REGULATORY FRAMEWORK (B) TASK FORCE

Regulatory Framework (B) Task Force Aug. 12, 2025, Minutes

Employee Retirement Income Security Act (ERISA) (B) Working Group Aug. 12, 2025, Minutes (Attachment One)

Prescription Drug Coverage (B) Working Group Aug. 11, 2025, Minutes (Attachment Two)

Prescription Drug Coverage (B) Working Group May 19, 2025, Minutes (Attachment Two-A)

Draft Pending Adoption

Draft: 8/19/25

Regulatory Framework (B) Task Force
Minneapolis, Minnesota
August 12, 2025

The Regulatory Framework (B) Task Force met in Minneapolis, MN, Aug. 12, 2025. The following Task Force members participated: Grace Arnold, Chair (MN); Allan L. McVey, Vice Chair, represented by Joylynn Fix (WV); Heather Carpenter represented by Sarah Bailey (AK); Mark Fowler represented by Yada Horace (AL); Maria Ailor represented by Fausto Burruel (AZ); Michael Conway represented by Debra Judy (CO); Andrew N. Mais represented by Jane Callanan (CT); Karima M. Woods represented by Howard Liebers (DC); Michael Yaworsky represented by Alexis Bakofsky (FL); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Shannon Hohl and Weston Trexler (ID); Holly W. Lambert represented by Alex Peck (IN); Vicki Schmidt represented by Craig VanAalst (KS); Sharon P. Clark represented by Shaun Orme (KY); Michael T. Caljouw represented by Kevin Beagan (MA); Robert L. Carey represented by Robert Wake (ME); Angela L. Nelson represented by Amy Hoyt (MO); Mike Causey represented by Robert Croom (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning represented by Martin Swanson and Michael Muldoon (NE); Justin Zimmerman (NJ); Ned Gaines (NV); Judith L. French represented by Laura Miller and Tony Bonofiglio (OH); Glen Mulready (OK); T.K. Keen (OR); Michael Humphreys (PA); Larry D. Deiter represented by Jill Kruger (SD); Cassie Brown represented by Latif Almanzan (TX); Jon Pike represented by Shelley Wiseman (UT); Scott A. White represented by Julie Blauvelt (VA); Patty Kuderer represented by Jane Beyer (WA); and Nathan Houdek represented by Coral Manning (WI). Also participating was: Marie Grant (MD).

1. Adopted its Spring National Meeting Minutes

Kruger made a motion, seconded by Swanson, to adopt the Task Force's March 25 minutes (*see NAIC Proceedings – Spring 2025, Regulatory Framework (B) Task Force*). The motion passed unanimously.

2. Adopted the Reports of its Working Groups

Bartuska made a motion, seconded by Fix, to adopt the following working group reports: 1) Employee Retirement Income Security Act (ERISA) (B) Working Group (Attachment One); 2) Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group; and 3) Prescription Drug Coverage (B) Working Group (Attachment Two). The motion passed unanimously.

3. Heard Opening Remarks

Commissioner Arnold said that during today's meeting, the Task Force will hear from AHIP and the BlueCross BlueShield Association (BCBSA) on new commitments by some of their member companies to streamline and simplify the prior authorization (PA) process. She explained that there would not be a lot of time for questions on this new initiative. As such, she anticipates limiting questions on it to Task Force members and interested state insurance regulators. Commissioner Arnold said the Task Force's agenda also includes an update on the work being done to develop a white paper on PA frameworks. She said that although PA is not going to be the subject of the bulk of the Task Force's agenda for its meeting today, she anticipates the Task Force discussing PA more over the next few months as it continues its work on the white paper.

4. Heard an Update from the BCBSA and AHIP on Health Plans' Commitment to Streamlining and Simplifying PA

Monica Auciello (BCBSA) provided a high-level overview of AHIP's and the BCBSA's PA industry initiative to streamline and simply the PA process. She said AHIP and the BCBSA sent a joint letter to the NAIC in July outlining

the commitments of about 60 health insurance plans across the country to join this initiative. She said these commitments were developed jointly by AHIP and the BCBSA at the direction of their chief executive officers (CEOs) who recognized and were aligned on the need to improve and drive meaningful change in the PA process to build a better system of health and better experience for members and providers.

Auciello said that, as payers, their mission is to ensure they provide coverage for care that is safe, effective, and evidence-based while ensuring health care resources are used wisely. She said that while PA is a critical tool in that process, both AHIP and the BCBSA recognize that the process is not perfect. She acknowledged that state insurance regulators and other state policymakers have been receiving calls and hearing complaints from members and providers expressing frustrations with the PA process, which reinforces the need for change.

Auciello said the PA industry initiative focuses on three key areas: 1) reducing the scope of claims subject to PA; 2) expanding real-time responses; and 3) enhancing communication and transparency on determinations. She said these commitments build on actions that individual plans have already begun. Auciello said the BCBSA appreciates the Task Force's work on the PA white paper. She said the BCBSA is also committed to working with the Task Force to identify additional opportunities to collaborate on the work already underway in many states to improve the PA process.

Jeanette Thornton (AHIP) said that as Auciello noted, the PA industry initiative stems from the recognition that people are frustrated with the PA process. She said that to address this, AHIP and the BCBSA began joint discussions with their leadership and worked through what can be done today to make the PA process work better for both patients and providers. She said the commitments being made to improve the PA process align around those goals. Thornton acknowledged the work that a number of states have already done to improve the PA process. She said many of the commitments reflect this work and build on it. She also said AHIP and the BCBSA recognize that they will need to work with providers as well as the states as they work to implement the initiative. Thornton discussed AHIP's and the BCBSA's outreach to provider, consumer, and employer stakeholders as they were developing these commitments.

Thornton said AHIP and the BCBSA are committed to measuring the progress of those plans that have committed to participating in the PA industry initiative and plan to hold them accountable with public reporting on their progress. She said AHIP and the BCBSA look forward to detailed briefings and discussions with the states and the NAIC on this progress. She discussed the commitments that participating plans have made by Jan. 1, 2026, concerning transparency in PA determinations. Those include: 1) explaining with clear and personalized language about any prior authorization denials, including information about next steps and available appeals processes; 2) providing staff to help plan members understand the PA process and their options after a PA determination is made; and 3) greater standardization of the data processes and questions supporting PA determinations.

Beyer asked if AHIP and the BCBSA intentionally have not included prescription drugs in their PA industry initiative because the federal Transparency in Coverage (TIC) rule does not include prescription drugs. Thorton acknowledged that PA industry initiative does not address every issue with PA. She said the vast majority of the PA requests do not involve prescription drugs. She said, however, the commitments regarding continuity of care do apply to prescription drugs. Thorton said she anticipates additional federal rules will include prescription drugs and that AHIP and the BCBSA will be actively involved in that process.

Commissioner Arnold asked Auciello and Thornton to expand on, if possible, the benchmarks and data that AHIP and the BCBSA plan to use to evaluate and monitor progress on the commitments being made as part of the PA industry initiative. Thornton said AHIP and the BCBSA plan to collect information from the participating plans and publicly report that information. She said that as far as benchmarks are concerned, AHIP and the BCBSA will be reporting plan progress for all the commitments, some of which will take effect in 2026 and others in 2027. In measuring that progress, AHIP and the BCBSA will be looking at where PA was reduced, how continuity of care

was supported, and what actions plans took to streamline and simplify their notices. Commissioner Arnold asked if AHIP and the BCBSA plan to survey patients and providers as another way of measuring progress. Thornton said they will commit to conducting such surveys.

AHIP and BCBSA were asked if they have specific plans to discuss the PA industry initiative with state insurance regulators and discuss how the commitments under that initiative could affect consumers in that state. Auciello said AHIP and the BCBSA have encouraged all their plan members participating in the initiative to have direct conversations with state insurance regulators on the actions they plan to take in their states both to align with the state's regulatory requirements and to ensure that state insurance regulators can also measure progress in streamlining and simplifying the PA process in their state.

Hohl asked if Thornton could elaborate on the timeline for plans participating in the PA industry initiative to complete certain commitments. Thornton said commitments to be completed by Jan. 1, 2026, are commitments to: 1) reduce the volume of in-network medical PAs and measure that reduction plans will provide data for public reporting of the extent of such reductions reflecting actions taken since January 2024; and 2) support continuity of care by honoring a previous plan's PA for the same service, under the same type of benefit in network for a 90-day transition period when a member changes plans after starting a course of treatment. She said the other set of comments applying on Jan. 1, 2027, concern standardization and faster decision time. She said the Jan. 1, 2027, date for these commitments is because AHIP and the BCBSA are dovetailing on what is required under the federal TIC rule.

Beagan asked if, as part of this industry PA initiative, AHIP and the BCBSA are looking to develop other guidelines related to utilization review, such as retrospective review and concurrent review. Thornton said they started with PA, but they could possibly extend it to those other areas. She said standardization will be particularly relevant if they move in that direction in the future. Trexler said standardization seems to be critical to many of the PA industry initiative commitments to streamlining and simplifying the PA process. He asked how state insurance regulators can assist AHIP and the BCBSA to have this commitment to more standardization be implemented in a timely manner. Thornton described the elements needed for the standardization piece to move forward. She said providers are a critical component. Thornton said AHIP and the BCBSA would be happy to talk more about standardization during a future Task Force meeting.

Carl Schmid (HIV+Hepatitis Policy Institute), speaking on behalf of the NAIC consumer representatives, said the NAIC consumer representatives appreciate the Task Force's and, as reflected in the AHIP and BCBSA PA industry initiative, the plans' attention to PA. He said despite the plan commitments being made, it is voluntary. He said there still needs to be state and federal laws in place to ensure these commitments become a reality. Schmid pointed out that many of these commitments are required by federal law, including the time frames for implementation for many of them. He also noted that for the commitment to reduce the number of claims requiring PA, there is no clear goal or percentage required to show such reductions. Schmid said there also remains the need to address prescription drugs. He said the NAIC consumer representatives look forward to continuing to work with the Task Force and AHIP and the BCBSA on PA.

5. Heard a Discussion on the Federal Deregulation Initiative

Katie Keith (Center for Health Policy and the Law at the O'Neill Institute, Georgetown Law) provided background on the Trump Administration's federal deregulation initiative. She said the Trump Administration has issued at least nine deregulatory directives in the first six months. These include directives requiring that 10 rules be cut for every new rule, allowing federal agencies to repeal regulations without public notice, and eliminating disparate impact liability for civil rights protections.

Keith said there has been less deregulatory action at the U.S. Department of Health and Human Services (HHS) to date. She said, however, that this most likely will not continue given the HHS' Request for Information (RFI): "Ensuring Lawful Regulation and Unleashing Innovation to Make America Healthy Again" issued in May.

Keith highlighted the HHS' deregulation activity to date, which includes: 1) revocation of guidance under the federal Emergency Medical Treatment and Active Labor Act (EMTALA); 2) revocation of Medicaid and the Children's Health Insurance Program (CHIP) guidance on health-related social needs and Section 1115 waivers; and 3) nonenforcement of the short-term, limited-duration (STLD) plan rule. She also discussed health care deregulatory action at other federal agencies, including the federal Consumer Financial Protection Bureau's (CFPB's) revocation of the federal No Surprises Act (NSA) reporting requirements and deceptive medical debt collection practices.

Keith said that in addition to the deregulatory actions she discussed that the HHS has taken to date, in February 2025, HHS Secretary Robert Kennedy, Jr. rescinded the Richardson waiver. She said that in rescinding that waiver, the Secretary said the prior policy was contrary to the text of the federal Administrative Procedure Act (APA) and imposed extra-statutory obligations on the HHS. She explained that the federal APA exempts certain agency actions from notice and comment procedures: 1) agency management, personnel, public property, loans, grants, benefits, or contracts; or 2) for "good cause" if notice and comment is "impracticable, unnecessary, or contrary to the public interest." The Richardson waiver required HHS to use notice and comment for these categories of agency action and to use the "good cause" exception "sparingly." She said that the February 2025 notice rescinding the Richardson waiver allows use of the "good cause" exception "in appropriate circumstances." Keith said despite rescinding the Richardson waiver, to date, HHS has continued to use notice and comment procedures for many of its health care rules.

Keith discussed implications for consumers and stakeholders regarding the Trump Administration's federal deregulation initiative. She said broad deregulation could disrupt the complex, highly regulated health system that consumers and patients rely on because of abrupt changes to consumer protection laws and other federal programs. She said notice and public comment are critical for transparency and allow those most affected to explain how proposed changes would support or limit access to care or impose new burdens on providers, insurers, state officials, and other stakeholders. Keith said deregulatory changes will contribute to confusion at the same time as federal agencies experience staffing reductions, reorganizations, and funding freezes.

Keith highlighted certain issues and considerations for state insurance regulators as the Trump Administration moves forward with its deregulation initiative. She said those include whether HHS will move forward more aggressively in the fall with deregulatory action and, if so, whether HHS will try to invoke the Richardson waiver or use the notice and comment processes. She said another issue to watch is how much litigation there will be and how it will change how the courts interpret the federal APA and its requirements.

Brian Blase (Paragon Health Institute) discussed some of the major items of insurance regulation that will affect the states this year and next year. He said the first is the STLD plan regulation. He explained that the federal agencies on Aug. 7 announced suspension of enforcement of the Biden Administration's STLD plan rule. Blase said the federal agencies should restore the policy adopted by the Trump Administration in 2018. He said there is no evidence that permitting STLD plans harmed the ACA market. He said that, in fact, the ACA market was strengthened in those states that fully permitted the sale of STLD plans under the 2018 rule. Blase discussed research supporting his assertion.

Blase next discussed farm bureau health benefit plans. He explained how they are regulated, noting that more than a dozen states exempt farm bureau health benefit plans from the definition of "insurance." He highlighted and detailed the average monthly premium costs as compared to certain ACA plans for such plans offered in Kansas, Missouri, and Nebraska.

Blase next discussed association health plans (AHPs). He said that in 2018, the U.S. Department of Labor (DOL) adopted a rule creating another pathway for small businesses to join together regardless of the type of business. He said the rule was struck down in 2019, and later the Biden Administration reversed it. Blase said that one action the Trump Administration could take is to initiate rulemaking addressing the court's concerns.

Blase next discussed individual coverage health reimbursement arrangement (ICHRAs). He said the Trump Administration adopted this rule in 2019 to provide another way for employers to offer health insurance. He explained that the rule allows employers to provide a tax-preferred contribution to employees to use toward purchasing an ACA-compliant individual market plan. He said there is a large set of rules for how employers can structure ICHRAs.

Blase discussed issues with enhanced ACA premium subsidies. He said that based on Paragon's research, those issues included billions in improper federal spending and potential enrollment fraud with more than one in three individual market enrollees using $0 of medical care in 2024, a huge increase from 2020. Blase said extending the enhanced subsidies would cost around $40 billion per year, including interest costs on additional deficits. He said Paragon suggests that Congress allow the enhanced subsidies to expire or fundamentally revise the provision.

Burruel asked Blase about the statistics on the individual market enrollment based on STLD plans based on favorable or unfavorable states. He said he would like more background on the statistics because he would assume that if a state is unfavorable towards STLD plans, there would be an increase in enrollment as compared to the favorable states. Blase said there is a paper he authored in 2023 posted on Paragon's website that describes his methodology. He said that using data from the Commonwealth Fund, Paragon splits states into favorable states and unfavorable states. Favorable states were those states that fully permitted STLD plans consistent with the Trump Administration's 2018 rule. Blase said that about half the states fell into that category, and about half the states fell into the other unfavorable category. He said that to get the numbers, Paragon obtained exchange enrollment in 2018 and 2023 in both of those categories of states. Paragon also obtained data on insurer participation and premium costs. He said Paragon was also surprised by the results, which ran against the narrative that expanding STLD plans would harm the individual market, reduce insurer participation, and increase premiums.

Commissioner Zimmerman said this has not been New Jersey's experience. He said New Jersey restricted STLD plans, which resulted in an increase in insurer participation. He acknowledged that it is just one state's experience, but he suggested that Blase provide the information supporting his findings. Blase agreed to submit the information to the Task Force.

Lucy Culp (The Leukemia & Lymphoma Society—LLS), speaking on behalf of the NAIC consumer representatives, said the NAIC consumer representatives have concerns about the Trump Administration's deregulation initiative. She said the NAIC consumer representatives are particularly concerned about the initiative as it relates to plans that are less generous to consumers than those on the ACA exchanges, such as Farm Bureau health benefit plans and STLD plans. She said the NAIC consumer representatives appreciate the discussions today on this issue and look forward to participating in additional discussions on the issue in the future.

6. Heard an Update on Work to Develop a PA Framework White Paper

Commissioner Arnold provided a quick update on the Task Force's work to develop a PA framework white paper. She said that at the beginning of July, the Task Force's small drafting group completed its work to develop an initial white paper draft. She said that on July 18, NAIC staff distributed the draft for a public comment period ending Aug. 29. Commissioner Arnold said that after the public comment period ends, she anticipates the Task Force holding at least one meeting to discuss the comments received and discuss whether it wants to incorporate any

of the suggested revisions. She said she believes the Task Force remains on track to adopt the white paper by the end of the year.

Having no further business, the Regulatory Framework (B) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/RFTF/National Meetings/2025 Summer Meeting/RFTF 8-12-25 MtgMin.docx

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Employee Retirement Income Security Act (ERISA) (B) Working Group
Minneapolis, Minnesota
August 12, 2025

The Employee Retirement Income Security Act (ERISA) (B) Working Group of the Regulatory Framework (B) Task Force met in Minneapolis, MN, Aug. 12, 2025. The following Working Group members participated: Robert Wake, Chair (ME); Andria Seip, Vice Chair (IA); Crystal Phelps (AR); Weston Trexler (ID); Craig Van Aalst (KS); Rebecca DeLaSalle (LA); Amy Hoyt (MO); Robert Croom (NC); Martin Swanson (NE); Jon Wycoff (NV); Craig Kalman (OH); Travis Jordan (SD); Ryan Jubber (UT); Julie Blauvelt (VA); Jane Beyer (WA); and Sarah Smith (WI).

1. Discussed ERISA Preemption of PBM Laws

Wake said that at the beginning of the year, the Working Group was asked by the leadership of the Health Insurance and Managed Care (B) Committee to provide insight on the issue of ERISA preemption of state pharmacy benefit manager (PBM) laws after the U.S. Supreme Court (SCOTUS) decision in *Rutledge v. PCMA*. This issue goes beyond the traditional saving clause issues because the Rutledge decision recognizes that some degree of regulating the entire PBM is not preempted by ERISA, even for PBMs that work with self-funded plans. However, there is a lot of controversy over how much room SCOTUS left. The issue remains in flux: ERISA preemption challenges to state PBM laws are continuing, some successfully, some not. The state laws being challenged are varied in scope and focus. SCOTUS recently denied a writ of certiorari in the case of *Mulready v. PCMA*. There is a lot of activity underway at the NAIC looking at state PBM laws. The Pharmacy Benefit Management (D) Working Group and the Prescription Drug Coverage (B) Working Group have been hard at work, and PBM laws have also been discussed at the Attorney Roundtable. The NAIC legal division is also tracking PBM litigation in the states.

Wake suggested, and the Working Group agreed, that convening a small group of interested regulators to discuss developing a guidance document looking at ERISA preemption of state PBM laws since the Rutledge decision made sense. The intent is to develop a final product that will guide state insurance regulators, using current case law, in assessing which PBM laws may be more or less susceptible to ERISA preemption.

2. Heard a Presentation from NABIP on Level-Funded Plans

Wake explained that another priority of the Health Insurance and Managed Care (B) Committee that was delegated to the ERISA (B) Working Group is to "examine alternative arrangements relating to the small group market." The planned presentation on level-funded plans is a first step in addressing this priority.

Susan Rider (National Association of Benefits and Insurance Professionals—NABIP) and David C. Smith (NABIP) presented on level-funded health benefits from the market perspective of agents, brokers, and consultants. Wake and Seip provided the presenters with a number of questions in advance that they addressed during their presentation.

Rider explained that NABIP represents more than 100,000 professionals who work with consumers of health and related products in the U.S. Beyond the usual agents, brokers, producers, and consultants, NABIP also works with related professionals like attorneys, certified public accountants (CPAs), and human resource professionals, as well as service providers like third-party administrators (TPAs), insurers, stop-loss carriers, and PBMs. NABIP

members serve the health insurance needs of large and small employers as well as people seeking individual health insurance coverage.

Rider explained that NABIP developed the "NABIP American Healthcare Consumer Bill of Rights" that lists 10 priorities NABIP professionals are committed to pursuing to uphold the rights of every American to have affordable, high quality health care: 1) right to access affordable health care; 2) right to quality care; 3) right to privacy and confidentiality; 4) right to individual autonomy; 5) right to health equity; 6) right to health education; 7) right to affordable medications; 8) right to emergency care; 9) right to health care advocacy; and 10) states rights. From a practical perspective, NABIP members are directly connected to, and best positioned to advocate on behalf of employers who are considering their options for financing health benefits, assessing the impact of regulation, and balancing the risks, rewards, and unanticipated consequences of buying decisions on their employees and covered dependents. The things NABIP looks at from a policy perspective include ways to finance health benefits and really understanding the impact of various regulations on the products and services that are delivered to clients.

Smith explained that level-funded is a financing vehicle by which employers are purchasing a health benefit option. These are self-funded plans that are exempt from certain Affordable Care Act (ACA) mandates. They can be underwritten based on risk, which is not permitted in fully insured group health plans for small employers. Healthier groups are carved out and put into these self-funded arrangements. State benefit mandates do not apply due to ERISA preemption. From a market perspective, there are an increasing number of competitive alternatives when compared to traditional markets, where there are fewer carriers compared to 10 years ago.

Level-funded arrangements are attractive to employers because, in the yin and the yang of market stability versus getting a product at the lowest possible cost, many small employers with healthy employees lost access to low-risk discounts that existed in states prior to the adoption of the ACA rules. Now, due to lower costs, there are options with narrow networks and other kinds of plan designs that create greater competition for employers trying to get coverage for their employees at the lowest possible cost.

Smith noted that one common question is what makes this appealing to carriers and service providers. In many states, those selling these products may be TPAs or stop-loss carriers rather than licensed health insurance providers. This allows more flexibility regarding who can offer products in the small group market. There is also greater flexibility because of ERISA preemption and the avoidance of compliance costs. This also allows carriers and other providers to have additional revenue come in because of PBM revenue. Medical loss ratio rules are not applicable to level-funded plans, meaning there is no requirement for a specific percentage of premiums to be allocated toward claims.

Smith indicated that concerns about level-funded plans stem from their frequent presentation as being just like fully insured health benefit plans. This nomenclature has led to purchasing decisions that are not always fully informed. NABIP has found that many employers do not understand that they are in a self-funded arrangement and are unaware of the requirements that go with that, such as the requirements of stop loss, like managing eligibility and subrogation, and other contract terms that apply to level-funded products, such as claims incurred versus paid. Smith shared some examples of employers not understanding their obligations. One example involved a workers' compensation claim that got pulled out of the health plan because of subrogation.

Smith noted that compliance obligations are often missed. Employers with fewer than 20 full-time employees (FTEs) follow state continuation rules, which only affect health insurance products and not self-funded plans. As a result, employees with level-funded plans do not have a continuation option, posing a challenge. Other

commonly overlooked rules are Form 5500 reporting, ACA reporting, excess claims fund handling, non-discrimination requirements for self-funded plans, mental health parity compliance, and certain state reporting obligations. Smith mentioned some emerging risks, such as Medicare estimation for employers with fewer than 20 employees. This means that an employer is counting any employee who is 65 or over as being on Medicare, whether they are enrolled or not, and the health plan is paying only what they would pay as a secondary payer. Other emerging risks include new federal reporting requirements like Prescription Drug Data Collection (RxDC), the No Surprises Act, and state requirements not otherwise preempted by ERISA and general fiduciary compliance. Smith said the reality is that level funding is the only way that some small employers can offer coverage to their employees, and they must be healthy to do it.

Smith described level-funded plans as arrangements where employers pay a monthly amount resembling a premium, typically covering three components. The first is stop-loss insurance, which features a specific attachment point to cap employer liability per participant and an aggregate attachment point to limit total liability for all participants within the contract period. The second component covered by the employer is an administration fee, which is used for managing medical and pharmacy benefit claims. The final component paid by the employer is the claims reserve, which is allocated to the administrator for claims below the stop-loss threshold. For example, Smith presented a scenario involving a group of 30 employees who pay an average monthly premium of $20,500. Over 12 months, $108,000 is allocated to the claims reserve, $96,540 is spent on stop-loss coverage, and $41,000 covers administrative costs. These figures exclude any additional revenue, rebates, or financial incentives received by the administrator or PBM.

Smith reviewed questions that were submitted by Wake and Seip in advance of the presentation:

A. Are there common stop loss attachment points?

Smith said there is a lot of variation when it comes to attachment points. Half of the states have stop-loss mandates, with specific minimum thresholds starting at $10,000, while at least two states set the minimum specific attachment point near $50,000. For each person covered under the plan, the group is responsible for paying the first $10,000 to $50,000 of claims per individual from the claims fund. With respect to aggregate attachment points, those range from 110% of expected claims to 125%. There is not a lot of consistency, and attachment points vary based on underwriting and exposure points.

B. Are there monthly limits on attachment points?

Wake said if the aggregate attachment point is calculated on an annual basis, an employer has to pay that amount in claims that year before the aggregate stop loss kicks in. If the plan is level funded, the employer is paying into the claim reserve on a monthly basis and will eventually reach the attachment point. But what happens if the claims come early and the claims reserve has not hit the attachment point yet? Smith said, in his experience, nearly every level-funded plan over the last five years includes a monthly accommodation that limits how much the group has to pay out of pocket. Ideally, a level-funded plan would prevent or preserve a group from having any claims exposure beyond what they put in their claims reserve. A monthly accommodation is critical for that to work. How the underlying aggregate attachment point is calculated is also a function of the contract type (12/15; 12/24; 12/27) because it needs to cover all the claims incurred during the plan year, as the employer thinks it is just like a fully insured plan. Wake asked whether the monthly accommodations accrue interest or are given as an interest-free loan, which then changes what the attachment point is. Smith said he has not seen anyone charged for that accommodation.

C. Are there annual or lifetime limits on stop loss?

Smith said he has never seen a cap on specific stop-loss reimbursements. He said that nearly every aggregate stop-loss contract he has seen has a $1,000,000 cap on aggregate stop-loss reimbursements. Smith said this can be problematic given the increasing number of 1,000,000-dollar claims seen over the past several years.

D. Are there situations where a benefit claim might not be fully covered by the combination of the claims fund and the stop-loss insurance?

There are situations where a claim may not be fully covered between the claim fund and stop loss insurance. Smith explained that when the stop loss contract terms have inadequate runout protection (such as a 12/15 versus a 12/27 contract), then there will be claims incurred during the contract period that are not paid until after the 15th month, and the group is going to have exposure for that. The employer buys the less expensive option and is often unaware of that potential lack of coverage. Smith said in his experience, large carriers selling level-funded plans are going to make sure that employers purchase adequate stop loss because they want to avoid negative regulatory attention or public scrutiny. Smaller TPAs and stop-loss vendors will sell the shorter contracts because they are not as worried about the attention.

E. What kind of tail coverage is typically provided?

Smith said tail coverage varies significantly based on what is in the market.

F. Are there any circumstances where the plan year will end with the policyholder still owing money after paying all 12 monthly installments?

Smith said NABIP has seen situations where plan years end with the policyholder still owing money even after they paid all 12 months because of stop-loss contract terms, and occasionally because of the delays, the increased adoption of reference-based or non-network plans has resulted in an increase in the length of time it takes for claims to be submitted, negotiated, and ultimately paid.

G. If there are any gaps in protection, how are they disclosed to the customer?

Smith indicated that gaps in coverage are relatively frequent. The most frequently observed gaps pertain to the definitions of "actively at work," dependent eligibility, and exclusions for certain benefits, such as those related to work accidents. Smith also noted that provisions regarding the right to recovery under subrogation, especially in relation to workers' compensation, have arisen on four occasions in the past five years. Another matter that has arisen concerns the way rebates are associated with aggregate accommodations. In two instances over the past year, groups that would have typically received returned claims reserves did not, due to a calculation method that included retained rebates. As a result, no claims funds were returned based on this approach. In Smith's experience, these issues are rarely explained well in simple language for review by the employer and usually are buried within the terms of the stop-loss or administrative agreement. This product is distributed by agents, brokers, and consultants who are accustomed to working within a regulated group market and have established expectations regarding how things are done. In the level-funded environment, there are notable differences between regulated and licensed carriers, TPAs, and stop-loss carriers. The rules and their enforcement vary, which results in an increased number of claims being denied or excluded under a level-funded plan.

H. Is there a contractual commitment that the monthly stop-loss premium, administrative fee, or claims fund contribution cannot change during the plan year?

Smith confirmed that there are usually contractual commitments not to change what the employer pays for stop-loss and administrative contracts, unless there is a change in membership that exceeds thresholds. Smith said they have seen a few issues tied to completion of the contract term, which sometimes means the group may not meet their minimum participant count or minimum premium/attachment points being satisfied. Other times, an

employer needing to sell their business or go out of business will occasionally create a problem where there is a gap in who is going to cover those claims.

I. Are these plans offering comprehensive medical and prescription drug benefits compared to fully insured plans?

Smith said in his experience, level-funded plans do cover all essential health benefits (EHBs); however, the benchmark plans used to ensure compliance may vary significantly based on carrier or service provider. For example, a plan in North Carolina was using a benchmark plan from Utah because it was not as comprehensive. There is also some variability in terms of what is covered outside of EHBs, like GLP-1 medicines, chiropractic care, or other limits on visits for certain services.

J. How are groups rated (because there can be underwriting)?

Smith said the underwriting has continued to change. Originally, when these products were coming to market, there were a lot of individual medical questionnaires. Within the last three years, there has been increased use of artificial intelligence (AI) underwriting, such as gradient AI, as well as an increased reliance on the data within the national pharmacy or the prescription drug database. Smith said there is also increased use of Consolidated Appropriations Act (CAA) data from current fully insured plans. Access to that data varies significantly based on the market and the carriers.

K. What are the typical premium levels compared to ACA small group plans?

Smith said if they were not cheaper than ACA plans, they would not have any growth. Level-funded pricing is generally 5% to 15% better than the fully insured alternative. In the market today, underwriting produces one of two outcomes: if you are a carrier or a service provider that is very good at cherry picking, you are finding the good, healthy groups and taking them out of the market. The employer groups that are left are turning to the residual market. Now, the only people who are left are the unhealthy small groups who will not survive the underwriting process. NABIP has seen carriers and service providers decline to quote a group that does not pass that threshold of affordability or their underwriting criteria.

L. How much churn is there in the market?

Smith said he has not observed too much churn, but with more people coming into the market, more incentives are being offered, such as guarantee claims balances and administration credits. This has resulted in more competition in the level-funded market than in the small group insured market.

M. What is the actual dividend experience for level-funded plans?

Smith said that based on NABIP's experience, the number of employers getting a claims refund is low (less than 20%), usually because the expense ratio between claims, administrative costs, and stop-loss varies significantly. Smith said if less than 50% of what an employer is paying each month is going into a claims fund, the chance of the employer getting any of that claims fund back is close to zero.

N. What are the expense and profit ratios?

Smith said the expense and profit ratios vary based on factors such as the percentage of monthly "rates" that are put into claims reserve, the amount of excess claims balance retained by the administrator or the carrier as "additional administrative fees," the specific stop-loss premium, and the aggregate stop-loss premium. Smith said that aggregate stop loss inside the level-funded market costs around three to eight times more than in the traditional self-funded market, partially because level-funded groups are smaller, and there is a much higher likelihood of an aggregate stop-loss claim than there is in the traditional self-funded market.

O. Is there any market for level-funded arrangements in the "small, large group" market (50-250)?
Smith said there are products available for groups above small group thresholds, with varying degrees of approaches, like minimum premium or balance funding.

P. Why do these employers self-fund rather than buy a large group policy with the same plan design?
Smith said employers who can get through the underwriting process will self-fund because of price. From the carrier perspective, there are three incentives to self-fund: 1) there is less transparency about additional revenue sources they may have, particularly related to PBMs; 2) what they are able to charge in stop loss; and 3) they are escaping state regulation and state benefit mandates. For those three reasons, it is going to be more attractive for a larger group with a moderate risk level to be level-funded than to be fully insured. Smith will talk to groups about the level-funding option as a way for certain employers to think about self-funding, and this is a way to dip their toe in that water, and if they are doing this right, they are building better reserving practices.

Smith made three recommendations. He said that it is important to remember that the first person an employer or client calls when faced with a rate increase is their agent or broker who sold them the policy. Each of Smith's recommendations reflects that perspective and what NABIP members see in different markets. Smith said that every state has a regulatory nexus to level-funded plans through the regulation of stop-loss insurance. In North Carolina, until 2021, stop loss could not be sold to groups smaller than 25 employees. Then it dropped to 20 employees, and in October, the legislature dropped it to 12 employees.

First, NABIP recommends common contract definitions for things like stop-loss contract terms, how they are defined, and requiring things like mirroring provisions. Second, clearer disclosure requirements for level-funded groups would ensure that employers know what they are purchasing. Smith said a number of years ago, his association put together a spreadsheet detailing the disclosure to employers to ensure that employers understood what they were buying when they bought a level-funded plan. Last, NABIP recommends the application of the compensation transparency rules to all level-funded service providers, such as TPAs, stop-loss carriers, and PBMs, so employers understand the cost impact of those services.

Smith said there should be information disclosed about not only the patients and the individual members who are covered, but also the employer who is buying a level-funded plan as opposed to a fully insured plan. He said detailed disclosure requirements will shift the power back to the employer to look at their options, which means provider and diagnosis information, high-cost claimant diagnosis and prognosis information, and dates of service and payment. Smith said dates of service and dates of payment do not matter in a fully insured world, but as was mentioned earlier, they are critical in a stop-loss contract. Smith said information about what was billed, allowed, and paid is essential to really understand network differences and how that fits into the larger picture of what was paid to the provider versus what was reported as paid.

Smith shared a story of a friend who is a small employer and has experienced volatility in the cost of providing a fully insured health benefit plan. This year's renewal was up 11.1%, two and a half times higher than the average renewal increase at any time over the past five years. The carrier issued the following statement: "increases in medical trends are largely due to healthier groups migrating to alternate funding arrangements, such as level-funded. As those groups exit the fully insured market, the remaining population has greater health care needs, which raises the average claims and trend." Smith said the truth is that level funding is creating instability in the small group market, and for small employers, that will become a bigger problem over the next three to five years.

Trexler mentioned that Idaho is seeing an increase in plans without provider networks using reference-based pricing (RBP). Idaho is experiencing more cases of employees getting unexpected balance bills without being

warned about these risks when the network was explained. Trexler inquired if Smith could offer any recommendations for mitigating those risks or for appropriately disclosing both the use of that strategy and its associated risks to employees.

Smith had two suggestions. The first suggestion is to create, at the state level, a mandate in terms of billing and how that is treated by any carrier or stop-loss provider, which is likely to require a lot of interaction with the medical community. Smith said RBP plans are creating conflict between providers who do not like to be told what they are going to get paid and employers and others pushing those plans, wanting to have some better restrictions and controls. Another solution is to expand the No Surprises Act to apply to consumers in level-funded plans. Smith argued that it is unfair for patients, whose employers selected their insurance plans, to be responsible for balance bills when providers reject the plan's payment terms. Smith stated that this concern is not exclusive to the small group market; rather, the question of how best to allocate risk between risk-bearing markets and employers requires careful consideration.

Trexler said there are issues with the state taking steps when there is no contract with providers, as in the RBP scenario. Rider said that there are some carriers who will negotiate the price upfront before the service, but this is problematic in an emergency situation, and then the broker or agent has to do a lot of work on the back end with the employer, especially if it is a small employer. Trexler asked if there was a disclosure that they are familiar with that could help educate a less sophisticated employer to understand the risks they are assuming in this situation. Rider said that she and Smith tend to over-disclose because they know that they will be supporting them on the back end if something is not right.

Smith said there is a big problem with selling level-funded plans as being just like fully insured plans. NABIP has worked to ensure members can educate employers by providing level-funded training. Wake asked if there was a point at which the risk is transferred away from the employer when it looks too much like a fully insured product to be considered self-funded, because it is being sold as if it is very similar to fully insured plans. Smith agreed that there may be a situation where you start to have a significant percentage (67%, for example) of an employer's costs being paid to risk transfer through stop loss or administrative fees that the plan stops being, in Smith's opinion, a self-funded group. Smith said that the issue is going to require a lot more attention. Up to this point, states are reluctant to regulate stop loss too aggressively. Smith joked that a little-known verse in the Schoolhouse Rock song about how a bill becomes a law is "I was once an article in the Washington Post." Once the issue makes the news, states are going to have to act.

Smith shared a historical perspective on the small group market. In 1992, states started looking at purchasing cooperatives during the Clinton-era health care reform. States were starting to see where cherry picking had undermined small group markets. Several states, including Florida, California, and others, prohibited risk underwriting and, in the aftermath of that, allowed some rate bands. The ACA closed those options, and now we are back in a place where the carriers that are very good at cherry picking healthy groups want to do this, and those that are not are left in the small group market. This year, at least one major national carrier has exited small group markets in several states but kept its level-funded plans, suggesting a trend that is likely to spread elsewhere. States will be left with the carrier of last resort being the only one in the market. Costs are going to continue to rise unless some kind of action is taken to protect the small group markets because long-term instability, as we have heard numerous times, will undermine every good market.

Wake mentioned proposed federal legislation that seems to preserve the status quo, which is that stop loss is not health insurance; however, there is also language that states are preempted from doing anything that would limit the use of stop-loss insurance, which seems to suggest that all state laws regulating risk transfer and attachment

points would be preempted. This proposed legislation, in different forms, has been around for a few years without traction. This seems to be a place where McCarran-Ferguson and the idea that insurance regulation is reserved to the states runs head-on into ERISA and preemption.

Seip noted that more level-funded plans are being sold in Iowa, as some small employers find the small group market too expensive. Seip appreciated the concerns with level-funded plans that NABIP identified and asked whether NABIP would be willing to share a list of disclosures that might be helpful. Although not all states regulate stop-loss attachment points, these products are still available, and educating consumers or employer groups about them would be beneficial. Smith said they would send sample language to NAIC staff to distribute.

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

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Draft: 8/18/25

Prescription Drug Coverage (B) Working Group
Minneapolis, Minnesota
August 11, 2025

The Prescription Drug Coverage (B) Working Group of the Regulatory Framework (B) Task Force met in Minneapolis, MN, Aug. 11, 2025. The following Working Group members participated: Joylynn Fix, Chair (WV); Ashley Scott, Vice Chair (OK); Sarah S. Bailey and Molly Nollette (AK); John Buono and Reyn Norman (AL); Crystal Phelps (AR); Erica Bowsher (AZ); Lena Bahar and Michael Shanahan (CT); Howard Liebers (DC); Sheryl Parker (FL); Andria Seip (IA); Shannon Hohl (ID); Matthew Pickett (IL); Julie Holmes (KS); Shaun Orme (KY); Frank Opelka (LA); Brianna Egan (MI); Norman Barrett (MN); Amy Hoyt (MO); Robert Croom (NC); Cheryl Wolff, Martin Swanson, and Margaret Otto (NE); Erin Porter and Ralph Boeckman (NJ); Viara Ianakieva (NM); Krista Porter (NY); Lindsi Swartz and Shannen Logue (PA); Glory Montalvo (PR); Jud Jones (TN); Shelley Wiseman and Ryan Jubber (UT); Jane Beyer (WA); Lori Luder and Darcy Paskey (WI); and Lauren White (WY). Also participating were: Tony Bonofiglio (OH); Mike Rhoads (OK); Chrystal Bartuska (ND); and Patrick Smock (RI).

1. Adopted its May 19 and Spring National Meeting Minutes

The Working Group met May 19 and heard presentations from AHIP, the HIV+Hepatitis Policy Institute, and The AIDS Institute on copay accumulators.

Swanson made a motion, seconded by Scott, to adopt the Working Group's May 19 (Attachment Two-A) and March 24 *(see NAIC Proceedings – Spring 2025, Regulatory Framework (B) Task Force, Attachment Three)* minutes. The motion passed unanimously.

3. Heard Presentations from PhRMA and the CFF on AFPs

Katelin Lucariello (Pharmaceutical Research and Manufacturers of America—PhRMA) said that before she discussed alternative funding programs (AFPs), she wanted to frame the issues that are the source of some of the concerns with AFPs. She said AFPs target specialty drugs, which are types of drugs that typically treat clinically complex conditions and diseases, such as HIV, hepatitis C, multiple sclerosis, rare and genetic conditions, and some cancers. She said these drugs provide significant value, not only from a patient benefit perspective, but from a value to the system perspective, because they often help patients return to daily activities and the workforce.

Lucariello said science has never been more promising in developing drugs to treat these conditions and diseases. She said, however, that insurer tactics challenge patient access to these drugs. She said drug manufacturer cost-sharing assistance is an important source of financial help for commercially insured patients in obtaining access to these drugs because, without such assistance, patients are more likely to abandon new prescriptions.

Lucariello said AFPs steer commercially insured patients to charitable or manufacturer patient assistance funds meant for uninsured and financially disadvantaged patients. She discussed the differences between AFPs and other patient assistance programs (PAPs) (e.g., accumulator adjustment programs and copay maximizer programs). She said AFPs differ because they: 1) are operated by third-party vendors; 2) target specialty medicines; 3) encourage health plans to remove coverage for specialty drugs on the premise that manufacturer PAPs will pay for them; and 4) require patients to enroll in the vendor program or pay 100% of the cost of their medicines if they do not enroll. Lucariello described how AFPs target PAPs, including how, as the first step, AFP

third-party vendors convince employers either directly or through benefits consultants to remove specialty drug coverage, leading to prescription denials for their employees who need a specialty drug. She said that after these denials, the AFP third-party vendor contacts the patient to entice the patient to enroll in the AFP to obtain coverage for the specialty drug, because if they do not, the patient's only option is to pay 100% of the cost of the medicine or not receive the medicine. Lucariello explained that the patient's enrollment through the AFP disguises the insured patient as "uninsured" so the patient can apply for patient assistance to cover the cost of prescriptions.

Lucariello discussed the hidden impacts of AFPs, including: 1) the use of deceptive practices to exploit assistance; 2) the depletion of patient assistance meant for uninsured patients; 3) potentially overpromising savings to employers; and 4) potentially causing delays and disruptions in treatment for patients. She said AFPs are costly, deceptive, potentially discriminatory, and dangerous for patients. Lucariello discussed how the states are beginning to address AFPs. She said Indiana and Maryland recently banned them, and Louisiana recently passed legislation to study them.

Lucariello discussed PhRMA's medicine assistance tool (MAT). She said PhRMA created the MAT to help patients navigate medicine affordability. The MAT makes it easier for those struggling to afford their medicines to find and learn more about various programs that can make prescription medicines more affordable. She described how the MAT works.

Seip asked about the pricing for the medicines patients obtain through an AFP. Lucariello said AFPs operate outside of the health plan. As such, to help patients pay for the drugs, an AFP accesses manufacturer or charitable dollars. Seip said she is more interested in learning the manufacturer's cost of the drug and whether the manufacturer's cost of the drug is different for certain groups or people because of the differences in the level of drug discounts offered by the drug manufacturer. Lucariello acknowledged the complexity of the drug pricing system in the U.S. She explained that in negotiations between pharmacy benefit managers (PBMs) and drug manufacturers, the PBMs negotiate discounts and rebates with the manufacturer, which impacts the net price the PBM pays for the drug. Lucariello said AFPs are not technically paying a particular price metric for the drug. Charitable foundations and manufacturer PAPs are not offering a discount off the price of a medicine; they are offering a dollar amount toward paying for the medicine. She said that, as such, drug manufacturers are not offering a different price for the medicine; rather, they are offering a dollar value toward the medicine. For commercial insurance, this equates to a dollar amount off the deductible, copay, or coinsurance for the drug.

Hohl asked Lucariello to elaborate on her remarks about AFPs helping people switch to different prescriptions. Lucariello said her statement is based, in part, on anecdotal evidence. She said there are a few lawsuits against AFPs on this issue. She said PhRMA has heard that in some cases, AFPs have reached out to physicians or encouraged patients to reach out to their physicians to obtain an alternative prescription.

Fix asked Lucariello to clarify the impact of patients using an AFP versus a manufacturer PAP regarding the patient's ability to draw down their out-of-pocket (OOP) costs. Lucariello said that, unlike manufacturer PAPs, patients using an AFP to obtain their medicine are not drawing down their OOP costs because they are outside of insurance coverage. As such, the patient could ultimately pay more for the drug.

Bartuska asked Lucariello to elaborate on her discussion about AFPs being potentially discriminatory because she would argue that there is discrimination in the entire medical market, not just the prescription drug market. As such, she believes more should be done to lower costs for all consumers, not just those consumers with high prescription drug costs. Lucariello said she can only speak from a drug manufacturer's perspective, and the

assistance drug manufacturers offer to reduce prescription costs for consumers. She acknowledged Bartuska's concern about health care costs across the entire medical system and the need to address those costs.

Rhoads asked what role consumers play in being enrolled in an AFP. Lucariello said that it is typically an employer plan sponsor contracting with the AFP, particularly in the self-insured market, where plan sponsors have more flexibility over the coverage they choose to offer to their employees. She said the employee technically has a choice of whether to enroll in the AFP, but it is an impossible choice, as they must decide whether to enroll with the AFP and have their medicine covered through these alternative routes or pay 100% of the cost for the medicine.

Fix asked how AFPs are funded. Lucariello said that sometimes smaller PBMs are the AFP's vendor, and they reach out to employers. She said that the AFP typically earns a fee from the employers they contract with, and that fee is based on the percentage of the assistance they can capture, which is typically 20% to 30%. Lucariello gave an example that if the AFP captures $100 in drug assistance, then the AFP would charge the employer $30 because it offset $100 in prescription drug costs for the employer.

Theresa Alban (Cystic Fibrosis Foundation—CFF) discussed AFPs, international drug importation, and patient experience. She highlighted how patients, particularly those requiring specialty medications, like those with cystic fibrosis, are particularly at risk of additional administrative burdens and other adverse impacts when an AFP is involved. Alban described how patients navigate AFPs and how AFPs try to source medication internationally. She said some AFPs have advertised to employers that drug importation is an effective way for their employees to receive their drugs and that the federal government has endorsed drug importation. AFPs have also said drug importation lowers drug costs for both the employer and the employee.

Alban said the CFF has concerns about the patient risks associated with drug importation, such as the potential for the lack of proper storage and handling, and the lack of transparency in the drug supply chain to understand who is supplying the medications. Alban also highlighted how patients navigating AFPs are subject to potential gaps in care and a constantly changing process to obtain their drugs because AFPs are increasingly requiring patients to obtain their medications internationally due to the increasing cost of specialty drugs.

Alban discussed potential issues with international drug importation. She described existing laws and regulations related to drug importation, including the U.S. Food and Drug Administration's (FDA's) personal importation policy and the Section 804 importation program under the federal Food, Drug, and Cosmetic Act, which allows states and American Indian tribes to import prescription drugs from Canada under specific conditions, potentially lowering drug costs for consumers. She said that despite these laws and regulations, patients are at risk of unregulated importation. Alban said state insurance regulators and other state policymakers can help prevent this by: 1) ensuring that scrutiny and oversight are incorporated into a Section 804 importation program proposal application; and 2) working with the FDA to enforce existing laws against illegal importation.

Wolff asked for more clarification on who pays for the drug in the AFP scenario. Alban said the employer, who has contracted with the AFP, or third-party administrator (TPA), pays a flat fee to the AFP as outlined in the contract. Then, the AFP tries to source the medication as cheaply as possible, which may be through drug importation or a drug manufacturer PAP.

Hohl said AFPs seem to target employer-based plans, particularly self-insured employer-based plans. She asked whether anyone on the federal level tracks complaints or if the CFF is working with federal agencies, such as the U.S. Department of Labor (DOL), the U.S. Department of Health and Human Services (HHS), or other federal

agencies to address some of the concerns and issues related to AFPs. Alban said the CFF has been working with some of these federal agencies, particularly with the FDA, to address concerns with drug importation.

Wolff asked how the pharmacy is paid. Alban said she can only speak from an international sourcing perspective. She said that from that perspective, the pharmacy has an exclusive contract with the AFP to source the medications. Alban noted the lack of transparency in this area, which hampers everyone's ability to truly understand how it all works.

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

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Prescription Drug Coverage (B) Working Group
Virtual Meeting
May 19, 2025

The Prescription Drug Coverage (B) Working Group of the Regulatory Framework (B) Task Force met May 19, 2025. The following Working Group members participated: Joylynn Fix, Chair (WV); Ashley Scott, Vice Chair (OK); Kayla Erickson, Sarah S. Bailey, and Molly Nollette (AK); Dusty Smith (AL); Amy Seale (AR); Lena Bahar and Paul Lombardo (CT); Howard Liebers (DC); Sheryl Parker (FL); Andria Seip (IA); Shannon Hohl (ID); Adam Flores and Eric Anderson (IL); Craig VanAalst (KS); Daniel McIlwain (KY); Kallie Ruggiero Somme and Nina Turner (LA); Joe Stoddard (MI); Norman Barrett (MN); Amy Hoyt (MO); David Dachs and Matthew Eberhardt (MT); Robert Croom and Charles Whitehead (NC); Cheryl Wolff (NE); Erin Porter and Ralph Boeckman (NJ); Sylvia Lawson and Gail A. Ross (NY); Alejandro Amparan (NM); Colette Hittner (OR); Lindsi Swartz (PA); Scott McAnally (TN); Tanji J. Northrup (UT); Jennifer Kreitler and John Kelcher (WA); Darcy Paskey (WI); and Lauren White (WY).

1. Heard Presentations from AHIP, the HIV+Hepatitis Policy Institute, and The AIDs Institute on Copay Accumulators

Fix said the purpose of the meeting was to hear presentations on the copay accumulator issue. Sean Dickson (AHIP) presented the effects of copay coupons on health insurance markets. He first discussed pharmacy costs and impacts, explaining that for every dollar spent on health care, 24 cents is spent on prescription drugs. He noted that specialty drugs account for 51% of total pharmacy spending, even though less than 2% of patients use specialty drugs. Dickson next discussed copay coupons and the commercial market. He said AHIP believes copay coupons discourage price competition and increase brand utilization. He discussed information supporting this belief. Dickson said banning copay coupons would decrease premiums and total cost-sharing, including lower cost-sharing for consumers who do not use coupons. He noted a study of coupon costs for multiple sclerosis (MS), finding that prohibiting coupons would reduce plan costs by 7.6%. The study also found that cost-sharing for MS patients using drugs without manufacturer coupons would fall by 6% due to lower total spending and greater price competition. Dickson discussed how higher health care costs due to manufacturer coupons impact all Americans. He explained how copay coupons lead to adverse selection and introduce bias by health condition and how health plans leverage coupon accumulators and maximizers to encourage price competition, reduce adverse selection, and treat patients equally. He also discussed coupons and manufacturer revenues.

Carl Schmid (HIV+Hepatitis Policy Institute) discussed how patient out-of-pocket costs have increased over the years, with most of the increase related to non-retail drugs. He noted that as out-of-pocket costs have risen, patients starting new therapy have increasingly abandoned their prescriptions at pharmacy counters. Schmid discussed how manufacturer copay assistance cards have helped consumers to be able to afford their prescription drugs, particularly for those consumers with certain conditions, such as those living with HIV. He also discussed the impact of copay accumulator adjustment and copay maximizers on patient costs in the commercial insurance market.

Schmid discussed the status of the 2021 Notice of Benefit and Payment Parameters federal rule, which permitted insurers to implement copay accumulator adjustment policies (CAAPs), allowing them to not count drug manufacturer copay assistance toward a beneficiary's out-of-pocket costs. He explained that the federal rule was invalidated in 2023, which left a previous 2020 rule in place. Under the 2020 rule, insurers could only use copay accumulators in limited circumstances. Schmid noted that the federal government has declined to enforce the 2020 rule's requirements and has promised updated rulemaking. He said no additional guidance has been provided to date, and insurers are violating the 2020 rule's requirements. Schmid thanked the NAIC for its recent

letter to the Trump Administration asking for clarity on the CAAP issue. He said that in the meantime, some states have moved forward and enacted laws prohibiting insurers from using copay accumulators under certain circumstances.

Stephanie Hengst (The AIDS Institute) provided an overview of how health insurance policies and plan design can help or hinder access to care for individuals with serious, complex, and chronic conditions. She discussed how patient out-of-pocket costs are becoming untenable, citing such costs for the average Silver health insurance marketplace plan in 2025. She noted that prescription drug costs are particularly hard for patients with serious, complex, and chronic conditions to afford because many of the drugs they are prescribed are assigned to the specialty tier, which means they are subject to coinsurance, which, on average, is about 40% after the patient's deductible is met. She said that, as Schmid discussed, this is why individuals with serious, complex, and chronic conditions need financial assistance from drug manufacturers or charitable foundations to afford their prescribed medications.

Hengst discussed The AIDS Institute's "Our Loss, Their Gain: Copay Accumulator Adjustment Policies in 2025" report and its findings on state report cards with respect to CAAPs. She discussed how the information in the report is compiled by reviewing plan documents available during open enrollment and looking for any indication in the language for copay accumulators, copay maximizers, or any sort of copay diversion policy in place. Hengst said that as part of that review, The AIDS Institute issues report cards for each state. The report cards provide a quick snapshot of what is happening in a particular state regarding CAAPs. She said a grade is assigned from A to F based on the percentage of health plans in the state with CAAPs. She said that prior to 2025, The AIDS Institute carved out states from its review that had passed laws prohibiting copay accumulators. However, for this year's report, The AIDS Institute reviewed all 50 states and the District of Columbia because it had been hearing from fellow advocates and patients that despite a state's prohibition on the use of copay accumulators, health plans still included CAAPs in their plan documents. Hengst discussed The AIDS Institute's efforts to confirm which plans have CAAPs in their plan documents, but that are not actually applying them because they have not updated their plan documents to reflect state law prohibiting CAAPs.

Hengst discussed one of the analyses that The AIDS Institute included in its 2025 report, which compared health insurance marketplace Silver plan premiums in each state for insurers with plans that have copay accumulators and those without copay accumulators. While acknowledging the many factors that impact rate-setting and premium costs, she said the analysis showed that there was not much of a significant difference in premium cost between those plans with or without copay accumulators. Hengst highlighted advocacy efforts to advance policy solutions on both the state and federal levels to address the copay accumulator and copay maximizer issue, including recent state laws enacted prohibiting CAAPs.

Fix asked for questions. Stoddard asked whether Dickson believes that AHIP considers rebates to have the same effect on price competition as copay accumulators. Dickson said rebates complicate an already confusing prescription drug distribution system, which does not allow consumers to compare prescription drug prices easily and directly.

Fix said that because the presenters differed on the impact of copay accumulators and CAAPs on premium costs, she believes the Working Group would appreciate more clarity on the reasoning for the different viewpoints.

Dickson discussed how the regulation of Affordable Care Act (ACA) marketplace plans, such as the medical loss ratio (MLR) requirements, results in more drug cost transparency, particularly regarding the dollars paid to the plan and not the pharmacy. He explained that when the manufacturer makes a payment directly to the pharmacy on behalf of the patient, it uses the same format insurers use to pay the pharmacy. This payment offsets the amount of money the plan and the patient pay to the pharmacy for the drug. He said that for an ACA marketplace

plan, if this results in the total net cost of the plan being lower than projected, the difference is paid to the patient in the form of a rebate due to MLR requirements.

Schmid said this discussion raises an issue that has been a point of contention for a while. He suggested that the NAIC seek clarity on the issue by talking to pharmacists and other stakeholders with the requisite knowledge. Schmid questioned why plans oppose copay accumulator bans if they have no financial impact. He said someone is collecting the money, and someone is spending it. He said someone is benefiting, and the NAIC should try to determine what is happening.

Hengst expressed support for Schmid's comments. She discussed The AIDS Institute's understanding of how CAAPs impact costs. Hengst also noted that the American Pharmacists Association (APhA) has volunteered to speak on this issue during a future Working Group meeting.

Fix thanked the speakers for participating in the meeting. She said the Working Group will continue its discussions of copayment accumulators and patient assistance programs during future meetings. She also said the Working Group will follow up with the APhA to schedule a future Working Group meeting to discuss the financial implications of copay accumulators and CAAPs.

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

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