Draft date: 10/29/26

2026 Fall National Meeting
Dallas, Texas

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE
Tuesday, November 17, 2026
10:45 a.m. – 12:00 p.m.
Convention Center—Texas AB—Level 3

ROLL CALL

John F. King, Chair	Georgia	Mike Chaney	Mississippi
Marie Grant, Vice Chair	Maryland	Ned Gaines	Nevada
Charles Bassett	Arizona	Alice T. Kane	New Mexico
Trinidad Navarro	Delaware	Glen Mulready	Oklahoma
Dean L. Cameron	Idaho	Michael Humphreys	Pennsylvania
Ann Gillespie	Illinois	Jon Pike	Utah
Sandra Darby	Maine	Erin K. Hunter	West Virginia
Julia Dreier	Minnesota		

NAIC Committee Support: Jolie H. Matthews/Brian R. Webb/Jennifer R. Cook

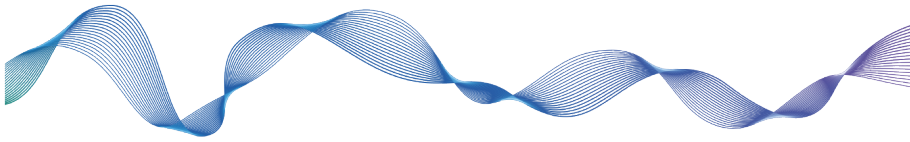
AGENDA

1. Consider Adoption of its Summer National Meeting Minutes — Attachment One
   —*Commissioner John F. King (GA)*

2. Consider Adoption of the Reports of its Task Forces and Working Groups—*Commissioner John F. King (GA)*
   A. Consumer Information (B) Working Group—*T.J. Patton (MN)*
   B. Health Care Affordability and Mitigation (B) Working Group —*Kate Harris (CO)*
   C. Health Actuarial (B) Task Force—*Director Anita G. Fox (MN) and Kevin Dyke (MI)*
   D. Regulatory Framework (B) Task Force —*Commissioner Marie Grant (MD)*
   E. Senior Issues (B) Task Force—*Commissioner Ned Gaines (NV)*

3. Consider Adoption of its 2027 Proposed Charges and its Task Forces' 2027 Proposed Charges—*Commissioner John F. King (GA)*

4. Consider Adoption of the Health Care Affordability and Mitigation (B) Working Group's Issue Briefs—*Kate Harris (CO)*



5. Hear a Discussion of CHOICE Arrangements—*Dr. Mehmet Oz (invited) (Federal Centers for Medicare & Medicaid Services—CMS)*

6. Hear an Update from the Federal Center for Consumer Information and Insurance Oversight (CCIIO) on its Activities of Interest to the Committee—*Peter Nelson (CCIIO)*

7. Discuss Any Other Matters Brought Before the Committee —*Commissioner John F. King (GA)*

8. Adjournment

Agenda Item #1

Consider Adoption of its Summer National Meeting Minutes
—Commissioner John F. King (GA)

Draft Pending Adoption

Draft: 8/20/26

Health Insurance and Managed Care (B) Committee
Columbus, Ohio
August 14, 2026

The Health Insurance and Managed Care (B) Committee met in Columbus, OH, Aug. 14, 2026. The following Committee members participated: John F. King, Vice Chair (GA); Charles Bassett (AZ); Dean L. Cameron (ID); Ann Gillespie (IL); Marie Grant (MD); Mike Chaney represented by Bob Williams (MS); Alice T. Kane represented by Viara Ianakieva (NM); Ned Gaines (NV); Glen Mulready (OK); Michael Humphreys (PA); Jon Pike (UT); and Erin K. Hunter and Joylynn Fix (WV). Also participating were: Heather Carpenter (AK); Doug Ommen (IA); Kevin Dyke (MI); Julia Dreier (MN); Angela L. Nelson (MO); TK Keen (OR); Michael Wise (SC); and Scott A. White (VA).

1. Adopted its Spring National Meeting Minutes

Commissioner Grant made a motion, seconded by Director Cameron, to adopt the Committee's March 25 minutes (*see NAIC Proceedings – Spring 2026, Health Insurance and Managed Care (B) Committee*). The motion passed unanimously.

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

Prior to asking for a motion to adopt the Committee's task force and working group reports, Commissioner King said that in adopting the report of the Regulatory Framework (B) Task Force, the Committee is not adopting the *Guidance Document—ERISA Preemption and State PBM Laws* (Guidance Document). The Committee will consider its adoption as the next meeting agenda item.

Commissioner Gaines made a motion, seconded by Commissioner Pike, to adopt the following task force and working group reports: 1) Consumer Information (B) Working Group, including its July 23 (Attachment One) and April 10 (Attachment Two) minutes; 2) Health Care Affordability and Mitigation (B) Working Group (Attachment Three); 3) Health Actuarial (B) Task Force; 4) Regulatory Framework (B) Task Force; and 5) Senior Issues (B) Task Force. The motion passed unanimously.

3. Adopted the Guidance Document

Commissioner Grant said the Regulatory Framework (B) Task Force adopted the Guidance Document during its Aug. 13 meeting. The Employee Retirement Income Security Act (ERISA) and Alternative Health Coverage (B) Working Group adopted it July 22. Commissioner Grant said the purpose of the Guidance Document is to provide information to state department of insurance (DOI) regulators and other state government officials regarding ERISA preemption of state pharmacy benefit manager (PBM) laws. The Guidance Document considers the different types of state PBM laws and how appellate courts have applied the reasoning of the U.S. Supreme Court case *Rutledge v. Pharmaceutical Care Management Association (PCMA)* to those laws. Commissioner Grant said the Guidance Document does not analyze cases that were still being litigated as of July 22, which is the date the ERISA and Alternative Health Coverage (B) Working Group adopted it. She noted, however, that recognizing the ongoing legal activity in this area, the Guidance Document includes an addendum summarizing ongoing cases involving ERISA preemption of state PBM laws.

Commissioner Grant made a motion, seconded by Director Cameron, to adopt the *Guidance Document—ERISA Preemption and State PBM Laws* (Attachment Four). The motion passed unanimously.

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4. Heard Remarks from the Mark Cuban Cost Plus Drug Company on Prescription Drug Affordability and Access

Mark Cuban (Mark Cuban Cost Plus Drug Company) discussed potential state insurance regulatory approaches to improve prescription drug affordability and access for consumers. The approaches he suggested included: 1) allowing cash purchases of prescription drugs that cost less than a patient's insurance cost-sharing amount to count toward the patient's deductible and out-of-pocket obligations. This would enable consumers to shop for lower-cost medications without losing credit toward their health plan requirements; 2) creating standardized PBM contracts to eliminate confusing or misleading terminology and make contract terms easier for employers, state insurance regulators, and purchasers to understand and make PBM and health plan contract pricing publicly available rather than treating it as proprietary information; 3) requiring greater PBM transparency regarding prescription drug pricing, rebates, fees, and PBM compensation arrangements; 4) requiring PBM licensing and condition licensure on compliance with state requirements and consumer protection standards and impose stronger consequences for repeat violations, including restricting PBMs from bidding on state contracts after repeated regulatory fines; 5) banning or limiting spread pricing and ensuring pricing is tied more closely to actual acquisition costs; 6) making specialty drug reforms by removing PBM discretion to determine which drugs are classified as "specialty drugs;" 7) eliminating gag clauses that prevent employers and purchasers from discussing PBM contracts or comparing terms; 8) requiring PBMs, third-party administrators (TPAs), and other entities providing claims processing services to give employers and plan sponsors access to their full claims data so they can analyze spending and identify cost-saving opportunities; 9) reducing PBM control over formularies and consider greater involvement by state medical directors, pharmacists, and other clinical experts in formulary development; and 10) expanding health care service and prescription drug price transparency so consumers can compare prices and choose lower-cost options.

Commissioner King thanked Cuban for the suggestions. He said that, like other state insurance commissioners, he is frustrated with the status quo with the high cost of health care and prescription drugs. Commissioner King acknowledged Cuban's efforts to lower the cost of prescription drugs for consumers with the founding of the Mark Cuban Cost Plus Drug Company. He outlined several obstacles hindering efforts by state insurance regulators to understand and address health care cost drivers. He asked Cuban, moving forward, what strategies and/or approaches he would suggest for state insurance regulators to address the rising cost of health care and prescription drugs. Cuban said he believes his suggestion to create standardized PBM contracts, coupled with requiring greater PBM transparency, particularly regarding contract pricing, and prohibiting gag clauses, could be a big step forward to address health care costs, particularly prescription drug costs.

Commissioner Mulready asked Cuban what has surprised him most in the health care arena since he launched his company. Cuban said he is surprised how uninformed company chief executive officers (CEOs) are regarding the cost of providing health care benefits to their employees. He acknowledged that CEOs are not expected to understand how their company's health care benefits work but given that health care benefit expenses are typically a company's second largest expense after payroll, perhaps they should have such awareness. Cuban outlined the complexities companies and their human resource (HR) departments faced when trying to negotiate contracts with insurers, TPAs, administrative services only (ASO) organizations, and PBMs to provide health care and prescription drug coverage to their employees.

Director Cameron said that in his remarks, Cuban mentioned that his company does not offer all prescription drugs. He asked Cuban to explain why. Cuban said the Mark Cuban Cost Plus Drug Company only offers about 78 brand-name drugs from the thousands of brand-name and specialty drugs available. He said that when he talks to the drug manufacturer company CEOs about selling their brand-name drugs through his company, the answer he receives about why they will not is that the big three PBMs, which control about 80% of the market, will diminish the positioning of the company's brand-name drug on the PBM's formularies, costing their company millions and millions of dollars. Cuban said that to address this, state insurance regulators should consider ways to reduce the control PBMs have on formulary development, such as creating standardized formularies.

Commissioner Humphreys said Pennsylvania has been working on legislation consistent with one of Cuban's suggestions for reducing prescription drug costs, which is to require insurers to count the cost of a prescription drug the consumer has found at the cheapest available to them toward a consumer's deductible and maximum out-of-pocket (MOOP) limit. He said that among the issues Pennsylvania has encountered is that insurers want the drug to be on the consumer's health plan formulary, require the consumer to go through step therapy, and impose prior authorization (PA) requirements. Commissioner Humphreys remarked that he knows of a Pennsylvania company that has been contracting with Mark Cuban Cost Plus Drug Company to make it the company's in-network pharmacy. He asked Cuban if he is seeing more interest from insurers in directing their PBMs to work with his company to obtain the lowest-cost available prescription drugs. Cuban said there has been some uptick in interest. He said Sidecar Health and Network Health are examples of insurers that have shown such recent interest.

5. Heard an Update from the CCIIO on its Recent Activities

Peter Nelson (Center for Consumer Information and Insurance Oversight—CCIIO) discussed the Trump Administration's vision for a more competitive individual health insurance market that delivers higher quality, more affordable health care to consumers. He said the CCIIO believes the keys to making this happen are: 1) emphasizing fraud prevention; 2) increasing price transparency; 3) providing more consumer choice; 4) encouraging innovative plan designs; and 5) expanding the use of individual coverage health reimbursement arrangements (ICHRAs).

Nelson said the CCIIO is still looking to provide more flexibility through the Affordable Care Act (ACA) Section 1332 waivers provision to potentially address some core problems with the ACA, such as its age rating curves. He said the rating curves have caused young people to leave the individual market because their premiums were too expensive, resulting in a smaller risk pool.

Fix asked Nelson about the CMS' proposed rule "Medicaid Program: Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes" (CMS-2452-P). The proposed rule would replace the current 6% indirect hold harmless threshold with state-specific thresholds based on tax structures enacted and imposed as of July 4, 2025. The proposed rule would formally implement Section 71115 of the One Big Beautiful Bill Act (OBBBA) H.R. 1, which was intended to crack down on state Medicaid financing. She asked for clarification on its application, particularly if it would impact ACA exchange user fees and Section 1332 assessments used to support state reinsurance programs. Nelson acknowledged that there have been some questions about this. He suggested that she submit comments on it during the public comment period. Commissioner Mulready said he had a similar question to Fix's question. He noted that if the CMS interprets the proposed rule as affecting Section 1332 assessments, it would discourage states from pursuing Section 1332 waivers, when the CMS would most likely want to incentivize the pursuit of such applications.

Director Carpenter said she was encouraged to hear Nelson discuss the Trump administration's vision for the individual market to address health care costs. She discussed Alaska's individual and small group market challenges, the increasing lack of affordable health care options, and the lack of tools in its toolbox to address it. Nelson acknowledged Alaska's unique issues with its markets. He reiterated that the Trump administration is working to implement policies that have the potential to address some of these issues in the long-term. Nelson encouraged Director Carpenter to reach out to the CCIIO to discuss some potential short-term solutions, such as using the Section 1332 waiver process.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.

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Agenda Item #2

Consider Adoption of its Working Group and Task Force Reports

—Commissioner John F. King (GA)

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Virtual Meeting

CONSUMER INFORMATION (B) WORKING GROUP
October 27, 2026 / October 7, 2026

Summary Report

The Consumer Information (B) Working Group met Oct. 27 and Oct. 7, 2026. During these meetings, the Working Group:

1. Discussed and adopted a revised *Frequently Asked Questions about Health Care Reform* (FAQ) document.

2. Discussed and adopted a consumer guide on the federal No Surprises Act (NSA).

3. Continued its discussion of the proposed consumer guide on mental health parity. The Working Group hopes to finalize the document by the end of the year or early next year.

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Draft: 11/4/26

Consumer Information (B) Working Group
Virtual Meeting
October 27, 2026

The Consumer Information (B) Working Group of the Health Insurance and Managed Care (B) Committee met October 27, 2026. The following Working Group members participated: T.J. Patton, Chair (MN); David Buono, Vice Chair (PA); Anthony L. Williams (AL); Debra Judy (CO); Randy Pipal (ID); Corbin McGhee (IL); Teresa Tetrick (IN); Patricia Dorn (MD); Melissa Panettiere and Jeana Thomas (MO); Donna Dorr and Mike Rhoads (OK); Jill Kruger (SD); Christina Keeley and Coral Manning (WI); and Joylynn Fix (WV).

1. Adopted the Updated FAQ Document

The Working Group reviewed annual updates to the document *Frequently Asked Questions About Health Care Reform* (FAQ). Patton reminded the group that the FAQ covers the Affordable Care Act (ACA) and is intended as a reference for state department of insurance (DOI) staff in assisting consumers.

Patton thanked regulators who updated the FAQ for 2027. He invited comments on the updates, specifically on the newly added question on Medicaid work requirements (Question 111) and the revised question on premium tax credit eligibility for noncitizens (Question 129).

No participants raised substantive concerns or comments about the new Question 111 during the meeting, and the item remains included in the revised FAQ as presented. Patton said Question 129 was revised to reflect 2027 eligibility restrictions for certain noncitizen groups relating to premium tax credits. Patton highlighted the change and requested comments. Working Group members supported the revised language.

Jeff Klein (American Bankers Association—ABA) provided comments on existing FAQ language about health savings accounts (HSAs). He recognized that the question appropriately describes bronze and catastrophic plans as HSA-eligible and he confirmed the drafting is accurate.

Harold M. Ting (Health Care Consumer Advocate) proposed adding a question-and-answer on the GLP-1 bridge program for Medicare beneficiaries. He shared draft language derived from the Center for Medicare Advocacy (CMA). Working Group members discussed the proposed addition and concluded that a question limited to Medicare benefits exceeded the scope of the FAQ, which focuses on the ACA and related policies. McGhee suggested offering a broader separate resource for multiple coverage topics (including GLP-1) that states could customize with their own specifics. Patton agreed that the GLP-1 content is useful but better provided as a separate resource rather than added directly into the ACA FAQ.

Fix made a motion, seconded by Judy, to adopt the FAQ with the revisions shared prior to the meeting (Attachment 1). The motion passed unanimously.

2. Discussed Other Matters

Patton reminded the Working Group that during its previous meeting, it adopted a template consumer guide on the No Surprises Act. He said the guide would soon be distributed by email and posted on the Working Group website.

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Patton said a drafting group continues to meet to refine a template consumer guide on mental health parity. He requested additional volunteers and encouraged contributors to help finalize the guide within the year.

Having no further business, the Consumer Information (B) Working Group adjourned.

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Draft: 10/21/26

Consumer Information (B) Working Group
Virtual Meeting
October 7, 2026

The Consumer Information (B) Working Group of the Health Insurance and Managed Care (B) Committee met October 7, 2026. The following Working Group members participated: T.J. Patton, Chair (MN); David Buono, Vice Chair (PA); Anthony L. Williams (AL); Debra Judy (CO); Patricia Dorn (MD); Jeana Thomas (MO); Donna Dorr (OK); Jill Kruger (SD); Jennifer Ramcharan (TN); Shelley Wiseman (UT); Andrew Davis (WA); Christina Keeley (WI); and Joylynn Fix (WV). Also participating were: Chrystal Bartuska (ND); and Michelle Heaton (NH).

1. Considered a Consumer Guide on the No Surprises Act

The Working Group reviewed a consumer-facing guide to the federal No Surprises Act. Buono stated that the guide appears to be finished pending any final feedback, and he encouraged final review by the Working Group. Patton thanked the drafting group and said the guide should help departments of insurance (DOIs) and consumers.

Members of the Working Group expressed support and praise for the guide's quality, and Kruger supported finalizing it.

Brenda J. Cude (University of Georgia) noted a small technical change replacing "ambulance service" with "ambulance company" to maintain consistency and clarity. Buono agreed to make the ambulance wording tweak and move the guide forward to the Health Insurance and Managed Care (B) Committee.

Fix made a motion, seconded by Kruger, to approve the guide (Attachment 1). The motion passed unanimously.

2. Discussed a Consumer Guide on Mental Health Parity

Patton presented a brief consumer guide on mental health parity developed by a drafting group. Patton said the guide was derived from similar guides used by the Colorado Division of Insurance and the Carter Center in Georgia.

Buono asked whether the guide targets marketplace plans specifically or all types of insurance, noting differences in coverage and applicability. Patton clarified that the original Carter Center document targeted marketplace plans, but the current draft is broader. He said the drafting group planned to include clarifying language about plan types.

Bartuska identified herself as chair of the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group chair and cautioned that consumers rarely can determine a parity violation on the front end because parity questions often require claims- and policy-level review. Bartuska emphasized that parity issues frequently emerge during claims analysis and that consumers typically lack the needed plan details to self-diagnose parity violations. Buono proposed presenting "red flags" that prompt consumers to contact state insurance regulators rather than suggesting consumers can identify parity violations themselves. Deb Steinberg (Legal Action Center—LAC) recommended incorporating warning signs and pointed to recent federal U.S. Department of Labor (DOL) public guidance as a model for consumer-facing red-flag language.

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Patton committed the drafting group to reviewing the DOL resource and working on simplification and links to additional information. He noted the drafting group will return to this guide after completing the Frequently Asked Questions About Health Care Reform document (FAQ document).

The Working Group clarified that its mental health parity guide is intended as a web-based document with links to more detailed resources, making it accessible to general consumers while enabling deeper dives for interested users. The drafting team stressed the need to avoid regulatory complexity and ensure clear signposting to state DOI contacts for plan-specific questions. Working Group members requested additional resources and expressed willingness to help refine the red-flag language.

Cude suggested starting with the basics of what consumers should know, followed by listing the next steps and simpler language to improve accessibility. Steinberg reiterated the need for red-flag indicators to help consumers identify when to contact state insurance regulators and suggested aligning with DOL public guidance.

3. Discussed the FAQ Document

The Working Group organized its annual update of the FAQ document ahead of the upcoming open enrollment. Patton explained the FAQ update process and solicited volunteers to review specific sections for 2027 changes.

Multiple Working Group members volunteered to review and, where necessary, revise questions and answers in the document. Joe Touschner (NAIC) said he will post a single Word document on SharePoint for collaborative edits and will accept emailed revisions when necessary. Touschner proposed a deadline of Oct. 21 for volunteer edits to support finalization before open enrollment, and the Working Group agreed to meet the week of Oct. 26 to consider approval of the revised FAQ. That way, the document will be ready for the November open enrollment window.

4. Discussed Other Matters

Jeff Klein (American Bankers Association—ABA) raised the idea of a consumer guide on health savings accounts (HSAs). Klein asked the Working Group to consider partnering on an HSA consumer guide in the next year and offered HSA Council resources and subject-matter support. Patton acknowledged the suggestion, asked NAIC committee support to add it to the Working Group's running list, and noted the earliest feasible consideration is in 2027, given the current workload and timing.

Having no further business, the Consumer Information (B) Working Group adjourned.

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Agenda Item #3

Consider Adoption of its 2027 Proposed Charges and its Task Forces' 2027 Proposed Charges
—Commissioner John F. King (GA)

Draft: 10/11/26
Adopted by the Executive (EX) Committee and Plenary, Dec. ??, 2026
Adopted by the Health Insurance and Managed Care (B) Committee, Nov. ??, 2026

2027 Proposed Charges

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

The mission of the Health Insurance and Managed Care (B) Committee is to consider issues relating to all aspects of health insurance.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Health Insurance and Managed Care (B) Committee** will:
   A. Respond to inquiries from Congress, the White House, and federal agencies.; Aanalyze the policy implications and their effect on the states of proposed and enacted federal legislation and regulations;, assess their effects on states, and communicate the NAIC's position through letters and testimony when requested.
   B. Monitor the activities of the Health Actuarial (B) Task Force.
   C. Monitor the activities of the Regulatory Framework (B) Task Force.
   D. Monitor the activities of the Senior Issues (B) Task Force.
   E. Serve as the official liaison between the NAIC and the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission), the National Committee for Quality Assurance (NCQA), and the Utilization Review Accreditation Commission (URAC).
   F. Monitor health insurance markets to evaluate and recommend standards and consumer protections, as well as address emerging issues in health care delivery and affordability.
   G. Coordinate with appropriate Market Regulation and Consumer Affairs (D) Committee groups, as necessary, on health benefit plan and producer enforcement issues.
   H. Coordinate with the Market Regulation and Consumer Affairs (D) Committee, as necessary, to collect uniform data and monitor market conduct trends on plans that are not regulated under the federal Affordable Care Act (ACA), including short-term, limited-duration insurance (STLDI), association health plans (AHPs), and packaged indemnity health products.

2. The **Consumer Information (B) Working Group** will:
   A. Develop helpful information or resources, as needed, that would be helpful tofor state insurance regulators and others in assisting consumers to better understand health insurance.
   B. Review NAIC publications that covertouch on health insurance to determine if they need updating. If updates are needed, suggest specific revisions to the appropriate NAIC group or NAIC division to make the changes.
   C. Identify communication goals, strategies, and tactics to reach communities that experience inequities in health insurance access, including through partnerships with community-based organizations.

3. The **Health Care Affordability and Mitigation (B) Working Group** will:
   A. Discuss state efforts ~~related to~~on health care—i.e., access, insurance plan designs, underlying medical and prescription drug costs, stability for health care and insurance as a whole, health insurer and provider consolidation or competition, the use of data in regulatory and policy decision making, and health care delivery and financing models—to achieve better patient outcomes, reduce disparities in coverage and affordability, and lower spending trends.
   B. Examine factors that contribute to rising health care costs and insurance premiums, as well as coverage losses. Review state initiatives to address cost drivers, consumer affordability, disparities in coverage, and coverage continuity.
   C. Explore sources and methods for state insurance regulators to obtain data to inform health reform initiatives.
   D. Disseminate materials and reports, via the NAIC, to the states and the U.S. territories wishing to use the information gathered by the Working Group.
   E. Take up other matters as directed by the Health Insurance and Managed Care (B) Committee.

NAIC Committee Support ~~Staff~~: Jolie H. Matthews/Brian R. Webb/Jennifer R. Cook

Draft: 9/11/26
Adopted by the Executive (EX) Committee and Plenary, Dec.dd, 2026
Adopted by the Health Insurance and Managed Care (B) Committee, mm/dd/2026
Adopted by the Health Actuarial (B) Task Force, 10/7/2026

2027 Proposed Charges

HEALTH ACTUARIAL (B) TASK FORCE

The mission of the Health Actuarial (B) Task Force is to identify, investigate, and develop solutions to actuarial problems in the health insurance industry.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Health Actuarial (B) Task Force** will:
   A. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary with respect to model requirements for appropriate long-term care insurance (LTCI) rates, rating practices, and rate changes.
   B. Provide support for issues related to the implementation of, and/or changes to, the federal Affordable Care Act (ACA).
   C. Continue to develop health insurance reserving requirements (*Valuation Manual* [VM]-25, Health Insurance Reserves Minimum Reserve Requirements).
   D. Develop LTCI experience reporting requirements in VM-50, Experience Reporting Requirements, and VM-51, Experience Reporting Formats, of the *Valuation Manual*.
   E. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary to other NAIC groups regarding their work on health actuarial matters.
   F. Monitor and evaluate the actuarial approach used in the multistate actuarial (MSA) rate review process, as outlined in the MSA Framework document, and make modifications, as appropriate. Additionally, monitor and evaluate the progress of the MSA rate review process and the state insurance department rate review actions regarding the MSA Framework.

2. The **Long-Term Care Actuarial (B) Working Group will**:
   A. Assist the Health Actuarial (B) Task Force in completing the following charges:
      i. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary with respect to model requirements for appropriate long-term care insurance (LTCI) rates, rating practices, and rate changes.
      ii. Continue to develop health insurance reserving requirements (*Valuation Manual* [VM]-25, Health Insurance Reserves Minimum Reserve Requirements).
      iii. Develop LTCI experience reporting requirements in VM-50, Experience Reporting Requirements, and VM-51, Experience Reporting Formats, of the *Valuation Manual*.
      iv. Monitor and evaluate the actuarial approach used in the multistate actuarial (MSA) rate review process as outlined in the MSA Framework document, and make modifications, as appropriate. Additionally, monitor and evaluate the progress of the MSA rate review process and the state insurance department rate review actions related to the MSA Framework.

NAIC Support Staff: Eric King

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Draft date: 10/11/26
Adopted by the Executive (EX) Committee and Plenary, ? __, 2026
Adopted by the Health Insurance and Managed Care (B) Committee, ? __, 2026
Adopted by the Regulatory Framework (B) Task Force, Oct. 29, 2026

2027 Proposed Charges

REGULATORY FRAMEWORK (B) TASK FORCE

The mission of the Regulatory Framework (B) Task Force is to: 1) develop NAIC model acts and regulations for state health care initiatives and 2) consider policy issues affecting state health insurance regulation.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Regulatory Framework (B) Task Force** will:
   A. Coordinate and develop technical assistance to states regarding state-level implementation issues raised by federal health legislation and regulations.
   B. Review managed health care reforms, their delivery systems occurring in the marketplace, and other forms of health care delivery. Recommend appropriate revisions to regulatory jurisdiction, authority, and structures.
   C. Examine regulatory factors contributing to disparities in coverage, and recommend appropriate steps to reduce those disparities.
   D. Consider the development of new NAIC model laws and regulations and the revision of existing NAIC model laws and regulations, including those affected by federal legislation and final federal regulations promulgated pursuant to such legislation.
   E. At the direction of the Health Insurance and Managed Care (B) Committee, through the work of the Employee Retirement Income Security Act (ERISA) and Alternative Health Coverage (B) Working Group, monitor, analyze, and report developments related to group coverage.
   F. Gather and share information, best practices, experience, and data to inform and support state flexibility options through the Affordable Care Act (ACA) and other health insurance-related policy initiatives.

2. The **Employee Retirement Income Security Act (ERISA) and Alternative Health Coverage (B) Working Group** will:
   A. Monitor, report, and analyze developments related to ERISA, and make NAIC strategy and policy recommendations regarding those developments.
   B. Monitor, facilitate, and coordinate with states and the U.S. Department of Labor (DOL) efforts on sham health plans.
   C. Monitor, analyze, and report, as necessary, developments on excepted benefits coverage; short-term, limited-duration (STLD) coverage; health care sharing ministry (HCSM) coverage; and coverage that is offered and marketed as a substitute for, or an alternative to, comprehensive major medical coverage.
   D. Monitor, facilitate, and coordinate with states and the DOL on compliance and enforcement efforts regarding the ACA that relate to ERISA.
   E. Review the *Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation* (ERISA Handbook), and modify it, as necessary, to reflect any ERISA developments. Report annually.

REGULATORY FRAMEWORK (B) TASK FORCE *(continued)*

3. The **Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group** will:
   A. Monitor, report, and analyze developments related to the MHPAEA, and make NAIC strategy and policy recommendations regarding those developments.
   B. Monitor, facilitate, and coordinate MHPAEA best practices with states, the U.S. Department of Labor (DOL), and the U.S. Department of Health and Human Services (HHS).
   C. Coordinate with and provide input to Market Regulation and Consumer Affairs (D) Committee groups, as necessary, regarding mental health parity market conduct examinations.

4. The **Prescription Drug Coverage (B) Working Group** will:
   A. Serve as a forum to educate state insurance regulators on issues regarding prescription drug coverage regulation and stakeholders in the prescription drug ecosystem.
   B. Gather and share information, best practices, experience, and data to inform and support dialogue and information-sharing among state insurance regulators on prescription drug coverage regulation issues, such as pharmaceutical drug pricing and transparency, formularies, pharmacy payments, pharmacy benefit managers (PBMs), and coverage options.
   C. Maintain a current listing of prescription drug coverage laws, regulations, and case law that fall under the purview of state-based insurance.
   D. Disseminate materials and reports via the NAIC to states and U.S. territories.
   E. Monitor, facilitate, and coordinate with states and federal agencies to ensure compliance and enforcement efforts regarding prescription drug coverage and PBMs.
   F. Provide assistance and input to the Market Regulation and Consumer Affairs (D) Committee and/or any of its groups, as necessary, on matters related to PBM enforcement.

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

Draft: 10/11/26
Adopted by the Executive (EX) Committee and Plenary, ____ __, 2026
Adopted by the Health Insurance and Managed Care (B) Committee, ____ __, 2026
Adopted by the Senior Issues (B) Task Force, Oct. 8, 2026

2027 Proposed Charges

SENIOR ISSUES (B) TASK FORCE

The mission of the Senior Issues (B) Task Force is to: 1) consider policy issues; 2) develop appropriate regulatory standards; and 3) revise, as necessary, the NAIC models, consumer guides, and training material on Medicare supplement insurance, long-term care insurance (LTCI), senior counseling programs, and other insurance issues that affect older Americans.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Senior Issues (B) Task Force** will:
   A. Develop appropriate regulatory standards and revisions, as necessary, to the NAIC models, consumer guides, and training material on Medicare supplement insurance, senior counseling programs, and other insurance issues that affect older Americans. Work with federal agencies to advance appropriate regulatory standards for Medicare supplement insurance and other forms of health insurance applicable to older Americans. Review the *Medicare Supplement Insurance Minimum Standards Model Act* (#650) and the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651) to determine if amendments are required based on changes to federal law. Work with the federal Centers for Medicare & Medicaid Services (CMS) to revise the annual joint publication *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*.
   B. Monitor the Medicare Advantage and Medicare Part D marketplace. Assist states with regulatory issues, as necessary. Maintain dialogue and coordinate with the CMS on regulatory issues, including solvency oversight of waived plans, agent misconduct, narrowed networks, and exposure to marketing and sales abuses. Assist states and serve as a clearinghouse for information on Medicare Advantage plan activity.
   C. Provide the perspective of state insurance regulators to Congress, as appropriate, and the CMS on insurance issues, including those concerning the effect and result of federal activity on the senior citizen health insurance marketplace and regulatory scheme. Review and monitor state and federal relations regarding senior health care initiatives and other impacts on the states.
   D. Monitor developments concerning State Health Insurance Assistance Programs (SHIPs), including information on legislation affecting the funding of SHIPs. Assist states with SHIPs issues and support a strong partnership between SHIPs and the CMS. Provide the perspective of state insurance regulators to federal officials on issues concerning SHIPs, as appropriate.
   E. Monitor, maintain, and review, in accordance with changes to Model #651, a record of state approvals of all Medicare supplement insurance new or innovative benefits for use by state insurance regulators and others. Review state-approved new or innovative benefits and consider whether to recommend that they be made part of standard benefit plan designs in Model #651.
   F. Develop appropriate regulatory standards and revisions, as necessary, to the NAIC models, consumer guides, and training material on long-term care insurance (LTCI), including the study and evaluation of evolving LTCI product design, rating, suitability, and other related factors. Monitor ongoing research and maintenance of guidance regarding reduced benefit options (RBOs) and make necessary modifications to the *Long-Term Care Insurance Model Act* (#640) and the *Long-Term Care Insurance Model Regulation* (#641). Work with federal agencies, as appropriate. Examine examples of health-related financial

exploitation of seniors and work with other NAIC committees, task forces, and working groups on possible solutions.

SENIOR ISSUES (B) TASK FORCE *(continued)*

G. Examine systemic inequities and discrimination in access, affordability, and outcomes for older insurance consumers.

NAIC Committee Support: David Torian

FROM THE NAIC CONSUMER REPRESENTATIVES

September 21, 2026

To: John King, Chair and Marie Grant, Vice Chair
Health Insurance and Managed Care (B) Committee

RE: Consumer Representatives' Comments on 2027 Charges for the Health Insurance and Managed Care (B) Committee

On behalf of the undersigned Consumer Representatives to the National Association of Insurance Commissioners (NAIC), we are pleased to provide the following comments on the proposed 2027 charges for the Health Insurance and Managed Care (B) Committee and the various work streams that fall under B Committee.

Health Insurance and Managed Care (B) Committee
We support the B Committee's charges as currently written and do not suggest making changes. We continue to support the new charge adopted last year to include a focus on health equity and addressing disparities in affordability of and access to insurance. We look forward to the Committee devoting more attention to give meaning and action to this particular charge in future work. We also appreciate the inclusion of addressing emerging affordability challenges in the charges and believe the Health Care Affordability and Mitigation (B) Working Group is an important work stream that should continue in 2027.

Regulatory Framework (B) Task Force
We urge the Regulatory Framework Task Force to include a charge specifically focused on non-discrimination protections, in addition to the existing charge addressing disparities in health care access and affordability. We believe consumer non-discrimination protections, including protections that prohibit insurance plans from using plan designs that provide substandard care and treatment for populations with higher health care utilization, are both essential and under-enforced.

We also appreciate the time and attention that the Regulatory Framework Task Force has devoted to consumer challenges in accessing their health care due to excessive prior authorization barriers. Due to the scope of the issue and the many fronts it is being addressed, we believe the Task Force should create a Prior Authorization Working Group. At a minimum the issue of prior authorization should be reflected in a formal charge.

We urge the Task Force to consider the following additional charges:

- Assess non-discrimination protections in health insurance and identify actions to improve broader knowledge and enforcement of, and compliance with, these protections.

- Identify actions states can take to address the growing challenges associated with prior authorization and other utilization management techniques, including data collection to better understand how prior authorization is being used, the impact on consumer access, and specific regulatory actions to protect consumers against inappropriate use of prior authorization.

Employee Retirement Income Security Act (ERISA) and Alternative Health Coverage (B) Working Group
We appreciate the Working Group's focus this year to examine state laws and regulations of PBMs as well as analysis of legal challenges to these laws based on ERISA preemption. As court challenges continue, we urge the NAIC to update the ERISA handbook to reflect new court decisions.

We also appreciate and support the expanded charge of this Working Group to include non-ACA regulated alternative health coverage arrangements. As federal policies push to expand the non-ACA regulated market, regulators should be prepared to address consumer access challenges that may emerge. Because of the outsized impact of these limited benefit non-ACA regulated products on consumers with more pronounced health care needs, we believe that the Working Group should adopt charge language that more fully addresses the potential for discriminatory plan designs in these markets as well as outsized negative impact on consumers with complex and chronic conditions. We urge the Working Group to add the following charge:

- Assess how non-discrimination protections apply to alternative health coverage and the short and longer term impacts of alternative health coverage on populations with higher health care needs.

Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group
We fully support the work of the MHPAEA Working Group and its focus on ensuring mental health and substance use disorder benefits are comparable to medical/surgical benefits so consumers can access the services, medications, and supports they need. We are grateful the Working Group conducted a survey this year to identify the policies, strategies, and tools that each state uses to enforce parity, and we strongly urge the Working Group to make the full results of this survey publicly available. Increasing transparency on MHPAEA enforcement will make it easier for states to learn from each other to adopt stronger protections and will enable consumers to more meaningfully enforce their rights and secure access to the mental health and substance use disorder care they need.

Prescription Drug Coverage (B) Working Group
We appreciate the efforts of the Working Group on challenges consumers encounter as they seek to access and afford their prescription drugs. We support the continuation of the current charges. We look forward to the Working Group's continued focus on PBMs and were pleased to see the partnership with the D Committee in developing the PBM Market Conduct Exam chapter. We look forward to working with regulators on implementation.

Consumer Information (B) Working Group
We urge the Working Group to adopt the following additional charge:

- Recommend actions NAIC can take to increase consumer use of state insurance departments for assistance.
- Identify communication goals, strategies and tactics to reach communities that experience inequities in health insurance access, including through partnerships with community-based organizations.

Health Care Affordability and Mitigation (B) Working Group
We fully support the work of the Health Care Affordability and Mitigation Working Group and believe this focus area is critical to addressing the most pressing consumer access challenges. We believe the charges for the Working Group could be strengthened by specific language addressing both non-discrimination and health care disparities. As states grapple with policy responses to rising health care costs, we are concerned that policies be assessed not just for their impact on premiums, but also for their impact on out-of-pocket costs for consumers, including on the continued ability of people with chronic and complex conditions to afford comprehensive coverage. We urge the Working Group to adopt the following language:

- Assess how states can balance non-discrimination protections with affordability policy levers and analyze differential impact of affordability challenges on marginalized communities.

Senior Issues (B) Task Force
We urge the Task Force to amend its charges as follows:

- Develop appropriate regulatory standards and revisions, as necessary, to the NAIC models, consumer guides, and training material on LTCI, including the study and evaluation of evolving LTCI product design, rating, suitability, and other related factors. Monitor ongoing research and maintenance of guidance regarding reduced benefit options (RBOs) and make necessary modifications to the *Long-Term Care Insurance Model Act* (#640) and the *Long-Term Care Insurance Model Regulation* (#641). Support regulator conversations to work across state agencies to identify innovative and systemic policy solutions to address the growing need for long term care services and public and private financing mechanisms to pay for care. Work with federal agencies, as appropriate.

We also urge the Task Force to identify a specific LTCI working group to support deeper discussion and problem solving around growing long-term care access and affordability gaps.

Health Actuarial (B) Task Force
We support continuing the current charges as is, without change.

We look forward to working with the B Committee in the coming year.

Sincerely,

Theresa Alban
Kellan Baker
Laura Colbert
Lucy Culp
Deborah Darcy
Adam Fox
Elizabeth Hagan
Marguerite Herman
Anna Hyde
Amy Killelea
Lindsey Murtagh
Sarah Phillips
Carl Schmid
Deborah Steinberg
Harold Ting
Silvia Yee

Agenda Item #4

Consider Adoption of the Health Care Affordability and Mitigation (B) Working Group's Issue Briefs—*Kate Harris (CO)*

Agenda Item #5

Hear a Discussion of CHOICE Arrangements—*Dr. Mehmet Oz (Federal Centers for Medicare & Medicaid Services—CMS)*

Agenda Item #6

Hear an Update from the Federal Center for Consumer Information and Insurance Oversight (CCIIO) on its Activities of Interest to the Committee—*Peter Nelson (CCIIO)*

Agenda Item #7

Discuss Any Other Matters Brought Before the Committee
—Commissioner John F. King (GA)