HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

Health Insurance and Managed Care (B) Committee March 25, 2026, Minutes

- Health Insurance and Managed Care (B) Committee Feb. 13, 2026, Minutes (Attachment One)
  - Health Insurance and Managed Care (B) Committee 2026 Revised Charges (Attachment One-A)
- Joint Health Insurance and Managed Care (B) Committee and Regulatory Framework (B) Task Force Feb. 13, 2026, Minutes (Attachment Two)
  - Regulatory Framework (B) Task Force 2026 Revised Charges (Attachment Two-A)
- Consumer Information (B) Working Group March 4, 2026, Minutes (Attachment Three)
- Health Care Affordability and Mitigation (B) Working Group March 24, 2026, Minutes (Attachment Four)
  - Health Care Affordability and Mitigation (B) Working Group, March 10, 2026, Minutes (Attachment Four-A)
- State Flexibility White Paper Adopted by the Committee (Attachment Five)

Draft Pending Adoption

Draft: 4/2/26

Health Insurance and Managed Care (B) Committee
San Diego, California
March 25, 2026

The Health Insurance and Managed Care (B) Committee met in San Diego, CA, March 25, 2026. The following Committee members participated: Grace Arnold, Chair (MN); John F. King, Vice Chair (GA); Charles Bassett (AZ); Trinidad Navarro represented by Susan Jennette (DE); Dean L. Cameron (ID); Ann Gillespie (IL); Marie Grant (MD); Robert L. Carey represented by Marti Hooper (ME); Mike Chaney represented by Bob Williams (MS); Alice T. Kane represented by Viara Ianakieva (NM); Ned Gaines (NV); Glen Mulready represented by Brian Downs (OK); Michael Humphreys (PA); Jon Pike (UT); and Allan L. McVey and Joylynn Fix (WV). Also participating were: Peter M. Fuimaono (AS); Michael Conway (CO); Michael T. Caljouw (MA); Kevin Dyke (MI); Eric Dunning (NE); D.J. Bettencourt (NH); Judith L. French (OH); Scott A. White (VA); and Rocky Patterson (WA).

1. Adopted its Feb. 13, 2026, and 2025 Fall National Meeting Minutes

The Committee met Feb. 13, 2026. During this meeting, it took the following action: 1) adopted its revised 2026 charges, which include renaming the Health Innovations (B) Working Group to the Health Care Affordability and Mitigation (B) Working Group.

The Committee also met Feb. 13 in joint session with the Regulatory Framework (B) Task Force. During this meeting, the Committee and Task Force took the following action: 1) adopted the Task Force's revised 2026 charges, which include renaming the Employee Retirement Income Security Act (ERISA) (B) Working Group to the ERISA and Alternative Health Coverage (B) Working Group.

Commissioner McVey made a motion, seconded by Director Gillespie, to adopt the Committee's Feb. 13, 2026 (Attachment One), the joint Committee and Regulatory Framework (B) Task Force Feb. 13, 2026 (Attachment Two), and Dec. 11, 2025 (*see NAIC Proceedings – Fall 2025, Health Insurance and Managed Care (B) Committee*) minutes. The motion passed unanimously.

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

Director Gillespie 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 March 4 minutes (Attachment Three); 2) Health Care Affordability and Mitigation (B) Working Group (Attachment Four); 3) Health Actuarial (B) Task Force; 4) Regulatory Framework (B) Task Force, including its *State Flexibility White Paper* (Attachment Five); and 5) Senior Issues (B) Task Force. The motion passed unanimously.

3. Heard a Presentation from Bailit Health on Health Insurance Affordability and State Options to Address It

Michael Bailit (Bailit Health) discussed state strategies for addressing the affordability crisis in the commercial health insurance market. He set the stage for the discussion by highlighting the adverse impact of high health care costs on consumers. He said that due to high health care costs, roughly 36% of adults in the U.S. say they have skipped or postponed needed health care in the last year; one in five have not filled a needed prescription. In addition, four in 10 adults report having debt resulting from medical or dental bills. Bailit also discussed health care cost drivers. He said that in 2022, nationally, hospital spending made up nearly half of total health care spending. He also described the growth in health care spending in recent years.

Bailit discussed state strategies for managing rising health care costs and addressing the problem of commercial health care market affordability, including: 1) hospital and prescription drug price caps; 2) enhancing market competition; 3) site-neutral payments and facility fee bans; and 4) limiting consolidation, vertical integration, and/or private equity. Bailit also posed the question of whether the lack of a functioning market for health care is part of the problem and whether health care can work as a market. He noted the following key aspects of the U.S. health care market that explain why it does not or cannot work as a market: 1) provider market consolidation; 2) lack of transparency on cost and quality; and 3) consumers not acting rationally when it comes to health care.

Bailit reviewed specific strategies that a wide array of states have adopted to address the growth in health care costs. He said most address hospital and pharmacy prices. He said data analysis has shown these to have been the primary forces driving up health care spending and commercial premiums for the past decade or more.

Bailit said several states, such as Minnesota, Rhode Island, and Utah, have initiatives to measure annual cost growth across markets, identify care cost drivers, and collaboratively develop strategies and opportunities for improving affordability. He discussed price caps that some states have instituted. Bailit said the states have three options for implementing a price cap: 1) state purchasing authority; 2) insurance regulation; or 3) provider price regulation. He discussed how Indiana and New Mexico instituted hospital price caps to slow the rise in health care costs. Bailit also highlighted Colorado's pharmacy price cap. He said Colorado was the first state to set an upper payment limit on a high-cost drug, which will be effective in 2027.

Bailit next discussed site-neutral payments and facility fee bans. He explained that site-neutral payment policies reduce the prices for certain services delivered within a hospital-owned or affiliated setting and those that can be safely provided in a lower-cost setting. Facility fee bans limit higher prices charged when hospitals acquire physician practices and shift services that were billed at office-based rates to outpatient hospital rates. Bailit provided examples of states using these strategies to manage health care costs. He next discussed price growth caps, which some states have used. A price growth cap limits how much provider payments can grow each year. He said the cap can be linked to an economic indicator, such as Consumer Price Index (CPI) or Gross State Product (GSP) growth. Bailit discussed Connecticut's pharmacy price growth cap, which prohibits any pharmaceutical manufacturer or wholesale distributor from selling a generic drug at a price above the wholesale acquisition cost after adjusting for any increase in the CPI.

Bailit discussed various state strategies to increase competition and address market changes to control rising health care costs. He said that to increase health plan competition, Nevada launched a public option on their state-based exchange (SBE) in January 2026. Bailit also provided examples of various state strategies being used to address market changes, including: 1) increasing transparency through ownership reporting requirements and expanded financial disclosures; 2) strengthening Corporate Practice of Medicine (CPOM) protections to preserve professional autonomy; and 3) addressing anticompetitive contracting practices of dominant insurers with providers, such as all-or-nothing contracting.

Commissioner Grant asked Bailit to discuss hospital rate-setting and global billing, which Maryland has used for years to control hospital costs. Bailit explained that hospital rate-setting was instituted in a number of states, but Maryland's program is the only one that remains. He said research has shown it has been effective in Maryland. He distinguished between hospital rate-setting and hospital global budgets. He said he believes hospital global budgets, particularly if done on a multi-payer basis, hold great attraction and potential in controlling health care costs because they do not involve fee-for-service payment coding games currently happening in the market between insurers and providers, especially if the rate of budget growth is controlled and not subject to market power. Bailit said that although global billing is a hard model to implement, it is worth trying.

Commissioner Caljouw asked Bailit to discuss state experiences with price capping in more detail and how they might be implemented with utilization controls, both in a hospital and pharmaceutical setting. Bailit agreed with

Commissioner Caljouw that if states cap prices, they are not controlling utilization, which creates opportunities for gaming the system. He said one reason the hospital global budget model is attractive is that it can address both price and utilization.

With respect to state experience with price capping and whether it is effective, Bailit said there has been a flurry of state price growth cap activity over the last few years, but the only program that has been in effect long enough to be evaluated is Oregon's. He said Oregon's program applies to state employees and teachers and has been found to have generated state savings. He said a second recent program evaluation found that there was no substantial harm caused to hospitals. Bailit said another related concept, the price growth cap, has been evaluated because Rhode Island has had a commercial price growth cap in place since 2010, and there have been two peer-reviewed published evaluations of it to date. He said both evaluations found that premiums in Rhode Island grew at a much slower rate than in other New England states, resulting in lower premiums and consumer savings.

Fix asked if facility fee bans have been effective in controlling health care costs. Bailit acknowledged the increasing number of states imposing facility fee bans. He said such bans have had some impact on costs, but obviously less impact if fees were addressed more broadly. Bailit said the critical aspect of facility fees for him and whether they will generate any meaningful savings, is limiting facility fees for both on-hospital and off-hospital campus facilities. He explained that a lot of facility fees are for professional offices located on the hospital campus but are not part of the hospital. Therefore, if you exempt facility fee charges on campus, most of the savings are lost. Bailit cited a recently published study of Medicare's limitation on facility fees to support his claim.

Director Bassett asked Bailit whether he had found in his research that fraud is a significant health care cost driver. Bailit said he is not aware of any studies on the issue. He explained that he would distinguish between fraud and gaming the system, which is occurring now between providers and insurers, with providers upcoding or maximizing the number of diagnoses in a claim to increase reimbursement.

Director Cameron asked Bailit about the data analysis he mentioned during his presentation. He asked if Bailit is aware of any studies of utilization trends based on Current Procedural Terminology (CPT) codes. Bailit referenced a few such studies, including the RAND Corporation's examination of hospital prices within the state using claims data that it obtains from insurers, and the Health Care Cost Institute's (HCCI's) collection of claim data from large insurers across the country, which it uses to perform analyses that include a metropolitan area drilled down on pricing utilization.

As a follow-up to Director Bassett's question about fraud, Director Cameron asked Bailit about artificial intelligence (AI) being used in billing practices to bill for health care services that are not provided. He asked if Bailit is aware of any study providing evidence of such actions. Bailit said there is currently a lot being written about hospitals using AI for billing, but he is not aware of it being used for fraudulent purposes.

4. Heard Remarks from CMS on Improving State/Federal Coordination on Issues Related to MA Plans

Alec Aramanda (Centers for Medicare & Medicaid Services—CMS) discussed CMS' state/federal coordination efforts related to Medicare Advantage plans. He first provided an overview of CMS and its priorities, including the number of beneficiaries it serves and its rule-making process. Aramanda said CMS also serves as the lead for management, oversight, budget, and performance issues relating to Part C (Medicare Advantage), Part D (prescription drug plans), and Medicare fee-for-service providers and contractors. He noted that one of CMS's priorities involves its work related to the Make America Healthy Again (MAHA) initiative.

Aramanda discussed CMS' work to move toward more market-based pricing using empirically reliable, auditable information from the commercial sector to help inform Medicare payment rates. He said CMS believes this effort will ultimately put the right kind of downward competitive pressure on pricing and ultimately make sure that the

relative allocation of resources available will show that providers are being adequately compensated for the high-value care that they deliver and patients are receiving the quality of care they deserve. He said that, also in doing this, CMS is looking to address the consolidation going on in the Medicare Advantage market and looking to remove incentives that create arbitrage opportunities that increase costs for patients and taxpayers and do not provide any measurable improvement in the quality of care provided.

Aramanda stated that another CMS priority is its star ratings system, which evaluates Medicare Advantage and Medicare Part D on a one-to-five-star scale, with five stars representing excellent performance. He said the star ratings program helps beneficiaries compare plans based on quality, covering areas like customer service, preventive care, and chronic condition management. High-rated plans (i.e., those with four or more stars) receive financial bonuses. Aramanda also mentioned CMS' work related to prior authorization and partnering with insurers to streamline and modernize the prior authorization process.

Aramanda discussed how unique Medicare is and the services it provides. He stated that a goal CMS shares with state insurance regulators is to ensure Medicare beneficiaries have access to timely, high-quality care close to their homes. He noted that Medicare Advantage is a federally administered program that provides broad federal preemption of state laws related to all aspects of Medicare Advantage plans except Medicare Advantage plan licensing and financial solvency. Aramanda said that CMS has a statutory obligation to ensure there are uniform national rules for Medicare Advantage plans to ensure Medicare Advantage beneficiaries receive consistent protection and high-quality care regardless of where they live. He noted that CMS has a memorandum of understanding (MOU) with each state enabling the sharing and coordination of that information as related to Medicare Advantage plan issues. He also noted CMS' commitment to meeting monthly with the Senior Issues (B) Task Force to enhance this coordination and information sharing.

Commissioner Arnold acknowledged and expressed appreciation for CMS' recent efforts to provide opportunities for information sharing and discuss Medicare Advantage plan issues with state insurance regulators.

Director Cameron asked Aramanda whether CMS has any data or information it could share on how many carriers it has terminated or actions it has taken related to market conduct issues. He said there appears to be a lack of clarity between the roles that states and CMS play when Medicare Advantage plan insurers act inappropriately, do not provide or deny access to seniors being able to enroll in their Medicare Advantage plans, shut down their websites, or hide applications. Aramanda said he does not have that information readily available and would be happy to follow up with the Committee to the extent that CMS can provide it.

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

Peter Nelson (Center for Consumer Information and Insurance Oversight—CCIIO) updated the Committee on the CCIIO's recent activities of interest and priorities. He said transparency and innovative plan design are high priorities for the CCIIO. He discussed provisions in the 2027 U.S. Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters (NBPP) proposed rule to accomplish these priorities. Nelson also noted the CCIIO's continued commitment to reducing waste, fraud, and abuse. He said the CCIIO is actively working more closely with stakeholders, including state insurance regulators, particularly as it relates to agents and brokers, to address the issue. Nelson also touted the provisions in the federal Working Families Tax Cut (WFTC) Act (better known as the One Big Beautiful Bill), which significantly expands health savings account (HSA) utility starting Jan. 1. The key changes include making bronze and catastrophic individual marketplace plans HSA-compatible, allowing tax-free HSA funds for direct primary care (DPC) fees, and increasing flexibility for dependents.

Commissioner King asked about the timing of finalizing the 2027 NBPP proposed rule. Nelson acknowledged the importance of finalizing it as expeditiously as possible. He said the CCIIO is currently reviewing comments received and hopes to finalize the rule as soon as possible.

Commissioner Humphreys stressed support for the CCIIO's efforts to provide greater transparency, which is also an important initiative in Pennsylvania. He asked whether there were any opportunities at the federal level to leverage the enrollee-level external data-gathering environment (EDGE) server to create additional data resources for the states to enhance their transparency efforts.

Jeff Wu (CCIIO) discussed the opportunities and limitations of the EDGE server data, explaining that the state all-payer claims database (APCD) would have more comprehensive data. He discussed the CCIIO's other efforts on transparency and those related to prior authorization.

Commissioner Pike expressed support for the CCCIIO's efforts related to transparency and similar initiatives. He expressed disappointment and frustration, however, with the delays in the essential health benefit (EHB) benchmark plan application process. Nelson said he understood Commissioner Pike's frustration. He said the CCIIO is working to establish a framework for EHB benchmark plans that align with Affordable Care Act (ACA) statutory requirements and hopes to resolve it soon.

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

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Draft: 3/5/26

Health Insurance and Managed Care (B) Committee
E-Vote
February 13, 2025

The Health Insurance and Managed Care (B) Committee conducted an e-vote that concluded Feb. 13, 2026. The following Committee members participated: Grace Arnold, Chair (MN); John F. King, Vice Chair (GA); Charles Bassett (AZ); Dean L. Cameron (ID); Ann Gillespie (IL); Marie Grant (MD); Robert L. Carey (ME); Ned Gaines (NV); Glen Mulready (OK); Michael Humphreys (PA); Jon Pike (UT); and Allan L. McVey represented by Joylynn Fix (WV).

1. Adopted its Revised 2026 Charges

The Committee conducted an e-vote to revise its 2026 charges (Attachment One-A), which included adding a new charge to "monitor health insurance markets to evaluate and recommend standards and consumer protections, as well as address emerging issues in health care delivery and affordability." The revisions also rename the Health Innovations (B) Working Group to the Health Care Affordability and Mitigation (B) Working Group and add a new charge taken from the Committee's charges to "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." The motion passed unanimously.

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/National Meetings/2026 Spring National Meeting/B Cmte 2-13-26 E-Vote MtgMin.docx

Revised: 2/2/26
Adopted by the Executive (EX) Committee and Plenary, ?. __, 2026
Adopted by the Health Insurance and Managed Care (B) Committee, Feb. 13, 2026

2026 Revised 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 the U.S. Congress (Congress), the White House, and federal agencies; analyze policy implications and their effect on the states of proposed and enacted federal legislation and regulations; 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. 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, and coverage continuity.~~
   ~~G. Continue to support efforts to address disparities in coverage and affordability and recommending appropriate steps to reduce those disparities.~~
   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.
   ~~H~~G. Coordinate with appropriate Market Regulation and Consumer Affairs (D) Committee groups, as necessary, on health benefit plan and producer enforcement issues.
   ~~I~~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 (STLD) insurance, association health plans (AHPs), and packaged indemnity health products.

2. The **Consumer Information (B) Working Group** will:
   A. Develop information or resources, as needed, that would be helpful to state insurance regulators and others in assisting consumers to better understand health insurance.
   B. Review NAIC publications that touch 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.

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE (*continued)*

3. The **Health ~~Innovations~~ Care Affordability and Mitigation (B) Working Group** will:
   ~~A. Gather and share information, best practices, experience, and data to inform and support health innovation at the state and national levels, including, but not limited to, state flexibility options through the ACA and other health insurance-related policy initiatives.~~
   ~~B.~~A. Discuss state ~~innovations~~efforts related to 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 Support Staff: Jolie H. Matthews/Brian R. Webb/Jennifer R. Cook

Draft: 3/6/26

Health Insurance and Managed Care (B) Committee
and Regulatory Framework (B) Task Force
E-Vote
February 13, 2025

The Health Insurance and Managed Care (B) Committee and the Regulatory Framework (B) Task Force conducted a joint e-vote that concluded Feb. 13, 2026. The following Committee members participated: Grace Arnold, Chair (MN); John F. King, Vice Chair (GA); Charles Bassett (AZ); Trinidad Navarro represented by Susan Jennette (DE); Dean L. Cameron (ID); Ann Gillespie (IL); Marie Grant (MD); Robert L. Carey (ME); Ned Gaines (NV); Glen Mulready (OK); Michael Humphreys (PA); Jon Pike (UT); and Allan L. McVey represented by Joylynn Fix (WV). The following Task Force members participated: Marie Grant, Chair (MD); Allan L. McVey, Vice Chair, represented by Joylynn Fix (WV); Mark Fowler (AL); Charles Bassett (AZ); Michael Conway represented by Debra Judy (CO); Joshua Hershman represented by Tricia Davé (CT); Michael Yaworsky represented by Alexis Bakofsky (FL); John F. King (GA); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron (ID); Ann Gillespie (IL); Holly W. Lambert represented by Alex Peck (IN); Vicki Schmidt represented by Craig Van Aalst (KS); Sharon P. Clark (KY); Michael T. Caljouw (MA); Robert L. Carey (ME); Grace Arnold (MN); Angela L. Nelson represented by Melissa Panettiere (MO); Eric Dunning represented by Martin Swanson (NE); Susan Ochs represented by David Wolf (NJ); Remedio C. Mafnas represented by Maryann Borja-Arriola (NM); Ned Gaines (NV); Judith L. French represented by Laura Miller (OH); Glen Mulready (OK); TK Keen (OR); Michael Humphreys (PA); Larry D. Deiter represented by Jill Kruger (SD); Amanda Crawford represented by Rachel Bowden (TX); Jon Pike (UT); Scott A. White represented by Julie Blauvelt (VA); and Patty Kuderer represented by Jane Beyer (WA).

1. Adopted Revised 2026 Charges for the Regulatory Framework (B) Task Force

The Committee and Task Force conducted a joint e-vote to revise the Task Force's 2026 charges. The revisions add a new charge taken from the former Health Innovations (B) Working Group to "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." This transferred charge allows the Task Force to complete the Health Innovations (B) Working Group's work to develop a state flexibility white paper, which will outline state flexibility options under ACA Sections 1331, 1332, and 1333. The revised Task Force charges also revise the name of the Employee Retirement Income Security Act (ERISA) (B) Working Group to the Employee Retirement Income Security Act (ERISA) and Alternative Health Care Coverage (B) Working Group to reflect its new charge taken from the Task Force's charges to "monitor, analyze, and report, as necessary, developments related to excepted benefit 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."

A majority of the Committee and Task Force members voted in favor of adopting the Task Force's revised 2026 charges (Attachment Two-A), with Delaware voting "no" on including STLD coverage under the purview of the ERISA and Alternative Health Care Coverage (B) Working Group but voting "yes" on the Task Force's transferred charge to allow it to complete the work of the former Health Innovations (B) Working Group to develop the state flexibility white paper.

Date: 1/23/26
Adopted by the Executive (EX) Committee and Plenary, ? __, 2026
Adopted by the Health Insurance and Managed Care (B) Committee, Feb. 13, 2026
Adopted by the Regulatory Framework (B) Task Force, Feb. 13, 2026

2026 Revised 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 the provision of technical assistance to the 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. Monitor, analyze, and report, as necessary, developments related to excepted benefits coverage, short-term, limited-duration (STLD) coverage, health sharing ministry coverage, and coverage that is offered and marketed as a substitute for, or an alternative to, comprehensive major medical 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 **ERISA and Alternative Health Coverage (B) Working Group** will:
   A. Monitor, report, and analyze developments related to ERISA, and make recommendations regarding NAIC strategy and policy with respect to those developments.
   B. Monitor, facilitate, and coordinate with the states and the U.S. Department of Labor (DOL) efforts related to sham health plans.
   ~~B.~~C. Monitor, analyze, and report, as necessary, developments related to 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.
   ~~C.~~D. Monitor, facilitate, and coordinate with the states and the DOL regarding compliance and enforcement efforts regarding the ~~Affordable Care Act (~~ACA~~)~~ that relate to ERISA.
   ~~D.~~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 developments related to ERISA. 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 recommendations regarding NAIC strategy and policy with respect to those developments.
   B. Monitor, facilitate, and coordinate best practices with the states, the DOL, and the U.S. Department of Health and Human Services (HHS) related to the MHPAEA.
   C. Develop and provide resources to the states to support a greater understanding of laws, policies, and market conditions related to the MHPAEA.
   D. Provide supplemental resources to support documentation and reporting in the MHPAEA chapter of the *Market Regulation Handbook*.
   E. 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 related to 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 issues related to prescription drug coverage regulation, 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 and regulations and case law that fall under the purview of state-based insurance.
   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. Monitor, facilitate, and coordinate with the 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 Support Staff: Jolie H. Matthews/Jennifer Cook

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/RFTF/National Meetings/2025 Fall Meeting/010_RFTF Adopted Revised 2026.docx

Draft: 3/17/26

Consumer Information (B) Working Group
Virtual Meeting
March 4, 2026

The Consumer Information (B) Working Group of the Health Insurance and Managed Care (B) Committee met March 4, 2026. The following Working Group members participated: T.J. Patton, Chair (MN); David Buono, Vice Chair (PA); Randy Pipal (ID); Michelle Baldock (IL); Alex Peck (IN); Patricia Dorn (MD); Donna Dorr (OK); Jill Kruger (SD); Jennifer Ramcharan (TN); Shelley Wiseman (UT); Andrew Davis (WA); Vicki Jones (WV); and Christina Keeley (WI). Also participating were: Susan Jennette (DE); and Martin Swanson (NE).

1. Discussed its Leadership Transition

Buono explained his decision to step down as chair. He reviewed the Working Group's 2025 accomplishments and said he wanted to give new leaders a chance to contribute. He said he would remain as vice chair unless another regulator expressed interest in taking on the role.

2. Discussed its Potential Activities for 2026

Patton led a discussion on the Working Group's potential activities for 2026. He said the Health Insurance and Managed Care (B) Committee communicated two priorities for the Working Group: updating the *Frequently Asked Questions (FAQ) about Health Care Reform* and collaborating with the federal Centers for Medicare & Medicaid Services (CMS) on its *Choosing a Medigap Policy* guide. He said the Working Group has time to complete one or two additional projects before those two documents are considered in advance of annual open enrollment periods.

Keeley said the No Surprises Act (NSA) generates a significant number of questions and complaints in Wisconsin. She said pharmacy benefits would be a secondary topic of interest for her state.

Jennette said network adequacy should be examined further. She said existing measures do not fully capture access to care for consumers. Swanson observed that level-funded plans are rising in adoption, with some running into difficulty and leaving employers with unexpected costs. He said a guide for employers on what to look for and how the money flows would be helpful. Patton said level-funded plans were not one of the types of coverage described in the Working Group's 2025 guide to shopping for health insurance. He said expanding the guide to include level-funded plans could be an option for this year.

Bonnie Burns (California Health Advocates—CHA) said some topics could be combined, such as unauthorized transfers and improper marketing. She questioned what form the topics would take, whether they would be guides for consumers in the purchasing decision, tips for dealing with problems like providers leaving a network, or other approaches.

Ramcharan expressed support for developing materials about network adequacy, especially in the context of mental health services and parity requirements. Patton said parity considerations are complicated, so the Working Group should consider whether it can adequately condense the appropriate issues for consumers.

Harry Ting (Health Care Consumer Advocate) suggested long-term care insurance (LTCI) as a potential topic. Patton said the Working Group would want to partner with the Senior Issues (B) Task Force if it addresses long-term care (LTC).

Anna Howard (American Cancer Society) voiced support for taking on preventive services. She said there have been updates to the policy that require their coverage with no cost-sharing, so it would be helpful to educate consumers about changes.

Lucy Culp (Blood Cancer United) asked whether the Working Group is aware of how many states have used the materials it developed and whether regulators and consumers find them usable.

Wayne Turner (National Health Law Project—NHeLP) supported developing content on pharmacy benefits and preventive services. He said the 2025 guide on shopping for health insurance should be revisited, given the expiration of enhanced premium tax credits and the implementation of Medicaid changes, such as work requirements. He said the 2024 prior authorization guide and 2023 claims and appeals guides could also be revised and updated.

Kris Hathaway (AHIP) said the Working Group should be mindful of the work of other NAIC groups and not duplicate work. She said preventive services, the NSA, and facility fees would be helpful topics for the Working Group to examine.

Deborah Steinberg (Legal Action Center—LAC) said the Working Group can focus on consumer-facing materials even as other groups consider policy or regulatory issues in similar topic areas. She said network adequacy is a priority topic for many consumer representatives.

Patton said Ramcharan described how their states have used Working Group materials, including posting them on the departments' websites and adapting a shopping guide for use at in-person events.

Patton asked regulators to weigh in on preferred topics by email.

Patton explained plans for providing input on the CMS Medigap guide. He said there is a short window to make suggestions, so he plans to form a small drafting group to suggest edits at the appropriate time.

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

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Draft: 3/31/26

Health Care Affordability and Mitigation (B) Working Group
San Diego, California
March 24, 2026

The Health Care Affordability and Mitigation (B) Working Group of the Health Insurance and Managed Care (B) Committee met in San Diego, CA, March 24, 2026. The following Working Group members participated: Kate Harris, Chair (CO); Kevin P. Beagan, Vice Chair (MA); Sanjeev Chaudhuri and Kelli Littlejohn Newman (AL); Sarah Bailey (AK); Paula Wallin (IA); Alex Peck (IN); Craig Van Aalst (KS); Megan Mason (MD); Jeana Thomas (MO); Chrystal Bartuska (ND); Viara Ianakieva (NM); Kristin Cly (OH); Travis Jordan (SD); Dan Paschal (TX); Ryan Jubber and Shelley Wiseman (UT); Todd Lovshin and Rocky Patterson (WA); Joylynn Fix (WV); and Coral Manning (WI). Also participating were: Robert L. Carey and Marti Hooper (ME) and Michael Humphreys (PA).

1. Adopted its March 10 Minutes

The Working Group met March 10. During this meeting, it discussed its charges and work plan and established a rough timeline for completing a collection of briefs on state policies to improve health care affordability.

Peck made a motion, seconded by Manning, to adopt the Working Group's March 10 minutes (Attachment Four-A). The motion passed unanimously.

2. Discussed its Charges and Work Plan

Harris reviewed the results of a KFF poll that showed roughly 30% of Americans cut back on other necessary expenses in order to afford health care. It also showed that 10% of former Marketplace enrollees have become uninsured.

Harris discussed the Working Group's intention to produce a document that lists policy options for states. She said the document would entail a series of one- or two-page briefs that outline changes states have made or could make to address health care affordability. Harris asked the Working Group to focus on policy changes to improve affordability rather than just identifying problems with high costs. She asked state insurance regulators and interested parties who suggested affordability topics to clarify what policy change could address the affordability concern.

Harris asked the Working Group whether it prefers to include a relatively long list of topics in its collection, with less detail devoted to each one, or a shorter list of topics with more detail. Fix expressed support for a deeper dive on a shorter list. She suggested the Working Group could address additional topics in future years. Bartuska agreed and added that the Working Group should focus on topics not addressed by other NAIC working groups. Carey asked the Working Group to prioritize its list of topics to the most viable options. Patterson said the Working Group should focus on systemic issues and causes of high costs, rather than symptoms of the problem of high costs.

3. Heard a Presentation from the CCHI and Brown University on Hospital Costs

Adam Fox (Colorado Consumer Health Initiative—CCHI) and Lindsey Murtagh (Brown University) presented on strategies to control hospital costs. Fox cited rising hospital costs, saying hospitals accounted for one-third of

health care cost growth over the past 20 years, 61% of which is due to increased prices. He said 40% of premiums go to hospitals. Fox said nearly all metro areas have highly concentrated hospital markets, and nearly half have only one or two health systems providing inpatient care. Fox said high hospital costs drive both higher premiums and higher out-of-pocket costs.

Fox said there is a spectrum of potential solutions for high costs that states can consider. The potential solutions include more transparency and reporting from hospitals, limiting facility fees, additional oversight of mergers and private equity ownership, and setting premium reduction targets as in Colorado Option plans. Fox said that Colorado Option enrollees paid less in premiums and out-of-pocket costs than enrollees in other plans in the state.

Murtagh described hospital cost control policies in other states. She reviewed Rhode Island's Affordability Standards, which require review and approval when hospital cost growth exceeds certain levels. She said the standards apply only to the fully insured market but have also helped reduce hospital prices for self-insured plans.

Murtagh said Oregon capped hospital prices through its state employee health plan. She said the plan realized 4% savings in total costs over the first two years and 9.5% reduction in consumers' out-of-pocket spending. Murtagh also referenced actions in Vermont, Indiana, and Washington in 2025 to set new limits on hospital prices.

Murtagh offered several key considerations for states regarding options to control hospital prices. She said states should carefully consider how to set caps because a cap set too high could increase prices, while a cap set too low could negatively impact hospitals' viability. She said percentage caps can lock in past differences in payment rates. She said some areas may need more investment, so the same cap should not necessarily apply across the board. She said it is important to have a mechanism to ensure that savings pass to consumers.

4. Heard a Presentation from the CBPP and GHF on State-Based Marketplace Approaches for Improving Affordability

Claire Heyison (Center on Budget and Policy Priorities—CBPP) and Laura Colbert (Georgians for a Healthy Future—GHF) presented on ways state-based marketplaces can improve affordability for consumers.

Heyison reviewed flexibilities available to state-based marketplaces (SBMs) that are not available to federally facilitated marketplaces. She discussed standardized plan options and said they are required by seven states with SBMs. She said standardized plan options frequently exempt certain key services from deductibles, particularly for people with chronic conditions. She said other cost sharing may have to rise slightly to exempt some services from deductibles.

Heyison said some outreach strategies can reduce barriers to enrollment and improve the risk pool by bringing younger and healthier people into coverage. These outreach strategies include culturally and linguistically appropriate messaging and using information from state data sources. She said SBMs can also employ facilitated enrollment using state tax forms, improve enrollment through sludge audits, and fund navigator programs.

Colbert said SBMs have the opportunity to offer a premium subsidy to replace some or all of the federal enhanced premium tax credits that have expired. She said New Mexico has been able to fully replace the expired credits, while other states have partially replaced them or subsidized cost-sharing amounts. She said states can use broad health insurance assessments, tobacco tax revenue, or marketplace user fees to fund additional subsidies.

Colbert said states with or without SBMs can use a state reinsurance program. She said two states, Colorado and Georgia, use tiered reinsurance programs to provide additional premium reduction in certain areas of the state.

Colbert said health insurance rate review authority is also available for nearly all states. She said nine states could move to prior approval authority rather than file and use. She said other states could increase public transparency in rate review or adopt cost targets as in Rhode Island.

Harris asked whether standard plans with some services offered pre-deductible have been linked to cost savings in research. Heyison said the District of Columbia is currently studying standardized plans.

Beagan said hospitals have claimed they are losing money. He asked about the tradeoffs in establishing hospital cost controls. Fox said Colorado employs a formula to give critical access hospitals higher cost targets. He said policy options must take into account the differing financial positions of different hospitals. Murtagh said a statewide cap may not make sense. She said Washington exempted its critical access hospitals from price caps.

Beagan asked how states can limit the amount of deductibles. Heyison said increasing premium support can help consumers purchase plans that have lower out-of-pocket costs. She said a state could also enact a cost-sharing wrap that reduces deductibles using state revenues.

Harris said a tax form check box in Colorado has not significantly increased enrollment. She asked how the policy can be adjusted to be more effective. Heyison said states could experiment with outreach to tax preparers to educate them about the check box and what it means.

Carey asked about differences in cost savings between fully insured and self-insured plans in Rhode Island. Murtagh replied that self-funded employers often operate in multiple states, and the Rhode Island savings may not be enough to reduce their premiums.

5. Heard Input on Working Group Activities from State Insurance Regulators and Interested Parties

Harris asked for feedback on any issues that had been raised in the Working Group.

Patterson suggested that affordability topics should not be left off entirely if they are being considered by another NAIC working group. He said the Health Care Affordability and Mitigation (B) Working Group could include content from another group in its collection.

Humphreys said the Working Group should consider the effects of the Rural Health Transformation (RHT) Program grants that are going to each state. He said state insurance regulators' affordability efforts should coordinate with the work done under the transformation grants, even though that may be difficult because the grant work comes from different state agencies.

Lucy Culp (Blood Cancer United) suggested that the Working Group prioritize topics that have a clear policy solution, are not being addressed by another group, target root causes, and have real consumer impact.

Fox said that in Colorado, rural hospitals' financing struggles are largely driven by the payment and utilization review policies of Medicare Advantage plans.

Humphreys said the use of artificial intelligence (AI) in coding should be examined, either by the Working Group or another NAIC group.

Having no further business, the Health Care Affordability and Mitigation (B) Working Group adjourned.

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Draft: 3/17/26

Health Care Affordability and Mitigation (B) Working Group
Virtual Meeting
March 10, 2026

The Health Care Affordability and Mitigation (B) Working Group of the Health Insurance and Managed Care (B) Committee met March 10, 2026. The following Working Group members participated: Kate Harris, Chair (CO); Kevin P. Beagan, Vice Chair (MA); Sarah S. Bailey (AK); Andria Seip (IA); Alex Peck (IN); Julie Holmes (KS); Amy Hoyt (MO); Chrystal Bartuska (ND); Viara Ianakieva (NM); Kristin Cly (OH); Jill Kruger (SD); Rachel Bowden (TX); Tanji J. Northrup (UT); Jane Beyer and Todd Lovshin (WA); Joylynn Fix (WV); and Coral Manning (WI). Also participating was Martin Swanson (NE).

1. Discussed its Charges and Work Plan

Harris reviewed the Working Group's charges, focusing on changes from the Health Innovations (B) Working Group's charges. She said the charges for the two groups are similar, but the Health Care Affordability and Mitigation (B) Working Group's charges specifically focus on factors that contribute to rising health care costs and insurance premiums. She said she would like to look at factors broadly, as they should be tied to premiums of state-regulated health insurance, but need not be directly tied. She also wants to focus on solutions, looking at practices that are working in one or more states.

Harris said the Working Group's goal is to produce a document that highlights affordability strategies. She would like the document to be usable for state policymakers. Rather than being a long white paper, Harris expects the Working Group to produce a series of one- or two-page briefs. The briefs would describe practices underway in states or well-supported by research.

Harris proposed a rough work plan and asked for the group's comments. She said the Working Group would first develop an outline, then form a drafting group, and later release a draft of the collection of briefs by the end of the summer. She said the Working Group would hope to finalize the document by the 2026 Fall National Meeting. Beagan said the Working Group is looking for ideas, whether about benefits or cost inputs. He said the Working Group should work to stay focused once it decides which affordability topics to cover.

Jeff Klein (American Bankers Association—ABA) suggested the Property and Casualty Insurance (C) Committee's Affordability Playbook as a model for the Working Group. Kristen Hathaway (AHIP) said affordability is a top issue for AHIP, and she promised to share materials the organization has already developed.

Kruger said it is appropriate for the Working Group's timeline to be aggressive, and producing a product quickly will be helpful for states like South Dakota that have not developed affordability strategies of their own.

2. Discussed State Affordability and Mitigation Activities

Harris reviewed topics that the Health Innovations (B) Working Group considered over the last several years. She listed presentations on: state affordability efforts collected by the Milbank Memorial Fund; hospital prices; hospital cost tool from the National Academy for State Health Policy (NASHP); hospital facility fees; price transparency; Colorado 1332 waiver; coverage of obesity drugs; prescription formularies; state essential health benefit (EHB) selections; multistate prescription drug purchasing; value-based care from AHIP; Centers for Medicare & Medicaid Services' (CMS) AHEAD model; and private equity in health care.

The Working Group added additional topics for consideration. Beagan said the cost of inputs is a concern in Massachusetts, particularly prescription drugs. He said information from NAIC's pharmacy benefit management (PBM) working groups may be helpful.

Fix said the PBM groups are happy to partner with the Health Affordability and Mitigation (B) Working Group. She added facility fees to the group's list of priorities. Bartuska seconded a focus on facility fees and also mentioned the practice of billing diagnostic or treatment services along with a preventive visit.

Beagan mentioned limited benefit plans as options that can increase choice and reduce costs, even if they are not right for everyone. Beyer suggested prescription drug affordability boards, state actions to address medical debt, and vertical integration as additional topics. Swanson raised the question of the actual cost of care and its relation to the amounts charged to insurers.

Harris asked the Working Group and interested parties to send any additional topic areas by Friday, March 13. She said the Working Group would discuss a draft list of topics during its meeting at the Spring National Meeting.

Having no further business, the Health Affordability and Mitigation (B) Working Group adjourned.

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Adopted by the Health Insurance and Managed Care (B) Committee, March 25, 2026
Adopted by the Regulatory Framework (B) Task Force, March 24, 2026

State Flexibility White Paper

Compiled by the NAIC Health Innovations (B) Working Group (2025) and the Regulatory Framework (B) Task Force (2026)

Contents

Introduction: State and federal roles in regulating health insurance

State insurance regulators have primary responsibility for regulating insurance in the United States, including health insurance. While the Supremacy clause of the Constitution assures that federal law takes precedence over state laws, Congress has recognized and validated states' roles in regulating insurance within specific markets. The McCarran-Ferguson Act of 1945 protects state authority to regulate the business of insurance. Generally, federal law preempts state insurance laws when the state law would prevent the application of a federal law.

Nonetheless, both states and Congress have taken steps to regulate health insurance. States generally supervise solvency, review health insurers' rates and the content of policies, and establish consumer protections for individual and group health insurance markets. Congress reserved for federal regulators the role of regulating self-funded employer health plans through the Employee Retirement Income Security Act of 1974 and the Medicare Modernization Act (MMA) limited the authority of states to oversee Medicare Advantage plans to only.

Over time, federal laws have added requirements for health insurers related to information privacy, availability of coverage, surprise billing, and some benefit mandates, among others.

In 2010, the passage of the Affordable Care Act (ACA) introduced extensive new federal regulations for individual health insurance markets. While maintaining markets in each state, the ACA established requirements in each state's market related to risk pools, enrollment

periods, coverage tiers, benefits, and consumer protections. It also created Marketplaces for consumers with coverage supported by federal premium tax credits (PTCs) for eligible individuals.

While the ACA's reforms apply nationwide, Congress also provided mechanisms in the law for states to alter how the ACA functions on a state-by-state basis. The state flexibility sections of the ACA allow for states, individually or working together, to change how coverage is delivered or waive requirements of the law entirely, as long as the states meet specified criteria. These criteria, often referred to as "guardrails" aim to assure that state flexibility maintains comparable levels of affordability, comprehensiveness, and breadth of coverage as the ACA makes available while not increasing costs to the federal government. Under two of the flexibility sections, states can access federal funding that would otherwise be used for ACA coverage in the state.

Section 1331 of the ACA allows states to contract directly with health plans to cover some individuals who would otherwise qualify for Marketplace coverage. Section 1332 includes broad authority to waive portions of the ACA as long as states meet the guardrails established in the Section. Section 1333 provides a process for states to enter into multistate compacts in order to allow the sale of individual insurance products in multiple states. This paper reviews each of these three sections, summarizing state experiences and offering considerations for states as well as potential recommendations to allow for greater flexibility to improve coverage options within states.

Section 1331 Basic Health Programs

Section 1331 of the Affordable Care Act allows states to create a Basic Health Program (BHP), a health benefits coverage program for low-income residents who would otherwise be eligible for subsidized coverage through the Health Insurance Marketplace. The Basic Health Program gives states the ability to provide more affordable coverage for these low-income residents and improve continuity of care for people whose income fluctuates above and below Medicaid and Children's Health Insurance Program (CHIP) levels.[1] While state legislation is not explicitly required by Section 1331, a state may need to pass a state law to establish authority to operate a Basic Health Program.

[1] Center for Medicare and Medicaid Services, *Basic Health Program,* https://www.medicaid.gov/basic-health-program, accessed September 28, 2025.

Benefits under a Basic Health Program are required by the ACA to include at least the ten essential health benefits specified in the Affordable Care Act. The monthly premium charged to eligible individuals must not exceed what an eligible individual would have paid if he or she were to receive coverage from a qualified health plan (QHP) through the Marketplace and additional limits apply to cost-sharing. A state that operates a Basic Health Program receives federal funding equal to 95 percent of the amount of the premium tax credits that would have otherwise been provided to (or on behalf of) eligible individuals if these individuals enrolled in QHPs through the Marketplace.[2] This amount may cover the costs of a state program, but depending on state circumstances and implementation choices, some additional state funding may be necessary.

Population eligible

Through the Basic Health Program, states can provide coverage to individuals who are citizens or lawfully present non-citizens, who do not qualify for Medicaid, CHIP, or other minimum essential coverage and have income between 133 percent and 200 percent of the federal poverty level (FPL). People who are lawfully present non-citizens who have income that does not exceed 133 percent of FPL but who are unable to qualify for Medicaid due to their non-citizen status, are also eligible to enroll.[3] However, lawfully present non-citizens with incomes below 100 percent of FPL are no longer eligible for premium tax credits beginning in 2026. And many other lawfully present non-citizens—all but those designated "eligible aliens"—will no longer be eligible for premium tax credits beginning in 2027. As a result, federal BHP funding will no longer be available to states for these populations.

Summary of federal statute, regulations, and guidance

Section 1331 of the ACA outlines the requirements for the Basic Health Program. Regulations finalized by HHS in 2014[4] further define the program, while subsequent regulation and guidance have refined the methods for calculating federal payments to states to support their programs.[5]

The law describes how the state contracts with health plans to cover eligible enrollees and the amount of federal payments. The ACA requires a competitive process to select the

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[2] Id. States also receive 95% of any payments the federal government would have made for cost-sharing reductions if the individuals were enrolled in Qualified Health Plans.

[3] Id.

[4] 42 CFR Part 600 and 45 CFR Part 144

[5] See https://www.medicaid.gov/basic-health-program

contracting health plans and provides several factors for consideration in making the contract awards. The statute lays out the process for the Secretary to determine the amount of federal funding for a state program, which includes 95% of the federal payments for premium tax credits and cost-sharing reductions that would otherwise go to Basic Health enrollees. The law also defines who is eligible for enrollment in Basic Health coverage and requires that BHP enrollees pay no more in premiums than they would for the second lowest cost silver plan in their states' marketplaces and no more in cost-sharing than would be applicable in a gold or platinum plan, depending on income.

The final regulation establishes a Basic Health Program Blueprint which states must develop and submit to HHS for certification. The Blueprint defines how the state will operate its Basic Health Program. The rule establishes eligibility and enrollment standards and enrollee financial responsibilities. It requires states to offer at least two plan choices to enrollees, except where it is not feasible to do so.

The 2014 rule set up the initial funding formula for BHPs. Because the amount of funding is tied to premium tax credits and cost-sharing reductions (CSRs), changes to state or federal policy since 2014 that alter PTC or CSR payments have affected the funding available to states with BHPs. The end of federal payments to insurers for CSRs in 2017 eliminated the CSR portion of Basic Health funding. The enhanced premium tax credits authorized in 2021-2025 significantly increased BHP funding for states before the enhanced credits expired. In 2023, HHS established a reinsurance factor in determining BHP funding—this allows states to maintain BHP funding even when they operate a reinsurance program that lowers silver plan premiums and thus PTCs.

State experiences

The experience of the states that have adopted BHPs under the ACA can help guide those that are considering the option. Effective in 2015, Minnesota and New York converted state coverage options that pre-existed the ACA to BHPs, grandfathering in certain provisions. New York in 2024 converted its BHP to a Section 1332 waiver, but has since reverted it back to a BHP, which is discussed further below. Oregon launched a new BHP in July 2024 and the District of Columbia established a new BHP in 2026.

Minnesota

MinnesotaCare offers comprehensive and affordable health insurance coverage for Minnesota children, parents, and adults without children. MinnesotaCare was established as a state-run program in 1992 to provide coverage for children and parents who were not eligible for Medicaid but still required financial assistance with health coverage.

In 2015, Minnesota became the first state to take up the Basic Health Program option, sunsetting its Section 1115 Medicaid waiver and converting coverage to the Section 1331 option. In the first full fiscal year that the program was operational, federal funding covered 70% of MinnesotaCare's costs[6].

MinnesotaCare covers adults ages 19-64 with incomes between 134-200% FPL who don't have access to other types of insurance, and legal immigrants including children in families with income from 0-200% of FPL who are otherwise not eligible for Medicaid.[7]

MinnesotaCare provides coverage to people who don't have access to employer-sponsored insurance and today continues to require that enrollees have no such access[8].

In 2024, MinnesotaCare covered 101,900 Minnesotans on average each month, about 60% of them adults without children, and the remainder families with children[9].

MinnesotaCare is administered by the Minnesota Department of Human Services, which is also the state's Medicaid agency. In compliance with BHP regulations, MinnesotaCare is administered through managed care, as was its predecessor state program. Rates paid to providers in the program mirror the rates paid in the state's Medicaid program (Minnesota Statutes 256L.11 Subd. 1). MinnesotaCare's benefit set mimics Minnesota's Medicaid benefits including things like behavioral health care, eyeglasses, and dental coverage, but excluding benefits such as waivered services and coverage for long-term care. MinnesotaCare lowered premiums from a maximum payment of $80 to $28 per month due to increased federal funding available from enhanced premium tax credits.

When MinnesotaCare was established, so too was the Health Care Access Fund (HCAF), a state account that receives revenue from a statewide tax on hospitals and other providers. The provider tax, then set at 2% of gross receipts, provided additional funding for MinnesotaCare and included providers and a premium tax on HMOs. The tax rate and base have varied over the years, but it remains a funding source for the non-federal share of BHP costs.

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[6] Minnesota Management and Budget. "BHP Trust Fund - February 2025 Forecast." 2025. https://mn.gov/dhs/assets/BHP_Trust_Fund_Feb25_tcm1053-671717.pdf.

[7] Minnesota Department of Human Services. "Minnesota Health Care Programs Eligibility Policy Manual." 2025. https://hcopub.dhs.state.mn.us/epm/3.htm.

[8] Id.

[9] Minnesota Department of Human Services, Reports and Forecasts Division. "February 2025 Forecast." 2025. https://mn.gov/dhs/assets/forecastDHS_202502_tcm1053-671523.pdf.

In SFY2024, federal funds covered about 87% of the state's MinnesotaCare costs. That is expected to change over the next four federal fiscal years, with a projection of federal funds covering 75% of costs in SFY29[10].

New York

New York's Essential Plan provides low cost coverage to New Yorkers with income above Medicaid limits and those ineligible for Medicaid due to Medicaid's five year bar for immigrants. Prior to the ACA, New York covered individuals with income up to 150% of the FPL and lawful immigrants not eligible for Medicaid in the state's Family Health Plus program. The Basic Health Program allowed the state to access federal funds to cover those previously served by Family Health Plus as well as a wider set of eligible enrollees. New York has expanded eligibility and shifted funding mechanisms in recent years to maintain affordable coverage for New Yorkers and respond to federal funding limits.

The Essential Plan covers New Yorkers under age 65, not eligible for Medicaid and CHIP, without an affordable offer of coverage, up to an income limit of 250% of FPL (increased from 200% in 2024). The plan charged premiums of $20 per month to enrollees above 150% of FPL until 2021, when it eliminated all premiums. There are no deductibles and limited cost-sharing only for individuals over 150% of FPL.

New York's Medicaid agency administers the Essential Plan and contracts with health plans to deliver it, largely overlapping with the health plans that provide Medicaid managed care. Provider payments started somewhat above Medicaid rates and have increased since 2021.

Due to state-specific circumstances, federal funding has covered the cost of New York's BHP and generated a surplus in the state's BHP trust fund. In 2024, New York transitioned its BHP to a Section 1332 waiver. This change allowed the state to raise the Essential Plan's eligibility threshold to 250% of the FPL, offer state subsidies for certain Marketplace enrollees, and provide reimbursement to insurers to adjust for the transition of enrollees between 200% and 250% of FPL out of the Marketplace and into the Essential Plan.

In October 2025, New York submitted a request to CMS to terminate the Section 1332 waiver and return the Essential Plan to a BHP. The state identified federal changes to premium tax credit eligibility for lawful immigrants as the reason for the change, saying associated reductions in waiver pass-through funding would leave the state with unsustainable funding obligations.

[10] Minnesota Management and Budget

Oregon

Oregon launched the Oregon Bridge Plan in 2024. The state sought to maintain coverage gains from the pause in Medicaid eligibility redeterminations during the COVID-19 public health emergency and reduce churn of consumers on and off of Medicaid.

Oregon's BHP covers consumers with income between 138% and 200% of the FPL. The benefits are almost identical to those in Medicaid, covering adult dental benefits in addition to the essential health benefits.

Oregon uses its Medicaid managed care entities to administer the plans and initially uses Medicaid-level provider payment rates. The state plans to reconsider payment rates as funding allows.

The state's actuarial analysis showed that the individual market would remain stable and healthy despite the transition of consumers to the BHP, though consumers with income greater than 200% of FPL would pay more in premiums due to decreased silver loading (see Individual Market Effects below). While Oregon considered several proposals to mitigate the impact of higher individual market premiums, it determined none were feasible.

District of Columbia

The District of Columbia received approval in 2025 to move Medicaid-enrolled adults and caregivers with incomes above 138% of FPL to a Basic Health Program, referred to as the Healthy DC Plan. Through 2025, DC covered childless adults in Medicaid up to 210% of the FPL and parents/caregivers up to 216%.

The Basic Health Program allows DC to access greater federal funds as it makes the Healthy DC Plan available to enrollees up to 200% of FPL. These consumers will pay no premiums or cost-sharing. Consumers with incomes above 200% of FPL will transition to Marketplace plans with premium tax credits.

DC's Health Benefit Exchange (Marketplace) administers the Healthy DC Plan and contracts with three managed care plans to offer coverage, each of which participate in Medicaid managed care.

Considerations for consumers, states, and insurance markets

Basic Health Programs have the potential to impact consumer costs both for those who enroll in the BHP and for Marketplace consumers who do not. BHPs require administration by state agencies and potential investment from the state budget. States evaluating the

establishment of a BHP should weigh a range of considerations to determine the most appropriate choice given state-specific circumstances and priorities.

Consumer coverage impacts

BHPs offer an opportunity to provide moderate-income consumers with coverage that is as or potentially more affordable than they could find through the Marketplace. They also have the potential to ease enrollment and coverage transitions for consumers, particularly those whose income fluctuates between the Medicaid and premium tax credit ranges.

Federal law requires that BHP premiums be no more than consumers would face for a benchmark Marketplace plan with cost-sharing limited to the level of gold and platinum plans. In practice, however, states with BHPs have offered coverage that is substantially more affordable, both in premiums and cost-sharing, than required by the law. DC, New York, and Oregon offer BHP plans with no premiums and no or minimal cost-sharing. Minnesota applies premiums only to consumers with incomes at the higher range of eligibility and cost-sharing lower than Marketplace plans, with some enrollees exempt from cost-sharing.

Enrolling and maintaining enrollment in a BHP is likely to be simpler for consumers than enrollment in a Marketplace plan with premium tax credits. Marketplace enrollment requires selection of a plan, often from dozens of choices at differing metal levels, and reconciliation of premium tax credits at tax time. States have chosen to operate BHPs more like Medicaid managed care, with longer periods of continuous enrollment, limited plan choices, and no reconciliation requirement.

BHP networks and benefits, too, are often more similar to Medicaid than Marketplace plans. When Medicaid managed care entities contract to provide Basic Health coverage, they often use the same networks. Benefits must include essential health benefits, but states may add additional benefits, such as adult dental and vision services.

The establishment of a BHP can also affect affordability for consumers who enroll in Marketplace plans—see the Individual Market Effects section below.

State considerations

Budget

Federal funding under the BHP formula is available to cover a substantial portion of a state's BHP costs. State funding, however, may be necessary to make up any difference between available federal funds and the costs of a BHP. Due to the link between BHP funding and premium tax credits, policy changes that increase PTCs offer states greater BHP funding and

reduce the need for state dollars, while decreased PTCs lower federal support for BHPs and increase state spending.

States have been able to offer more affordable and more robust coverage through BHPs than is available in their Marketplaces by using provider payment rates closer to those used in Medicaid than the commercial rates paid by Marketplace plans. The gap between lower Medicaid rates and higher Marketplace provider payment rates determines how much "room" a state has to increase the generosity of BHP plans relative to Marketplace plans. States with higher provider payments in Marketplace plans, and thus higher Marketplace premiums and PTCs, are more likely to be able to fully fund a BHP with 95% of PTCs that would otherwise be paid on behalf of enrollees. The size of the gap is also determined by a state's choice of provider payment levels in the BHP—states that pay a multiple of their Medicaid rates may need to invest greater state funds to cover BHP costs.

States considering a BHP should plan for the possibility of changes to their BHP funding due to changes in the PTC amounts (and cost-sharing reduction payments, if any) paid in their states. The 2017 federal decision to end cost-sharing reduction payments removed these funds from BHP funding, though the BHP funding formula was subsequently adjusted to account for this change. The enhanced premium tax credits enacted in 2021 increased federal funds for BHPs, but the increase was temporary with the enhanced credits expirng in 2025.

Medicaid and Marketplace roles in implementation

While the eligibility criteria for BHP enrollment mirror those of premium tax credits for Marketplace coverage, many of the potential benefits of a BHP for consumers and states stem from the similarity of BHP coverage with Medicaid. For consumers, Medicaid-like affordability and benefits can make BHP coverage more favorable than Marketplace coverage. For states, using Medicaid as a starting point for provider payment rates, health plan contracting, eligibility determinations, and other program administration can offer efficiencies and cost savings in operating a BHP.

A state contemplating a BHP, then, should consider the extent to which it can align rules between Medicaid and the BHP. Since BHP funding cannot be used for administrative costs, states should consider the resources available to implement the eligibility updates required by administration of a BHP.

BHPs have the potential to ease coverage transitions for consumers whose eligibility shifts between Medicaid, BHP, and Marketplace coverage. This may be most likely to be achieved in a state with a state-based Marketplace, so Medicaid, BHP, and Marketplace systems can

more easily coordinate with each other. Nonetheless, Oregon has implemented a BHP while using the federal platform for Marketplace eligibility.

Individual market effects

States, especially state insurance regulators, should consider the effects of a BHP on a state's market for individual coverage. BHPs serve individuals who would otherwise be eligible for Marketplace coverage and for cost-sharing reduction plan variations since their incomes are between 138% and 200% of the federal poverty level. Covering this population in a BHP removes them from the individual market risk pool and can affect costs and market stability for the remaining risk pool.

One way a BHP alters a state individual market is through muting the effects of silver loading. Through silver loading, insurers add to silver plan premiums the cost of providing enhanced actuarial value plans to lower-income consumers. The higher silver plan premiums raise premium tax credits, making bronze and gold plans more affordable for subsidized consumers (subsidized consumers' costs for silver plans are unchanged since PTCs rise with their premiums). With a BHP, Marketplace plans don't cover individuals with income below 200% of the FPL, the enrollees eligible for silver plan variations with 87% or 94% actuarial value. The silver load in BHP states only needs to account for the 73% actuarial value plans available for consumers with income between 201% and 250% of the FPL. This minimal silver load reduces the affordability boost for bronze and gold plans that would be available in the absence of a BHP. So the BHP reduces affordability for some higher-income Marketplace enrollees at the same time it can provide more generous coverage for those enrolled in the BHP. The size of this effect varies with state circumstances, so states should evaluate the impacts and weigh how the coverage and affordability benefits for lower-income consumers compare to added costs for those with greater incomes.

Covering consumers with income below 200% of FPL in a BHP also reduces the size of the individual market. And if those who become eligible for a BHP are significantly more or less in need of health care services than others in the individual market, the individual risk pool could see improvement or deterioration. A less healthy risk pool could raise premiums for unsubsidized consumers, particularly for those over 400% of FPL do not qualify for subsidies with the expiration of enhanced PTCs. Changes in the size and health status of the risk pool could also lead insurers to reconsider their participation if the market is too small or too risky for their business goals.

Section 1332 State Innovations Waivers

Summary of statutes, regulations, and guidance

Section 1332 of the Affordable Care Act (ACA) allows states the flexibility to pursue innovative approaches to high-quality health care coverage by waiving certain ACA provisions. These waivers, referred to as State Innovation waivers, allow states to adapt coverage options to meet the needs of their states while still retaining the ACA's basic consumer protections. Section 1332 of the ACA provides that "State legislation" must grant the authority to implement the law.[11]

Only certain provisions of the ACA are deemed waivable. They include:

- Requirements for QHPs (42 U.S.C. §§ 18021 – 18024)
- Provisions relating to Exchanges, including requirements for plans, enrollment periods, navigators, and establishing a single risk pool for markets (42 U.S.C. §§ 18031-18033)
- Cost sharing reductions for low-income individuals (42 U.S.C. § 18071);
- Provisions relating to Premium Tax Credits (26 U.S.C. § 36B); and
- The requirement for large employers (that is, employers with more than 50 employees) to provide coverage and accompanying tax penalty if they do not (26 U.S.C. § 4980H).

Provisions that cannot be waived by a 1332 waiver include guaranteed issue requirements, age rating, and prohibitions on use of health status and gender rating.

Guardrails and the limitations they introduce

In order to receive approval from the Department of Health and Human Services (HHS) and the Treasury Department, states must meet four statutory guardrails.

- **Comprehensiveness:** Coverage must be at least as ***comprehensive*** as coverage without the waiver.
- **Affordability:** The state plan must provide coverage and cost-sharing protections as ***affordable*** as coverage available to people absent the waiver.
- **Comparable Number of Insured:** ***The number of people with health coverage must be comparable*** with the waiver in place to without the waiver.

[11] 42 U.S.C. § 18052, available at https://www.law.cornell.edu/uscode/text/42/18052.

- **Deficit-Neutrality:** The waiver must be ***deficit-neutral*** to the federal government over ten years.[12]

The guardrails provide strong, clear guidance to ensure that state reforms meet federal standards and do not result in a race to the bottom. However, when combined, they may also provide limits on the types of innovation that states can pursue under the 1332 waiver option. For example, expanding the number of people covered while maintaining or improving affordability and comprehensiveness is likely to increase expenditures, and thus violate the deficit neutrality guardrail without the addition of state funds. If a waiver satisfies the guardrails, it is subject to HHS and Treasury discretion on whether to approve a state's application.

Funding and applications

States can potentially access federal funds to support their waiver plans. If a waiver's policy changes result in lower federal spending on Marketplace subsidies, the state can generally receive those savings as "pass-through funding." One way to reduce federal subsidy costs is to reduce individual market premiums. Pass-through funding can be used to fund the costs of implementing the waiver, for example reinsurance program payments or a state subsidy program. States must supply their own funds for any waiver costs that exceed their pass-through funding.

To assure compliance with the statutory guardrails and determine accurate pass-through funding amounts, Section 1332 comes with substantial procedural requirements for states. States must complete a detailed application with actuarial analysis demonstrating how the guardrails are maintained. They must commit to ongoing reporting and coordination regarding waiver outcomes and any state policy changes that may affect the waiver.

State experiences

Twenty-one states have applied for and successfully received section 1332 waivers – in fact, some states have multiple waivers. Most states have waivers leveraging federal pass-through funds to support reinsurance programs for individual market stability. A handful of states have sought further market reforms through section 1332 waivers – including Colorado, Washington, Nevada, and New York (New York's waiver and its current status are

[12] See United States of Care, Using 1332 Waivers to Promote Access to Affordable Coverage, updated February 2025, available at: https://unitedstatesofcare.org/wp-content/uploads/2023/05/1332-Chart.pdf.

discussed in more detail above as part of the 1331 Section). However, several states have been denied section 1332 waivers for proposed reforms, or have received determinations that their applications were incomplete.

Reinsurance waivers and related state choices

The most common use of 1332 waivers to date has been to allow operation of state-based reinsurance programs. Through reinsurance, insurers with high-cost enrollees receive payments from the reinsurance program to offset some of their spending for these enrollees. These payments allow for lower base premiums.

As of 2025, 19 states operate state-based reinsurance programs by waiving the single risk pool requirement under section 1312(c)(1) of the ACA to the extent that it would otherwise require excluding total expected state reinsurance payments when establishing the market-wide index rate.[13] Most states use a claims-based model, where qualifying insurers are reimbursed for a percentage ("coinsurance rate") of an enrollee's claims costs exceeding a specified threshold ("attachment point") and up to a specified ceiling ("reinsurance cap"). Alaska uses a conditions-based model, where insurers are reimbursed for all medical and prescription drug costs of enrollees with one or more of pre-determined high-cost conditions. Idaho uses a hybrid conditions and claims cost-based model for its section 1332 state-based reinsurance program.[14,15]

The scope and impact of a reinsurance program is dependent on the amount of state funding that states use to leverage further federal passthrough of savings. CMS' analysis of the impact of section 1332 state-based reinsurance programs demonstrate high success in the ability of such programs to retain insurers and reduce rates in the individual market.[16]

Reinsurance Example: Colorado

Colorado's approved 1332 waiver consists of two programs that reduce individual market premiums. Program one, the reinsurance program, has operated under a Section 1332

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[13] CCIO Data Brief on State Innovation Waivers: Section 1332 Waivers, April 2024, available at https://www.cms.gov/files/document/cciio-data-brief-042024-508-final.pdf.

[14] Maine also used a hybrid program from plan years 2019-2021, *see id*.

[15] Daniel Meuse, Section 1332 Innovation Waivers in the New Federal Paradigm, presentation to NAIC Health Innovations Working Group, April 22, 2025. Another source for further summaries and analysis of state reinsurance waivers is State Health Access Data Assistance Center (SHADAC). Resource: 1332 State Innovation Waivers for State-Based Reinsurance [Internet]. University of Minnesota, Minneapolis (MN) [cited November 8, 2025]. Available from: https://www.shadac.org/publications/1332-state-innovation-waivers.

[16] See https://www.cms.gov/files/document/cciio-data-brief-042024-508-final.pdf.

waiver since 2020. Program two, the Colorado Option program, began implementation in Plan Year 2023 and includes a standardized health insurance plan and required premium reduction targets. Colorado generated $339,125,752 in 1332 waiver pass-through funding in 2025.

Colorado House Bill 19-1168 established the state-based individual market reinsurance program starting in plan year 2020. The reinsurance program uses a tiered payment parameter structure to emphasize savings for certain areas of the state that have historically had the highest rates by paying more toward consumer claims in higher cost areas. For example, Tier 2 (the Eastern Plains) and Tier 3 (the Western Slope) receive higher coinsurance rates to achieve higher premium reductions relative to Tier 1 (the Denver Metro). A claims-based attachment point reimbursement model is used to reimburse issuers annually following the applicable plan benefit year. Colorado's 1332 waiver reinsurance program will have saved Coloradans over $2.1 billion between 2020 and 2025.

Reinsurance Example: Wisconsin

Wisconsin's initial Section 1332 waiver was approved in July, 2018, for January 1, 2019-December 31, 2023. Then, Wisconsin received a 5-year waiver extension that runs January 1, 2024-December 31, 2028. Through its 1332 waiver, Wisconsin operates a reinsurance program called the Wisconsin Healthcare Stability Plan (WIHSP). The goal of WIHSP is to create a stable individual insurance market where consumers have a choice of health plans. It aims to maintain affordability of premiums by reimbursing insurers for a portion of any claims that exceed an attachment point in a given plan year. State law requires the commissioner of insurance to set payment parameters to define the portion of insurer costs that WIHSP reimburses each year by May 15th before the applicable plan year. For plan year 2024, 15 individual market insurers received reinsurance payments. The total budget for WIHSP payments is $265 million per year which is comprised of the federal pass-through and state general funds. The amount of state funding that goes into the WIHSP budget each year varies based upon the level of federal pass-through received. The annual federal pass-through has ranged from $127 million to $229 million with required state funds ranging from $0 to $47 million.

Other Approved 1332 Waivers

In recent years, several states have used 1332 waivers in ways to impact the individual market beyond reinsurance. Colorado's experience is described in more detail below. Other states that have recently sought and received approval for innovations beyond reinsurance include Nevada and Washington.

Colorado Option Program

The Colorado General Assembly passed House Bill 21-1232 in June 2021 to create the Colorado Option program and to allow the state to apply for a 1332 waiver amendment to capture pass-through savings generated from the Colorado Option. The driving principles of the Colorado Option program are to make health insurance in the individual and small group markets more accessible and affordable.

To support these goals, the Colorado Option program creates a standardized health benefit plan offered in the individual and small group markets. Issuers must offer Colorado Option Plans at the bronze, silver, and gold metal levels in all counties where they offer non-Colorado Option plans. Colorado Option plans captured 47% of all enrollments on Colorado's state-based exchange during Plan Year 2025 open enrollment.

Health insurance companies are also required to reduce premiums on Colorado Option plans. These premium rate reduction requirements, which rely on the 1332 waiver authority, are incorporated into "target premiums" each year for issuers. These targets establish the measure, or "trigger", by which a Colorado Option public hearing may be initiated. In cases where issuers fail to meet their targets, the Commissioner of Insurance is authorized to hold a public hearing to investigate the reasons why premiums remain above the targets. These premium rate reduction targets and the associated public hearing process give the Commissioner of Insurance the ability to set a reimbursement rate between an issuer and hospital/health-care provider for Colorado Option plans, which then passes on savings to consumers in the form of lower premiums. Lower premiums generate savings to the federal government in premium tax credits and these savings become pass-through funds for the state.

The Premium Rate Reduction and public hearing process encouraged carriers and hospitals to lower reimbursement rates for Colorado Option plans without the need for formal legal proceedings, and therefore the Commissioner vacated adjudicatory hearings for the Plan Years 2024 through 2026 Premium Rate Reduction processes." [17]

Waivers Applied for But Not Approved

A handful of states have applied for section 1332 waivers that have not been implemented – either due to the state withdrawing the application, the federal government determining

[17] Colorado Division of Insurance, ACA Section 1332 Waiver Reinsurance & Colorado Option Programs, December 12, 2024.

that an application was incomplete or could not be approved, or receiving a suspension of the waiver. Examples of these applications are below.

Georgia

Georgia originally received approval for its section 1332 waiver in November 2020 effective for Plan Year 2022. This waiver included a reinsurance program ("Part I") and the Georgia Access Model ("Part II"), which would have replaced the Marketplace in the state with a system under which private entities such as carriers, web-brokers, and agents would provide marketing, outreach, and the front-end shopping experience for consumers.[18] However, the federal administration changed from the Trump Administration to the Biden Administration in January of 2021, and in June 2021, CMS sent correspondence to Georgia requesting updated analyses on Part II of its waiver in light of new federal priorities and guidance. On August 9, 2022, CMS suspended implementation of the Georgia Access Model, citing a lack of compliance with the coverage guardrail that requires that the number of people with health coverage be comparable with the waiver as without the waiver. Georgia subsequently moved to establish Georgia Access as a state-based Marketplace, which was approved in September of 2024.[19]

Iowa

On August 21, 2017, Iowa submitted a 1332 State Innovation Waiver application, known as the Iowa Stopgap Measure, to the U.S Treasury Department and the U.S. Department of Health and Human Services. The Iowa Stopgap Measure was designed to stabilize Iowa's Affordable Care Act (ACA)–compliant individual market through a series of modifications: (1) a requirement that all insurers in the individual market offer a single standard plan, similar to the ACA's silver plan; (2) elimination of CSR subsidies for those with incomes between 200 and 250 percent of the federal poverty level (FPL); (3) a new premium tax credit structure (tax credits would vary by age and income and would be extended to

[18] Fact Sheet – Georgia: State Innovation Waiver under Section 1332 of the PPACA, November 1, 2020, available at https://www.cms.gov/cciio/programs-and-initiatives/state-innovation-waivers/section_1332_state_innovation_waivers-/1332-ga-fact-sheet.pdf.

[19] The Centers for Medicare and Medicaid Services greenlights Georgia's transition to a state-based healthcare exchange, Georgia Access

individual market enrollees with incomes above 400 percent of the FPL); and (4) federally funded reinsurance on all annual individual market claims above $100,000.[20]

Iowa submitted additional information to address CMS questions regarding the Measure's compliance with the 1332 guardrails. However, after additional questions and information from CMS regarding the limits of available federal funding, in October of 2017, Iowa's Insurance Department submitted a letter of withdrawal for its 1332 waiver application, indicating that 1332 waivers are not designed to fix the collapsing individual market and that Congress needed to pass legislation to address the circumstances.[21]

Considerations for consumers, states, and insurance markets

Reinsurance

Consumer coverage impacts

State-based reinsurance programs have successfully lowered base premiums, aiding in the affordability of coverage for some consumers, generally those who do not qualify for premium tax credits. At this point, the waivers are relatively straightforward in design, meet the ACA's statutory guardrails, and may improve issuer participation and reduce year to year volatility.

However, premium tax credits insulate many lower income individual market enrollees from base premium costs. Consumers who are eligible for premium tax credits may not always see direct benefit from a reinsurance program, depending on the structure and scope of the program.

Budget

A key consideration for states is how to fund the state share of reinsurance costs. Reinsurance program costs are determined by the program structure and the claims experience of participating insurers, while federal pass-through funds are set by the amount of premium reduction a reinsurance program is expected to achieve. The state is responsible for covering any difference between the program costs and available federal pass-through funds.

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[20] Nowak, Sarah A., Preethi Rao, Jodi L. Liu, and Christine Eibner, The Effects of Iowa's Proposed Stopgap Measure on Health Insurance Costs and Coverage. Santa Monica, CA: RAND Corporation, 2017. https://www.rand.org/pubs/research_reports/RR2228.html.

[21] Letter available at https://www.cms.gov/cciio/programs-and-initiatives/state-innovation-waivers/downloads/ia-letter-withdraw-1332-waiver.pdf.

The share of costs covered by federal funds varies by state and by year depending on state-specific factors and changes in policy. Federal funds can cover virtually all a state reinsurance program's costs or less than half. If other factors are held equal, federal funding for reinsurance waivers is larger where a larger share of enrollees received PTCs. Policies that increase premium tax credits due to state residents, such as the enhanced premium tax credits, boost the pass-through funds available to a state. Conversely, a reduction in premium tax credits (except for those resulting from the waiver itself) limits the pass-through funds.

States have chosen different methods for funding their state share of costs. About half of reinsurance programs use assessments on health insurance premiums. Other states use broader premium taxes, general funds, shared responsibility payments (individual mandate penalties), or a mix of these sources.

The continued success of reinsurance waivers depends on stable state and federal financing and clear guidance on future pass-through funding levels.

Other waiver types

States have used the flexibility of section 1332 waivers to make other changes in their health insurance markets. Hawaii was the first state to implement a section 1332 waiver; it replaced the ACA's Small Business Health Options Program (SHOP) with its pre-existing employer coverage program. Colorado (as described above) and Nevada require Marketplace insurers to meet premium reduction targets in addition to their reinsurance programs. Washington offers access to Marketplace coverage regardless of immigration status, without changing eligibility for federal premium tax credits. These uses show that section 1332 can be used for specific state objectives, provided the state meets the guardrails established in federal law.

Section 1333 Health Care Choice Compacts

Background

Summary of statute and 2019 request for information

Section 1333 of the Public Health Service Act, codified at 42 USC §18053, establishes statutory authority for states to create "health care choice compacts" (HCC Compacts)". The law directs HHS/CMS, in consultation with NAIC, to issue regulations for the creation of these compacts. The regulations are required under section 1333 to authorize two or more states to enter into an agreement where a qualified health plan could be sold in the

individual markets of all the states and only be subject to the laws and regulations of the state where the plan is written or issued. Section 1333 clarifies that such health care choice compacts are also subject to the following requirements:

- A state must be **authorized by state law** to enter into a health choice compact;
- A compact must provide coverage that is at least as **comprehensive** as essential health benefits and offered through Marketplaces;
- A compact must provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as **affordable** as those under federal law;
- A compact must provide coverage to at least a **comparable** number of its residents as would be provided under federal law;
- A compact **may not increase the Federal deficit**; and
- A compact **may not weaken state enforcement** of market conduct, unfair trade practices, network adequacy, and consumer protection standards (such as rate review), and disputes arising under the contract of the state where the purchaser resides.

Thus, HCC Compacts under section 1333 must meet similar guardrails to waivers approved under section 1332, with the additional caveat that state consumer protections where the purchaser of insurance resides cannot be weakened. Section 1333 also does not contemplate states receiving pass-through funding, unlike section 1332 waivers.

CMS released a Request for Information on HCC Compacts in March 2019. At that time, NAIC commented that states already have authority to permit sales of non-domiciled plans to their residents and thus, separate federal authority to do so was not needed. The comments noted concern about the risks of market instability if plans were sold across state lines and stated that federally-directed sales of health insurance coverage across state lines would frustrate the ability of state insurance regulators to fulfill one of their central obligations—to provide protection and counsel to insurance consumers in their states. CMS did not at that time follow up with proposed regulations.

On June 30, 2025, CMS sent a letter to NAIC President Jon Godfread seeking input to inform the development of Section 1333 regulations. The NAIC responded in a letter to CMS on October 2, 2025. In that letter, the NAIC emphasized that state regulators value the flexibility available under the Affordable Care Act, which allows state regulators to respond to individual market characteristics that are best managed at the state level. NAIC held that federal regulations that allow states to maintain flexibility in state or compact decision-making will ensure their effectiveness in guiding the development of compacts.

Comparison with other multi-state compact authority

The National Center for Interstate Compacts at the Council of State Governments maintains a database of enacted Interstate Compacts. The database currently contains 271 Interstate Compacts, covering a wide range of policy areas, from setting boundaries between states, to water rights and disaster response among many other areas. The Council notes that benefits of compacts may include the following:[22]

- Providing state-developed solutions to shared and complex policy
- Settling interstate disputes
- Responding to national priorities in consultation or partnership with the federal government
- Helping states maintain sovereignty in matters traditionally reserved for the states
- Creating economies of scale to reduce administrative costs
- Addressing regional issues that affect multiple states

The multi-state compact most familiar to insurance regulators is the Interstate Insurance Product Regulation Commission (IIPRC). IIPRC allows for multi-state approval of annuity, life insurance, disability income, and long-term care insurance products. Each of these are fixed indemnity products that are largely independent of state-specific market considerations. Insurers pay a fixed indemnity payment amount to (or on behalf of) a consumer and the amount of the payment is not tied to the cost or network participation of a service provider. IIPRC describes its history on its website[23]:

> The IIPRC was created and established as a "joint public agency" by Compacting States that enacted the Interstate Insurance Product Regulation Compact (Compact Statute). The Compact Statute delegates to the Commission a limited regulatory function traditionally within state insurance departments, that is, to accept, review, and approve or disapprove individual and group annuity, life insurance, disability income, and long-term care insurance products submitted by insurance companies for use in Compacting States. The Commission adopts Uniform Standards, Rules and filings requirements constituting the exclusive provisions applicable to the content and approval of such products, rates and advertising on behalf the Compacting States.

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[22] CSG National Center for Interstate Compacts, "Frequently Asked Questions," available at https://compacts.csg.org/faq/.

[23] Interstate Compacts and the Insurance Compact, https://www.insurancecompact.org/about/faq.

> The IIPRC came into existence in March 2004, when it was enacted into law by the first state, Colorado, creating an offer to its sister states and then by the second state Utah, constituting an acceptance of the Compact. Article XIII, Section 2 of the Compact Statute required enactment by twenty-six (26) Compacting States or, alternatively, by States representing greater than forty percent (40%) for the Commission to become operational. Both of these operational thresholds were met in May 2006 and 27 Compacting States held the Commission's inaugural meeting in June 2006. The Commission's product operations commenced in June 2007, when the first product filing was submitted, and was approved in July 2007. As of May 16, 2022, 44 states, the District of Columbia, and Puerto Rico (46 Compact Member Jurisdictions) representing approximately 75% of the nationwide premium volume for asset-based insurance products have adopted over 100 Uniform Standards covering all individual product lines and several employer/employee group products.

In the years following the passage of the Affordable Care Act, an organization called "Competitive Governance Action" proposed a "Health Care Compact."[24] The purpose of the Health Care Compact was to restore "authority and responsibility for health care regulation to the member states."[25] It would allow member states to enact legislation to suspend the operation of all federal laws, rules, regulations and orders regarding health care that are inconsistent with the laws and regulations adopted by the member state pursuant to the compact. It would also give member states the rights to federal funds in an amount equal to total spending on health care in the member state during federal fiscal year 2010.[26] Nine states[27] adopted legislation authorizing them to enter into the Compact, but no further action to receive Congressional consent or otherwise stand up the compact has taken place.

Section 1333 of the ACA establishes a somewhat different model of compact in that it requires approval by a federal official, the Secretary of Health and Human Services.

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[24] Health Care Compact, website, available at https://www.healthcarecompact.org/about.html.

[25] CSG National Center for Interstate Compacts, "Health Care Compact." available at https://compacts.csg.org/faq/.

[26] Health Care Compact website, "The Problem & Solution" available at https://www.healthcarecompact.org/about.html

[27] CSG National Center for Interstate Compacts, "Health Care Compact" available at https://compacts.csg.org/faq/.

Considerations for consumers, states, and insurance markets

Potential areas of regulation impacted by HCC compact

HCC Compacts, as outlined in the ACA, are subject to a number of restrictions, including application only to qualified health plans in the individual market. Potential areas of regulation could include mandated benefits (so long as essential health benefits continue to be met), and plan standards, such as plan design (so long as other guardrails continue to be met).

Section 1333 of the ACA also makes clear what state regulatory authority cannot be weakened under such a compact:

- market conduct
- unfair trade practices
- network adequacy
- consumer protection standards (such as rate review), and
- disputes arising under the contract of the state where the purchaser resides.

Additionally, a plan issued under a section 1333 Compact must be licensed in each state or voluntarily submit to each state's regulatory authority. It must also clearly notify consumers that the policy may not be subject to all of the laws of the state where the consumer lives.

Pros and cons for states

Multi-state compacts under Section 1333 could allow a range of market adjustments, from offering the same qualified health plan across multiple states to greater integration of multiple states' markets. While the precise parameters of Section 1333 compacts have not been defined, they could potentially add to market stability, encourage more market participants, and give insurers greater leverage to negotiate better rates.

In its October 2025 consultation letter to CMS, the NAIC noted that state flexibility and input will be paramount in making Section 1333 waivers effective. NAIC cautioned against federal regulations that limit how states work together to harmonize differing rules, how a compact is governed, and how a compact is funded.

Given the extensive federal regulation of qualified health plans under the ACA, states may value greater ability to set QHP standards and certification processes, even without a state-based marketplace. As noted in the NAIC's 2025 letter to CMS, flexibility is very important to states when discussing both section 1332 and section 1333 waivers. Consumer protection is of paramount importance to state insurance regulators, and a key element of

the Section 1333 compact is that plans offered across state lines would continue to be subject to important consumer protection laws in each state in which they are offered.

The potential for state flexibility and increased stability for plans offered in the individual market are some of the more attractive features of a Section 1333 compact. States may be able to minimize the impact of certain federal level policy changes by relying on state or compact-defined standards for qualified health plans, rather than federal standards. However, the extent to which a Section 1333 compact would allow plans to avoid federal standards is uncertain.

States that are part of a Section 1333 compact may be able to work together to develop plans that meet the unique needs of the member states and may be more nimble in responding to threats to the stability of the individual market, like significant network changes. Furthermore, states participating in a Section 1333 compact would also be able to closely coordinate changes to consumer protection and market conduct laws to minimize the impact of state level policy changes on the Section 1333 compact plans.

However, maintaining a nimble and coordinated compact would require an effective and flexible governance structure for the compact itself. An effective compact would require long-range planning and cooperation between governors, state agencies and legislatures. Legislatures in particular may require multi-year lead times in developing new policy. Thus, creating a smoothly functioning compact will require a concentrated, coordinated effort over a several year period, with no funding currently identified to support these efforts.

In contrast with the insurance products reviewed and approved by the IIPRC, health insurance often depends on state-specific factors. Rather than an indemnity model, comprehensive health insurance operates on an expense-incurred model and relies on localized provider contracting and networks. State policymakers may wish to retain more authority over health insurance policy and regulation than they have over the life, disability, and long-term care insurance handled by IIPRC.

The biggest unknown about the Section 1333 compact today is the lack of federal regulations outlining specifics. States would gain greater clarity if CMS defines the scope of flexibility granted, specifies whether the four guardrails shared with Section 1332 will be interpreted the same way, and provides more information on the guardrail on consumer protections. States will also require details about the approval process by CMS, funding, and procedural issues. These outstanding questions are also a significant deterrent to states that may be contemplating a compact under Section 1333.

Discussion, including combining state flexibilities

Each of the provisions discussed above offers states some flexibility to design coverage options that meet their specific needs. Below are potential areas where federal guidance could assist in greater state flexibility aligned with greater opportunities for consumer protection.

Section 1331 Basic Health Programs offer important flexibilities and federal funding opportunities for states to design coverage options that best suit their state needs. However, they may also have adverse impacts on individual markets and on individual market participants above 200% FPL by removing healthier lives from the risk pool in the individual market.

Section 1332 waivers have been used widely to provide individual market stability and in more recent years, have been used to implement innovations that address coverage needs of states. However, consistent interpretation of guardrails is needed, as is greater certainty and transparency surrounding the process for pass-through calculations.

Section 1333 waivers have not yet been implemented. Some have argued that standards for an individual market plan offered through a compact put regulation of state insurance products beyond federal changes and offer insurers, consumers, and regulators greater certainty, stability, and predictability.[28] Others caution that compacts are not likely to increase options, reduce operational complexity for insurers, or reduce premiums. Other issues that would need to be resolved include risk adjustment at the state level.[29] It is also unclear how a section 1333 compact could help stabilize markets without the ability for federal pass-through funds. This raises the question of whether an accompanying 1332 waiver would also be needed for states pursuing such an option. Clear federal guidance is needed on several issues before states can consider further pursuing these compacts.

Pursuing any of these flexibility options, alone or in combination, requires long-range planning and cooperation between governors, state agencies, and legislatures, as well as funding for actuarial modeling and venues for robust stakeholder engagement. Careful

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[28] *See* "Section 1333 Health Care Choice Compacts: Opportunities for States to improve the individual health insurance market through state compacts under the Affordable Care Act", by Peter J. Nelson, July 2024, available at https://files.americanexperiment.org/wp-content/uploads/2024/07/Health-Care-Choice-Compacts.pdf.

[29] See "A blast from the past: Dusting off ACA Section 1333 Compacts", Stacey Pogue, March 2025, available at https://chir.georgetown.edu/a-blast-from-the-past-dusting-off-aca-section-1333-compacts/.

design is needed to avoid anti-selection and prevent risk pool fragmentation. Federal technical assistance and funding for planning could assist states in taking further advantage of the ACA's state flexibility provisions.

Conclusion

State flexibility under the ACA has already shown success in achieving greater affordability for consumers across many states. The law's flexibility options have the opportunity to play an increased role in maintaining accessible health coverage for consumers as the federal regulatory landscape changes. States are anticipating increased Medicaid disenrollments and future challenges for ACA market risk pools, among other tests for state health insurance regulation. Ever increasing health care costs also continue to drive premiums upward, leading to affordability challenges for individuals and small businesses. Clear and consistent guidance as well as flexibility from the federal government will help states to pursue state innovation options that best meet their coverage needs.

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