-scope PBM-health plan contracts, as defined in state law, that are currently in-force.

For example, a state may determine that new rules apply to a PBM's in-scope operations for a contract with a health plan that is issued, renewed, recredentialed, amended or extended on or after the effective date of any regulatory changes as prescribed by the commissioner and provide that the commissioner will establish a timeline for compliance.

States should also clarify the applicability of licensing standards upon the date of license. For example, a state may consider, as a condition of licensure, any in-scope contract must comply with the state's licensing standards that relate to that contract upon issuance, renewal, recredentialing, or amendment, on or after the effective date of the PBM's license.

States should take care to provide that their licensing standards are not intended and should not be construed to conflict with existing relevant federal law.

Note: States should refer to state and federal law and consult the NAIC'S ERISA Handbook for additional, general guidelines.

Licensing Requirements

States should provide for the licensing process, including addressing the following items:

- License required – States should provide that a person may not establish or operate as a pharmacy benefit manager in this state for health plans subject to state insurance regulation without first obtaining a license from the commissioner.

- Commissioner authority to establish key requirements – States should permit the commissioner to adopt regulations establishing the licensing application and financial reporting requirements for pharmacy benefit managers.

- Key application materials – States should require a person applying for a pharmacy benefit manager license to submit an application for licensure in the form and manner prescribed by the commissioner. The state should specify key documents and forms to include in the application, such as:

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

  (2) Organizational Chart detailing entity structure of officers;

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

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

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

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

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

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

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

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

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- Non-refundable application fee – States should specify that a person submitting an application for a pharmacy benefit manager license shall include with the application a non-refundable application fee as prescribed by the commissioner and applicable state laws and regulations.

  Note: States should consider setting the licensing fee to reflect the median PBM licensing fee across states when adjusted to exclude outliers. States may wish to consider the most updated information reflecting the median fee, including an NAIC compilation of state licensing fees, if available.

- Authority to deny a license – States should authorize the commissioner to refuse to issue or renew a license if the commissioner determines that the applicant or any individual responsible for the conduct of affairs of the applicant is not competent, trustworthy, financially responsible or of good personal and business reputation or has been found to have violated the insurance laws of this state or any other jurisdiction, or has had an insurance or other certificate of authority or license denied or revoked for cause by any jurisdiction. States should specify written advance notice requirements should the commissioner elect to refuse to issue or renew a license.

- Renewal requirements – States should provide for renewal requirements, including:

  (1) Validity – States should specify that, unless surrendered, suspended or revoked by the commissioner, a license issued under this section shall remain valid as long as the pharmacy benefit manager continues to do business in the state and remains in compliance with the provisions of the state's statutes and any applicable rules and regulations, including the payment of an annual/biennial/triennial license renewal fee as prescribed by applicable state laws and regulations and completion of a renewal application on a form prescribed by the commissioner.

  (2) Timing for renewal – States should specify when such renewal fee and application must be received. For example, a state may specify that they must be received by the commissioner on or before the designated renewal date or the anniversary of the effective date of the pharmacy benefit manager's

initial or most recent license as prescribed by the commissioner and applicable state laws and regulations.

(3) Key application materials – The state should specify what materials should be included in the renewal application. For example, states may wish to specify that the renewal application must include:

(a) Audited financials or other financial statement form approved by the commissioner showing financial solvency as determined by the commissioner; and

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

- Requirements After Inactivation of License – States should clarify the requirements that apply to a PBM after its license becomes inactive, including whether the PBM must maintain surety and E&O bonds for a defined period of time and what, if any, reporting requirements may continue to apply for a limited time. For example, states may use language such as the following:

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

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

Proof of Network Adequacy Requirements and Reporting.

Note: States should consider their existing network adequacy laws when establishing PBM network adequacy or other standards.

While many states impose network adequacy standards on health insurance issuers contracting with PBMs to ensure prescription drug access, states may also wish to establish standards for a PBM's own pharmacy networks that are in-scope to promote reasonable patient access. If a state elects to apply network adequacy requirements directly to PBMs, it may consider language such as the following:

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

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

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

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

Enforcement

States should provide for enforcement of licensing requirements, including addressing the following items:

- Commissioner enforcement authority – States should specify that the commissioner must enforce compliance with all applicable laws and regulations of the state, unless this is already addressed generally in state insurance law.

- Regulatory Examinations – If state statutes do not already provide general authority, states should provide for the commissioner's authority to examine a licensed PBM's relevant books and records to determine compliance with state law and clearly specify when such information or data is not subject to public disclosure. For example, states may use language such as the following:

  (1) The commissioner may examine or audit the relevant books and records of a licensed pharmacy benefit manager for a health plan subject to state insurance regulation to determine compliance with all state laws and regulations.

  (2) All pharmacy benefit managers licensed in this state shall provide to the commissioner or their designee convenient and free access, at all reasonable office hours, to all books and records directly relating to compliance with the PBM laws and regulations of the state.

  (3) The cost of the examination shall be the responsibility of the pharmacy benefit manager. It can be considered that if the examination was the result of a complaint filed and it is determined that the complaint was not justified, the commissioner can consider not requiring payment from the pharmacy benefit manager.

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

    (a) Considered proprietary and confidential;

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

    (c) Not subject to subpoena; and

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

- Use of examination materials – States should specify that the commissioner may use any document or information provided during the regulatory examination to determine compliance with all applicable state laws and regulations.

- Enforcement of additional operational standards – If a state imposes additional operational standards on PBMs, the state may grant the commissioner authority to impose a penalty on a pharmacy benefit manager or the health plan with which it is contracted, or both, for any violation of those operational standards enumerated in state laws and regulations.

- Appeals – Unless addressed in a general statute, states should provide for an appeals process for any administrative action or fine imposed upon a pharmacy benefit manager in accordance with state laws and regulations.

Effective and Compliance Dates

When establishing new licensing standards, a state's statutes should clarify the transition period for a person doing business in the state as a pharmacy benefit manager on or before the effective date of any changes in state laws or regulations. Depending on the complexity of the standards, PBMs should be given at least six (6) months to one (1) year to come into compliance following the effective date of the change.

Note: States' laws or regulations may vary on when a change in state law or regulation is effective and when compliance is required. As such, states should review their laws and regulations and ensure the effective and compliance dates are drafted accordingly, ensuring there is clarification on the application to existing PBM-health plan contracts that are in-force on the effective date, compliance date, or date of licensure, whichever is applicable.

SECTION 3: ILLUSTRATIVE OPERATIONAL REQUIREMENTS UNDER LICENSE

The following section moves beyond core licensure standards. These include additional PBM operational standards that some states have enacted or proposed that are tied to a PBM's license to operate in the state.

Gag Clauses and Other Pharmacy Benefit Manager Prohibited Practices

Some states have adopted or considered restrictions to prohibit specified practices to address concerns about transparency and patient access to information. These standards go beyond core licensure requirements but may be enforced as part of the PBM's authority to operate in the state. The following language illustrates approaches states may consider when addressing related prohibited practices tied to a PBM's license.

- Gag clause prohibition – While gag clauses are generally not permitted, states may wish to specify that in any participation contracts between a pharmacy benefit manager and pharmacists or pharmacies providing prescription services for health plans subject to state insurance regulation, no pharmacy or pharmacist may be prohibited, restricted or penalized in any way from disclosing to any covered person any healthcare information that the pharmacy or pharmacist deems appropriate regarding:

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

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

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

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

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

- Total cost transparency – States may consider providing that a pharmacy benefit manager may not prohibit a participating pharmacy or pharmacist providing prescription services for health plans subject to state insurance regulation from discussing information regarding the total cost for pharmacist services for a prescription drug or from selling a more affordable alternative to the covered person if a more affordable alternative is available.

- Permissible disclosure to regulators – States may consider providing that a pharmacy benefit manager contract with a participating pharmacist or pharmacy providing prescription services for health plans subject to state insurance regulation may not prohibit, restrict, or limit disclosure of information to the commissioner, law enforcement or state and federal governmental officials, provided that:

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

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

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

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

- Limits on contract termination – States may wish to prohibit a pharmacy benefit manager from terminating the contract of or penalizing a participating pharmacist or pharmacy providing prescription services for health plans subject to state insurance regulation for:

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

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

Submission of Key Service Contracts and Arm's Length Agreements

Some states have adopted or considered requiring applicants for PBM licenses to submit representative copies of key service contracts or arm's length agreements to confirm compliance with prohibited practices or other non-core licensing requirements, such as network adequacy and reporting. These standards go beyond core licensure requirements but may provide the regulator with additional information to confirm the PBM's compliance with state law prior to license issuance. The following language illustrates approaches states may consider when requiring additional materials prior to license issuance.

- Representative service contracts – States may wish to specify that a person submitting an application for a pharmacy benefit manager license must file representative copies of its standard pharmacy network/provider participation agreement, standard health carrier/client services agreement, and any material subcontracting or delegation agreements as part of the license application.

- Arm's length agreements – States may wish to specify that if any facilities, personnel, services, or networks are provided or held by an entity other than the person submitting the application, including a parent company, subsidiary, or affiliate, the person submitting the application must maintain and submit an arm's length agreement establishing the person's legal right of access to and use of those resources in accordance with good corporate governance.

Digital Infrastructure and Information Security

Some states have adopted or considered requiring applicants for PBM licenses to provide information relating to their digital infrastructure and information security. These standards go beyond core licensure requirements but may provide the regulator with additional information to confirm the PBM's compliance with state law prior to license issuance. The following language illustrates approaches states may consider when requiring additional materials prior to license issuance.

- Digital infrastructure – States may wish to specify that a person submitting an application for a pharmacy benefit manager license must demonstrate, as part of the license application, that it has adequate digital infrastructure, personnel, systems, and processes to securely process claims, safeguard records, and

implement reasonable cybersecurity and breach-reporting measures.

- Information security – States may wish to specify the documentation applicants must provide to demonstrate operational readiness and information security controls, including:

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

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

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

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

- Maintenance – States may wish to, further, specify that licensees must maintain such infrastructure, controls, and documentation on an ongoing basis throughout the term of licensure and make them available to the commissioner upon request.

SECTION 4: ADDITIONAL POLICY RESOURCES

States may choose to explore policy options that go beyond core and non-core PBM licensure requirements. These considerations often involve regulating aspects of PBM operations or the pharmacy benefit itself. For additional detail on these policy approaches, states should consult the following resources:

- The *Health Carrier Prescription Drug Benefit Management Model Act* (#22), which provides standards for the establishment, maintenance and management of prescription drug formularies and other procedures used by health insurance issuers that provide prescription drug benefits.
- The *Health Benefit Plan Network Access and Adequacy Model Act* (#74), which establishes standards for the creation and maintenance of networks by health carriers to ensure the adequacy, accessibility and quality of health care services offered under a managed care plan.
- Chapter XX, Conducting the Pharmacy Benefit Manager Examination, of the *Market Regulation Handbook*
- *Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation* and *Guidance Document – ERISA Preemption and State PBM Laws* (NAIC Guidance Documents)
- *A Guide to Understanding Pharmacy Benefit Manager and Associated Stakeholder Regulation* (NAIC White Paper)
- *Compilation of State Pharmacy Benefit Manager Business Practice Laws*

The following sample requirements reflect policy standards that some states have explored or implemented as part of broader PBM regulation. These examples illustrate obligations linked to pharmacy benefits and PBM business practices. For more information, consult the *Compilation of State Pharmacy Benefit Manager Business Practice Laws*.

Sample Requirements Beyond Licensure Include:

- Parity in treatment of affiliated and non-affiliated pharmacies
- Retroactive or point of sale fees limits

- Reporting or transparency requirements relating to pharmacy reimbursements and/or rebates
- Pharmacy credentialing or network participation requirements

Draft: 3/9/26

Market Analysis Procedures (D) Working Group
Virtual Meeting
February 23, 2026

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Feb. 23, 2026. The following Working Group members participated: Jo A. LeDuc, Chair (MO); Raymond A. Guzman, Vice Chair (MD); Chelsy Maller (AK); Teri Ann Mecca (AR); Cheryl Hawley (AZ); Don McKinley (CA); Jamie Crise (CO); Steve DeAngelis (CT); Pratima Lele (DC); Karen McGlynn (FL); Patrick Tallman (IL); Charles Thomas (KS); Lori Cunningham (KY); Lisa Fullington (LA); Danielle Torres and Christopher Gleason (MI); David Dachs (MT); Elouisa Tyler (NM); Peggy Willard-Ross (NV); Larry Wertel (NY); Guy Self (OH); Landon Hubbart and Shelly Scott (OK); Karen Veronikis (PA); Rachel Moore (SC); Melissa Gerachis (VA); Karla Nuissl and Jared Holshauser (VT); Sandy Ray (WA); Darcy Paskey and Jamie Adams (WI); and Theresa Miller (WV). Also participating was: Bryan Stevens (WY).

1. Adopted its Nov. 3, 2025, Minutes

The Working Group met Nov. 3, 2025, and took the following action: 1) reported on its activities during its September and October regulator-only meetings; 2) adopted the recommendations of the Market Analysis Prioritization Tool (MAPT) Recommendations Ad Hoc Group; 3) heard a report from the Market Regulation Certification (D) Working Group on the drafting of a market analysis requirement in the Voluntary Market Regulation Certification Program; 4) discussed possible new lines of business for the Market Conduct Annual Statement (MCAS); 5) discussed the Nov. 10 lunch-and-learn; and 6) discussed revisions to the Market Analysis Review System (MARS) Level 2 guidance in the *Market Regulation Handbook.*

Torres made a motion, seconded by Veronikis, to adopt the Working Group's Nov. 3 minutes *(see NAIC Proceedings – Fall 2025, Market Regulation and Consumer Affairs (D) Committee, Attachment Two)*. The motion passed unanimously.

2. Discussed its 2026 Charges and Plans

LeDuc said the Working Group's first three charges remain the same as in 2025. She noted that last year, the Working Group primarily focused on its second charge: assessing available market analysis data to identify needed improvements in the effectiveness of the data for market analysis. She said this led to recommendations to enhance the private passenger auto (PPA) MAPT and merge it with the MCAS-MAPT for the PPA line of business.

LeDuc said the fourth charge is to consider a new line of business for MCAS. She said the suggestion received last year to possibly add auto and home warranty business to MCAS was not pursued due to a lack of consistent authority across jurisdictions. The Working Group will not plan to spend more than a meeting or two on this charge unless it reaches an agreement to add a new line of business.

Finally, LeDuc said the fifth charge is to monitor the effectiveness and usefulness of the public MCAS ratios. She said Guzman will lead that discussion, and the Working Group will dive deeper into the ratios and consider implementing regulator-only ratios as the year progresses.

3. Heard a Report on the MAPT Recommendations

LeDuc said that last year, after extensive discussion, the Working Group agreed to the subject matter expert (SME) group's recommended changes to the PPA MAPT, which included additional data elements such as the data collected through MCAS and the deletion of some data elements not determined to be useful in the current MAPT.

LeDuc said that in the Working Group's report to the Market Regulation and Consumer Affairs (D) Committee, the Working Group informed the Committee that it will be requesting approval to draft a project proposal to engage an external party to retool the prioritization tool for the PPA line of business using current technologies. She said that, due to other matters before the Committee during the Fall National Meeting, it was not able to bring this to a vote. She said the Working Group will again make this request at the Spring National Meeting.

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

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

Stevens said that at the 2025 Fall National Meeting, the Market Regulation Certification (D) Working Group adopted the new market analysis certification requirement 12—Department Market Analysis Activity. He said this new standard requires conducting at least 30 market analysis activities, which are recorded in the MARS (Market Actions Reporting System) or the Market Actions Tracking System (MATS). He said the number of analyses will be a stretch goal for some jurisdictions, including his. For that reason, it was not made a mandatory requirement but only a primary requirement. The Working Group will be presenting this requirement to the Market Regulation and Consumer Affairs (D) Committee for adoption at the Spring National Meeting.

5. Discussed MCAS Ratios

LeDuc said the review of MCAS ratios will be a recurring agenda item as the Working Group reviews all public MCAS ratios. She said the Working Group has a charge to create and monitor the effectiveness of public MCAS ratios. This charge acknowledges the work already done whenever a new line of business is added to MCAS, but since the Working Group creates and adopts the public MCAS ratios, it is reasonable that it should also monitor their usefulness. She said that as the Working Group progresses through the year, she also wants to open the discussion to any potential regulator-only non-public ratios that anyone may find useful.

Guzman said that in a previous meeting, Maryland made a motion to change the denominator of the PPA and homeowner (HO) ratio 7 on lawsuits. He said the current denominator measures lawsuits against the number of claims closed without payment, but many lawsuits are not a result of a claim closed without payment. He said there would be a greater correlation with the number of lawsuits if the denominator were changed to autos insured or dwellings in force. He noted that the suggested ratio could be created as a non-public ratio to test out its usefulness. He also suggested a ratio to incorporate the data element of lawsuits closed with consideration of the claimant.

Guzman also said that the long-term care (LTC) ratio 3—the number of claimants divided by the number of contracts in force—measures the average number of claimants per contract but is of little use. He said there could be variations in this ratio that depend on the type of customer and the products provided by the carrier, which limits its usefulness for comparing companies. He also said it is unclear whether we would want to see it as a high or a low ratio. LeDuc asked Randy Helder (NAIC) to research the rationale behind this specific ratio. Guzman noted that there are also some LTC data elements, such as cancellations during the free look period and rescissions, that are not used in any ratios. He suggested additional public or non-public ratios could be created with these.

Holshauser said that when investigating companies with a high LTC ratio 6, which measures the percentage of benefit requests denied, Vermont discovered that a high number of partial benefit payments were reported as denied benefits.

Guzman suggested beginning the ratio discussions with the 7 PPA and HO ratios and then taking each line of business in turn. LeDuc said that will be the Working Group's approach.

Guzman also said that during the Market Conduct Annual Statement (D) Working Group discussions in 2025, he raised the point that some of the health MCAS ratios were lower, and Maryland noted that a lower ratio was a market conduct concern. Those ratios were health ratios 2, 4, 8 through 15, and 18. He said that even though the lower ratio was more concerning, the MCAS tools still rank them from highest to lowest, which could be misleading. He thought that, before suggesting changes, it would be helpful to discuss the usefulness of MCAS rankings. Holshauser said this also occurs with some pet insurance MCAS ratios. LeDuc asked Teresa Cooper (NAIC) whether it was possible to adjust the rankings so that the lowest ratios are ranked as most concerning. Cooper said that it may take some work. First, the ratios need to be identified, and then it is important to realize that this would impact the ability to trend with prior years. She also said that Maryland indicated it does not use rankings very much, so a discussion should be held about their usefulness. Helder agreed with Cooper and said the Working Group should discuss whether rankings should be done before any work is done to change them.

LeDuc asked Guzman if they are not using ranks because of the reversed health ratios or because they feel they are not helpful. He said rankings are not used in their analysis because they are just incorrect. Helder said the rankings only sort the ratios into 20 buckets of 5% each, from highest to lowest. That can be done simply by sorting the ratios themselves and, if necessary, sorting the ratios lowest to highest. The rankings are just one step removed from the raw data that should be reviewed in any analysis. Cooper suggested a straight percentage ranking may be better than a ranking of 1 to 20. LeDuc said an outside consultant may help with the question of rankings.

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

LeDuc said the Working Group has a perennial charge to consider new lines of business for MCAS. She asked the Working Group and interested parties to send any ideas for new lines of business to Helder by March 31 for discussion at the next meeting.

7. Discussed the Lunch-and-Learn Schedule

Guzman said Working Group members, interested regulators, and market analysis chiefs (MACs) should have already received invitations to the March 16 lunch-and-learn on how Maryland uses MCAS data in its investigations.

Guzman said that, going forward in 2026, the Working Group plans to hold one lunch-and-learn per quarter. In addition to March 16, there will be lunch-and-learns on June 22, Aug. 24, and Nov. 9. There are no topics or leaders for those sessions yet, but Helder will be asking for topics and ideas as the dates approach. He asked the Working Group to let Helder and him know which topics they would like covered, and Helder and he will find the right regulators to lead the sessions.

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

Draft: 2/20/26

Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
February 5, 2026

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Feb. 5, 2026. The following Working Group members participated: Joshua Guillory, Chair (LA); Tolanda McNeal, Vice Chair (AZ); Christina Huff (FL); Paula Shamburger (GA); Lori Cunningham (KY); Raymond A. Guzman (MD); Danielle Torres (MI); Jo A. LeDuc (MO); Martin Swanson (NE); Jonathan Wycoff (NV); Guy Self (OH); Cassie Soucy (OR); Karen Veronikis (PA); Tony Dorschner (SD); Rhonda Bowling-Black (TN); Melissa Gerachis (VA); Andy Swokowski (WA); Theresa Miller (WV); and Rebecca Rebholz (WI).

1. Discussed its Review of the LTC MCAS Blank

Guillory said he looked forward to finalizing the long-term care (LTC) Market Conduct Annual Statement (MCAS) blank. He reminded the Working Group that during its December meeting, it completed its review of the current blank and reviewed proposed changes. The draft blank presented includes all proposed changes as data elements and was exposed for a 30-day comment period, with one comment received.

Guillory introduced the first proposed data element in the interrogatory section: "Have you had any significant rate changes?" He explained that this element was proposed by Arizona but was withdrawn during the comment period. Arizona indicated the data element would be too complex for companies to answer uniformly, as each state views LTC rates differently. Additionally, the information could be gathered from the forms and rates section. After consideration, it was determined that this would not be a valuable addition to the dataset.

Guillory asked Working Group members, state insurance regulators, and interested parties for questions or comments on the removal of the data element. Hearing none, he stated the item would be removed from the draft. He also noted that formal votes were not planned because positions had not been finalized.

Guillory then moved to the next proposed element: whether there is a reason the reported LTC information may identify the company as an outlier or be substantially different from previously reported data, including an option to add comments.

Dorschner shared his perspective based on general experience working with companies. He questioned whether companies would truly know whether they are outliers and expressed concern that they might not be able to answer the question effectively. Guillory noted that similar questions appear on blanks for other lines of business. Teresa Cooper (NAIC) indicated that similar questions are included on other blanks.

Guillory added that the question is included in the property/casualty (P/C) blanks. Based on his experience, companies have learned when to raise explanations and often use the question to comment on automatic validation questions generated by the system. Torres stated that she supports LeDuc's suggestion to break the question into separate questions for the different product types.

Guillory asked whether there were any comments, either supporting or opposing, to breaking the question into three separate questions. Hearing no objections, he directed that the next draft reflect the question broken into three separate questions to allow responses by product type.

Guillory introduced the next proposed data element: whether the company was still actively writing policies in the state at year's end, noting it should be a simple yes-or-no question. He asked for comments from Working Group members and regulators. Hearing none, he then asked for input from interested parties.

Guillory noted a comment suggesting that the question would also be helpful if broken out by product type. He asked for comments or questions on adding a product type to this item. Hearing no objections, he stated the draft would be updated to include product lines for this question and noted that the revised draft would be available for another comment period.

Guillory then introduced the next proposed element: reporting the number of class action lawsuits. Ray Nelson (AHIP) stated that AHIP reviewed notes from when the original LTC requirements were developed and noted that class action lawsuits had been discussed at that time. He explained that definitional issues were identified, and instead of adding a separate class action lawsuit item, the group chose to capture lawsuit information as reflected in lines 59–63. He recommended retaining the existing approach in lines 59–63 and abandoning the proposed new class-action-lawsuit data element.

Cooper noted that prior discussions included the possibility that, if the item were included, it might be more appropriate to place it in a lower section of the blank since it requests a numerical response. Guillory acknowledged Cooper's point and asked for comments on whether, if retained, the data element should be moved to the lawsuit section rather than remain in its current location. Hearing no immediate feedback, he asked for further comments from any parties and then from Working Group members on whether the item should be included or excluded based on the feedback received.

McNeal asked Nelson to clarify whether AHIP's recommendation was to exclude the class action lawsuit question entirely from both sections. Nelson confirmed that AHIP's recommendation was not to include the question in either section. He explained that lines 59–63 already capture open and closed lawsuits during the reporting period. He reiterated that prior discussions identified definitional challenges, including how to define a class action lawsuit and determine when it is considered open. For those reasons, the existing lawsuit activity section was previously determined to be the appropriate method for capturing this information. Guillory summarized the differing suggestions on the item and asked whether there were any additional comments or questions before moving on.

Guillory transitioned to the General Information section, noting that the items are already broken out by lines of business. He introduced the first two data elements: written premium during the period and earned premium during the period. He then asked for comments from Working Group members and other parties.

Nelson stated that LTC premium information is already provided to the NAIC at the state level through other reporting mechanisms, including the annual statement state pages and Form 5 of the LTC Experience Exhibit. To avoid redundancy, he requested that the premium data elements be removed. He added that policy count data provides a better indicator of a company's LTC block size.

Cooper noted that LTC is the only line of business within MCAS that does not currently include premium data reporting. Guillory made a final call for comments or questions and indicated that the suggestion would be considered.

Guillory moved to the next proposed data element under Line 20, which included edits and additions to application activity: the number of applications approved during the period, the number pending at the beginning and end of the period, the number received, the number denied, and the reasons for denial. He proposed addressing the items incrementally, beginning with the number of applications approved during the period, and invited comments from Working Group members and regulators.

Nelson stated that Working Group members had provided feedback raising concerns about the application-related data elements. He explained that application data is often stored in separate systems and may not move into administrative systems until a policy becomes active, making retrieval burdensome. Some data elements may not exist in a format that supports reporting. He added that "new business issued during the period" would be more reflective of the intended purpose of the data request. He also expressed concern that underwriting practices vary significantly by company and product design, making application and denial data less comparable across carriers. AHIP recommended focusing on policies issued rather than application data.

Guillory asked Nelson to clarify whether those concerns applied to all proposed application-related data elements. Nelson confirmed that the concerns generally applied across the application questions, including approvals. He noted that administrative systems track policy issue dates but may not track the specific application approval date, making reporting difficult.

Guillory referenced a chat comment from LeDuc asking how the proposed item differs from policies issued, noting that this aligned with Nelson's comments. He asked whether the original proponents of the amendments wished to speak.

Guillory summarized the discussion, stating that concerns included: (1) the data may not exist in a reportable format; (2) it may be burdensome to compile even if it exists; and (3) it may duplicate or overlap with other data elements, such as policies issued.

Cooper commented that similar questions may exist in other statements or lines of business, which may have been the source of the proposed additions.

Guillory stated that the comments would be taken under advisement for the next draft and thanked Nelson for gathering member feedback. He clarified that while the discussion began with Line 20, the comments addressed a broader set of application-related questions. He asked if there were any additional comments specific to the other application items that had not already been covered.

Guillory moved to the proposed items between Lines 22 and 23, beginning with the number of lapses during the period and the proposed addition of the number of policies terminated or canceled due to nonpayment.

Ayah Abedali (American Council of Life Insurers—ACLI) shared member company feedback requesting that, if these items are added, firm definitions be provided, including examples of the types of terminations intended for each question. She also suggested that overlapping questions with existing elements should be reconsidered.

Guillory asked for clarification on where confusion might exist, noting that, from a regulatory and company perspective, categories such as canceled due to nonpayment, canceled by the insurer for other reasons, free looks, and terminated at the insured's request seemed straightforward. He acknowledged that definitions would be addressed during the development of rules and definitions but requested more detail on the concerns.

Abedali responded that, specifically regarding "terminated at request of insured," companies indicated they were unaware of reasons other than free looks or full surrenders for terminating cash value policies or annuities with LTC benefits. She noted that free looks are already captured in an existing question, raising concerns about potential overlap.

Guillory referenced LeDuc asking whether the intent was for the sum of the three new elements to equal the

current lapse figure. Guillory asked Cooper if that had been the intent. She stated she was not aware of the original intent.

Guillory responded that the feedback and question would be taken under advisement. He noted that if the elements are retained, definitions and clarification—including whether the totals are intended to reconcile—would be addressed in the data definitions. Hearing no further discussion or comments, he stated the group would take the feedback under advisement for future drafts and moved on to the next item.

Guillory continued with the General Information section under Line 30, introducing proposed additions related to adverse determinations: the number of adverse determinations overturned upon request for internal review (excluding additional voluntary levels of review), and the number of adverse determinations upheld upon request for internal review (with the same caveat).

Abedali said, for complaints-related items, member companies indicated the proposed changes would require extensive manual research. While the data may be valuable for follow-up inquiries or market conduct exams, companies expressed concern that it would be burdensome for annual reporting.

Guillory asked whether companies could program system changes within a year if given sufficient lead time. Abedali responded that she was not certain but would take that question back to the ACLI's members. Guillory shared his perspective that comparing companies with high numbers of adverse determinations overturned could be a valuable tool for market conduct regulators in prioritizing investigations or inquiries. Hearing no further comments, he stated the feedback would be taken under consideration for future drafts.

Nelson clarified that under Line 30 there were five additions, not just the two highlighted in blue, and asked whether all were intended as additions. Hal Marsh (NAIC) confirmed that the additional three items were also additions and had not been properly color-coded.

Nelson also asked for clarification on the effective reporting year for any approved changes. Guillory initially stated the reporting would be for 2027, and Cooper clarified that if approved in 2026, the changes would apply to the 2027 data year and be reported in 2028.

Guillory asked for comments on the additional three proposed items: customer-requested appeals, final adverse determinations overturned, and final adverse determinations upheld. Nelson indicated that his prior comments regarding burden would also apply to these items.

Guillory stated that, with no further comments on the six adverse determination items, the group had completed its review of the proposed data elements. He explained that the blank would be updated to reflect the discussions and adjustments made during the meeting. The revised draft would be shared with the Working Group and exposed for a 30-day comment period. He instructed members to submit any additional comments to NAIC committee support.

Cooper asked for clarification that elements without suggested revisions or discussion would remain in the draft for further consideration. Guillory confirmed that items without discussion would remain as drafted. For items that received comments, those would be taken under consideration, and options or revised drafts would be presented at a future meeting. He noted that some items could potentially come to a vote later.

2. Reviewed Items to be Discussed at Working Group Meetings

Guillory noted two items currently brought forward: 1) whether occupational accident coverage should be considered casualty coverage (similar to workers' compensation) rather than health coverage in some states or by some carriers, and 2) a proposal to include the phrase "maximum benefit limit" in the definition of partial payment under the excluded payment claims revision.

Cooper clarified that a proposal form had been received involving prior revisions. She explained that there had been an inconsistency between the blank and the data column definitions, resulting in a prior strikeout. The current proposal seeks to reverse that strike and modify certain data elements. She noted that further discussion is needed to determine the intended outcome.

Guillory stated that these items would be discussed in more detail at the next meeting and invited brief preliminary input.

Caren Alvarado (Crum & Forster) explained that she raised the occupational accident issue because of industry confusion over whether the product should be included in other health MCAS reporting. She noted that other health MCAS typically applies to accident-only products issued through association groups or trusts. Occupational accident coverage, however, is often offered in lieu of workers' compensation and is typically issued to cover independent contractors, such as trucking companies, rather than employees. She requested clarification on whether the product was intended to be included.

Guillory then referenced the second proposal form, stating it would also be discussed in more detail at the next Working Group meeting, as it involves more complex revisions.

Guillory thanked participants for their engagement and stated that the group made significant progress. He expressed the goal of finalizing the updated blank draft and related data definitions in the coming months to complete the long-term care review.

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

SharePoint/NAIC Support Staff Hub/D Working Groups/MCAS Blanks WG (TES)/2026 MCAS Blanks WG

Draft: 1/20/25

Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
December 18, 2025

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Dec. 18, 2025. The following Working Group members participated: Joshua Guillory, Chair (LA); Tolanda Coker, Vice Chair (AZ); Sheryl Parker (FL); Chris Heisler (IL); Paula Shamburger and Elizabeth Nunes (GA); Lori Cunningham (KY); Raymond A. Guzman (MD); Danielle Torres (MI); Jo A. LeDuc (MO); Martin Swanson (NE); Jonathan Wycoff (NV); Guy Self (OH); Spencer Peacock (OR); Karen Veronikis (PA); Rachel Moore (SC); Tony Dorschner (SD); Rhonda Bowling-Black (TN); John Kelcher (WA); and Rebecca Rebholz (WI). Also participating was: Timothy N. Schott (ME).

1. Adopted its Nov. 6 Minutes

The Working Group met Nov. 6 and took the following action: 1) adopted its Oct. 2 minutes; 2) discussed the "required to file" procedures for Market Conduct Annual Statement (MCAS) filings; and 3) discussed the review of the long-term care (LTC) MCAS.

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

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

Erica Weyhenmeyer (National Association of Mutual Insurance Companies—NAMIC) summarized that member feedback strongly supported continuing with option three, noting that the table was a relatively recent introduction. She explained that carriers are actively working on required actions to ensure completion and compliance. While there have been some variations in communication and issues related to waivers, the overall feedback indicates that carriers are implementing plans, attempting to comply, and addressing identified issues. She emphasized that additional feedback from the Working Group regarding what it is observing would be valuable, as it would help relay information, align expectations, and give a better understanding of what outcomes the Working Group would like to see.

Guillory asked regulators to share feedback on issues they are seeing with the current required-to-file process, noting a key concern that regulators have no effective way to identify improper or incomplete filings without conducting a manual review of all companies required to file MCAS. He invited regulators to comment on this issue or any other problems they are encountering. He noted that both regulators and industry have raised concerns regarding the required-to-file process and that alternatives have been considered, including making no changes at all. Guillory emphasized that any agreed-upon changes would not apply to the 2025 reporting cycle but would instead take effect for the 2026 data year, to be reported in 2027. He stated that no vote would be taken at this meeting, with a potential vote anticipated in January 2026, and encouraged Working Group members to review the options and be prepared to discuss them at the next meeting.

LeDuc explained that regulators are seeing fairly straightforward issues that primarily involve companies incorrectly answering the supplemental exhibit questions—either answering "yes" when they should answer "no," or "no" when they should answer "yes." She noted that when companies answer "no," they are unable to file

because the NAIC system does not open for them. When they answer "yes," regulators expect a filing that never arrives, creating an outstanding item that must be tracked down.

Weyhenmeyer responded that this clarification was helpful in understanding how the systems interact and indicated she could share this feedback with NAMIC's membership.

Guillory then asked if there were any additional comments and, hearing none, moved on to the next item.

3. Continued its Review of the LTC MCAS

Guillory then discussed the Working Group's review of the LTC MCAS reporting blank and related data column definitions, in accordance with the Working Group's charge to review and update MCAS data elements for lines of business in effect for more than three years. He noted that the Working Group completed its review of the blank the prior week and exposed it for a 30-day public comment period ending December 7, 2025, during which no comments were received, as confirmed by Hal Marsh (NAIC). Guillory directed Working Group members to this meeting's attachments for the current blanks and data column definitions and explained that one attachment contains a compiled list of items still under discussion, which would be the focus of the current discussion. He noted that the last two items in one of the attachments would be considered at a later time, as they may apply to all lines of business rather than just LTC. Guillory emphasized that no votes would be taken during this meeting but invited discussion on the outstanding items, beginning with a proposed interrogatory data element regarding whether companies have experienced significant rate changes, noting that a clear definition—such as a threshold percentage increase or decrease—would be needed. He opened the floor for feedback from Working Group members, regulators, and other interested parties. No feedback was received.

Guillory moved the discussion to the second proposed interrogatory data element. He asked Working Group members and other participants to consider, ahead of the next meeting, how "significant rate change" might be defined if that interrogatory is ultimately included.

Guillory then introduced the second proposed interrogatory, which would ask whether a company was still actively writing policies in the state at year-end, with separate breakouts for standalone policies, life hybrids, and annuity hybrids. He opened the floor to all participants for comments or questions on this proposed data element.

LeDuc cautioned that while the proposed question regarding whether a company is actively writing policies may appear simple, it is likely to generate significant confusion and follow-up questions about what "actively marketing" means. She emphasized that if this data element is added, it would be important to include a clear definition, description, or guidance to avoid inconsistent interpretations.

Guillory stated that the comment would be noted. He then invited additional comments from the group.

Schott noted that his comment related to the first proposed data element on significant rate changes, explaining that the Interstate Insurance Product Regulation Commission (Compact) already uses a threshold to determine what constitutes a significant rate change. He indicated that the threshold is approximately 15%, though he was not entirely certain, and suggested that tying the definition to an existing standard could be helpful.

Guillory agreed that reviewing thresholds used elsewhere, such as in the Compact or other standards, would be prudent when considering how to define significant rate changes for the first interrogatory. He then asked if there were any further comments on either item.

Guzman said he supported Schott's suggestion, sharing that in Maryland, the cap for approving a rate increase is 15% in any given year. He explained that while companies can request higher increases, they must be spread over multiple years in 15% increments and require approval. He stated that this approach could be a useful reference and seconded the idea of using a similar threshold for the proposed data element.

Guillory introduced item three, which concerns the reporting of the number of class action lawsuits. He explained that this question currently exists in the disability income MCAS interrogatories and that the Working Group needs to consider whether it should remain in the interrogatory section or be moved to the lawsuit reporting section. He also noted related considerations, including whether the definition of lawsuits should be revised and whether updates should be made across all lines of business for consistency. He invited comments from the Working Group, but none were offered.

Guillory introduced item four, which asks whether a company uses managing general agents and, if so, to list their names. He noted that the Working Group had previously discussed concerns that requiring names may be excessive and suggested that states needing this information could request it directly when a company answers affirmatively. He invited feedback on whether the question should ask generally about managing general agents (MGAs) or also require listing names.

LeDuc stated that Missouri would not support requiring the names of MGAs, explaining that it is too much information for the purpose of the MCAS.

Guillory asked for additional comments, noting that a similar question applies to third-party administrators (TPAs).

Guzman shared that Maryland generally agrees with LeDuc's position, noting that while listings of MGAs and TPAs are requested during the market conduct examination process, requiring that level of detail at the MCAS stage may not be particularly useful. He emphasized that this information is more appropriate once an exam is underway rather than during preliminary MCAS review.

Guillory asked whether other MCAS blanks require listing the names of TPAs or are typically structured as yes/no questions. Teresa Cooper (NAIC) responded that she would need to confirm, but believed that while one or two blanks may require listings, most are limited to yes/no responses.

Kelcher added that in Washington, the reports he reviewed include counts but do not require names.

Guillory noted that Louisiana approaches the issue differently by requiring TPAs to report annually who they work for, though not through MCAS, and stated that the Working Group would take the matter under consideration. He again asked for additional comments.

Guzman added that, based on his recollection, the travel subject matter expert (SME) group may request names in its MCAS blank, though he was uncertain.

Guillory introduced item six, which concerns reporting direct premium written during the period, noting that it appears to be a straightforward data element. He asked whether anyone had comments, but no one did.

Guillory then addressed item seven, which includes several application-related data elements, such as direct written premium during the period, earned premium during the period, the number of applications pending at the beginning and end of the period, the number of applications received during the period, and the number denied during the period. He also noted a related consideration that, if these elements are included, data element number 20, currently defined as the number of new business policies or contracts issued during the period, should

be reviewed and possibly revised to instead reflect the number of applications approved during the period for consistency. He opened the floor to Working Group members and regulators for comments on item number seven.

Guillory introduced item number eight, which addresses cancellations as a replacement for reporting the number of lapses during the period. He outlined the related data elements, including the number of policies terminated due to nonpayment, cancellations initiated by the insurer for reasons other than nonpayment or free-look provisions, and cancellations made at the request of the insured. He asked for comments on this item and, hearing none, moved on.

Guillory then presented item nine, which relates to complaints and internal reviews. He explained that the proposed data elements would track the number of adverse determinations overturned upon request for internal review and the number upheld upon request for internal review, explicitly excluding voluntary levels of review. He invited comments on this item. No feedback was offered.

Guillory began by addressing complaints and complaint request activity, noting that there had been some prior comments on this topic.

Guillory then reviewed questions 32 and 33, explaining that there had been a question about whether the counts in question 33 include the counts in question 32. He clarified that if new claimant requests or terminations were not completed by the end of the period, they would be included in both buckets.

Guillory further discussed question 32, which involves new claimant requests determined not to be actual requests during the period. He explained that if a company adjusts the counts so they no longer match prior numbers, they should include a comment explaining why the counts differ. If the counts do match, companies should add a comment explaining that some requests were determined to be not pertinent.

Guillory concluded by inviting any additional questions or comments on Parts A or B of this section, noting that the language involved was detailed and warranted careful review.

Guillory addressed the scenario in which an insurance benefit eligibility is initially denied but then overturned on appeal in the following year. He explained that the Working Group decided not to request an amendment to the prior year's report; the denial would remain in the first year, and it would be reported as a new claimant request the following year.

Guillory also noted that during the Working Group's November meeting, there were no comments regarding changes or edits to the existing data elements or adding new data elements.

Guillory then indicated that the discussion on claimants and claim request activities appeared to be concluded, as no further comments were offered.

Guillory introduced the discussion on benefit payment request activities, specifically question 49. He explained that the comment period had been opened and highlighted a scenario in which a monthly bill includes an itemized list of expenses, most of which are approved, but one or more items are denied as not covered under the policy. He noted that the main question for discussion is whether companies still need to account for these smaller denials, given that the overall claim was approved.

Guillory stated that this issue is still open for discussion and that comments were requested to be sent to the NAIC. He emphasized the focus on understanding what information would be useful for regulators and what

companies would prefer in reporting these partial denials. He then invited regulators to provide feedback or comment on any related topics.

LeDuc commented that on the health side, claim-related information is typically collected at a line level because some items in a claim may be paid while others are denied. She questioned the level at which the data is actually being collected—whether at the line code level—and suggested that if it is already collected that way, there may not be an issue. If it is not collected at that level, then the Working Group may need to consider adjustments.

Guillory acknowledged LeDuc's point and noted that Marsh was already looking into it. He reviewed the benefit payment requests section himself and agreed that if the data is already collected at the line level, companies would simply report approvals or denials at that level, making the concern moot. He suggested verifying the definitions to be sure.

Guillory directed to the benefit payment requests section, clarifying that this is distinct from general claims. He read the following definition: "Each request or demand for benefit payment is treated as a distinct benefit payment request, and continuing payments for the same service should also be treated as separate requests. The period of time from the company's receipt of documentation to payment should be captured for each approved request."

Guillory concluded that, based on this definition, reporting appears to be at the line-item level, and he asked if anyone had a different interpretation or was aware that it is being done differently.

LeDuc stated that it appears the company or member asking the question may not realize the level of detail—or "grain"—at which they are supposed to report. She agreed with Guillory that the current definitions address the question and that reporting at the line-item level for individual claim requests is already addressed.

Guillory agreed and suggested that if anyone disagreed, the Working Group could consider adding clarifying language to explicitly confirm that reporting is at the line-item level. He invited further comments or thoughts from the Working Group.

Guzman said he interprets the guidance the same way but agreed that including additional clarity in the definition would help alleviate any potential ambiguity.

Guillory checked for other comments or questions. He acknowledged Kelcher's clarification that MCAS questions for private passenger auto (PPA) do ask for the names of MGAs and TPAs, which is relevant to the earlier discussion. He then asked if anyone disagreed that the current guidance can be interpreted to report at the line-item level and suggested that any clarification could be addressed and possibly voted on in a future call.

Guillory closed the discussion on benefit payment requests and transitioned to the next section on lawsuit activity, noting that no comments or questions had been received so far. He invited the Working Group to raise any issues regarding the current lawsuit questions.

Guillory introduced the final section, which covers items to be considered at a later time. He explained that some of these items may require changes beyond the LTC blank. He highlighted data elements four through nine, including a question asking whether the company experienced a significant event or business strategy affecting the reporting period. He noted that the wording is inconsistent across lines of business, with the current version being the most common, and suggested that the Working Group consider whether consistent wording across all lines would be beneficial or problematic. He invited discussion on this topic.

Guillory then addressed a new data element regarding the number of class action lawsuits. He noted that if the group decides to include it, they would also need to decide whether it belongs in the interrogatory section or the lawsuit section and whether the question should be expanded to other lines of business. He asked for any comments or questions on this data element.

Guillory opened the floor for any additional comments or questions on the LTC blank, inviting members to raise any new points they may have reviewed in the intervening period.

4. Discussed Other Matters

Ray Nelson (AHIP) asked a procedural question regarding the LTC blank. He wanted to know whether there would be a step where a draft of new instructions or materials would be available for review and comment, or if the group would move directly toward finalization.

Guillory responded that, generally, because this work did not go before an SME group or subcommittee, the usual process is to take a vote on the wording for each question. He deferred to Cooper to confirm or add to his explanation. Cooper explained that after decisions are made on each individual item, a complete blank and data column definitions would be compiled for the Working Group to review and approve, ensuring that all items are accurately captured. Guillory agreed with Cooper and clarified that a draft would be provided for review, followed by a comment period on the "final draft," and then a vote to approve or adjust that draft.

Guzman raised a concern regarding the health MCAS ratios, noting that while it might be more appropriate for the Market Analysis Procedures (D) Working Group, he wanted to bring it to the attention of this Working Group. He explained that in reviewing health MCAS data for large carriers and completing level one reviews in the market analysis review system, an issue was identified that has likely existed since the inception of these ratios.

Guzman described that some health MCAS ratios are structured such that a lower ratio is preferable to a higher one. For example, ratio four measures the percentage of network claims paid within 30 days. In this case, a lower ratio is concerning for the carrier, whereas a higher ratio indicates better performance.

Guzman pointed out that the issue arises because the ranking system assumes that a higher ratio equals a higher rank, which is inconsistent with the intended interpretation of these ratios. As a result, carriers with the lowest percentages of claims paid within 30 days were incorrectly ranked very low, while carriers with the highest percentages were ranked highest, contrary to what the data should reflect.

Guzman noted that this miscalculation affects multiple ratios, including timeliness ratios four through eight, and other ratios where a higher value is actually worse. He emphasized that the ranking error exists both in the MCAS Market Analysis Prioritization Tool (MAPT) and the level one reviews in the Market Analysis Review System (MARS), impacting all the data they examined. He concluded by bringing this issue to the Working Group's attention for consideration.

Cooper responded to Guzman, acknowledging that she is aware of how the ranks are calculated. She suggested that the situation may simply be a training issue. She explained that the system was designed with the understanding that some ratios are better when higher and some are better when lower. The rankings are meant to distribute companies by size so that analysts can see where a company falls in the range and then determine whether a high or low value is favorable.

Guzman agreed that Cooper's explanation makes sense, but clarified the core issue. He noted that the rank

formula itself does not account for whether a higher or lower ratio is preferable. As a result, the system may signal a potential issue with a company when, in reality, a high ratio represents a positive outcome and a low ratio is the true concern.

Guillory addressed the discussion on the health MCAS ranking issue, noting that it likely falls outside the Working Group's mission and would be better suited for the Market Analysis Procedures (D) Working Group. He emphasized that analysts are expected to interpret ranks in context, understanding that a low rank is not always bad and a high rank is not always good, depending on the specific measure. He suggested that any systemic changes to make ranking consistent across all measures would need to be coordinated with the Market Analysis Procedures (D) Working Group and asked Cooper to confirm his summary.

Guzman agreed that the issue is better addressed by the Market Analysis Procedures (D) Working Group. He appreciated the opportunity to raise it in the current meeting but noted that adjustments would likely be discussed and implemented through the Market Analysis Procedures (D) Working Group to ensure consistency.

Guillory thanked Guzman for raising the topic and acknowledged that tangential issues like this are interesting and valuable, noting that many participants serve across multiple working groups. He then shared a comment from Jared Holshouser (VT), who reported encountering the same ranking issue and conducting their own analysis because the built in ranks were not helpful. Guillory offered to discuss that further offline if needed.

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

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

Draft: 3/18/26

Market Conduct Examination Guidelines (D) Working Group
Virtual Meeting
March 12, 2026

The Market Conduct Examination Guidelines (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met March 12, 2026. The following Working Group members participated: Brett Bache, Chair, Segun Daramola, and Brian Werbeloff (RI); Danielle Torres, Vice Chair, Amy Bonito, Airic Boyce, Sheri Clark, and Joe Keith (MI); Chelsy Maller and Molly Nollette (AK); Teri Ann Mecca (AR); Tolanda Coker and Katherine Jessen (AZ); Nick Gill (CT); Tina Ching, Pratima Lele, and Sudi Tasissa (DC); Simone Edmonson, Paula Shamburger, and Tia Taylor (GA); Daniel Mathis and Will Speicher (IA); Chris Heisler (IL); Mary Lou Moran (MA); Julie Hesser, Teresa Kroll, Jo A. LeDuc, and Win Nickens (MO); Chrystal Bartuska, Tyler Erickson, and Colton Schulz (ND); Gregory S. Arce, Victoria W. Fowler, and Keith E. Nyhan (NH); Ralph Boeckman (NJ); Sylvia Lawson (NY); Rodney Beetch (OH); Landon Hubbart, Shelly Scott, and Zach Palank (OK); Cassie Soucy (OR); David Buono, Gary Jones, and Paul Towsen (PA); Tara Nixon and Rachel Moore (SC); Stephen Mondini, Thomas Morgan, and Matthew Tarpley (TX); Andrea Baytop, Melissa Gerachis, and Bryan Wachter (VA); Isabelle Turpin Keiser (VT); Sandy Ray (WA); and Jamie Adams, Barbara Belling, Lori Luder, and Darcy Paskey (WI).

1. Heard Opening Remarks

Bache extended a welcome to all new and returning Working Group members. New working group member jurisdictions are North Dakota, represented by Schulz, and South Carolina, represented by Moore and Nixon. Bache also welcomed the new Working Group vice chair, Torres, and thanked the previous chair, Tarpley, for his leadership and contributions as Working Group chair from 2023 to 2025.

2. Discussed its 2026 Charges and Work Plan

Bache said the Working Group 2026 charges are posted on its web page. Bache said to address charges one through three, which are to: 1) develop examination standards; 2) monitor NAIC models; and 3) develop standardized data requests (SDRs), the Working Group will: 1) re-expose a draft of a revised Chapter 21A—Conducting the Property and Casualty Travel Insurance Examination, which was revised in 2025 to take comments received from the U.S. Travel Insurance Association (USTIA) and the American Property Casualty Insurance Association (APCIA) into consideration; 2) re-expose a draft of a new pet insurance chapter, which was revised in 2025 in consideration of comments received from Virginia; 3) continue to develop pet insurance SDRs for pet insurance in force policies, claims and complaints for Working Group exposure; and 4) develop market conduct examiner guidance for inclusion in the *Market Regulation Handbook* (Handbook) based upon the Regulatory Guidance Document adopted by the Accelerated Underwriting (A) Working Group on Aug. 6, 2024, and by the Life Insurance and Annuity (A) Committee at the 2024 Summer National Meeting.

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

Bache said one of the 2026 charges of the Pharmacy Benefit Management (D) Working Group is to develop new examination standards for pharmacy benefit managers (PBMs) and related regulated entities for inclusion in the Handbook. Bache said that PBM subject matter experts (SMEs) met in numerous drafting sessions in 2025, and the Pharmacy Benefit Management (D) Working Group released an exposure draft of a new Handbook chapter in 2025 to address conducting PBM examinations. Bache said the Pharmacy Benefit Management (D) Working Group is currently revising the exposure draft to take into account comments received on the draft and is nearing completion. Upon adoption of the PBM guidance by the Pharmacy Benefit Management (D) Working Group, that Working Group will refer the document to this Working Group for consideration and re-exposure, during which the Working Group will discuss and build out the PBM guidance to incorporate appropriate market conduct examination procedures.

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

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

3. Discussed Coordination on Cybersecurity Events

Bache said that at both the 2025 Summer and Fall National Meetings, the Market Regulation and Consumer Affairs (D) Committee discussed developing a Cybersecurity Incident Response Framework to address an effort by state insurance regulators to coordinate a multi-jurisdictional, coordinated response to regulated entity cybersecurity incidents. Prior to the 2025 Fall National Meeting, state insurance regulator cybersecurity SMEs met to discuss the project, and that work will continue in 2026, as it has been deemed a priority by the 2026 NAIC leadership.

Buono and Schulz presented their thoughts on the Working Group's project in 2026 to develop a cybersecurity incident response framework, which will serve as the foundation for a coordinated, structured, yet flexible approach to managing state insurance regulator response to multi-jurisdictional regulated entity cybersecurity events.

The Working Group's ensuing discussion addressed: 1) the issue of defining triggering thresholds (i.e., the number of jurisdictions/policyholders impacted, size of insurer, etc.); 2) the complexities of identifying lead states; 3) balancing market conduct and financial solvency state insurance regulation depending upon how state insurance departments classify regulated entity cybersecurity incidents (market conduct versus financial solvency); 4) ensuring effective communication between market conduct and financial solvency state insurance regulators; and 5) ultimately, consumer protection. In addition to containing a structured process, the to-be-developed framework will need to be flexible to allow for event-specific regulator responses. Upon completion of the cybersecurity incident response framework, updates to the Cybersecurity (H) Working Group's adopted Cybersecurity Event Response Plan, NAIC handbooks, and related materials may be needed.

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

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Draft: 3/30/26

Pharmacy Benefit Management (D) Working Group
San Diego, California
March 23, 2026

The Pharmacy Benefit Management (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met in San Diego, CA, March 23, 2026. The following Working Group members participated: Joylynn Fix, Chair, and Allan L. McVey (WV); Marcus Wilson, Vice Chair, represented by Sebastian Arduengo (VT); Kayla Erickson and Molly Nollette (AK); Kelli Littlejohn Newman (AL); Maria Ailor and Tolanda McNeal (AZ); Sophie Thomas and Lila Cummings (CO); Kurt Swan (CT); Susan Jennette (DE); Samantha Heyn and Sheryl Parker (FL); Paula Shamburger (GA); Andria Seip (IA); Dean L. Cameron and Shannon Hohl (ID); Jack Engle and Ryan Gillespie (IL); Grant Lindman (IN); Craig Van Aalst (KS); Shaun Orme (KY); Frank Opelka (LA); Mary Lou Moran (MA); Joe Stoddard (MI); T.J. Patton and Norman Barrett (MN); David Dachs (MT); Robert Croom (NC); John Arnold and Tahmidur Rahman (ND); Cheryl Wolff, Martin Swanson, Maggie Reinert, and Michael Muldoon (NE); Ralph Boeckman (NJ); Jonathan Wycoff (NV); Carole Ann Kinnaw (NY); Kristin Cly (OH); Ashley Scott (OK); Keith Turner and Colette Hittner (OR); Lindsi Swartz (PA); Tara Nixon (SC); Jud Jones (TN); Tanji J. Northrup (UT); Stephen Hogge (VA); Sandy Ray (WA); Lori Luder and Coral Manning (WI); and Lauren White and Jill Reinking (WY).

1. Adopted its Feb. 5, 2026, and 2025 Fall National Meeting Minutes

The Working Group met Feb. 5, 2026. During this meeting, the Working Group took the following action: 1) heard a presentation from the Pharmaceutical Research and Manufacturers of America (PhRMA) on the 340B Drug Pricing Program and anticipated changes beginning Jan. 1, 2026.

Cameron made a motion, seconded by Jennette, to adopt the Working Group's Feb. 5, 2026 (Attachment Six-A), and Dec. 9, 2025, minutes (*see NAIC Proceedings – Fall 2025, Market Regulation and Consumer Affairs (D) Committee, Attachment Five*). The motion passed unanimously.

2. Heard a Discussion on the Impact of the Recently Enacted Federal PBM Legislation and the Recent FTC Settlement on State PBM Laws

Allison Shields (NAIC) updated the Working Group on the recently enacted federal pharmacy benefit manager (PBM) legislation and the Federal Trade Commission (FTC) settlement. She said that on Feb. 4, the FTC announced a settlement with Express Scripts to resolve its lawsuit alleging that Express Scripts and its affiliated entities artificially inflated the list price of insulin drugs by using anticompetitive and unfair rebating practices, and impaired patients' access to lower list price products, ultimately shifting the cost of high insulin list prices to vulnerable patients. The settlement requires Express Scripts and its affiliated entities to adopt fundamental changes to their business practices that increase transparency and end business practices that have kept drug prices high. Shields detailed key provisions in the settlement order, which Express Scripts and its affiliated entities must make by Jan. 1, 2028, or as soon as "commercially feasible." She noted that it is anticipated the FTC could reach similar settlements with OptumRx and CVS Caremark in the coming months.

Shields next discussed the recently enacted federal PBM legislation. She said that as part of the Consolidated Appropriations Act of 2026 (CAA), on Feb. 3, U.S. Congress (Congress) passed a package of PBM reforms. Shields said the reforms center on rebate pass-through, increased transparency, standardized reporting, and expanded federal oversight. For the commercial market, both fully insured and self-insured group plans, the changes are effective for plan years after August 2028. She said the changes for the Medicare Part D plans mirror the law's

requirements for the commercial market, except for provisions to strengthen the "any willing pharmacy" provisions. The changes for the Medicare Part D plans are effective beginning Jan. 1, 2028.

Shields said that with respect to any impact on state PBM laws, generally, because states already have PBM laws involving certain areas included in the federal law, such as rebating, spread pricing, network adequacy, and other transparency provisions, there could be the need for harmonizing and working with the federal agencies charged with implementing the federal law, particularly for those states that license PBMs, to ensure that the state can continue to enforce its laws.

Fix asked Shields to keep the Working Group informed as the federal agencies responsible for implementing the PBM reform provisions begin their rulemaking process.

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

Jennette provided an update on the work to develop changes to State Based Systems (SBS) to better handle PBM complaints. She said the small group of states she is working with to make these changes has continued to meet with the SBS team every few weeks. The next meeting is scheduled for April 1. Jennette said the online complaint form has been completed, and related work is ongoing and should be ready to turn over to the programmers. She noted that throughout the process, she has received input and feedback from industry and different states. Jennette said the SBS PBM complaint module remains on track for completion by the end of the year.

4. Discussed the Revised Draft PBM Examination Chapter

Fix said that on Nov. 25, 2025, the Working Group exposed an initial draft of a PBM examination chapter for a public comment period ending Jan. 16, 2026. She said the Working Group met Feb. 5 to discuss the comments received. Following that meeting, the Working Group's Pharmacy Benefit Manager Examination Chapter Drafting Group met to discuss what revisions to make to the initial draft based on the comments received. Based on the Drafting Group's recommended revisions, the Working Group distributed a revised draft of the PBM examination chapter on March 13.

Fix asked Working Group members if they had any comments on the revised draft. Newman said she submitted comments on behalf of the Alabama Department of Insurance (DOI) on the revised draft suggesting additional changes, including: 1) adding definitions for independent pharmacy, chain pharmacy, and 340B pharmacy because many state laws define reimbursement to independent pharmacies and chain pharmacies separately; 2) adding more detailed language to allow examiners to better determine if manufacturer rebates are being passed through appropriately; 3) adding "federal" to many of the standards sections when "state" laws are referenced due to recent and most likely continued enactment of federal PBM laws; and 4) adding additional language to the utilization review standards concerning artificial intelligence (AI). Fix asked if any interested regulators had any comments. None did, so Fix asked for comments from interested parties.

Carl Schmid (HIV+Hepatitis Policy Institute), speaking on behalf of the NAIC consumer representatives, expressed support for the revised draft. He also expressed support for some of the Alabama DOI's suggested revisions to the draft, particularly those related to AI and copay assistance programs.

Christine Cappiello (Anthem Blue Cross and Blue Shield), speaking on behalf of the Coalition, which includes the Cigna Group, CVS Health, Elevance Health, UnitedHealth Group (UHG), and Examination Resources, said the Coalition appreciates the changes made from the initial draft, but it still has concerns. She said the Coalition looks forward to continuing to work with the Working Group to fine-tune the draft. Newman said she had reviewed the

comments received on the initial draft and, with respect to the Coalition's comments, had a question about its comment stating the draft would burden examiners. She asked how the draft would burden the states that contract with third parties, given that they are used to handling the level of examination complexity envisioned in the draft. Newman also questioned the Coalition's concerns about having to submit unredacted documents. She said examiners need such documents to properly conduct an examination. Newman said the Working Group could address this concern by including stronger confidentiality language in the draft. Seip agreed with Newman's comments concerning the need for unredacted documents.

Fix asked the Working Group whether it was ready to move forward to refer the revised draft to the Market Conduct Examination Guidelines (D) Working Group for its consideration. Seip said she would welcome additional time to review the Alabama DOI's comments before referring the draft to the Market Conduct Examination Guidelines (D) Working Group. Opelka, Wolff, and Hohl agreed with Seip's comments to hold the draft for additional Drafting Group discussion and possible revision. Fix said she would schedule a Drafting Group meeting within the next few weeks to discuss the Alabama DOI's comments and determine any additional revisions to the draft based on those comments. She said the Working Group remains on track to complete its work and refer the draft to the Market Conduct Examination Guidelines (D) Working Group for its consideration prior to the Summer National Meeting.

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

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Draft: 3/5/26

Pharmacy Benefit Management (D) Working Group
Virtual Meeting
February 5, 2026

The Pharmacy Benefit Management (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Feb. 5, 2026. The following Working Group members participated: Joylynn Fix, Chair (WV); Susan Jennette, Vice Chair (DE); Heather Carpenter and Sarah S. Bailey (AK); Kelli Littlejohn Newman (AL); Tolanda McNeal (AZ); Sophie Thomas (CO); Kurt Swan and Tricia Davé (CT); Samantha Heyn (FL); Paula Shamburger (GA); Johanna Nagel (IA); Shannon Hohl (ID); Chris Heisler (IL); Grant Lindman (IN); Craig Van Aalst and Julie Holmes (KS); Shaun Orme (KY); Nina Hunter (LA); Mary Lou Moran (MA); Joe Stoddard (MI); T.J. Patton (MN); David Dachs (MT); Robert Croom (NC); John Arnold (ND); Cheryl Wolff (NE); Ralph Boeckman and Erin Porter (NJ); Jonathan Wycoff (NV); Maria K. Garg (NY); Sara Donlon (OH); Ashley Scott (OK); Colette Hittner (OR); Gary Jones and David Buono (PA); Jud Jones (TN); Tanji J. Northrup (UT); Marcus Wilson, Sebastian Arduengo, and Karla Nuissl (VT); Sandy Ray (WA); Lori Luder (WI); and Lauren White (WY).

1. Discussed the Comments Received on Draft PBM Examination Standards Chapter

Fix said the Working Group received comments on the initial draft of the proposed pharmacy benefit manager (PBM) examination standards chapter from: the NAIC consumer representatives; the Coalition, which includes the Cigna Group, CVS Health, Elevance Health, UnitedHealth Group, and Examination Resources; the Indiana Department of Insurance (DOI); The INS Companies; the Iowa Insurance Division; the Michigan Department of Insurance and Financial Services (DIFS); the National Association of Chain Drug Stores (NACDS); Navitus Health Solutions (Navitus); the National Community Pharmacists Association (NCPA); Risk & Regulatory Consulting (RRC); and the Vermont Department of Financial Regulation (DFR). She said the purpose of this meeting is to allow the commenters to provide a high-level overview of their comments to the Working Group.

Lindman said the Indiana DOI submitted comments suggesting that the Working Group review a few draft definitions, including "biologic drugs," "generic drugs," and "manufacturers," to ensure their accuracy and completeness.

Stoddard said the Michigan DIFS submitted comments in a redline version of the draft, suggesting a wide range of revisions, both substantive and non-substantive. He said he would leave it up to the Working Group to review those suggestions and decide which ones to accept or reject. Stoddard said that in addition to the suggested revisions, the Michigan DIFS had a few higher-level comments, such as why some of the proposed PBM examination standards are formatted differently from others. He also highlighted that the draft does not include the DIFS's language submitted for inclusion in the Working Group's recently adopted draft *Pharmacy Benefit Manager Licensure and Regulations Guidelines for Regulators* document. He asked the Working Group to consider incorporating the suggested language into the draft.

Wilson said the Vermont DFR suggests a few revisions to the draft's definition section to: 1) add a definition of "health plan" to describe employer-sponsored health plans that contract with PBMs to provide prescription drug benefits to their employees; and 2) include an explanatory note concerning the term "specialty drug" to highlight that the term is not a category recognized by federal law or regulation, but that it is instead a term of art used in the industry to describe drugs that have high costs or have special dispensing or handling requirements. He said the Vermont DFR also has a few non-substantive suggested revisions regarding possible redundancy in language and numbering.

Carl Schmid (HIV+Hepatitis Policy Institute), speaking on behalf of the NAIC consumer representatives, expressed strong support for the draft. He said the NAIC consumer representatives have a few suggested edits, such as ensuring PBM-affiliated group purchasing organizations (GPOs) are included in the scope of PBM exams because GPOs are set up to collect fees and rebates in addition to the rebates individual PBMs collect and report. Schmid said that when state insurance regulators conduct PBM exams, particularly when examining drug prices and rebates, the costs paid to GPOs, along with the income GPOs receive, need to be accounted for. Schmid said that while the NAIC consumer representatives are pleased that more states are regulating PBMs and will conduct market conduct examinations, they would like to see greater transparency and public reporting of this work. As such, the NAIC consumer representatives urge states to report the results of these examinations, identify both good and bad actors, and impose fines on violators.

Franca D'Agostino (The Cigna Group), Leanne Gassaway (CVS Health), Christine Cappiello (Elevance Health), and Mollie Zito (UnitedHealth Group), speaking on behalf of the Coalition, discussed the Coalition's comments submitted on the draft. After reviewing the draft, the Coalition suggests several targeted revisions intended to increase language precision, promote regulatory consistency, align standards with existing statutory authority, and reduce operational burden without diminishing regulatory visibility. They provided a high-level summary of the Coalition's key recommendations, which are also reflected in the redline document included in its comment letter, which include recommendations for the draft the Coalition believes will: 1) improve accuracy and consistency of PBM role descriptions and operational processes; 2) consolidate and streamline redundant text; 3) clarify statutory versus non-statutory requirements; 4) ensure the safe treatment of confidential and proprietary information and adopt guidelines for the use of outside contracting firms/examiners; 5) focus document requests on material, relevant information; 6) refine utilization review standards to reflect PBM functions; and 7) improve audit standards for clarity and workability.

Craig Moore (Examination Resources) said Examination Resources had quite a few comments, which are reflected in the redline document. He said the comments fell into four main areas: 1) minor comments suggesting simple wording revisions to increase reader comprehension; 2) comments suggested to facilitate and/or encourage the development of specific PBM expertise rather than relying on language more specific to insurance operations or medical-related operations as opposed to PBMs; 3) comments suggested to add additional language or other tools that will support more efficient and effective examinations; and 4) requesting data in formats already used by PBMs and pharmacies.

Matthew Sankey (The INS Companies) said The INS Companies urges the Working Group to consider revisions to the draft in three areas: 1) in the definitions section—define the different types of pharmacies that exist in the marketplace; 2) in the third paragraph of the scheduling coordination and planning of scope section—based on the differences in state PBM laws, for PBMs that provide a current examination report indicating that no unaddressed regulatory concerns exist, clarify when additional analysis may still be necessary; and 3) in the pharmacy benefit manager operations/management section—add additional standards related to the organizations and structure of the PBM and its relationship to affiliated entities and related to the services a PBM may perform on behalf of non-affiliated PBMs.

Robyn Crosson (Navitus) said that, as expressed in its comments, Navitus believes that protecting consumers and ensuring compliance can be accomplished without the burdensome, extensive disclosure requirements outlined in the draft. She suggested the Working Group work with willing members of the PBM industry to find that right balance of regulation that allows state insurance regulators to hold PBMs accountable when appropriate, without overburdening the entire industry. Crosson said that, like some of the Coalition's comments, Navitus also urges the Working Group to limit information requests to the markets state insurance regulators are entrusted to oversee. She said Navitus' comments also detail its concerns with the draft in four areas: 1) jurisdictional integrity; 2) point of sale rebates; 3) duplicative and unnecessary disclosure requirements; and 4) redactions.

Joel Kurzman (NCPA) said that while the NCPA is highly supportive of the draft, it believes a critical element is missing and applicable to all standards: the need to enforce existing PBM regulations and to impose consequences for PBMs that do not meet those requirements. He said that for this, the NCPA again suggests state insurance regulators review its "Best Practice for PBM Regulation Enforcement" document. Kurzman said the NCPA has included additional comments in its comments on select standards regarding the regulation between PBMs and pharmacies. He said that, for the qualifications of examiners in Chapter 14 of the *Market Regulation Handbook*, as referenced in the draft, the NCPA believes special attention is warranted for PBM examiners. The NCPA strongly recommends that independent retail experience as a pharmacist be considered an essential qualification for those examining PBMs. Pharmacists are uniquely qualified to understand pharmacy operations, the relationship and dynamics between PBMs and pharmacies, and the impact of policy on patient care. Kurzman said that, for the proposed PBM standards for complaints, grievances, and appeals, the NCPA urges the Working Group to add more detail on the registration process for documenting them. He said the NCPA urges the NAIC to standardize a PBM complaint form. He acknowledged the Working Group's ongoing work to address this issue.

2. Discussed Next Steps

Fix thanked everyone for their comments. She said that following this meeting, the PBM Examination Chapter Drafting Group plans to meet to review the comments, discuss which suggested revisions are included, and, if any, include them in the revised draft. She said she anticipates that after the drafting group finishes its work, the Working Group will distribute a revised draft for review and discussion during the Working Group's meeting at the Spring National Meeting.

Gassaway asked about next steps with the draft after the Working Group completes its work. Fix said that after the Working Group decides its work to develop the initial PBM examination standards chapter draft is complete, then it will refer the draft to the Market Conduct Examination Standards (D) Working Group for its consideration and additional work to finalize the draft for the Market Regulation and Consumer Affairs (D) Committee's consideration and adoption.

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

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