HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

Draft Pending Adoption

Draft: 8/21/25

Health Insurance and Managed Care (B) Committee
Minneapolis, Minnesota
August 13, 2025

The Health Insurance and Managed Care (B) Committee met in Minneapolis, MN, Aug. 13, 2025. The following Committee members participated: Glen Mulready, Chair (OK); Ann Gillespie, Co-Vice Chair (IL); Grace Arnold, Co-Vice Chair, and Fred Andersen (MN); Dean L. Cameron (ID); Marie Grant (MD); Anita G. Fox and Kevin Dyke (MI); D.J. Bettencourt (NH); Alice T. Kane represented by Viara Ianakieva (NM); Jon Pike (UT); Kaj Samsom represented by Mary Block (VT); Patty Kuderer (WA); and Allan L. McVey and Joylynn Fix (WV). Also participating were: Heather Carpenter (AK); Maria Ailor (AZ); Martin Sullivan (GA); Andria Seip (IA); Michael T. Caljouw (MA); Robert Wake (ME); Angela L. Nelson (MO); Michael Muldoon (NE); Michael Humphreys (PA); and Patrick Smock (RI).

1. Adopted its Spring National Meeting Minutes

Commissioner McVey made a motion, seconded by Commissioner Arnold, to adopt the Committee's March 26 minutes (*see NAIC Proceedings – Spring 2025, Health Insurance and Managed Care (B) Committee*). The motion passed unanimously.

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

Commissioner Pike made a motion, seconded by Director Gillespie, to adopt the following task force and working group reports: 1) Consumer Information (B) Working Group, including its June 26 minutes (Attachment One); 2) Health Innovations (B) Working Group (Attachment Two); 3) Health Actuarial (B) Task Force; 4) Regulatory Framework (B) Task Force; and 5) Senior Issues (B) Task Force. The motion passed unanimously.

3. Adopted the Revised LTCI MSA Framework

Dyke said the Health Actuarial (B) Task Force forwarded a memorandum to the Committee on the revisions to the long-term care insurance multistate actuarial framework (LTCI MSA Framework) (Attachment Three). He said that as described in the memorandum, the key revisions to the LTCI MSA Framework are: 1) a change from two actuarial rate review methodologies to a single rate review methodology; 2) a revised cost-sharing formula; and 3) moving the governance of the LTCI MSA Framework and related processes to the Health Actuarial (B) Task Force, and other related work such as reduced benefit options (RBOs), to the Senior Issues (B) Task Force. Dyke said that the revisions were discussed in open session multiple times and that all the revisions were exposed for public comment by the Long-Term Care Actuarial (B) Working Group and/or the former Long-Term Care Insurance (B) Task Force. He said the former Long-Term Care Insurance (B) Task Force adopted the revisions changing the actuarial rate review methodology from two to one and the revisions moving the governance of the LTCI MSA Framework and related processes to the Health Actuarial (B) Task Force, and other related work such as RBOs, to the Senior Issues (B) Task Force on Dec. 18, 2024. The Health Actuarial (B) Task Force adopted the revised cost-sharing formula on July 14.

Andersen updated the Committee on the LTCI MSA Framework. He said that as discussed during his update to the Committee at the Spring National Meeting, the Long-Term Care Actuarial (B) Working Group revised the LTCI MSA Framework to include a single multistate methodology, which the former Long-Term Care Insurance (B) Task Force and the Health Actuarial (B) Task Force adopted late last year. He said that, as he also discussed, the second part of the proposed revisions to the LTCI MSA Framework, the cost-sharing formula, took a little longer to reach consensus. He explained that the cost-sharing formula is a way to increase the cost-sharing burden for the

company as the cumulative rate increases over time. He said that one concern the Long-Term Care Actuarial (B) Working Group identified with the current cost-sharing formula is that it allows rate increases that are too high when there are very high cumulative rate increases, which tended to occur for people aged 85 and older who have held on to their policies for 25 or more years. Given this, there was agreement among the Long-Term Care Actuarial (B) Working Group members that the cost-sharing burden for companies needs to increase in these cases.

Andersen said that also during his update to the Committee at the Spring National Meeting, he said the Long-Term Care Actuarial (B) Working Group exposed, for a public comment period ending May 12, an alternative proposal providing a 95% company cost-sharing burden after a certain cumulative amount. Andersen said that following the end of the public comment period, the Working Group discussed the comments received and adopted an alternative proposal on June 2 to increase the company cost-sharing burden from 50% to 85% when cumulative rate increases get high. The Health Actuarial (B) Task Force adopted it on July 14. Andersen urged the Committee to adopt the revised LTC MSA Framework.

Commissioner Mulready expressed appreciation for all the work done by both the Long-Term Care Actuarial (B) Working Group and the Health Actuarial (B) Task Force to revise the LTCI MSA Framework. He expressed concern, however, on whether the states will adopt it and whether the companies will use it for their rate filings. Andersen said he shares Commissioner Mulready's sentiment, but he said that given all the discussions and disagreement and then agreement as they worked through the drafting process, he is optimistic that a vast majority of the states will adopt it.

Fix said that for the Committee's consideration, a company reached out to her asking for information on what states they should approach to encourage them to vote for the revised LTCI MSA Framework. She said companies want the NAIC to adopt it because they want consistency. Director Cameron expressed support for adopting the revised LTCI MSA Framework. He noted all the work done to date. He acknowledged that it is not perfect, but he believes it is a good step forward. He said it has already been shown that improvements can be made if needed, but, as revised, the LTCI MSA Framework makes it more efficient and easier for companies to file their needed rate increases and provide the data justifying them.

Director Fox made a motion, seconded by Commissioner McVey, to adopt the revised LTC MSA Framework (*see NAIC Proceedings – Spring 2025, Health Actuarial (B) Task Force, Attachment One*). The motion passed unanimously.

4. Discussed 2025 State Legislative Activity of Interest to the Committee

Acting Director Carpenter, Christina Haas (DE), and George McNab (OH), who are members of the NAIC's State Insurance Department Legislative Liaison Roundtable (Roundtable), discussed current trends and emerging trends in legislation considered and enacted legislation from recently concluded 2025 state legislative sessions.

Haas said that in 2025, state legislatures are building significant momentum as they work to improve patient access, reduce provider burden, and increase transparency in health care delivery. She said today, they would discuss three major policy areas state legislatures are grappling with: 1) prior authorization (PA) reform; 2) pharmacy benefit manager (PBM) regulation; and 3) mandated coverage for biomarker testing.

Beginning with PA, Haas said stakeholders view PA from vastly different perspectives. Some insurers view it as a cost-control tool, while some providers often see it as a barrier to needed patient care. She said that today, 49 states, the District of Columbia, and Puerto Rico have enacted some form of PA law. Haas said that many of these laws include "gold carding"—essentially a fast pass for providers who consistently receive approval for their requests. More than 20 jurisdictions now have some form of gold carding law, and that number continues to grow.

Acting Director Carpenter described Alaska's experience with its PA bill during the 2024 state legislative session and the discussions with various stakeholders, including state legislators, to reach consensus and enact PA legislation during Alaska's recently concluded 2025 state legislative session. Hass also discussed Delaware's efforts to enact PA reform legislation this year. She noted that consensus on certain provisions, such as reviewer qualifications, in recent PA reform legislation was key to enactment. She stressed that this is an important piece because, as some have reported, including the American Medical Association (AMA), artificial intelligence (AI) is leading to more claim denials.

McNab discussed PBM regulation. He said that like PA reform, PBM regulation has received heightened attention in recent state legislative sessions. He said that such legislation focused on transparency, pricing fairness, and accountability. McNab said that in 2025, laws enacted on PBM regulation required PBMs to disclose: 1) their ownership; 2) how they calculate rebates; and 3) what they charge health plans compared to what they reimburse pharmacies. He said spread pricing, where PBMs profit by charging plans more than they reimburse pharmacies, is also under fire, with multiple states banning or limiting this practice. McNab said other laws target pharmacy reimbursement, anti-steering practices, and network adequacy. He said another major trend requires PBMs to act as fiduciaries, meaning they must prioritize the consumer's best interest over maximizing profits. He said many states are also stepping in to protect 340B program pharmacies from discriminatory PBM practices and are reining in utilization management tactics like step therapy and PA delays. He said examples of such reform can be found in recent legislation enacted in Alaska, Colorado, Connecticut, Hawaii, Illinois, Montana, Nebraska, New Jersey, New Mexico, North Carolina, Oklahoma, and Wisconsin. McNab noted that states like Alabama, Indiana, Missouri, and Nevada are also advancing reforms through omnibus legislation, tackling multiple PBM concerns at once. McNab said that in response to these new laws and regulations, PBMs are beginning to explore flat-fee models instead of profit-based ones, and they are partnering with AI-driven tech companies to improve transparency and efficiency.

Haas discussed Delaware's experience with regulating PBMs. She said Delaware has had regulatory authority over PBMs for several years now, and it has completed some of the nation's first in-depth PBM market conduct exams. She said that she hesitates to state that Delaware is far ahead of other states because PBMs continue to resist being regulated by the states. She said this is done, in part, through litigation forcing the states and state legislatures to decide whether to continue enforcement, halt it, or amend the law entirely. Haas said the NAIC's State Insurance Department Legislative Liaison members have had robust discussions on the PBM regulation issue. She said that it increasingly appears that PBM reform efforts will continue to be a hot-button issue even in those states with existing PBM reform laws. Haas said that as state regulatory efforts advance, Roundtable members expect to see the states attempt to address other entities that operate in the pharmaceutical benefit management area, such as group purchasing organizations (GPOs) and pharmacy services administrative organizations (PSAOs).

Acting Director Carpenter shared Alaska's most recent experience with enacting PBM reform legislation, focusing on its work to transition PBMs from registration to licensure. She discussed how Alaska used the resources and expertise of the Roundtable members to determine the approach it should take to update its laws regulating PBMs, which led to it adding new disclosure requirements and clarifying its examination requirements regarding PBMs.

McNab said that in summary, both PA process reform and PBM regulation are undergoing rapid change. She said the legislative momentum is clear, and while many of the reforms are still too new to fully evaluate, the overall trajectory is moving toward more transparent, more accountable, and more patient-centered health care delivery.

Haas touched on a relatively new health benefit mandate that has emerged as a common legislative effort over the last few years in state legislatures—biomarker testing. Biomarker testing is a laboratory procedure that samples tissue, blood, or other body fluid to check for certain genes, proteins, chromosomes, or other molecules

that may be a sign of a disease or condition or may increase a person's risk for developing diseases or conditions. She said that about half of the states that have enacted this mandate have used the National Council of Insurance Legislators (NCOIL) model as a base. She said the states are also receiving model legislation on the subject from the American Cancer Association (ACA). Haas discussed potential issues with legislation mandating coverage for such tests that states should consider in reviewing legislative proposals or implementing existing state law related to this mandate. She said a state adoption resource will be posted on the Legislative Liaison Connect page soon.

Haas said Roundtable members would be happy to present to the Committee in the future on any of the issues they discussed today and many others. She welcomed Committee members and other state insurance regulators to join their monthly meetings as a great way to engage Roundtable members and stay informed on current and emerging state legislative trends.

5. Heard a Presentation from HealthPartners

Pahoua Yang Hoffman (HealthPartners) presented on "Supporting Medicaid Members & Patients: Eligibility Redeterminations & Learnings," during which she discussed HealthPartners' strategies for working through Minnesota's Medicaid eligibility redetermination process for its members and lessons learned. Hoffman described Minnesota's Medicaid eligibility determination process, noting that Minnesota's systems are paper-based and rely on U.S. Mail for renewal notification. This means that health plans can educate and direct their members to navigators or counties, but they cannot physically help them submit eligibility paperwork. She discussed the challenges health plans, including HealthPartners, must navigate as part of the eligibility determination process and the importance of partnering with others and multichannel communication.

Hoffman described the outreach HealthPartners did to its members and patients in the fall and winter of 2022 before Minnesota's eligibility redetermination began. This included 459,600 direct-to-consumer messages through direct mail, email, text, and prerecording calls. HealthPartners also leveraged social media through ads on Facebook. She said that during the eligibility redetermination process, which began in March 2023 and is ongoing, HealthPartners applied key learnings from its pre-redetermination outreach. Hoffman said one of the surprising key learnings was that prerecorded telephone calls had the most expansive reach of all the direct-to-member channels, especially when recorded in multiple languages. She said HealthPartners also enhanced its website landing page and added blog posts discussing the need to submit eligibility paperwork and why.

Hoffman discussed the results of HealthPartners' direct-to-member campaign and key takeaways. She said the key takeaways include: 1) multichannel and frequent outreach strategies to increase member engagement; 2) the use of social media to yield higher interaction rates; and 3) continuous message and support to Medicaid members to ensure they maintain eligibility. Commissioner Arnold suggested that the strategies HealthPartners used to engage their Medicaid members and patients could be adopted for the non-Medicaid market.

6. 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 discussed the CCIIO's work to support premium rate approval for 2026 and the implementation of the federal 2025 Marketplace Integrity and Affordability Final Rule and H.R. 1, The One Big Beautiful Bill Act (OBBBA). Nelson said Aug. 13 is the federal deadline for filing initial 2026 premium rates. He said there will be an opportunity, if needed, Sept. 11–12 for rate refilings to make any necessary corrections.

Nelson also discussed state innovation opportunities through federal Affordable Care (ACA) waivers, such as Section 1332 and Section 1333 waivers. He said he presented at the Health Innovations (B) Working Group meeting Aug. 12 on the opportunity for states to increase their regulatory flexibility and stability under Section

1333 of the ACA through health care choice compacts. He said Section 1333 directs the Secretary of the Department of Health and Human Services (DHHS), in consultation with the NAIC, to establish a regulatory framework that allows two or more states to enter into a health care choice compact to facilitate the sale of health insurance across state lines. He discussed the benefits to the states of entering into such compacts. Nelson said he looks forward to having additional discussions with the NAIC on Section 1333.

Director Gillespie asked whether there would be a federal response to the increase in 2026 rates due to the impending expiration of the enhanced premium subsidies. Nelson said there have been some discussions in Congress, but the CCIIO will for wait to see what, if anything, Congress decides to do. He said that the CCIIO is prepared to implement whatever the Congress might pass. Nelson said that from the federal Centers for Medicare & Medicaid's (CMS') perspective, with respect to the premium rate increases and approaching open enrollment period, CMS is doing everything it can to create a thoughtful communication strategy to ensure that consumers are prepared and that agents and brokers are prepared to communicate what needs to be communicated so that consumers have the information they need to make the best choices for themselves and their families. Director Fox also expressed concern about the impending increase in premium rates and the seemingly lack of a federal communication strategy to: 1) explain the changes to consumers; and 2) help providers and vulnerable populations manage their impact. Nelson discussed potential strategies the states can use, such as creating reinsurance programs under Section 1332. He also encouraged the states to reach out to the CCIIO to discuss potential strategies and tools.

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

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/National Meetings/2025 Summer National Meeting/Final Minutes/08-Bmin.docx

Draft: 7/23/25

Consumer Information (B) Working Group
Virtual Meeting
June 26, 2025

The Consumer Information (B) Working Group of the Health Insurance and Managed Care (B) Committee met June 26, 2025. The following Working Group members participated: David Buono, Chair (PA); Anthony L. Williams (AL); Michelle Baldock (IL); Alex Peck (IN); Terri Smith (MD); Amy Hoyt and Jeana Thomas (MO); Monica Snowden (NM); Donna Dorr (OK); Jill Kruger (SD); Vickie Trice (TN); Shelley Wiseman (UT); and Christina Keeley (WI). Also participating were: Martin Swanson (NE); and Victoria Fowler (NH).

1. Adopted its April 14 Minutes

The Working Group met April 14 to discuss plans for a consumer guide for purchasing health insurance and avoiding improper marketing.

Wiseman made a motion, seconded by Hoyt, to adopt the Working Group's April 14 minutes (Attachment One-A). The motion passed unanimously.

2. Discussed a Consumer Guide on Selecting a Health Plan and Avoiding Improper Marketing Practices

Buono said the draft consumer guide (Attachment One-B) is intended for state departments of insurance (DOIs) to use and adapt as they see fit. He said the guide is intended to provide consumers with basic education, help them ask the right questions, and warn them about improper marketing they might encounter. He said the drafting group considered creating multiple guides for different plan types but decided on a single guide with links to additional information on specific plan types.

Buono said the draft attempts to strike a balance between providing accurate information and keeping the text readable. Buono described the initial sections of the document, including an introduction, a reference to public and employer coverage, and definitions. Brenda J. Cude (University of Georgia) asked whether definitions were taken from existing documents, such as the Summary of Benefits and Coverage (SBC). Buono responded that the drafting group borrowed liberally from other sources. However, it did make adjustments to some definitions. The Working Group discussed adding the definitions of out-of-network and network types, such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs). The Working Group decided that the variety of network types would add too much complexity for the purposes of the guide, but that a future document could provide more information on networks.

Buono said the guide describes different plan types and provides a table at the end that offers a more complete list of plan types. Cude suggested linking to more information about essential health benefits (EHBs). Cude and J.P. Wieske (Horizon Government Affairs) suggested adding a drafting note to advise states that the federal three-month limit for short-term, limited-duration (STLD) plans may change. Swanson encouraged the inclusion of language directing consumers to check that agents are not only licensed by the state but also appointed by the appropriate insurer to sell the plans they are marketing.

Buono highlighted the sections of the guide that warn consumers about red flags and suggest tips for them to follow. The Working Group discussed plan marketing that offers free meals or cash bonuses and concluded that the guide appropriately warns about free offers. Snowden suggested that language warning consumers not to rely

on verbal promises be more prominent. The Working Group discussed whether written documentation is accessible and reviewed by consumers. It decided to include: 1) a warning not to rely on verbal promises; 2) a tip to get written documentation; and 3) and a recommendation to keep records. The Working Group discussed keeping a tip for consumers to take their time and adding advice to be aware of legitimate deadlines, like the end of enrollment periods.

The Working Group discussed recommended questions for consumers to ask. Participants discussed the importance of consumers understanding whether plans marketed to them are insurance and whether they are major medical plans. Working Group members observed that some non-insurance discount plans are marketed to consumers seeking comprehensive coverage and that other misleading marketing obscures the difference between plan types. The Working Group decided to add a question intended to clarify whether a plan provides comprehensive health coverage.

The Working Group discussed adding the term "producer" where agents and brokers are referenced. Some Working Group members mentioned that "producer" is used in state regulation but may not be a familiar term to consumers. The Working Group decided to add "producer" to the document.

Buono asked the Working Group whether the draft should be updated with the relatively minor edits discussed in the meeting and reviewed for readability by Dr. Cude. The Working Group agreed on these as the next steps for the document.

Buono mentioned that the Working Group would soon consider updates to *Frequently Asked Questions About Health Care Reform*. He said the document may need a few more updates this year due to recent changes to federal rules as well as new legislation.

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

SharePoint/NAIC Support Staff Hub/B CMTE/National Meetings/2025 Summer National Meeting/Final Minutes/Consumer Info Minutes 6.26.docx

Draft: 5/2/25

Consumer Information (B) Working Group
Virtual Meeting
April 14, 2025

The Consumer Information (B) Working Group of the Health Insurance and Managed Care (B) Committee met April 14, 2025. The following Working Group members participated: David Buono, Chair (PA); T.J. Patton, Vice Chair (MN); Debra Judy (CO); Randy Pipal (ID); Michelle Baldock (IL); Alex Peck (IN); Patricia Dorn (MD); Jeana Thomas (MO); Hadiya Swann (NC); Elouisa Macias (NM); Donna Dorr (OK); Jill Kruger (SD); Vickie Trice (TN); Shelley Wiseman (UT); and Christina Keeley (WI). Also participating were: Susan Jennette (DE); and Martin Swanson (NE).

1. Discussed a Consumer Advisory on Health Insurance

Buono explained an oversight related to the Working Group's Feb. 6 meeting. He said the calendar appointment was not sent to interested parties, so very few non-regulators were able to join the call. He apologized and said the Working Group values input from interested parties. He said the Feb. 6 meeting minutes are included in the Health Insurance and Managed Care (B) Committee's Spring National Meeting materials and are also available by request from NAIC support staff.

The Working Group discussed developing a consumer advisory to help consumers choose a suitable health plan and warn them about misleading marketing practices. Buono said improper marketing takes many different forms, so the Working Group could work on a series of guides on different plan types. He explained that a small drafting group discussed the idea and concluded that consumers do not necessarily understand the different plan types in the market or seek out information on plan types. He said the small group recommended drafting a document that provides consumers with the questions they should ask when shopping for health insurance. He said the guide or advisory document could point out why the questions matter and provide warnings for plans that may be unsuitable for certain consumers. Buono said the Working Group could use guides it previously developed and guides or advisory documents already in use by state departments of insurance as references.

Keeley suggested including information on improper marketing in the set of questions. She said consumers might better understand the products they purchase if they are armed with the right questions. Harry Ting (Health Care Consumer Advocate) asked when consumers would consult the advisory. Buono said the goal would be to get the information to consumers when they are shopping during an enrollment period, either during the annual open enrollment period or after a life change. Patton said the Working Group provides information on Affordable Care Act (ACA) plans each year, but it has not put out as much material on other plan types.

Jennette said a plain guide will not be appealing to consumers. Dorn said Maryland's consumer warnings are paired with information on ACA plan premiums. Buono said Maryland's materials are of high quality.

Wayne Turner (National Health Law Program—NHeLP) said the Working Group should educate consumers on the differences between ACA-compliant plans and other plan types. He said a consumer advisory should go further and guide consumers on how to find important plan information, like summaries of benefits and coverage and denial rates. He said the information is not readily available but is findable. He added that consumers should be educated on the difference between assisters funded by grants and producers who may be influenced by commissions.

Lucy Culp (The Leukemia & Lymphoma Society—LLS) asked how a consumer guide differs from a consumer advisory or other document types. She asked how information can be most easily available to consumers when they need it. Buono said not all states have existing materials. He said the NAIC should work to get any materials developed by the Working Group to the states. He said states can shape the material into different forms once they have access to it, so it could be made into a guide, warning, or something different depending on state needs. Patton said there are trade-offs in different forms. He said guides focused on one plan type can be concise, but they are limited in scope. He said the Working Group will have to decide how to balance different needs. Culp said that even experts cannot always tell what plan type marketers are selling.

Claire Heyison (Center on Budget and Policy Priorities—CBPP) said that one document with questions may be better because consumers do not know the difference between plan types, and many questions would be the same across plan types. She said two important questions, regardless of plan type, are: "Does the plan cover pre-existing conditions?" and "Can I see plan documents?"

Swanson said the Improper Marketing of Health Insurance (D) Working Group is willing to help with the document. He said consumers want to ask the right question to either get off the phone with a producer or get confidence that the plan is legitimate. He suggested questions about whether the marketer is licensed, who they represent or sell for, and where they are located.

Brenda J. Cude (University of Georgia) said the NAIC shoppers' guides on home insurance and auto insurance may offer useful formatting ideas. She said the Working Group should consider whether it wants to create content for anyone who finds it to use, suggest ways to use the content, or format the content into final products that do not require editing. She said the Working Group should pursue the first two options to encourage flexibility in the use of the materials. She said materials focused on states rather than consumers would have more drafting notes. Buono said the NAIC is best positioned to distribute the advisory or guide, but states should feel free to use bits and pieces from it, or the whole document if they would like.

Dr. Ting said a guide should help consumers find a credible producer to work with.

Buono asked states to send any related materials they already use, including alerts or warnings to consumers.

Patton said the Working Group should seek to accomplish three goals with the project: 1) provide a concise description of plan types; 2) provide consumers with useful questions to ask; and 3) offer examples of problematic marketing practices. A potential fourth consideration is how to consolidate or separate this information. Culp said some of the work done in the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171) on definitions would be helpful for the first goal.

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

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A CONSUMER'S GUIDE FOR PEOPLE BUYING HEALTH INSURANCE ON THEIR OWN

Buying health insurance can feel overwhelming, especially with the wide range of plans and companies out there. If you are interested in buying insurance for yourself or your family, this guide provides some tips to help you understand how to proceed.

Government-Sponsored and Employer-Based Coverage

Before you buy health insurance on your own, it's worthwhile to check whether you are eligible for coverage through a government program or an employer.

- Medicare: If you are 65 or older, have received Social Security Disability Insurance benefits for at least 24 months, or have End Stage Renal Disease or Lou Gehrig's Disease (ALS), then you are likely to qualify for Medicare. To find out more, contact [the name of your state's SHIP program] at [your state's SHIP program phone number] or an insurance broker or agent who is approved to sell Medicare-related plans.
- Medicaid: Medicaid serves people who qualify by income. It pays for comprehensive services at little or no cost. If you feel you might qualify for this program, call [name of state Medicaid agency] at [state Medicaid phone number] to learn more. People who qualify for Medicaid and Medicare can receive benefits from both programs.
- Employer-Sponsored Coverage: Many employers offer health coverage as a benefit to employees, their spouses, and dependents. Check with your or your spouse's employer to find out details and costs.

1. Know Key Terms Before You Shop

- **Premium:** What you pay each month for your health plan's coverage.
- **Deductible:** The amount you pay out-of-pocket before insurance starts paying.
- **Copayment (Copay):** Fixed fee per doctor visit, hospital day or stay, or prescription. For example, $20 for a doctor's visit or $30 to see a specialist.
- **Coinsurance:** The percentage of costs you pay. For example, 30% of hospital charges.
- **Out-of-pocket maximum:** The most you'll pay per year before insurance covers 100%. Not all plans have an out-of-pocket maximum.
- **Annual or lifetime maximum benefit:** The most a health plan will pay each year, or as long as you have a policy, toward your health costs. After that amount is reached, the plan will not pay any more toward your health costs. Health plans that are subject to the Affordable Care Act do not have these limits.

- **Provider:** An individual or facility that provides health care services.
- **Network:** The facilities, providers and suppliers your health insurer has contracted with to provide health care services. If your health plan uses a provider network, then you will pay less if you see a provider in the network.
- **Pre-existing condition:** A health problem like asthma, diabetes, or cancer you had before your health insurance went into effect. Some health plans do not cover services to treat pre-existing conditions.

2. Find Which Type of Health Plan Is Right for You

- **Marketplace Plans [If applicable, replace with name of Marketplace plans in your state]:** If you are under age 65, you should look into these plans because you may qualify for financial help. These plans are required by law to ensure individuals have access to a comprehensive range of services, also called the 10 "essential health benefits," which include:
    - Outpatient care
    - Emergency services
    - Hospitalization
    - Maternity and newborn care
    - Mental health and substance use disorder services
    - Prescription drugs
    - Rehabilitative and habilitative services and devices
    - Laboratory services
    - Preventive and wellness services
    - Pediatric oral and vision care

  Marketplace plans must cover services to treat pre-existing conditions. Under these plans, you may qualify for financial assistance that reduces monthly premiums or out-of-pocket costs when you get care. To find out more, contact [phone number for Marketplace plans in your state], an insurance broker, agent, or health insurance navigator. **[Add link to Marketplace or navigator resources.]**

- **Short-Term, Limited Duration Plans:** These plans offer coverage for up to 3 months. They are not required to cover comprehensive services and they can exclude services to treat pre-existing conditions.

- **Other Types of Health Insurance:** There are other types of health insurance plans you can buy on your own. Insurers may offer insurance coverage outside of the **[insert State Marketplace name]** that may or may not cover the essential health benefits listed above. Financial help is only available for coverage purchased on the **[Name of Marketplace]**. Other types of insurance plans may cover fewer services, only cover specific conditions, or pay you directly a fixed amount that is not related to services rendered. See more on other types of coverage. **[Link to Types of Health Coverage Table]**

- **Other Types of Coverage that are Not Insurance**

    - **Health Care Sharing Ministry Plans:** These plans are sponsored by faith-based organizations. They are not insurance plans. The plans use a portion of plan member contributions to pay health benefits. They do not guarantee how much they will pay for services they cover.

- **[Include if applicable] Farm Bureau Plans:** Individuals and families may qualify for coverage through the Farm Bureau, a private company. This coverage is not insurance and may not include the consumer protections provided by Marketplace plans.

- **Discount plans:** Under a discount plan, you pay upfront in order to receive a reduced fee when you receive services from a participating provider. These plans are not insurance and they do not cap the amount you may owe for healthcare services.

Compare Types of Health Coverage **[Link to Types of Health Coverage Table]**

3. Watch Out for Red Flags

- **Be aware of the source of information or marketing.** Unsolicited calls, texts, or emails from unknown sources should be approached with caution. Legitimate agents and brokers can be verified with your state insurance department.
- **If something sounds too good to be true, it probably is.** Ads that offer comprehensive coverage for $50 per month are often misleading.
- **Beware of offers of up-front payments to you.** Ads that offer a gift or a government subsidy card you can use on groceries, bills, or medical needs for signing up may be deceptive and illegal.
- **Look out for added fees.** Fees in addition to the health plan premium could mean you're signing up to join an association. Know what you're paying for.
- **Avoid pushy sales tactics:** If someone pressures you to sign today or says, "this offer is expiring now," be cautious.
- **Clarify vague plan details:** Walk away if a sales person can't provide you a Summary of Benefits and Coverage or an official plan document.
- **Don't rely on verbal promises:** Get written documentation of:
  - What's covered
  - What's not covered
  - Costs (including premiums, deductibles, copays)

4. Tips to Follow

- **Take your time:** Don't rush your decision.
- **Compare multiple plans:** Ask a trusted friend, family member, or local health navigator to review plans with you if you're unsure.
- **Review documents carefully before signing.** Check provider networks and Summaries of Benefits and Coverage.

5. Ask the Right Questions

- **Is the plan an insurance plan?** If not, you will not have government protections that require the plan to pay its stated benefits.

- **Which services are covered and not covered?** Does the plan cover hospital services, primary care and specialty physician services, other medical services like lab and imaging, prescriptions, mental health services?
- **Are your preferred providers in the network?** Check whether physicians, hospitals or other providers you want to continue to use are in the network and any limitations that apply.
- **Does the plan cover treatment for pre-existing conditions?**
- **Does the plan have an annual or lifetime limit on the amount it will pay for your care?**
- **Is there an out-of-pocket maximum that limits your total cost for deductibles, co-insurance, and co-pays?**
- **Are preventive services required to be covered at no cost to you?**
- **Are your prescription drugs covered, and how much will you pay for those drugs under the plan?**
- **If you are dealing with a broker or agent, is s/he licensed in your state?** Licensed insurance brokers and agents are required to meet state specific qualifications. If the person is licensed, ask for their state insurance license number. With that number, you can check that person's credentials at **[state DOI webpage for licensed producers]**. Later, if you have a complaint or suspect fraud, you can report that person to **[relevant state insurance department's phone number]**.

By following this guide, you'll be in a stronger position to get the coverage you need — and avoid falling for scams or misleading sales pitches.

Types of Health Coverage

Plan Type	What is Covered?	What is Not Covered?	Usually Pays You or Pays Your Provider Bill	Is This a Marketplace Plan?
Hospital Indemnity Policy: Pays a set dollar amount per hospitalization	Any covered hospital visit	Any services other than hospitalization	Usually pays you a set amount regardless of the amount of your hospital bill	No
Other Fixed Indemnity Policy: Pays a set dollar amount per service	Any covered service	Services for pre-existing conditions, maternity, ambulance	Usually pays you a set amount regardless of the amount of your provider bills	No
Critical Illness Policy: Pays a set dollar amount per diagnosis	Any covered specific diagnosis, such as cancer	Services for pre-existing conditions, maternity, ambulance	Usually pays you a set amount regardless of the amount of your provider bills	No
Disability Income Protection: Pays a set dollar amount per period if you become disabled	Any covered disability	Services for pre-existing conditions, maternity, routine physicals	Usually pays you a set amount regardless of the amount of your provider bills	No
Accident Only Policy: Pays a set dollar amount for covered accidents	Any covered accident	Services for pre-existing conditions, maternity, routine physicals	Usually pays you a set amount regardless of the amount of your provider bills	No
Limited Benefit Policy: Pays a set dollar amount for each service	Often doctor visits, lab services, some hospital services	Services for pre-existing conditions, maternity, infertility, mental health conditions	May pay you or your provider, but the amount may not be related to the amount of the provider bill	No
Vision or Dental (Limited Scope) Policy: Pays for a specific set of services within the scope of the policy	Limited services for coverage type	Services outside the scope of coverage and for pre-existing conditions, maternity, ambulance	Usually pays your provider	No
Short Term, Limited Duration Insurance: Depending on your state, may only be available for months	Limited medical services	Usually services for pre-existing conditions, maternity, infertility, mental health conditions, ambulance	Usually pays your provider	No

Draft: 8/20/25

Health Innovations (B) Working Group
Minneapolis, Minnesota
August 12, 2025

The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met Aug. 12, 2025. The following Working Group members participated: Marie Grant, Chair (MD); Amy Hoyt, Vice Chair (MO); Sarah Bailey (AK); Debra Judy (CO); Scott Shover (IN); Julie Holmes (KS); Chrystal Bartuska (ND); Viara Ianakieva (NM); Craig Kalman (OH); TK Keen (OR); Glory Montalvo (PR); Debra Diaz-Lara (TX); and Joylynn Fix (WV). Also participating were: Michael Caljouw (MA); Brian Downs (OK); and Jane Beyer and Todd Lovshin (WA).

1. Adopted its June 20 Minutes

The Working Group met June 20 and took the following action: 1) heard presentations from states on their experiences in implementing Sections 1331 and 1332 of the Affordable Care Act (ACA); and 2) heard a presentation from the Center for Consumer Information and Insurance Oversight (CCIIO) on Section 1333 of the ACA.

Hoyt made a motion, seconded by Fix, to adopt the Working Group's June 20 minutes (Attachment Two-A). The motion passed unanimously.

2. Heard a Presentation on Health Care Choice Compacts under Section 1333 of the ACA

Peter Nelson (CCIIO) presented on health care choice compacts authorized by Section 1333 of the ACA. He reviewed some of the history of multi-state compacts in health insurance. Buying health insurance across state lines can mean different things. One model for health insurance compacts is that only regulations of the state in which a policy is issued would be applicable, not the laws and regulations of a consumer's home state. This model was discussed in past decades by the George W. Bush Administration and think tanks. This model would involve federal laws that preempt state laws to allow multi-state sales. Another approach was considered by smaller states. States with small markets were interested in creating a larger pool of consumers to attract more insurance issuers. The ACA adopted the latter model, which allows states to provide alternatives to the federal law.

Nelson said Section 1333 of the ACA would allow the sale of qualified health plans from one state to another. Section 1333 includes exceptions to the rule that only the issuing state's laws and regulations apply. The home state of the consumer can still apply consumer protections, including market conduct rules, unfair trade practices limits, and network adequacy rules. Section 1333 incorporates guardrails that are almost identical to those that apply to waivers under Section 1332 of the ACA. The guardrails guarantee that coverage remains available, comprehensive, and affordable and that the federal deficit does not increase. Section 1333 additionally requires that consumer protections from the consumer's home state remain in place.

Nelson said states might want to enter a compact that requires federal approval to allow the federal government to give up some of its sovereignty. Section 1333 allows the federal government to give up some sovereignty, as long as the Secretary of Health and Human Services (HHS) approves.

Nelson addressed a number of questions about Section 1333, and CMS seeks input from NAIC on all of the questions. He explained what federal laws and regulations may be waived under Section 1333. It starts with

the requirements applicable to qualified health plans, identifying these requirements as an area of flexibility. States can use a compact to establish a more stable regulatory environment. Different administrations have implemented the ACA differently, frequently reversing decisions from prior administrations. A compact would give states the power to set a consistent policy. Policy has changed from administration to administration on standardized plans and network adequacy, and these are areas where states could regulate through a compact. He requested feedback from state insurance regulators in this area.

Nelson discussed the guardrails for Section 1333. The Secretary of HHS has some discretion in interpreting the guardrails. He said it likely makes more sense to apply the guardrails in the same ways for Sections 1332 and 1333, but there could be a difference in interpretation for good reason. He invited comments on what good reasons there may be to apply the guardrails differently. For Section 1333's unique guardrail on consumer protection, the statute includes a description of what areas must be included. He cited statutory references to market conduct, unfair trade practices, network adequacy, and consumer protection standards, including rating standards and contractual disputes.

Nelson said CMS intends to issue regulations on Section 1333. CMS would do so to allow states to increase the size of their risk pools and to maintain consistent rules.

Nelson said it would be a heavy lift for states to enter a compact. States must adopt compact language into state statutes, or they could possibly defer to a state official to define the compact. There could potentially be funding for states to establish a compact. The amount available would be relatively small unless Congress decides to appropriate more funds for the purpose. CMS welcomes comments on what level of funding would be helpful for states.

Nelson said CMS would not offer specific incentives for states to enter a compact. States stand to benefit from more regulatory stability, and regulatory flexibility would encourage states to participate. However, it will be a state decision on whether to join a compact.

Nelson said CMS requirements on legislation to enter a compact would likely depend on the type of compact. States could potentially be required to ensure that guardrails are protected on an ongoing basis. 1333 compacts do not have expiration dates, unlike 1332 waivers. Because compacts are longer-term arrangements, there may need to be strong guarantees with respect to the guardrails.

Beyer asked whether Section 1333 compacts could encompass both individual and small group plans. Nelson responded that the statute clearly states that Section 1333 only applies to the individual market. Congress would have to change the law to apply it to small group coverage.

3. Heard Stakeholder Input on an Outline for a White Paper on State Flexibility Under the ACA

Adam Fox (Colorado Consumer Health Initiative) and Claire Heyison (Center on Budget and Policy Priorities) provided feedback on the outline for a white paper on state flexibility under the ACA shared by the Working Group. Fox said there have been a variety of approaches by states for each flexibility section. It is important for consumers that the guardrails for each section be protected. States have used Sections 1331 and 1332 to improve affordability, and this should be highlighted in the white paper. Some waiver concepts raise potential concerns, including those that were rejected by CMS in the past. The white paper should capture both the benefits and the cautions that exist with opportunities for state flexibility.

Heyison said regulators should ensure there are strong guardrails for Sections 1332 and 1333. Waivers should not degrade affordability, comprehensiveness, or consumer protections for the individual market overall.

States should consider how they can use 1333 compacts to improve consumer protections in ways that are not already available to them and whether the waiver structure allows states to undermine federal protections.

Fox said his organization has many tools to assist consumers with state-regulated health plans. There is concern that a 1333 compact would reduce consumers' ability to push back when they are not treated appropriately by their insurer because the plan may not be regulated by the consumer's home state.

Grant requested that any additional written comments be submitted to the Working Group by Aug. 22.

Having no further business, the Health Innovations (B) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/B CMTE/National Meetings/2025 Summer National Meeting/Final Minutes/Minutes 8.12

Draft: 7/2/25

Health Innovations (B) Working Group
Virtual Meeting
June 20, 2025

The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met June 20, 2025. The following Working Group members participated: Marie Grant, Chair (MD); Amy Hoyt, Vice Chair (MO); Sarah Bailey (AK); Debra Judy (CO); Andria Seip (IA); Alex Peck (IN); Julie Holmes (KS); Viara Ianakieva (NM); Daniel Bradford (OH); Jesse O'Brien (OR); R. Michael Markham (TX); and Tanji J. Northrup (UT). Also participating were: Weston Trexler (ID); and Jane Beyer (WA).

1. Adopted its April 24 Minutes

The Working Group met April 24 and heard presentations on three sections of the Affordable Care Act (ACA) that provide flexibility to the states.

Hoyt made a motion, seconded by Holmes, to adopt the Working Group's April 24 minutes (Attachment Two-A1). The motion passed unanimously.

2. Heard a Presentation on Health Care Choice Compacts under Section 1333 of the ACA

Peter Nelson (Center for Consumer Information and Insurance Oversight—CCIIO) presented on health care choice compacts authorized by Section 1333 of the ACA. He said the Trump Administration is considering the impacts of health care choice compacts. He said such compacts could give states more choice and stability in their insurance markets. Nelson requested input from states as the federal government considers the effects of the compacts. He said a letter would soon go to the states to solicit input. He said the law directs the federal Centers for Medicare & Medicaid Services (CMS) to consult with the NAIC and issue regulations on Section 1333 compacts. He reviewed past comments from the NAIC, which he said concluded that new regulations were unnecessary because of existing state authority to enter into compacts. He said states have had success under existing compacts and agreed that states have authority outside of Section 1333 to enter multistate compacts.

Nelson said the biggest benefit of compacts in health insurance is that they create efficiencies in regulation and allow insurers to operate in a standardized way across states. He said states can already enter a compact outside of Section 1333, but it requires approval from U.S. Congress (Congress) if the compact impinges on federal sovereignty. He said Section 1333 offers new opportunities and allows the sale of health insurance across state lines. A Section 1333 compact would allow insurers to offer plans in multiple states while abiding by the laws and regulations of the state where the policy is written. He said the law includes protections for consumers.

He said Section 1333 has guardrails similar to Section 1332 with regard to affordability, coverage, comprehensiveness, and deficit neutrality. In addition, he said Section 1333 also requires the maintenance of consumer protections, such as network adequacy, in a consumer's home state.

Nelson said that in the coming months, he would like to focus on what else a Section 1333 compact could mean for states, including how states can take control over insurance markets back from the federal government. He said taking back federal control is how Section 1333 differs from other compact authorities. He said CMS is working to determine which federal authorities can be transferred to states. Qualified health

plan (QHP) certification requirements represent one possibility. Nelson said federal policy has vacillated as federal administrations have changed. He said states would benefit from more stability, and a compact would allow them to decide together how to regulate QHPs.

Nelson said that states in a compact have a voice in regulatory decisions they do not have when federal officials make decisions. He said there are benefits, especially for smaller states, to create an attractive market for insurers to do business.

Commissioner Grant asked whether states need specific statutory authority for a Section 1333 compact. Nelson confirmed that states are required to pass legislation and added that state legislation can take different shapes. He said some legislation might include the compact language in its entirety, while other examples might authorize a state executive to sign onto a compact.

Seip asked about compacts for rate setting or benefit design, given that states have different statutory requirements. Nelson said that issuers must be licensed in every state where they sell, regardless of a compact. He said different benefits could create adverse selection issues. He said examples like this are where states have struggled in the past to set up compacts because it required them to give up some control. He said that, alternatively, the compacting states could establish a compact commission with representation from each state to sort through these issues. Seip asked whether the same would apply to rates. Nelson said each state could have its own rate review process or could allow the compact to take on certain duties to gain efficiencies. He said states would need to retain certain authorities as spelled out in Section 1333, including consumer protections.

Beyer asked whether a compact would create a single risk pool across multiple states. Nelson said it would be up to compacting states—they could each maintain a separate risk pool, but it may make sense to combine risk pools to gain efficiency. He said any compact arrangement would be a heavy lift, as decisions like these would need to be made across states.

Hoyt asked whether there would be one compact or separate compacts among different groups of states. Nelson said multiple compacts could exist between contiguous or non-contiguous states.

Commissioner Grant asked whether Section 1332 and Section 1333 could be used together. Nelson said the two sections could be used together. He said Section 1332 involves approval from the U.S. Department of the Treasury (Treasury Department) and potentially state pass-through funds. He said it could be argued that similar funding could be available under Section 1333, but it may be more efficient to make use of both sections to access pass-through funds.

3. Heard Presentations on State Experiences with Flexibility Under Sections 1332 and 1331 of the ACA

A. Section 1332

Trexler presented on Idaho's experience seeking state innovation waivers under Section 1332 of the ACA. He reviewed the guardrails that states must meet for waiver approval.

Trexler said Idaho began considering Section 1332 waivers in 2019. The initial coverage choice waiver would have allowed individuals to keep commercial coverage rather than enrolling in expanded Medicaid coverage. He said some individuals may have preferred commercial coverage due to network availability, fluctuating income, or a desire to keep an entire family on one plan. He said Idaho submitted an application showing how

it met the four guardrails, but it was not approved because the federal government determined it would add to the federal deficit. He said a second attempt relied on authority under a governor's executive order. That waiver did not receive approval because state legislation is required.

Trexler said the legislature authorized a reinsurance waiver in 2022. He said this waiver application moved much more smoothly because several states had already gone through this process, and Idaho followed the same path. He said the waiver was approved and went into effect for plan year 2023. He said Idaho uses a portion of its premium tax to fund the state share of the reinsurance costs. He said the program has led to 12%–20% lower premiums compared to what they would be without the waiver.

Trexler said that this year, the legislature has renewed interest in a coverage choice waiver. A new waiver plan would allow individuals the choice to opt out of Medicaid and select a qualified health plan with tax credits. He said Idaho is working to develop a new waiver application to implement this direction from the legislature. He said Idaho does not want to jeopardize the state's existing reinsurance waiver. He said the state seeks to waive the definition of "coverage month" in federal law.

B. Section 1331

O'Brien and Clare Pierce-Wrobel (Oregon Health Authority—OHA) presented on Oregon's basic health plan, called the Oregon Bridge Plan (OBP). O'Brien said Section 1331 allows Oregon to repurpose 95% of premium tax credit funds for a certain population to offer a new health plan. He said the OBP aims to keep people covered despite the return to Medicaid eligibility redeterminations following the COVID-19 pandemic and to minimize churn between coverage sources.

O'Brien said insurance regulators in Oregon had three main concerns with the basic health plan. First, rates may be affected due to a smaller individual market risk pool. He said potential increases in rates were offset by higher morbidity in the population, leaving the individual risk pool. Second, the basic health plan removes the majority of consumers who are eligible for cost-sharing reductions, meaning the need for silver loading is greatly reduced. This, in turn, reduces silver premiums and the tax credit available for some consumers. Third, the expiration of enhanced premium tax credits reduces the amount of funding available for the basic health plan and potentially compounds the other premium effects.

Pierce-Wrobel reviewed data on health insurance coverage by income level. She said the highest rate of uninsurance prior to the pandemic was individuals between 138% and 200% of the federal poverty level (FPL), which makes up the group that would be covered by the basic health plan. She said the state established a task force to develop the plan, and it met extensively with marketplace carriers. She said the task force recommended using existing Medicaid plans to deliver the program so that enrollees did not need to change plans moving between Medicaid and the OBP.

Pierce-Wrobel said actuarial analysis indicated that there would only be a small impact on silver loading. She said the biggest impact the state worked to control was the net premium increase for consumers at some income levels. She said individuals are expected to move to the OBP over three years. She said a small number of individuals who remain in the individual market would face premium increases, concentrated among those over 400% of the FPL. She said the impact on consumers at lower income levels was $50 or less per month.

Pierce-Wrobel said Oregon considered some ways to mitigate these premium effects. She said the state considered an additional state subsidy, but it was not possible because the state uses the federal marketplace platform. She said the state considered using gold plans as the premium tax credit benchmark, but this also had operational limitations and policy concerns. She said the state considered a Section 1332 waiver to

establish a basic health plan look-alike and access pass-through funds. Pierce-Wrobel said the state determined that the pass-through funding would not be sufficient for this purpose. She said enrollment in the OBP has been lower than expected, so the impacts on the individual market have been less than expected.

Pierce-Wrobel said the federal reconciliation legislation would potentially impact basic health plans, including Medicaid eligibility rules and work requirements. She said that, for other states, switching to the basic health plan could be accelerated if automatic re-enrollment in marketplace plans is prohibited through federal law. She said that despite the uncertainty, there are benefits to having a basic health plan, including offering a plan for those who lose Medicaid eligibility, more financial protection for those who would lose enhanced premium tax credits, and mitigating the effect of the end of silver loading at the federal level.

Commissioner Grant said the Working Group has been charged with developing a white paper on the state flexibility sections. She said the Working Group would meet in regulator-to-regulator session in July to discuss an outline of the paper and in open session at the Summer National Meeting to solicit stakeholder input on the outline.

Having no further business, the Health Innovations (B) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/B CMTE/National Meetings/ National Meetings/2025 Summer National Meeting/Final Minutes/ Health Innov Minutes 6.20.25.docx

Draft: 5/12/25

Health Innovations (B) Working Group
Virtual Meeting
April 24, 2025

The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met April 24, 2025. The following Working Group members participated: Marie Grant, Chair (MD); Sarah Bailey (AK); Debra Judy (CO); Andria Seip (IA); Alex Peck (IN); Julie Holmes (KS); Robert Wake (ME); Viara Ianakieva (NM); Daniel Bradford (OH); Andrew R. Stolfi (OR); R. Michael Markham (TX); Tanji J. Northrup (UT); and Joylynn Fix (WV). Also participating was Weston Trexler (ID).

1. Heard Presentations on State Flexibilities Under the Affordable Care Act

Grant reviewed the Working Group's plans for the year. She said the current meeting would review state flexibilities under the Affordable Care Act (ACA), and the next meeting would allow states to speak about their experiences using the flexibilities. She said the Working Group plans to meet in person at the Summer National Meeting and subsequently complete work on a white paper that can be shared with the B Committee and other regulators.

Sabrina Corlette (Georgetown University Center for Health Insurance Reforms—CHIR) presented on basic health programs (BHPs) under ACA Section 1331. She said basic health programs replace Marketplace plans for individuals up to 200% of the federal poverty level. The federal government pays states 95% of the amount eligible individuals would have received in premium tax credits in the absence of a BHP. Any surplus of funds must be reinvested in the program. Corlette said the federal government reviews states' blueprints for BHPs, but there is limited statutory discretion for the Secretary of Health and Human Services (HHS) to disapprove an application.

Corlette said that until 2023, Minnesota and New York were the only states with BHPs. Since then, New York transitioned its BHP to a Section 1332 waiver, and Oregon added a BHP. She said that BHPs made fiscal sense for Minnesota and New York because prior to the ACA, both states were using state funds to cover similar populations. She said both Minnesota and New York build BHPs on Medicaid with provider payments and coverage based on Medicaid. She said both states offer benefits beyond the requirements of federal law. She said New York covered its entire program cost with federal funds, while in some years, Minnesota had to add a share of state funds.

Corlette said BHPs can be a cost-effective method of providing coverage to low-income residents, but cost-effectiveness depends on benefit design and market conditions. She said BHPs can aid with continuity of care for individuals transitioning from Medicaid. Challenges with BHPs include increased costs for Marketplace enrollees and changes in provider access for individuals who move from Marketplace plans to BHP. She added that any federal changes that reduce the funds available for premium tax credits also reduce the funding for BHPs.

Corlette said BHPs interact with the rest of the individual health insurance market. She said that, because of the added costs on silver-level plans due to cost-sharing reductions, BHPs can reduce the premium tax credits available for Marketplace enrollees with income above 200% of the federal poverty level. She said that because BHPs shrink the size of the individual market, it can make it less appealing for insurers to offer plans in the individual market. She said the effects of BHPs on the risk pool vary market to market and state to state.

Corlette said an important consideration for states is whether there is a large difference between provider payments in Medicaid and in the individual market. She said analyses have shown that the cost-effectiveness of

BHPs varies quite a bit based on this difference, with more cost-effectiveness when there is a large difference in payment levels.

Dan Meuse (State Health and Value Strategies) presented on state innovation waivers under Section 1332 of the ACA. He said that BHPs are a ready-made solution, and by contrast, Section 1332 is a tool for states to achieve a policy goal. It provides an opportunity to do something different from what is laid out in the ACA and its regulations.

Meuse said changes a state makes under Section 1332 must meet four guardrails, including coverage, affordability, scope, and deficit neutrality for the federal government. He said the approval process includes a review of whether a state's program meets the guardrails. He said states must identify a law they would waive under Section 1332.

Meuse said a key feature of Section 1332 is pass-through funding. He said these are any funds a state's waiver saves from federal spending on premium tax credits. These funds are passed through to the state and can be spent on the state's waiver program.

Meuse said most states with Section 1332 waivers have reinsurance programs, with 19 implementing reinsurance alone and four states with reinsurance in addition to another waiver provision. He said the ACA created a national reinsurance program that ended in 2017. He said at that time, several states had carriers looking to leave the individual market and others with high variability in prices, as well as some states with a risk of counties without any individual market plans. He said reinsurance creates an environment where premiums are more predictable. He said the majority of reinsurance costs are covered by pass-through funds, though nearly all programs require some state funding.

Meuse described the public option plans operated under Section 1332 waivers in two states. He said Colorado and Nevada require certain plans to meet premium reduction targets and other standards. He said Maryland and Washington allow the purchase of Marketplace plans regardless of immigration status. He said Georgia developed a waiver plan to offer plans without a Marketplace, but this portion of its waiver is suspended, leaving only a reinsurance program. Meuse said Hawaii's waiver allows the state's pre-ACA employer mandate requirements to remain in effect. He said New York has the largest waiver, which allows individuals under 250% of the federal poverty level to participate in an expanded BHP.

Meuse said an end to enhanced premium tax credits will lower state pass-through amounts. He said lower enrollment in Marketplace plans due to the 2025 Marketplace Integrity and Affordability Proposed Rule would also lower pass-through amounts. He said Section 1332 waivers do not increase pass-through amounts because they enroll more individuals. He said potential new guidance from the Trump administration could change the policy priorities that receive approval as a state waiver.

Seip asked about Hawaii's Section 1332 waiver. Meuse said Hawaii has a unique situation because in the 1970s, it passed a mandate for private employers to offer health coverage. Its mandate requirements conflicted with small group requirements under the ACA, so the state sought a waiver of the ACA requirements. He said with the waiver, the state can continue to operate its employer mandate and receive a small amount of pass-through amounts due to federal savings on small business tax credits.

Randy Pate (Randolph Pate Advisors) presented on interstate health care compacts under Section 1333 of the ACA. He said HHS has not issued regulations under Section 1333 even though the ACA contemplated regulations by 2012. He said the section allows the sale of health insurance across state lines.

Pate said states may want to consider Section 1333 compacts because they offer greater flexibility and decision-making authority for states. He said they also offer greater stability in regulations because a state-level compact will be insulated from changes in federal administrations.

He said a compact must first be enacted under state law. It must comply with guardrails similar to the Section 1332 guardrails. Additionally, a Section 1333 compact may not weaken state consumer protection laws. He said that Section 1333 is under a constitutional foundation different from Section 1332, so the compact could be considered to have the force of federal law, depending on how regulations are written. He added that Section 1333 compacts do not have a statutory term limit, in contrast with the maximum five-year terms of Section 1332 waivers.

Pate said Section 1333 compacts could accomplish most of the policy changes that could be pursued under Section 1332. He cited examples of changing the premium tax credit structure, using flat or age-adjusted credits, or implementing reference-based pricing as part of the tax credits. He said states could also take a more minimal approach, such as by addressing network adequacy requirements. He said many other ideas are possible, such as specialized plans for chronic conditions or changes to actuarial value levels.

Pate said the Trump administration or a future one could issue regulations under Section 1333. The regulations could be minimal, defining the statutory guidelines, or they could be more extensive and provide templates for states to follow in adopting a compact. He said federal policymakers would need to decide whether to interpret the guardrails as they have under Section 1332 and how pass-through funding would work. Pate said a state interested in a Section 1333 compact would need to find one or more like-minded states to work with and develop administrative capacity. He said the current director of the Center for Consumer Information and Insurance Oversight (CCIIO) authored a paper on Section 1333 compacts last year, so it will be interesting to see whether there is a proposed rule under this administration.

Trexler asked whether states can move forward before regulations are issued in consultation with the NAIC. He also asked whether the Internal Revenue Service (IRS) would be able to administer a different tax credit structure for states with a Section 1333 compact. Pate said consultation with the NAIC is required under the statute, so it would need to take place first. He said it is early in the administration, so there is still an opportunity for consultation and issuing regulations. He said the IRS has limited ability to administer different versions of the premium tax credit, but that could change over time. He said an alternative approach is for compacting states to administer the tax credits using pass-through funds. Grant said the Working Group should consider the key issues for the NAIC to bring to any consultation regarding Section 1333 regulations.

Grant asked whether a Section 1333 compact could be paired with a Section 1332 waiver to achieve more ambitious changes. Pate said the two authorities could be paired. He said Section 1333 allows compacting states to alter rules for qualified health plans, without further definition on what can be done. He said regulations would be important in providing further definition. Amy Killelea (Consumer Representative) urged regulators to consider the impact on consumer protections under any of the state flexibilities. She said the federal floor of protections has been important and should be maintained.

Having no further business, the Health Innovations (B) Working Group adjourned.

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NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

MEMORANDUM

TO: Commissioner Glen Mulready, Chair of the Health Insurance and Managed Care (B) Committee

FROM: Kevin Dyke, Chair of the Health Actuarial (B) Task Force
Fred Andersen, Chair of the Long-Term Care Actuarial (B) Working Group

DATE: July 23, 2025

RE: Amendments to the LTCI MSA Framework

Please find attached an amended version of the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework) for consideration by the Health Insurance and Managed Care (B) Committee. The key amendments are: 1) a change from two actuarial rate review methodologies to a single rate review methodology; 2) a revised cost-sharing formula; and 3) moving the governance of the LTCI MSA Framework and related processes to the Health Actuarial (B) Task Force, and other related work such as reduced benefit options, to the Senior Issues (B) Task Force.

The amendments described above were discussed in open session multiple times. All amendments were exposed for public comment by the Long-Term Care Actuarial (B) Working Group, and/or the former Long-Term Care Insurance (B) Task Force. Comments received were discussed and addressed. Amendments described in #1 and #3 above were adopted by the Long-Term Care Insurance (B) Task Force on December 18, 2024, and amendments described in #2 above were adopted by the Health Actuarial (B) Task Force on July 14, 2025.

The revisions to the LTCI MSA Framework are recommended for adoption by the Committee.

If you have any questions about the amendments, please contact NAIC staff, Eric King or Jane Koenigsman.

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