Draft date: 10/30/26

2026 Fall National Meeting
Dallas, Texas

PRESCRIPTION DRUG COVERAGE (B) WORKING GROUP
Sunday, November 15, 2026
8:00 – 9:00 a.m.
Convention Center—Texas C123—Level 3

ROLL CALL

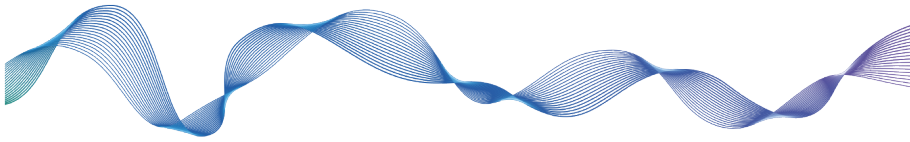
Joylynn Fix, Chair	West Virginia	Cheryl Wolff	Nebraska
Ashley Scott, Vice Chair	Oklahoma	Ralph Boeckman/ Erin Porter	New Jersey
Kelli Littlejohn Newman	Alabama		
Kayla Erickson/Sarah Bailey	Alaska	Sahar M. Hassanin/ Alejandro Amparan/ Viara Ianakieva	New Mexico
Tolanda McNeal	Arizona		
Tricia Davé	Connecticut	Sylvia Lawson/Gail A. Ross	New York
Howard Liebers	District of Columbia	Robert Croom/ Charles Whitehead	North Carolina
Sheryl Parker/Alexis Lamm	Florida		
Shannon Hohl	Idaho	TK Keen	Oregon
Kaitlyn Edicola	Illinois	Lindsi Swartz	Pennsylvania
Vicki Schmidt/Kara Bergman	Kansas	Carlos Vallés	Puerto Rico
Shaun Orme	Kentucky	Scott McAnally/Jud Jones	Tennessee
Frank Opelka	Louisiana	Tanji J. Northrup	Utah
Joe Stoddard	Michigan	Jennifer Kreitler/Ingrid Ulrey/ Sofia Pasarow	Washington
Norman Barrett/T.J. Patton	Minnesota		
Amy Hoyt	Missouri	Lori Luder	Wisconsin
David Dachs	Montana	Lauren White	Wyoming

NAIC Committee Support: Jolie H. Matthews

AGENDA

1. Consider Adoption of its Oct. 5 and Summer National Meeting Minutes —*Joylynn Fix (WV)* — Attachment A, Attachment B

2. Hear a Discussion on Group Purchasing Organizations (GPOs) —*Joylynn Fix (WV)*
   A. Pharmaceutical Research and Manufacturers of America (PhRMA) —*Kate Sikora (PhRMA)*
   B. Texas Star Healthcare Consulting, LLC—*Kim A. Caldwell (Texas Star Healthcare Consulting, LLC)*



3. Discuss Any Other Matters Brought Before the Working Group
   —*Joylynn Fix (WV)*

4. Adjournment

Agenda Item #1

Consider Adoption of its Oct. 5 and Summer National Meeting Minutes
—Joylynn Fix (WV)

Draft: 11/4/26

Prescription Drug Coverage (B) Working Group
Virtual Meeting
October 5, 2026

The Prescription Drug Coverage (B) Working Group of the Regulatory Framework (B) Task Force met Oct. 5, 2026. The following Working Group members participated: Joylynn Fix, Chair (WV); Kayla Erickson and Sarah Bailey (AK); Kelli Littlejohn Newman (AL); Tolanda McNeal (AZ); Tricia Davé (CT); Howard Liebers (DC); Sheryl Parker (FL); Shannon Hohl (ID); Matthew Pickett (IL); Kara Bergman (KS); Daniel McIlwain (KY); Frank Opelka (LA); Joe Stoddard (MI); Julia Dreier, Norman Barrett, and T.J. Patton (MN); Amy Hoyt and Melissa Panettiere (MO); Trevor Graff (MT); Robert Croom and Charles Whitehead (NC); Cheryl Wolff and Martin Swanson (NE); Tim Stroud (NJ); Alejandro Amparan and Nicole Baca (NM); Maria Garg and Gail A. Ross (NY); Jesse O'Brien and Numi Griffith (OR); Lindsi Swartz (PA); Carlos Vallés (PR); Kyle Robinson (TN); Tanji J. Northrup (UT); Jennifer Kreitler and John Kelcher (WA); Lori Luder (WI); and Lauren White (WY). Also participating were: Michelle Heaton (NH); and Stephen Hogge (VA).

1. Heard Presentations on PA and Prescription Drugs

Fix said the purpose of the meeting was to hear presentations on prior authorization (PA) and prescription drugs as a follow-up to recent Regulatory Framework (B) Task Force meetings on PA. She said AHIP and the Blue Cross and Blue Shield Association (BCBSA) announced an initiative about a year ago to streamline the PA process. She said the initiative has not yet addressed prescription drugs, although the issue is on its list for later consideration. Fix said that Health Insurance and Managed Care (B) Committee leadership views prescription drugs as one of the highest touchpoints for PA, so the Working Group agreed to examine the issue. She said that during this meeting, each presenter will discuss, from their perspective, how PA integrates with their work and the differences between medical and pharmacy benefits. The goal is to identify where reforms, technology, or regulatory alignment can reduce friction and improve patient access.

A. PCMA

Johnny Garcia (Pharmaceutical Care Management Association—PCMA) discussed the PA process from the pharmacy benefit perspective and distinguished it from medical PA. He said medical PA covers clinician-administered drugs, imaging, and procedures. Providers often submit these requests manually through a portal or by fax. Garcia explained that pharmacy PA covers drugs patients pick up at the pharmacy counter, which are billed electronically through the pharmacy benefit manager (PBM). He said pharmacy PA can be completed at the point of prescribing using real-time benefit tools, but it also can occur after the pharmacy processes the prescription and determines PA is needed, which is the more traditional approach and involves more back-and-forth with prescribers. Garcia said PBM clinical staff, including pharmacists and physicians, review pharmacy requests, and an automated process quickly approves prescriptions that meet all criteria. He said about 7% of medical claims and 4% of prescription claims require PA, and data on the two are often conflated.

Garcia explained the goals of prescription drug PA, with the primary concern being clinical considerations and cost as a secondary factor. He said patient safety comes first, as PA flags medications with known interactions, misuse, or risks before they are dispensed. Garcia provided two clinical examples to illustrate how the PA process works. He said drugs subject to PA are first reviewed by independent pharmacy and therapeutics (P&T) committees of physicians, pharmacists, and nurses. He said these committees review clinical guidelines and recent studies, noting that medical information is doubling every 72 days. He said the PBM and the health plan then decide whether to apply PA, considering clinical criteria first and cost second.

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Garcia said the clinical review is sound, but the process breaks down at the handoff from the prescriber. He encouraged the Working Group to focus on technology already in place. He said 2024 data shows that 47% of transactions are manual, and 53% use electronic prior authorization (ePA), although a PCMA member recently reported rates as high as 90%. He discussed the benefits of ePA with respect to the time required to review a PA request and reduced administrative costs compared to fax or phone PA requests.

Garcia said a federal Centers for Medicare & Medicaid Services (CMS) final rule, CMS-0057-F, addresses medical prior authorization and requires plan compliance by Jan. 1, 2027. He said CMS has also proposed a rule, CMS-0062, for the pharmacy benefit that would standardize the PA process. He said the comment period for the proposed rule opened in April and closed in June. He encouraged the Working Group to monitor CMS requirements and ensure alignment to avoid competing requirements.

B. Centene

Ryan Nimtz (Centene) said Centene serves 26 million members in all 50 states, primarily through Medicaid, Medicare, and the health insurance exchanges. He said Centene delegates claims processing, network management, and rebate administration to its PBM. He said Centene retains utilization management (UM), formulary management with its P&T committees, and benefit design. He said Centene requires turnaround times from 24 to 72 hours for pharmacy PA. Nimtz said Centene meets these time frames nearly 100% of the time, with an average turnaround of about 6.5 hours.

Nimtz said about 87% of Centene's PA requests arrive through ePA, in which prescribers answer preset questions within their electronic medical record (EMR) or through portals such as CoverMyMeds or Surescripts. He said this skips the intake step and speeds review. He said Centene also works with providers to enable real-time benefit checks in EMRs so prescribers can see PA requirements and lower-cost alternatives when writing prescriptions. Nimtz said the remaining 13% arrive via fax, phone, web portal, or mail and undergo intake and data entry.

Nimtz explained that after receiving a PA request, Centene staff build the case, conduct any provider outreach, and prepare recommendations for a clinician, either a pharmacist or a physician, who makes the PA decision. He said Centene then notifies the provider and member and enters any authorization in the PBM system so the member can obtain the medication at the pharmacy. Nimtz said the appeals process is similar, with turnaround times of about three to seven days that vary by state. He said appeals involve additional requirements, such as specialty matching of reviewers and member consent for appeals submitted on a member's behalf.

C. NAIC Consumer Representatives

Carl Schmid (HIV+Hepatitis Policy Institute) presented findings from a study published this summer in JAMA. He said researchers at the Johns Hopkins public health school and the CMS authored the study, and the Arnold Foundation and Johns Hopkins funded it. He said the study examined claims data from 2018 to 2024 for first fills of single-source brand-name drugs. He said its figures differ from those presented by the PCMA, which he believes include all prescription claims, most of which are for generic drugs. Focusing on exchange plans, Schmid discussed the study's findings on the percentage of claims paid on first fill and how that percentage has declined over the years for certain reasons, such as the drug not being on the formulary or rejection for UM. He noted that the study's findings showed that commercial plans performed somewhat better on paid claims but about the same on UM.

Schmid said the study also tracked claims over 90 days. He said that for exchange plans in 2024, 41% of prescriptions were filled on first fill, 21% were eventually filled, 6% were filled with a substitute, and 34% were never filled, up from 16% in 2018. He acknowledged the never-filled figure includes drugs not on the formulary.

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Schmid said the study's findings showed that across all payers, about 53% of never-filled prescriptions were due to PA and UM. He said exchange plans had the highest rate of claims not filled after 90 days.

Amy Killelea (Equality Arlington) discussed findings from research conducted with colleagues at the University of Virginia and the Georgetown University Center on Health Insurance Reforms (CHIR). Before discussing the specifics of the research findings, she emphasized to the Working Group the degree of variability in the application of PA and in the clinical criteria embedded in PA policies. She said such variability is a blinking red light for arbitrary coverage determinations that are not necessarily tethered to discernible clinical standards.

Killelea discussed the University of Virginia study on PA for preexposure prophylaxis (PrEP) in the qualified health plan (QHP) market, which found wide variation in its application. She said changes in federal law and regulation mean the findings are no longer fully current, but they illustrate the variability. Killelea said the CHIR research examined the underlying PA coverage criteria fully insured plans use for continuous glucose monitors. She said these are devices, but they are usually covered under the pharmacy benefit and follow the same rules. She said many plan policies did not align with the American Diabetes Association (ADA) clinical standard of care, but the specific clinical standard used matters less than the degree of variability. She said the evidence base for continuous glucose monitors does not vary enough to justify different plans using different clinical criteria, which indicates the criteria are not tied to clinical evidence. She said the degree of variability increases the risk of arbitrary decision-making. Killelea said the research also found that the same carrier sometimes applied different criteria to the same medication or device depending on whether it was covered under the pharmacy or medical benefit. She said this should not occur because the clinical criteria used for PA review should not vary by coverage pathway.

Deborah Steinberg (The Kennedy Forum) discussed PA for individuals with substance use disorders (SUDs) and mental health conditions. She said PA requirements delay access to addiction and psychiatric medications. She said that by the time a request is approved, a patient may no longer be able or willing to seek treatment, and this window can be a matter of life or death. She said plans often require periodic new PAs even for patients stable on a medication for years, which can cause missed doses and returning symptoms. Steinberg said these delays increase preventable hospitalizations and emergency department visits and worsen other health conditions. She said people whose conditions are less well managed are more likely to experience involvement with the criminal legal system and challenges at work, at school, and in the community.

Steinberg said plans without PA on medications for opioid use disorder (MOUD) have better access, treatment initiation, and retention, along with lower rates of recurrence and risky opioid use. She said Medicare required plans to remove PA from buprenorphine-naloxone a few years ago, and that in its research, RTI International found increased access and fewer emergency department visits and hospital admissions. She said state insurance regulators should also monitor dosage and quantity limits not based on science.

Steinberg said some medications fall under the medical benefit, such as methadone provided in opioid treatment programs, naloxone provided by a provider or public health agency, and medications injected by a provider. She said these medications also should not face burdensome PA requirements. She said removing PA requirements only for pharmacy benefit medications could build in bias because of racial and other disparities in access. She acknowledged that ePA is faster, but behavioral health providers have not received the same funding as other providers to adopt electronic systems, and many work in small or solo practices. She also said these requests contain sensitive, stigmatized health data. Steinberg reminded the Working Group that PA, step therapy, dosage limits, and the development and application of coverage criteria are non-quantitative treatment limitations (NQTLs) subject to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), which means these limits may not be more restrictive than those for medical and surgical conditions, both as written and in operation.

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D. Discussion

Fix asked each presenter to identify one change that would streamline PA for prescription drugs. Garcia said the change he thinks would streamline PA for prescription drugs would be to align with the requirements CMS has proposed and ensure that electronic health record (EHR) and EMR systems operate within those guidelines. He said EHR standards would allow data to be pulled directly from these systems, thereby speeding the process. Nimtz said the change he believes would streamline the PA process is continuing the move to electronic processes and addressing the EMR funding concerns raised by other presenters because it would help plans make PA decisions as quickly as possible. Schmid said the changes he believes would be helpful are: 1) reducing the number of drugs subject to PA; and 2) enhancing transparency and alignment with clinical guidelines. Killelea said streamlining the PA process is good, but with the move toward artificial intelligence (AI) and automation, the risk is simply doing a bad thing faster. She said state insurance regulators should examine how PA decisions are made and whether they are tied to an evidence-based clinical standard of care. She said state insurance regulators need to ensure PA does not become a barrier to clinically indicated care. Steinberg said it is important to remember the patients affected, who are often suffering, and that adding requirements does not serve them.

Heaton asked Schmid how the JAMA study could evaluate PA using claims data, since a claim would not exist if a PA were denied up front. She asked whether the denials reflected PA itself or a lack of familiarity with which drugs require PA. Schmid said he would provide the study to NAIC committee support for distribution so Working Group members could review it. He said the authors described their methodology in detail.

Hogge said the Virginia Bureau of Insurance has facilitated a work group on ePA for four to five years and has issued several reports. He said the work group started its work with prescription drug PA and has now moved to medical ePA. Hogge said that the work group has recently identified concerns about retrospective, rather than prospective, PA for drugs under the pharmacy benefit. He explained that prescriptions are sometimes sent to pharmacies before a PA request has been processed or even submitted. He said patients then arrive at the pharmacy to find their prescription is not ready, and some give up. He said the work group agreed this year that, given real-time electronic options, PA requests should be reviewed and approved before the prescription is sent rather than pushed to the pharmacist before the PA process is finished or even initiated. He suggested the Working Group consider this issue.

Fix said one interested party has asked to address the Working Group on this topic. She asked other interested parties that wish to present to contact her, Ashley Scott (OK), or NAIC committee support. Fix said she will discuss next steps with Health Insurance and Managed Care (B) Committee leadership through the Regulatory Framework (B) Task Force and directly with Commissioner John F. King (GA), chair of the Committee, who has identified PA as a priority. She said the Working Group will continue to discuss the issue, possibly during a future national meeting.

Having no further business, the Prescription Drug Coverage (B) Working Group adjourned.

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Draft: 8/17/26

Prescription Drug Coverage (B) Working Group
and the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group
Columbus, Ohio
August 12, 2026

The Prescription Drug Coverage (B) Working Group of the Regulatory Framework (B) Task Force met in Columbus, OH, Aug. 12, 2026, in joint session with the MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force. The following Prescription Drug Coverage (B) Working Group members participated: Joylynn Fix, Chair (WV); Ashley Scott, Vice Chair (OK); Sarah Bailey (AK); Kelli Littlejohn Newman (AL); Tolanda McNeal (AZ); Tricia Davé (CT); Tina Ching (DC); Sheryl Parker (FL); Andria Seip (IA); Shannon Hohl (ID); Chris Heisler (IL); Craig Van Aalst (KS); Shaun Orme (KY); Frank Opelka (LA); Joe Stoddard (MI); Brogan Dinolfo and Teresa Kroll (MO); Matthew Eberhardt (MT); Robert Croom (NC); Michael Muldoon, Maggie Reinert, and Cheryl Wolff (NE); Jesse O'Brien (OR); Richard L. Hendrickson (PA); Jud Jones (TN); Tanji J. Northrup (UT); Sofia Pasarow (WA); Darcy Paskey (WI); and Lauren White (WY). Also participating were: Lila Cummings and Debra Judy (CO); Kevin P. Beagan (MA); and Jill Kruger (SD). The following MHPAEA (B) Working Group members participated: Chrystal Bartuska, Chair (ND); Michelle Heaton, Vice Chair (NH); Crystal Phelps (AR); Leanette Henagan (AZ); Lila Cummings and Debra Judy (CO); Kurt Swan (CT); Tina Ching (DC); Elizabeth Nunes and Simone Edmonson (GA); Andria Seip (IA); Chris Heisler (IL); Mary Kwei (MD); David Dachs (MT); Robert Croom (NC); Jack Childress (NV); Tony Bonofiglio (OH); Ashely Scott (OK); Richard L. Hendrickson (PA); Renee Boyce (SC); Jill Kruger (SD); Daniel McAdams (TX); Tanji J. Northrup (UT); Julie Fairbanks (VA); Sofia Pasarow (WA); Darcy Paskey (WI); Joylynn Fix (WV); and Jill Reinking and Lauren White (WY). Also participating was: Molly Nollette (AK).

1. Adopted the Prescription Drug Coverage (B) Working Group's Spring National Meeting Minutes

Hohl made a motion, seconded by Seip, to adopt the Working Group's March 23 minutes *(see NAIC Proceedings – Spring 2026, Regulatory Framework (B) Task Force, Attachment Two)* minutes. The motion passed unanimously.

2. Adopted the MHPAEA (B) Working Group's April 2 Minutes

The MHPAEA (B) Working Group met April 2, 2026. During this meeting, the Working Group took the following action: 1) discussed its work plan, and 2) heard an update on the use of prior authorization templates.

Kruger made a motion, seconded by Scott, to adopt the Working Group's April 2 minutes (Attachment Three- A). The motion passed unanimously.

3. Heard Presentations on Insurance Coverage of Medications to Treat Substance Use Disorders

Dr. Marcus Bachhuber (Center for Evidence-Based Policy) and Dr. Matthew Sankey (The INS Companies) presented on insurance coverage of medications to treat substance use disorders. Bachhuber defined substance use disorders and said they are characterized by continued use despite consequences, persistent desire to cut down, tolerance, and withdrawal. He said substance use disorder shares many characteristics with other chronic medical illnesses. He said patient values, preferences, and prior experiences drive medication selection.

Bachhuber described three drugs used to treat opioid use disorder: methadone, buprenorphine, and naltrexone. He characterized treatment with medication as effective and lifesaving and said any medication is superior to treatment without medication. He said there is no one best option among the drugs; they are delivered in different

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settings for different patients. He described additional medications that are used as opioid reversal agents or to treat opioid withdrawal.

Bachhuber listed the prescription drugs used to treat alcohol use disorder and tobacco use disorder. He shared statistics on the success of different treatments for tobacco use disorder, which showed the highest success rates with drug treatments. He said the use of drugs in treating substance use disorder is not optional, extra, or ancillary, but a core method of treatment.

Bachhuber cited several common issues with the placement of these drugs on insurance formularies. He said plans place the medications on high tiers, lack coverage for some forms, require prior authorization, or cover them through medical rather than pharmacy benefits. He provided examples of how confusion over medical versus pharmacy benefits can lead to treatment delays and patient harm.

Bachhuber cited resources from the Center for Evidence-Based Policy and other sources for state insurance regulators.

Sankey presented issues with formulary development, medical vs. pharmacy benefits, parity analysis, and utilization management techniques related to medications to treat substance use disorders. He described how health plan formularies are developed by pharmacy benefit managers (PBMs) at the national level and may not be appropriately adjusted for state benefit mandates. He provided examples of drugs that may be covered by either a medical benefit or a pharmacy benefit and questioned whether consumers or prescribers have enough information to understand this distinction. He described formulary tiering, prior authorization, step therapy, and quantity limits as practices that may raise parity concerns.

Sankey provided examples of parity findings related to medications to treat substance use disorders. He said buprenorphine lock out limitations, substance use disorder medications not being considered maintenance drugs, inappropriate quantity limits on buprenorphine/naloxone and buprenorphine, and naloxone product limitations were examples of parity problems.

Sankey described some of the issues with the transition of naloxone from a prescription drug to an over-the-counter (OTC) medicine. He said some health plans lack coverage for OTC items, and some have higher copays when a state lacks tiering or cost-sharing mandates.

Sankey provided tips for state insurance regulators' review of health plan formularies. He recommended obtaining a list of RxNorm Concept Unique Identifiers (RxCUIs), running the formulary tools from the federal Centers for Medicare & Medicaid Services (CMS), and developing a list of RxCUIs that require further review, with attention to tiering, prior authorization, and copays. He suggested focusing on new medications and making a checklist of RxCUIs.

Sankey suggested that states could implement ongoing compliance checks for formularies because formularies can change during the year.

Bartuska asked about differences between providers' recommendations for patients and what insurers decide will be covered. She asked how guidelines from the American Society of Addiction Medicine (ASAM) relate to such differences and whether insurance companies deviate from ASAM recommendations. Bachhuber said ASAM guidance is one of the standards used. He said ASAM suggests open access to treatment, but this may not be a realistic position. He said some drugs have similar efficacy but massive cost differences. He said it is reasonable to prefer a lower cost treatment, though this approach can be taken to an extreme. He said unnecessary utilization

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controls have largely been removed, and those that remain focus on choosing lower-cost treatments among those with similar efficacy. He said ASAM levels of care provide clear guidance, though insurers and providers may have different interpretations based on the same information. Sankey added that ASAM guidelines were published in 2020 and may not capture newer medications.

Jones asked why medical providers may be hesitant to purchase medications and bill for them through the medical benefit when they are dispensed. Bachhuber said the main issue is matching purchases with the volume of treatments the clinic will administer. The medications have expiration dates and refrigeration requirements, so clinics do not want to purchase medications that may not be used.

4. Discussed Other Matters

Bartuska described the MHPAEA (B) Working Group's efforts to survey states on their parity activities. She said a survey instrument was developed and distributed to states. She said the Working Group continues to collect responses, which include information on state laws and regulations, use of reporting templates, and enforcement activities. She said the Working Group met in regulator-to-regulator session to discuss the survey. She said the Working Group plans to release the full results to state insurance regulators and a summary of responses to interested parties. She asked that states submit responses to NAIC committee support by Aug. 31.

Having no further business, the Prescription Drug Coverage (B) Working Group and the MHPAEA (B) Working Group adjourned.

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Agenda Item #2

Hear a Discussion on Group Purchasing Organizations (GPOs)—*Joylynn Fix (WV)*

A. **Pharmaceutical Research and Manufacturers of America (PhRMA)—*Kate Sikora (PhRMA)***
B. **Texas Star Healthcare Consulting, LLC—*Kim A. Caldwell (Texas Star Healthcare Consulting, LLC)***



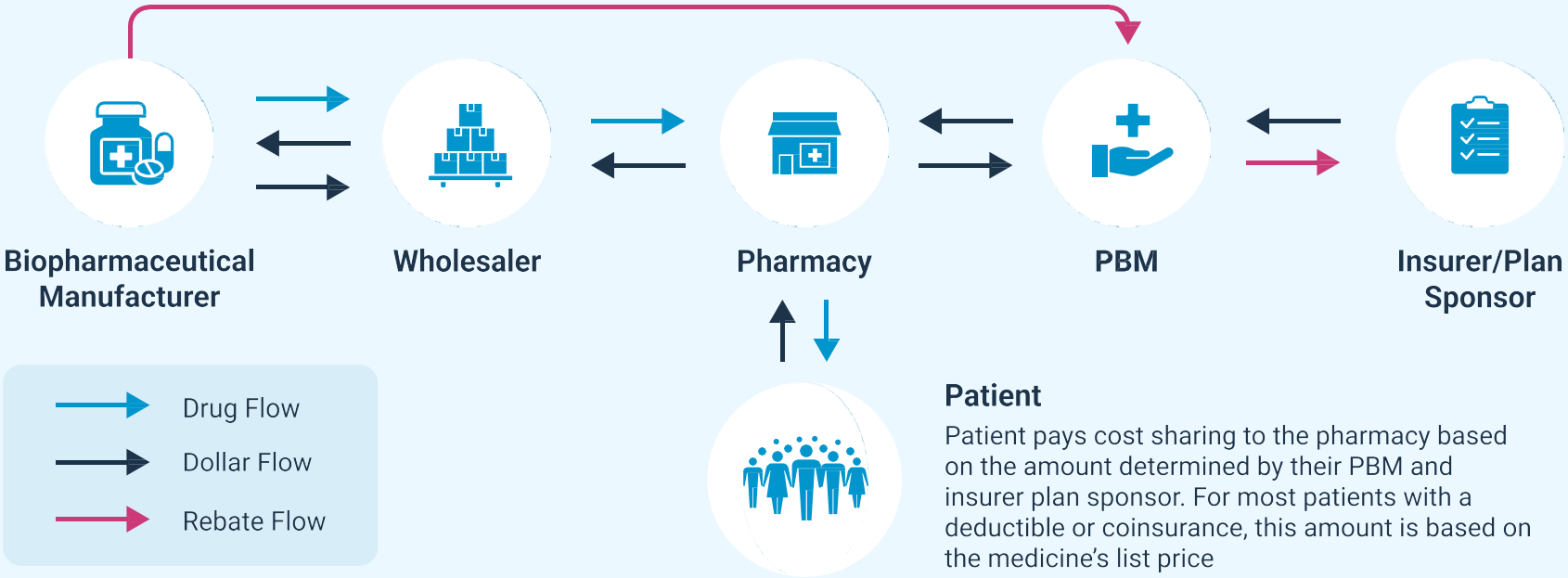
Vertical Integration and PBM Group Purchasing Organizations (GPOs)

Prepared for NAIC

November 2026

Background on Vertical Integration

PBMs Negotiate With Drug Manufacturers “on Behalf of” Health Plans



Source: PhRMA. (February 2025). Follow the Dollar: How the Pharmaceutical Distribution and Payment System Shapes the Prices of Brand Medicines. Available at: https://cdn.aglty.io/phrma/global/resources/import/pdfs/Report%20-%20Follow%20the%20Dollar%20-%20February%202025.pdf.

Vertical Business Relationships Within the U.S. Drug Channel, 2026



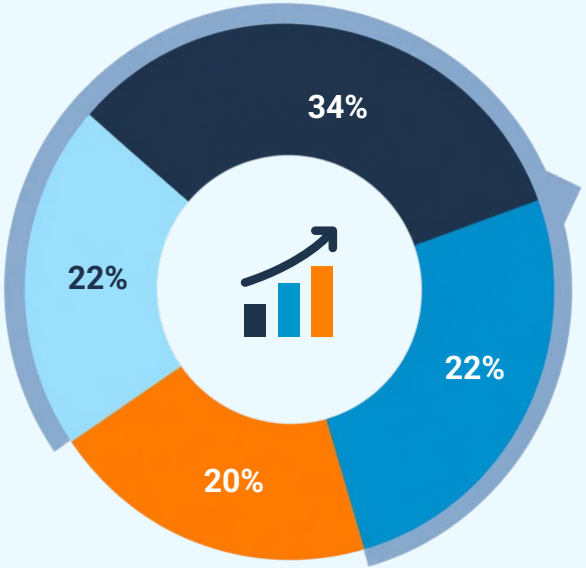
Source: Drug Channels Institute. (April 2026). Mapping the Vertical Integration of Insurers, PBMs, GPOs, Specialty Pharmacies, and Healthcare Services: DCI's 2026 Update. Available at: https://www.drugchannels.net/2026/04/mapping-vertical-integration-of.html

The Influence PBMs Have Over Patient Access and Affordability Continues to Grow

Negotiating power is increasingly concentrated among a small number of PBMs.

Insurers & PBMs determine:

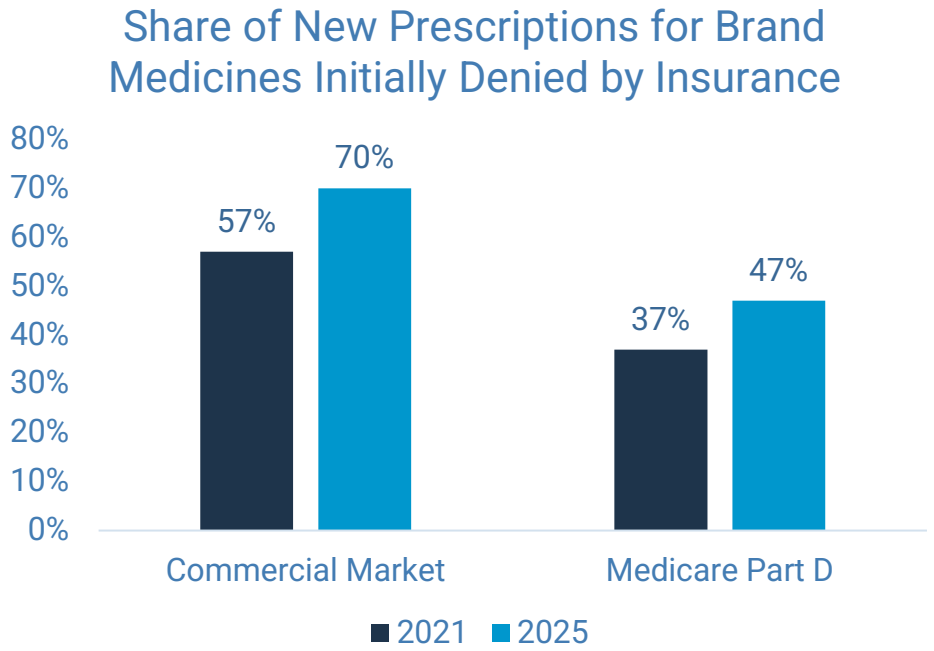
- **If medicine is covered** on the formulary
- **Patient Out-of-Pocket Cost** based on tier placement
- **Access Barriers** like prior authorization or fail first
- **Provider Incentives** through preferred treatment guidelines and pathways



Top 3 PBMs' Market Share:

80%

Insurers and PBMs Increasingly Deny Coverage for Brand Medicines

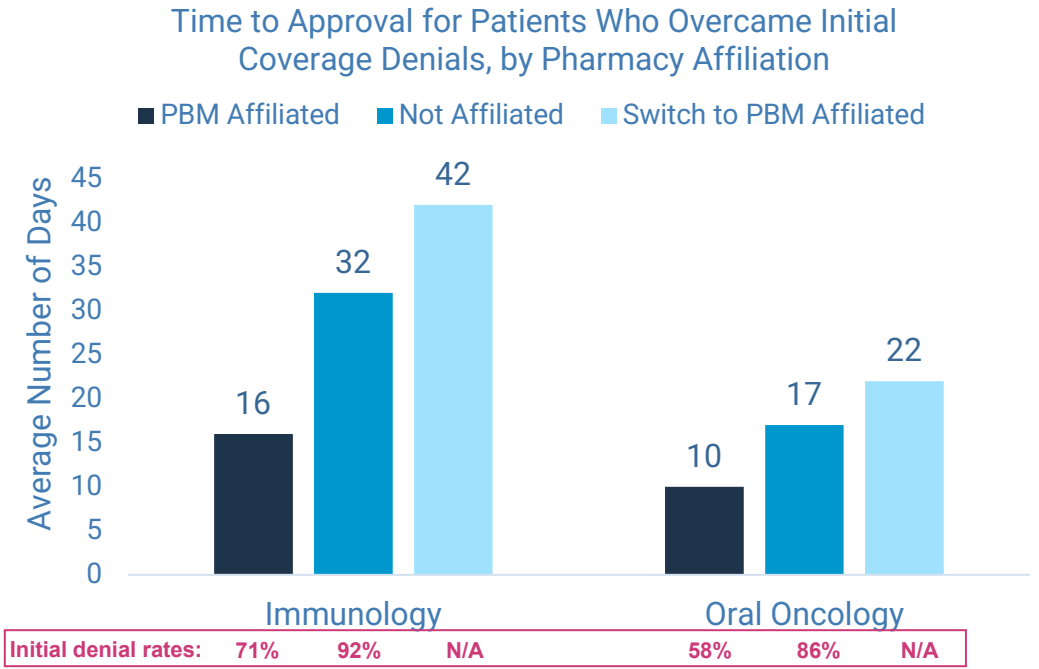


24% of commercially insured and 14% of Medicare Part D prescriptions for new brand medicines were never able to gain approval within one year.

Most denials were due to formulary exclusions, prior authorization or step therapy requirements.

Source: IQVIA. (April 2026). Increasing Payer Control for Commercial Patients Initiating Branded Medicines. Available at: https://www.iqvia.com/locations/united-states/blogs/2026/03/increasing-payer-control-for-commercial-patients-initiating-branded-medicines

PBM Steering To Vertically Integrated Pharmacies Can Delay Patient Access to Brand Medicines



Average treatment delays for oncology and immunology patients initially denied at a pharmacy not affiliated with their PBM but later approved at a PBM-affiliated pharmacy were three to six weeks, respectively.

Source: IQVIA. (March 2026). How PBMs' Vertically Integrated Pharmacies Shape Access Pathways for Oncology and Autoimmune Patients. Available at: https://www.iqvia.com/locations/united-states/library/white-papers/how-pbms-vertically-affiliated-pharmacies-shape-access.

PBM GPOs

Big Three PBMs Have Created Their Own "Group Purchasing Organizations" (PBM GPOs)



What they are:

The three largest PBMs have each established a separate "GPO":

- Express Scripts/Ascent Health Services
- CVS Caremark/Zinc Health Services
- OptumRx/Emisar Pharma Services

Ascent is based in Switzerland, Zinc in the United States, and Emisar in Ireland.



What they do:

PBM GPOs reportedly may aggregate, collect, and distribute manufacturer rebates, discounts, and fees, primarily for the commercial market. Certain of these payments can influence formulary placement and other coverage terms.

PBM GPOs do not act in the same way traditional hospital GPOs do.



How they're structured:

Moving rebate negotiations and payments to affiliated entities can make it harder for employers, patients, and regulators to determine how much remuneration is retained within vertically integrated organizations and how much is passed through to plan sponsors.

Source: Fein, A., Five (or Maybe Six?) Reasons that the Largest PBMs Operate Group Purchasing Organizations. Drug Channels Institute. (2023). Available at: https://www.drugchannels.net/2023/05/five-or-maybe-six-reasons-that-largest.html; House Committee on Oversight and Reform. (July 2024). The Role of Pharmacy Benefit Managers in Prescription Drug Markets. Available at: https://oversight.house.gov/wp-content/uploads/2024/07/PBM-Report-FINAL-with-Redactions.pdf; ; See Federal Trade Commission, Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies (July 2024) (FTC Report) at 1 ("PBMs are at the center of the complex pharmaceutical distribution chain that delivers a wide variety of medicines from manufacturers to patients.").

PBM GPOs Contribute to Rising Health Care Costs for Patients and Plan Sponsors

How are PBM GPOs Operating?

PBM GPOs may **collect rebates, discounts, and other price concessions** from drugmakers in exchange for favorable formulary positions, and other preferential coverage.

PBM GPOs reportedly are being used to generate new revenue streams that are often not transparent and generally are **not used by the PBM to provide direct benefit to patients or plan sponsors**

PBM GPOs likely operate in the **commercial market only**.

Experts have also raised concerns that PBM GPOs may be an attempt by PBMs to **avoid future regulatory or legislative reforms and oversight including rebate reform.**

Source: House Committee on Oversight and Reform. (July 2024). The Role of Pharmacy Benefit Managers in Prescription Drug Markets. Available at: https://oversight.house.gov/wp-content/uploads/2024/07/PBM-Report-FINAL-with-Redactions.pdf; Drug Channels Institute. (May 2023). Five (or Maybe Six?) Reasons that the Largest PBMs Operate Group Purchasing Organizations. Available at: https://www.drugchannels.net/2023/05/five-or-maybe-six-reasons-that-largest.html; Federal Trade Commission. (July 2024). Interim Staff Report. Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies. Available at: https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf; Hunterbrook. (January 2026). "Bullshit" — The New Way Health Giants Hide Billions. Available at: https://hntrbrk.com/investigations/pbmgpo

PBM GPOs Lack Transparency and Obscure Compensation

1. In 2023, the State of Ohio filed suit against several PBMs and Ascent, alleging that they used the PBM GPO to **share pricing, discount, and rebate information, which contributed to increased drug prices**.

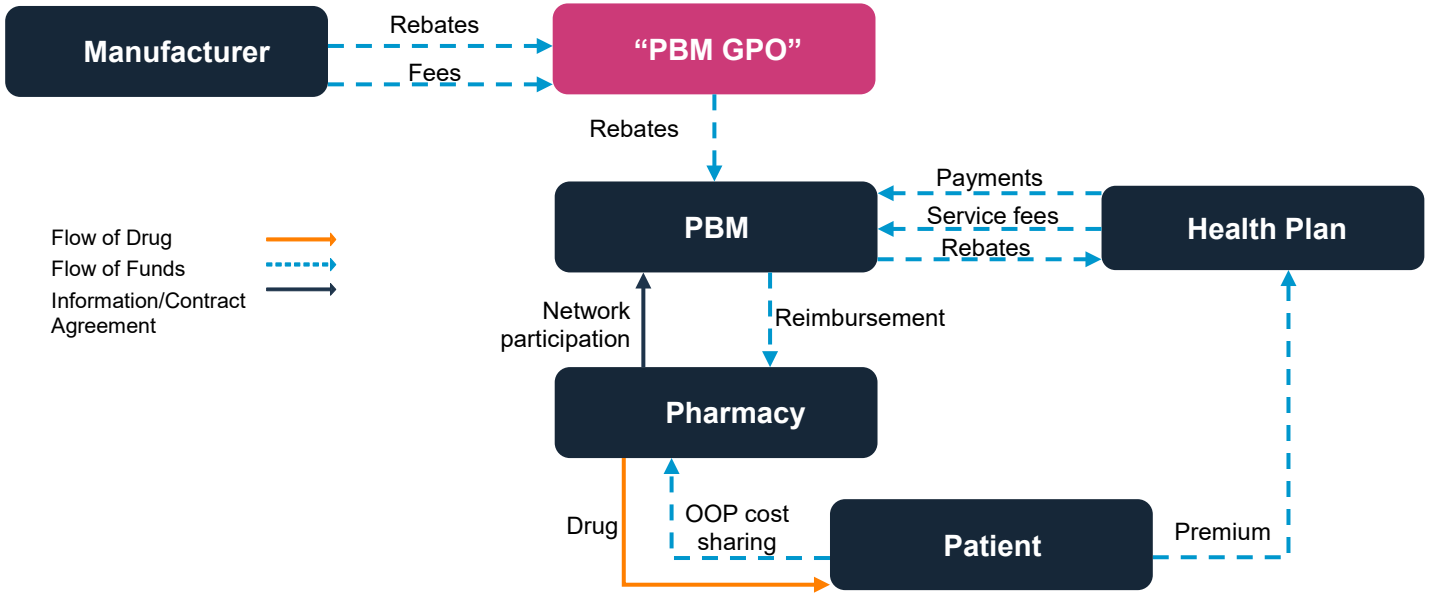
2. A lawsuit filed by the State of Hawaii highlighted the ability of PBM GPOs to **"…categorize and recategorize income streams, which allows [PBMs] to … determine how they will define 'rebates'** and, by extension, their obligation to pass through 'rebates.'"

3. The Illinois Attorney General entered into a $45 million settlement with CVS Caremark and Zinc to resolve claims that the two **obscured payments from drug manufacturers, including rebates and fees, that should have been paid to the state.**

PhRMA RESEARCH • PROGRESS • HOPE

Source: Ohio Attorney General. (March 2023). Yost Sues Express Scripts, Prime Therapeutics and 5 Others, Blaming Exorbitant Drug Prices on Their Collusion.. Available at: https://www.ohioattorneygeneral.gov/Media/News-Releases/March-2023/Yost-Sues-Express-Scripts-Prime-Therapeutics-and-5; Oahu First Circuit Court, Hawaii. (October 2023). *State of Hawaii* v. *CaremarkPCS Health, LLC., Express Scripts, INC., OptumRx, INC.* Available at: https://ag.hawaii.gov/wp-content/uploads/2023/10/SOH-v-CaremarkPCS-Health-et-al-COMPLAINT.pdf; Office of Governor J.B. Pritzker. (May 2025). Illinois Recovers $45 Million Settlement from CVS Caremark. Available at: https://gov.illinois.gov/news/press-release.31292.html

Hypothetical Flow of Funds for Prescription Drugs with PBM GPO Middlemen



Source: Healthcare Dive. CVS reportedly creating group purchasing organization for PBM business. July 2020. https://www.healthcaredive.com/news/cvs-reportedly-creating-group-purchasing-organization-for-pbm-business/580889/; Drug Channels Institute. Five (or Maybe Six?) Reasons that the Largest PBMs Operate Group Purchasing Organizations. May 2023. https://www.drugchannels.net/2023/05/five-or-maybe-six-reasons-that-largest.html; Livingston S. Powerful drug-industry middlemen have quietly launched businesses to get better deals from drugmakers. It could drive up costs for patients. Business Insider. November 22, 2021. https://www.businessinsider.com/inside-pharmacy-benefit-managers-new-drug-negotiating-businesses-2021-11; Drug Channels. Five (or Maybe Six?) Reasons that the Largest PBMs Operate Group Purchasing Organizations. May 24, 2023. https://www.drugchannels.net/2023/05/five-or-maybe-six-reasons-that-largest.html

PBM Reform Will Drive Greater Transparency and Accountability in the Commercial Market

DOL PBM Fee Disclosure Rule	2026 Consolidated Appropriations Act	FTC Settlements With PBMs
Comprehensive PBM and PBM-affiliate fee disclosures and transparency to plan fiduciaries (e.g., employers) for ERISA plans	2026 CAA enacted provisions including Part D and commercial transparency, Part D delinking and ERISA market pass through	Proposed consent agreements seek to outline wide range of changes to business practices including formulary and cost sharing changes in Standard Offering

PBMs are likely to continue to change their business models in response to federal and state PBM reform efforts.

PhRMA RESEARCH • PROGRESS • HOPE

Source: Healthcare Dive. CVS, FTC reach proposed settlement in insulin pricing case. (March 2026). Available at: https://www.healthcaredive.com/news/cvs-caremark-ftc-proposed-settlement-insulin-lawsuit/815581/

Group Purchasing Organizations (GPOs) and the Pharmaceutical Supply Chain

Kim A. Caldwell, RPh

November 15, 2026

NAIC Prescription Drug Coverage (B) Working Group

GPOs Combine Purchasing Power

Health care providers

Hospitals, nursing homes, PBMs, pharmacies, home health agencies

The GPO

Combines purchasing volume to negotiate discounts

Suppliers

Manufacturers, distributors, and vendors offer discounts

100+

YEARS

Aggregated purchasing in health care and other industries has lowered costs for patients, consumers, and businesses.

Member benefits

Members gain lower costs and fewer in-house contracting needs through collective bargaining.

Seen as pro-competitive

The U.S. Supreme Court, Federal Trade Commission, and Department of Justice have recognized that group purchasing can be pro-competitive and create efficiencies that benefit purchasers.

Group Purchasing Examples

Independent pharmacies

Buying groups

Help smaller pharmacies get supplier discounts on prescription drugs and other products.

State Medicaid programs

35 states

Join multistate or intrastate groups for supplemental manufacturer rebates, typically saving 3% to 5%.*

Vaccines for Children (VFC) Program

40%+

of vaccines are bought by the federal government, which negotiates discounted bulk rates for existing and new vaccines and distributes them to state health departments and public agencies.

Sources: NCSL · Health Affairs · CDC

*While Medicaid may not utilize GPOs as they generally operate in the commercial market, some states do join multistate bulk purchasing pools in order to drive down the cost of drugs, similar to GPOs

How PBMs and Manufacturers Use GPOs

Since 2018

PBMs have long aggregated purchasing. Since 2018, they have created new GPO entities to further improve negotiating power.

Combined volume

GPOs pool the formulary volume of multiple plans and PBMs, “[enabling] the group to gain access to more competitive rebate arrangements.”

Smaller PBMs

Smaller and regional PBMs benefit from higher volume and can compete against larger PBMs. Examples: Kroger, Capital Rx, Southern Scripts.

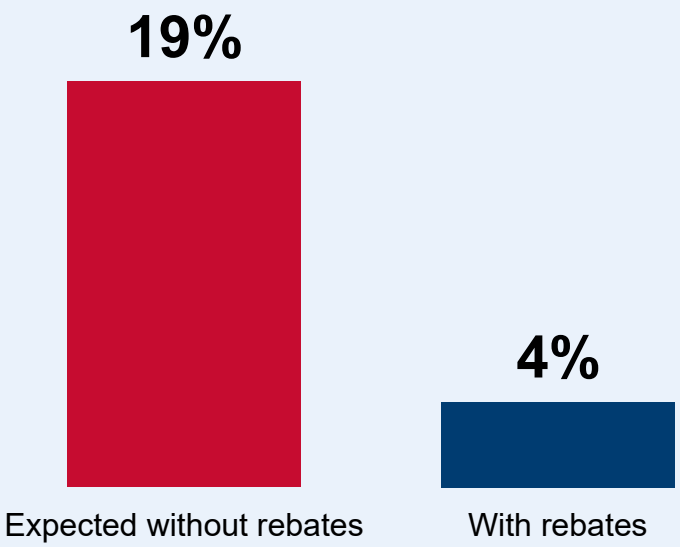
Manufacturer services

GPOs provide “various fee-based services for manufacturers,” such as compiling data for marketing or U.S. Food and Drug Administration (FDA) compliance, paid separately from rebates.

PBMs Use GPOs to Drive Down Prices

Medicare drug spending growth

Drugs with rebates vs. expected without



Rebates lower drug spending: 4% growth instead of the 19% price increase expected without them.

Collective purchasing power

Large and small PBMs join GPOs to gain collective purchasing power.

Competition drives concessions

Where competition exists, PBMs help plans win manufacturer price concessions that support financial sustainability.

Legislative watch-point

Some states are considering mandates on how plans share rebate savings and compensate PBMs, plus new reporting rules, that would replace private negotiations.

Plan Sponsors Control Rebates

Plan sponsors are the PBM's clients and decide how rebates are used:

- **Lower premiums or cost sharing**
- **Richer benefits**
- **PBM compensation**

CAA 2026

100%

of rebates passed to the employer plan, which still decides how to use them.

Reporting and audits

PBMs must report rebates and spending semiannually and allow annual plan-selected audits.

2023 SURVEY

90%

of employer plan sponsors use rebates to benefit employees.

Key Takeaways

1. GPOs pool purchasing volume to win lower prices across health care.
2. Many healthcare entities and organizations use GPOs to strengthen negotiating power and secure manufacturer rebates.
3. Plan sponsors decide how rebates are used; CAA 2026 requires full pass-through to plans.
4. Group purchasing also supports independent pharmacies, state Medicaid programs, and vaccines.

Policy implication

Policies restricting their use, mandating how price concessions are managed, or establishing other costly requirements will reduce the savings achieved. Policies should support efficient group purchasing that reduces net costs and benefits consumers.

Agenda Item #3

Discuss Any Other Matters Brought Before the Working Group—*Joylynn Fix (WV)*

PBM LICENSURE/REGISTRATION TRACKING DOCUMENT – JULY 2025

STATE	CITATION	WHAT	WHO	LANGUAGE
AL	Ala. Code § 27-45A-4	License--PBM	DOI	To conduct business in this state, a pharmacy benefit manager must be licensed by the Commissioner. (DOI views more like registration)
AK	AS § 21.27.010* *Effective 1/1/2026	License--PBM	DOI	A person may not act as a… pharmacy benefits manager… unless licensed under this chapter.
AZ	A.R.S. § 20-3333	License--PBM	DOI	A pharmacy benefit manager shall apply for, obtain and maintain a valid **certificate of authority** to operate as a pharmacy benefit manager in this state.
AR	A.C.A. § 23-92-504	License--PBM	DOI	A person or organization shall not establish or operate as a pharmacy benefits manager in Arkansas for health benefit plans without obtaining a license from the Insurance Commissioner under this subchapter.
CA	Cal.Health & Safety Code §§ 1385.003 to 1385.005	Register--PBM	State Department of Public Health	A pharmacy benefit manager required to register with the department pursuant to Section 1385.004 shall complete an application for registration with the department that shall include, but not be limited to, all of the information required by subdivision (c).

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PBM LICENSURE/REGISTRATION TRACKING DOCUMENT – JULY 2025

STATE	CITATION	WHAT	WHO	LANGUAGE
CO	C.R.S.A. § 10-16-122.1	Register--PBM	DOI	Starting in 2024, a person shall not establish or operate as a PBM in this state unless the person has registered with the commissioner in accordance with this subsection (2.5) and commissioner rules. Notwithstanding the definition of a PBM in section 10-16-102(49), this registration requirement applies to all PBMs doing business in this state, including a PBM that is not directly connected with a carrier.
CT	Conn. Gen. Stat. § 38a-479bbb	Register--PBM	DOI	No person shall act as a pharmacy benefits manager in this state without first obtaining a certificate of registration from the commissioner.
DE	18 Del.C. § 3353A	Register--PBM	DOI	A pharmacy benefits manager shall register with the Commissioner as a pharmacy benefits manager before providing pharmacy benefits management services in this State to a purchaser.
DC				
FL	Fla. Stat. § 624.490 Fla. Stat. § 626.8805	License--PBM	DOI	Effective January 1, 2019, to conduct business in this state, a pharmacy benefit manager must register with the office. Upon receipt of a completed registration form, the required documents, and the registration fee, the office shall issue a registration certificate. Effective 2024, a PBM must also hold a valid certificate of authority (COA) as an administrator. Registration + COA = License

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STATE	CITATION	WHAT	WHO	LANGUAGE
GA	O.C.G.A. § 33-64-2	License--PBM	DOI	No person, business entity, or other entity shall act as or hold itself out to be a pharmacy benefits manager in this state, other than an applicant licensed in this state for the kinds of business for which it is acting as a pharmacy benefits manager, unless such person, business entity, or other entity holds a license as a pharmacy benefits manager issued by the Commissioner pursuant to this chapter.
GU				
HI	HRS § 431S-3	Register--PBM	DOI	Notwithstanding any law to the contrary, no person shall act or operate as a pharmacy benefit manager without first obtaining a valid registration issued by the commissioner pursuant to this chapter.
ID	Idaho Code § 41-349	Register--PBM	DOI	A person may not perform, offer to perform, or advertise any pharmacy benefit management service in this state unless the person is registered as a pharmacy benefit manager with the department of insurance.
IL	215 ILCS 5/513b2	Register--PBM	DOI	To conduct business in this State, a pharmacy benefit manager must register with the Director.

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STATE	CITATION	WHAT	WHO	LANGUAGE
IN	IC 27-1-24.5-18	License--PBM	DOI	A person shall, before establishing or operating as a pharmacy benefit manager, apply to and obtain a license from the commissioner under this chapter.
IA	Iowa Code § 510B.2	Certificate--TPA	Commissioner Iowa Code § 510.21	A pharmacy benefits manager doing business in this state shall obtain a certificate as a third-party administrator under chapter 510, and the provisions relating to a third-party administrator pursuant to chapter 510 shall apply to a pharmacy benefits manager.
KS	K.S.A. § 40-3823	License--PBM	DOI	No person shall act or operate as a pharmacy benefits manager without first obtaining a valid license issued by the commissioner.
KY	KRS § 304.9-053	License--PBM	DOI	In order to conduct business in this state, a pharmacy benefit manager shall first obtain a license from the commissioner. The license shall be in lieu of an administrator's license as required by KRS 304.9-052.
LA	La. R.S. § 40:2867 La. R.S. § 22:2865 La. R.S. § 40:2867	License—PBM Optional: Board of Pharmacy Permit	DOI	Every pharmacy benefit manager that does business in this state shall be licensed as required by the Louisiana Insurance Code. A pharmacy benefit manager shall be deemed to be a third-party administrator for purposes of this Part. As such, all provisions of this Part shall apply to pharmacy benefit managers; however, notwithstanding the provisions of R.S. 22:1651(F), every pharmacy benefit manager shall be required to be licensed by the commissioner of insurance.

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PBM LICENSURE/REGISTRATION TRACKING DOCUMENT – JULY 2025

STATE	CITATION	WHAT	WHO	LANGUAGE
ME	24-A M.R.S. § 4348	License--PBM	DOI	Beginning January 1, 2020, a person may not act as a pharmacy benefits manager in this State without first obtaining a license from the superintendent in accordance with this section and paying the licensing fee required under section 601, subsection 28-A.
MD	Md. Code Ann. § 15-1604	Register--PBM	DOI	A pharmacy benefits manager shall register with the Commissioner as a pharmacy benefits manager before providing pharmacy benefits management services in the State to purchasers.
MA	M.G.L.A. 176O § 21	Register—TPA	DOI 211 CMR 148.03	...a third party administrator, a pharmacy benefit manager or other similar entity with claims data, eligibility data, provider files and other information relating to health care provided to residents of the commonwealth and health care provided by health care providers in the commonwealth.
	M.G.L.A. 176Y § 2	License—PBM	DOI	No person, business or other entity shall establish or operate as a pharmacy benefit manager without obtaining a license from the division...
MI	M.C.L.A. 550.821	License--PBM	DOI	A pharmacy benefit manager that provides services to residents of this state shall apply for, obtain, and maintain a license to operate as a pharmacy benefit manager from the director.

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PBM LICENSURE/REGISTRATION TRACKING DOCUMENT – JULY 2025

STATE	CITATION	WHAT	WHO	LANGUAGE
MN	Minn. Stat, § 62W.03	License--PBM	DOI	Beginning January 1, 2020, no person shall perform, act, or do business in this state as a pharmacy benefit manager unless the person has a valid license issued under this chapter by the commissioner of commerce.
MS	Miss. Code Ann. § 73-21-157	License--PBM	Board of Pharmacy	Before beginning to do business as a pharmacy benefit manager, a pharmacy benefit manager shall obtain a license to do business from the board.
MO	Mo. Rev. Stat. § 376.393	License--PBM	DOI	No entity subject to the jurisdiction of this state shall act as a pharmacy benefits manager without a license issued by the department. The department shall establish by rule the application process and license fee for pharmacy benefits managers.
MT	M.C.A. 33-2-2403(1)	License--PBM	DOI	A person may not perform an act or do business in this state as a pharmacy benefit manager without a valid license issued under this part by the commissioner.
NE	Neb.Rev.St. § 44-4605	License--PBM	DOI	A person shall not establish or operate as a pharmacy benefit manager in this state for a health benefit plan without first obtaining a license from the director under the Pharmacy Benefit Manager Licensure and Regulation Act.
NV	NRS 679B.133(3)(a)	License--TPA	DOI Nev. Rev. Stat. Ann. § 683A.08524	"Administrator" has the meaning ascribed to it in NRS 683A.025, and includes a pharmacy benefits manager.
NH	N.H. Rev. Stat. § 402-N:2	Register--PBM	DOI	A person or organization shall not establish or operate as a pharmacy benefits manager in this state for health benefit plans without registering with the insurance commissioner under this chapter.

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STATE	CITATION	WHAT	WHO	LANGUAGE
NJ	N.J.S.A. 17B:27F-1.1	License--PBM	DOBI	A corporation, business, or other entity shall not act as a pharmacy benefits manager without first obtaining a license from the department or as a pharmacy services administrative organization without first obtaining registration from the department.
NM	N.M. Stat. Ann. § 59A-61-3	License--PBM	DOI	A person shall not operate as a pharmacy benefits manager unless licensed by the superintendent in accordance with the Pharmacy Benefits Manager Regulation Act [59A-61-1 NMSA 1978] and applicable federal and state laws.
NY	N.Y. Ins. Law § 2905 N.Y. Ins. Law § 2906	License--PBM	DOI	No person, firm, association, corporation or other entity may act as a pharmacy benefit manager on or after January first, two thousand twenty-four without having authority to do so by virtue of a license issued in force pursuant to the provisions of this article. The superintendent may issue a pharmacy benefit manager's license to any person, firm, association or corporation who or that has complied with the requirements of this article, including regulations promulgated by the superintendent.
NC	N.C. Gen. Stat. Ann. § 58-56A-2(a)	License--PBM	DOI	A person or organization may not establish or operate as a pharmacy benefits manager for health benefit plans in this State without obtaining a license from the Commissioner of the Department of Insurance.

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STATE	CITATION	WHAT	WHO	LANGUAGE
ND	N.D. Cent. Code § 26.1-27.1-02	Register--TPA	Commissioner NDCC, 26.1-27-03	A person may not perform or act as a pharmacy benefits manager in this state unless that person holds a certificate of registration as an administrator under chapter 26.1-27.
OH	ORC Ann. §§ 3959.01, 3959.09; OH Bulletin No. 2018-2	License--TPA	DOI	Upon approval of the application for an administrator license and payment of appropriate filing fees, the applicant shall be granted a license by the superintendent of insurance and an appropriate certificate of authority to operate as an administrator will be issued to the applicant.
OK	Okla. Stat. Ann. tit. 59, § 358	License--PBM	DOI	In order to provide pharmacy benefits management or any of the services included under the definition of pharmacy benefits management in this state, a pharmacy benefits manager or any entity acting as one in a contractual or employment relationship for a covered entity shall first obtain a license from the Oklahoma Insurance Department, and the Department may charge a fee for such licensure.
OR	Or. Rev. Stat. § 735.532	License--PBM	Department of Consumer and Business Services	A person may not transact business or purport to transact business in this state as a pharmacy benefit manager unless the person has a license to transact business as a pharmacy benefit manager issued by the Department of Consumer and Business Services.
PA	Pa. Stat. Ann. tit. 40, § 4521	Register--PBM	DOI	To conduct business in this Commonwealth, a PBM or auditing entity must register with the department.

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PBM LICENSURE/REGISTRATION TRACKING DOCUMENT – JULY 2025

STATE	CITATION	WHAT	WHO	LANGUAGE
PR	24 L.P.R.A. § 12035	License--PBM	Department of Health	In order to operate and offer services in Puerto Rico, PBMs must obtain a license issued by the Office of the Regulatory Commissioner of Pharmacy Benefits and Service Administrators within the Department of Health.
RI	R.I. Gen. Laws §§ 27-29.1-7; 27-20.7-12	Certificate--TPA	DOI	No person shall act as, or offer to act as, or hold himself or herself out to be an administrator in this state without a valid certificate of authority as an administrator issued by the commissioner.
SC	S.C. Code Ann. § 38-71-2210	License--PBM	DOI	A person or organization may not establish or operate as a pharmacy benefits manager in this State for health benefit plans without obtaining a license from the Director of the Department of Insurance.
SD	S.D. Codified Laws § 58-29E-2	License--TPA	Director SDCL § 58-29D-22	No person or entity may perform or act as a pharmacy benefits manager in this state without a valid license to operate as a third party administrator pursuant to chapter 58-29D.
TN	Tenn. Code Ann. § 56-7-3113	License--PBM	DOI	No person or entity shall administer the medication or device portion of pharmacy benefits coverage provided by a covered entity or otherwise act as a pharmacy benefits manager in this state unless the person or entity has obtained licensure through the department of commerce and insurance.

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STATE	CITATION	WHAT	WHO	LANGUAGE
TX	Tex. Ins. Code § 4151.151	Certificate--TPA	Commissioner Ins. Code § 4151.053	In this subchapter, "pharmacy benefit manager" means a person, other than a pharmacy or pharmacist, who acts as an administrator in connection with pharmacy benefits.
UT	Utah Code Ann. § 31A-46-201	License--PBM	DOI	A person may not perform, offer to perform, or advertise any pharmacy benefits management service in the state unless the person is licensed as a pharmacy benefit manager under this chapter.
VT	Vt. Stat. Ann. tit. 18, § 9421 Vt. Stat. Ann. tit. 18, § 3611	Register—PBM License--PBM	DOI DOI	A pharmacy benefit manager shall not do business in this State without first registering with the Commissioner on a form and in a manner prescribed by the Commissioner. A person shall not establish or operate as a pharmacy benefit manager for health benefit plans in this State without first obtaining a license from the Commissioner of Financial Regulation.
VI				
VA	Va. Code Ann. § 38.2-3466. Administrative Letter 2020-04	License--PBM	State Corporation Commission	Unless otherwise covered by a license as a carrier, no person shall provide pharmacy benefits management services or otherwise act as a pharmacy benefits manager in the Commonwealth without first obtaining a license in a manner and in a form prescribed by the Commission.

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PBM LICENSURE/REGISTRATION TRACKING DOCUMENT – JULY 2025

STATE	CITATION	WHAT	WHO	LANGUAGE
WA	Wash. Rev. Code Ann. § 48.200.030	Register--HCBM	DOI	To conduct business in this state, a health care benefit manager must register with the office of the insurance commissioner and annually renew the registration.
WV	W. Va. Code Ann. § 33-51-8	License--PBM	DOI	A person or organization may not establish or operate as a pharmacy benefits manager in the State of West Virginia without first obtaining a license from the Insurance Commissioner pursuant to this section: Provided, That a pharmacy benefit manager registered pursuant to §33-51-7 of this code may continue to do business in the state until the Insurance Commissioner has completed the legislative rule as set forth in §33-51-10 of this code: Provided, however, That additionally the pharmacy benefit manager shall submit an application within six months of completion of the final rule.
WI	Wis. Stat. Ann. § 632.865(3)	License--PBM	DOI	No person may perform any activities of a pharmacy benefit manager without being licensed by the commissioner as an administrator or pharmacy benefit manager under s. 633.14.
WY	Wyo. Stat. § 26-52-101	License--PBM	DOI	No person shall act or hold himself out as a pharmacy benefit manager in this state unless he obtains a license from the department.

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