

Draft Pending Adoption

Attachment --
Health Insurance and Managed Care (B) Committee
x/xx/26

Draft: 3/31/26

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

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

1. Adopted its March 10 Minutes

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

Peck made a motion, seconded by Manning, to adopt the Working Group's March 10 minutes. The motion passed unanimously.

2. Discussed its Charges and Work Plan

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SharePoint/NAIC Support Staff Hub/B CMTE/HCAM/Minutes 3.24