Draft Pending Adoption

Draft: 12/15/25

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Discussed the Draft Cybersecurity Incident Response Framework

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

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

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

5. Heard a Presentation from the IRES

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

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

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

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

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

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

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

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

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

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

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

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

Draft Pending Adoption

6. Discussed Producer Licensing Issues

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

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

B. Implementation of Revised NAIC Uniform Producer Licensing Applications

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

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

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

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

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

D. NAIC PICS Alerts for the NIPR Attachment Warehouse

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

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

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

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

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

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

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

A. Market Analysis Procedures (D) Working Group

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

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

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

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

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

A. Discussed Other Matters

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

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

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

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Revision marks reflect proposed changes from the Guidelines adopted by the Pharmacy Benefit Management (D) Working Group, Dec. 9, 2025

Draft 12/9/25

PHARMACY BENEFIT MANAGER LICENSURE AND REGULATION GUIDELINES GUIDANCE FOR REGULATORS

Maintained by the
Pharmacy Benefit Management (D) Working Group of the
Market Regulation (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

~~**Section 1. Short Title**~~

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

~~**Section 2. Purpose**~~

~~A.~~ Thi~~s~~e purpose of this document ~~establishes the~~ 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

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the licensure ~~and regulation~~ of pharmacy benefit managers ~~providing claims processing services or other prescription drug or device services for health benefit plans~~and their operations as defined in state law.

~~B.~~ ~~The purpose of this document is~~State insurance regulators may wish to license PBMs to:

(1) Promote, preserve, and protect the public health, safety and welfare ~~through effective regulation and licensure of pharmacy benefit managers~~; 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 ~~provide for consumer savings, and fairness~~to ensure access and affordability in prescription drug benefits~~;~~.

~~(2)~~ PBM licensing best practices include:

~~(3)~~(1) Provid~~e~~ing for powers and duties of the commissioner; and

~~(4)~~(2) Prescrib~~e~~ing enforcement standards and appeals processes ~~penalties and fines~~ for violations of state law.

The document includes the following sections:

1. Guidelines for PBM licensing standards – 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: GUIDELINES FOR PBM LICENSING STANDARDS

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

~~Section 3.~~ Definitions

~~**Drafting Note:**~~ States should ensure that key terms are clearly defined in state law when establishing licensing standards for PBMs. ~~review and modify the definitions below, if needed,~~ Definitions of terms such as covered person, health plan, health carrier, pharmacist, and pharmacy used in the licensure of PBMs should be ~~for~~ consisten~~t~~cy 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.

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Commented [A1]: We recommend deleting definitions because states should rely on existing statutes governing health insurance issuer regulation for these key terms. The text has been updated to clarify that only the definition of 'pharmacy benefit manager' is essential for new licensure standards, as other terms are already addressed in state law.

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

~~(1) Receiving payments for pharmacist services;~~

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

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

~~B. "Commissioner" means the Commissioner of Insurance.~~

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

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

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

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

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

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

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

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

~~(2) Disbursing or distributing rebates;~~

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

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

~~(5) Developing and maintaining formularies;~~

~~(6) Designing prescription benefit programs; or~~

~~(7) Advertising or promoting services.~~

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

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

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

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

Commented [A2]: Edits simplify the definition and clarify scope.

(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 ~~performs any claims processing and other~~administers or processes prescription drug ~~or device services~~benefits exclusively for its enrollees.

~~Section 4.~~ 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 that are currently in-force.

~~A.~~ ~~This document shall~~ For example, a state may determine that new rules apply to a PBM's in-scope operations for a contract ~~or~~ with a health ~~benefit~~ plan that is issued, renewed, recredentialed, amended or extended on or after the effective date of any regulatory changes as prescribed by the commissioner ~~including any health carrier that performs claims processing or other prescription drug or device services through a third party.~~ and provide that t~~T~~he commissioner ~~shall~~ will establish a timeline for compliance.

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~~B.~~ States should also clarify the applicability of licensing standards upon the date of license. For example, a state may consider, ~~A~~as a condition of licensure, any in-scope contract ~~in existence on the date the pharmacy benefit manager receives its license to do business in this state shall~~ must comply with the ~~guidelines of this document~~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.

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~~C.~~ ~~Nothing in this document is intended or shall~~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.

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

Commented [A3]: We suggest inclusion of the *Guidance Document - ERISA Preemption and State PBM Laws* as a reference here upon adoption.

~~**Section 5.**~~ **Licensing Requirement**s

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

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

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

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

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  (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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- ~~A person submitting an application for a pharmacy benefit manager license shall file representative copies~~

Commented [A4]: This item has been moved to Section 3 because it is not a part of core licensing criteria, but reflects additional, non-core obligations that may be tied to a PBM's license.

~~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.~~

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

Commented [A5]: This item has been moved to Section 3 because it is not a part of core licensing criteria, but reflects additional, non-core obligations that may be tied to a PBM's license.

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

Commented [A6]: This item has been moved to Section 3 because it is not a part of core licensing criteria, but reflects additional, non-core obligations that may be tied to a PBM's license.

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

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

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

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

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

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

- Non-refundable application fee – States should specify that ~~A~~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 up to $1,000, reflecting the median PBM licensing fee across states when adjusted to exclude outliers.

- Authority to deny a license – States should authorize ~~T~~the commissioner ~~may~~ 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.

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

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

Commented [A7]: States have varying time frames for renewal based on their unique needs and resources.

(2) Timing for renewal – States should specify when ~~S~~such renewal fee and application ~~shall~~ 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 ~~shall~~ must include:

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

Commented [A8]: This item has been deleted because it reflects a substantive policy consideration rather than a licensing standard. Licensing guidelines should remain focused on core requirements for PBM licensure and oversight, while broader policy issues requiring statutory authority are outside the scope of this document. It is, instead, referenced in Section 4 re: additional policy considerations.

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

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

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

Commented [A9]: This item has been deleted because it reflects a substantive policy consideration rather than a licensing standard. Licensing guidelines should remain focused on core requirements for PBM licensure and oversight, while broader policy issues requiring statutory authority are outside the scope of this document. It is, instead, referenced in Section 4 re: additional policy considerations.

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

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

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

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

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

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

~~(4)~~(1) ~~Proof of~~ Network Adequacy ~~Requirements and Reporting.~~

Commented [A10]: This item has been moved to Section 3 because it is not a part of core licensing criteria, but reflects additional, non-core obligations that may be tied to a PBM's license.

~~(a) A pharmacy benefit manager's network shall be reasonably adequate, shall provide for convenient patient access to pharmacies within a reasonable distance from a patient's residence~~

~~and shall not be comprised only of mail order pharmacy benefits but have a mix of mail order and physical stores in this state.~~

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

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

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

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

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

- ~~K.~~ Requirements After Inactivation of License. – 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:

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

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

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

Commented [A11]: Items A through D have been moved to Section 3 because they are not a part of core licensing criteria, but reflect additional obligations that states may wish to impose and tie to a PBM's license.

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

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

~~(2)~~(1) ~~The availability of alternate therapies, consultations, or tests;~~

~~(3)~~(1) ~~The decision of utilization reviewers or similar persons to authorize or deny services;~~

~~(4)~~(1) ~~The process that is used to authorize or deny healthcare services or benefits; or~~

~~(5)(1) Information on financial incentives and structures used by the insurer.~~

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

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

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

~~(2)(1) 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.~~

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

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

~~(2)(1) 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.~~

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

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

~~Section 7.~~ Enforcement

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

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

~~B.~~ 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:

Commented [A12]: These provisions have been deleted because they reflect a substantive policy consideration rather than a licensing standard. Licensing guidelines should remain focused on core requirements for PBM licensure and oversight, while broader policy issues requiring statutory authority are outside the scope of this document. It is, instead, referenced in Section 4 re: additional policy considerations.

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

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

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

(a) Considered proprietary and confidential;

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

(c) Not subject to subpoena; and

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

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

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

~~E.~~• Appeals – Unless addressed in a general statute, states should provide for ~~A~~an appeals process for any administrative action or fine ~~should be provided to the~~imposed upon a pharmacy benefit manager in accordance with state laws and regulations.

~~Section 8. Regulations~~

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

~~Section 9.~~ Effective and Compliance Dates

When establishing new licensing standards, a state's statutes should clarify the transition period for ~~A~~a person doing business in ~~this~~ the state as a pharmacy benefit manager on or before the effective date of any changes in state laws or regulations. ~~shall have~~ 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.

Commented [A13]: We recommend deletion as this relates to financial regulation examinations of insurance companies.

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Commented [A14]: We suggest deletion of this as it is duplicative of the commissioner's authority noted under bullet 2 of the licensing requirements

~~Drafting~~ **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 ~~modify the language in this section~~ 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.

Proof of Network Adequacy Requirements and Reporting.

Commented [A15]: This item has been moved to Section 3 because it is not a part of core licensing criteria, but reflects additional, non-core obligations that may be tied to a PBM's license.

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.

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

Commented [A16]: Theis item has been deleted because it reflects a substantive policy consideration rather than a licensing standard. Licensing guidelines should remain focused on core and non-core requirements for PBM licensure and oversight, while broader policy issues requiring statutory authority are outside the scope of this document. It is, instead, referenced in Section 4 re: additional policy considerations.

~~Drafting~~ **Note:** States should consider their existing network adequacy laws when establishing PBM ~~may not be able to include mail order to meet~~ network adequacy or other standards ~~to meet regulatory reporting standards~~.

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

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

Commented [A17]: Items A through D have been moved to Section 3 because they are not a part of core licensing criteria, but reflect additional obligations that states may wish to impose and tie to a PBM's license. Language has also been updated for consistency within the guidance document.

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 ~~I~~in any participation contracts between a pharmacy benefit manager and pharmacists or pharmacies providing prescription ~~drug coverage~~services for health ~~benefit~~ 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 ~~insurer~~health plan.

- Total cost transparency – States may consider providing that ~~A~~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~~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~~a pharmacy benefit manager ~~may not~~from terminate~~ing~~ the contract of or penalize~~ing~~ a participating pharmacist or pharmacy providing prescription services for health plans subject to state insurance regulation ~~due to a pharmacist or pharmacy~~for:

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

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

Submission of Key Service Contracts and Arm's Length Agreements

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Commented [A18]: This item has been moved to Section 3 because it is not a part of core licensing criteria, but reflects additional, non-core obligations that may be tied to a PBM's license.

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

Commented [A19]: This item has been moved to Section 3 because it is not a part of core licensing criteria, but reflects additional, non-core obligations that may be tied to a PBM's license.

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*

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Commented [A21]: Suggest inclusion following adoption

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: 3/17/2026

PHARMACY BENEFIT MANAGER LICENSURE AND REGULATION GUIDANCE FOR REGULATORS

Maintained by the
Pharmacy Benefit Management (D) Working Group of the
Market Regulation (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

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Virtual Meeting

MARKET ANALYSIS PROCEDURES (D) WORKING GROUP
February 23, 2026

Summary Report

The Market Analysis Procedures (D) Working Group met Feb. 23, 2026. During this meeting, the Working Group:

1. Adopted its Nov. 3, 2025, minutes (*see NAIC Proceedings – Fall 2025, Market Regulation and Consumer Affairs (D) Committee, Attachment Two*).

2. Discussed its 2026 charges and plans. The Working Group plans to: 1) consider a new line of business for the MCAS; 2) review the public and non-public ratios developed with MCAS data; and 3) request approval from the Market Regulation and Consumer Affairs (D) Committee to retain a consultant to assist in enhancing the MAPT with new technology, such as artificial intelligence (AI).

3. Heard an update from the Market Regulation Certification (D) Working Group on the status of a new market analysis requirement. The Working Group adopted the requirement during the 2025 Fall National Meeting and will bring it to the Market Regulation and Consumer Affairs (D) Committee for consideration and adoption.

4. Discussed suggestions to improve the value of the MCAS auto and homeowner public ratio 7 regarding lawsuits by changing the denominator to a data element that better correlates with the number of lawsuits. The Working Group will continue its discussions of MCAS ratios and rankings as the year progresses.

5. Solicited suggestions for a new line of business to be included in MCAS.

6. Discussed and set tentative dates for the quarterly lunch-and-learns. The first lunch-and-learn was held March 16. Maryland hosted the session and discussed how it uses MCAS data in its analysis and investigations. The tentative dates for future lunch-and-learns are June 22, Aug. 24, and Nov. 9.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Virtual Meeting

MARKET CONDUCT EXAMINATION GUIDELINES (D) WORKING GROUP
Thursday, March 12, 2026

Summary Report

The Market Conduct Examination Guidelines (D) Working Group met March 12, 2026. During this meeting, the Working Group:

1. Discussed its 2026 charges and work plans, which include carry over items from 2025: 1) re-exposing a revised Chapter 21A—Conducting the Property and Casualty Travel Insurance Examination of the *Market Regulation Handbook* (Handbook), which had been revised in consideration of American Property Casualty Insurance Association (APCIA) and U.S. Travel Insurance Association (USTIA) comments received; 2) re-exposing the new pet insurance chapter for the Handbook, which was revised in consideration of comments received from Virginia; 3) developing new pet insurance in-force policy, claims, and complaints standardized data requests (SDR); 4) developing market conduct examiner guidance for inclusion in the Handbook based upon the Regulatory Guidance Document adopted by the Accelerated Underwriting (A) Working Group on Aug. 6, 2024, and by the Life Insurance and Annuity (A) Committee at the 2024 Summer National Meeting; 5) discussing the development of a shared regulator-only collaborative space in NAIC Connect where uniform market conduct tools can be shared by market regulators; and 6) continuing coordination with the Innovation, Cybersecurity, and Technology (H) Committee and its NAIC committee support to develop artificial intelligence (AI)-related market conduct examiner guidance.

   New projects to be discussed by the Working Group in 2026 include a forthcoming Cybersecurity Incident Response Framework and a forthcoming chapter in the Handbook containing market conduct examination standards for pharmacy benefit managers (PBMs) and related regulated entities.

2. Heard from the Working Group chair that all exposure drafts before the Working Group, as well as any forthcoming exposure drafts, such as the cybersecurity incident response framework guidance, the new pet insurance SDRs, PBM examination guidance and the market conduct examiner guidance based upon the Accelerated Underwriting (A) Working Group's Regulatory Guidance Document are subject to the Working Group's established adoption process, which includes public exposure, a comment period or periods, and review and discussion at Working Group meetings, where regulators and non-regulators will have the opportunity to submit and present comments/provide feedback.

3. Heard from the Working Group chair that the Working Group's page on the regulator-only NAIC Connect site, which went live in February 2025, currently has more than 250 followers. The chair encouraged regulators to join the Working Group's Connect page and mentioned the applicability of the NAIC Connect platform as a possible means to address the Working Group's charge to develop a shared regulator-only collaborative space where state insurance regulators can share tools, such as exam call letter templates, report templates, and other helpful market regulation tools.

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4. Received an update from Colton Schulz (ND), vice chair of the Cybersecurity (H) Working Group, and David Buono (PA), chair of the Market Actions (D) Working Group, regarding state insurance regulator multi-jurisdictional coordination on responses to regulated entity cybersecurity incidents and the development of a Cybersecurity Incident Response Framework to guide regulators' responses to cybersecurity events, which will be assigned to the Working Group. Based upon the discussion occurring at the March 12 meeting, in addition to containing a structured process, the to-be-developed structured framework will need to be flexible to allow for event-specific regulator responses. The Cybersecurity Incident Response Framework may ultimately include, but will not be limited to, guidance on clarifying the role of a lead state, defining triggering thresholds (i.e. number of jurisdictions/policyholders impacted, size of insurer, etc.), and coordination mechanisms for market conduct and financial solvency regulator responses to multistate regulated entity cybersecurity events.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Virtual Meeting

MARKET INFORMATION SYSTEMS (D) WORKING GROUP
February 25, 2026

Summary Report

The Market Information Systems (D) Working Group met Feb. 25, 2026, in regulator-to-regulator session, pursuant to paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings. During this meeting, the Working Group:

1. Discussed its Nov. 5, 2025, meeting, which included the following action:
   A. Discussed its Oct. 1, 2025, meeting actions.
   B. Considered a recently submitted Uniform System Enhancement Request (USER) request to add complaint coverage codes for auto and home warranties.
   C. Discussed the Market Information Systems (MIS) data analytics reports and received a demonstration of Regulatory Information Retrieval System (RIRS) metrics being created in ThoughtSpot. The expectation is for the reports to be available in the first quarter of 2026.
   D. Adopted revisions to the NAIC i-Site+ help section for the Market Analysis Review System (MARS) Level 1.

2. Considered the USER request for complaint coverage codes for auto and home warranties. State Based Systems (SBS) will work directly with the requesting state to map the codes to "State Specific" in the Complaint Database System (CDS).

3. Reviewed the status of outstanding USER forms and other projects impacting MIS.

4. Received a demonstration of the recently developed ThoughtSpot tools to allow states to view the completeness, timeliness, and accuracy of the data in the MIS.

5. Began work to revise the guidance in i-Site+ for CDS.

6. Discussed and set tentative dates for the quarterly lunch-and-learns. The first lunch-and-learn was held March 9. The tentative dates for future lunch-and-learns are June 5, Aug. 17, and Nov. 2.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Virtual Meeting

MARKET REGULATION CERTIFICATION (D) WORKING GROUP

Summary Report

The Market Regulation Certification (D) Working Group did not meet prior to the Spring National Meeting. During 2026, the Working Group plans to:

1. Continue receiving and reviewing applications for provisional certification of NAIC member states/territories. Currently, 22 states are provisionally certified. The Working Group's goal is to provisionally certify 35 states/territories by the Fall National Meeting.

2. Present for consideration of the Market Regulation and Consumer Affairs (D) Committee the adopted proposed draft of a new market analysis certification requirement, 12—Department Market Analysis Activity, with a primary requirement to conduct at least 30 market analysis activities, which are recorded in the Market Analysis Review System (MARS) or the Market Action Tracking System (MATS).

3. Discuss plans for the implementation of the full Voluntary Market Regulation Certification Program.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Virtual Meeting

SPEED TO MARKET (D) WORKING GROUP

Summary Report

The Speed to Market (D) Working Group did not meet prior to the Spring National Meeting. During 2026, the Working Group plans to:

1. Review the *Product Filing Review Handbook* for substantive revisions.

2. Develop a System for Electronic Rates & Forms Filing (SERFF) usage scorecard for each jurisdiction. The Working Group will also review the reports that will be made available in the modernized SERFF and encourage state/territory staff to utilize these reports to report to their department leadership.

3. Educate state/territory staff about existing channels to collaborate on complex product filings and best practices for handling form and rate reviews to support speed to market initiatives, including NAIC Connect discussion groups and working group calls. Identify potential barriers to state/territory collaboration through these forums and explore ways to address these barriers.

4. Review suggestions and determine if any changes to the Product Coding Matrices (PCM) should be recommended.

5. Monitor the progress of the SERFF modernization and provide expertise and assistance, as needed.

6. Hear regular updates from the Interstate Insurance Product Regulation Commission (Compact) and provide expertise and assistance, as needed.

