Draft date: 2/26/26

2026 Spring National Meeting
San Diego, California

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE
Wednesday, March 25, 2026
10:45 a.m. – 12:00 p.m.
Manchester Grand Hyatt—Seaport Ballroom—Level 2

ROLL CALL

Grace Arnold, Chair	Minnesota	Mike Chaney	Mississippi
John F. King, Vice Chair	Georgia	Ned Gaines	Nevada
Charles Bassett	Arizona	Alice T. Kane	New Mexico
Trinidad Navarro	Delaware	Glen Mulready	Oklahoma
Dean L. Cameron	Idaho	Michael Humphreys	Pennsylvania
Ann Gillespie	Illinois	Jon Pike	Utah
Robert L. Carey	Maine	Allan L. McVey	West Virginia
Marie Grant	Maryland		

NAIC Committee Support: Jolie H. Matthews/Brian R. Webb/Jennifer R. Cook

AGENDA

1. Consider Adoption of its Feb. 13, 2026, and 2025 Fall National Meeting Minutes—*Commissioner Grace Arnold (MN)* — Attachment One

2. Consider Adoption of the Reports of its Working Groups and Task Forces —*Commissioner Grace Arnold (MN)*
   A. Consumer Information (B) Working Group—*T. J. Patton (MN)*
   B. Health Care Affordability and Mitigation (B) Working Group —*Kate Harris (CO)*
   C. Health Actuarial (B) Task Force—*Director Anita G. Fox (MI) and Kevin Dyke (MI)*
   D. Regulatory Framework (B) Task Force —*Commissioner Marie Grant (MD)*
   E. Senior Issues (B) Task Force—*Commissioner Ned Gaines (NV)*

3. Hear a Presentation on Health Insurance Affordability and State Options to Address It—*Michael Bailit (Bailit Health)*

4. Hear a Discussion on Improving State/Federal Coordination on Issues Related to the Medicare Advantage Program—*Alec Aramanda (Federal Centers for Medicare & Medicaid Services [CMS])*

5. Hear an Update from the CMS' Center for Consumer Information and Insurance Oversight (CCIIO) on its Recent Activities—*Peter Nelson (CCIIO)*

6. Discuss Any Other Matters Brought Before the Committee —*Commissioner Grace Arnold (MN)*

7. Adjournment

Agenda Item #1

Consider Adoption of its Feb. 13, 2026, and 2025 Fall National Meeting Minutes
—Commissioner Grace Arnold (MN)

Draft: 3/5/26

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

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

1. Adopted its Revised 2026 Charges

The Committee conducted an e-vote to revise its 2026 charges (Attachment One), which included adding a new charge to "monitor health insurance markets to evaluate and recommend standards and consumer protections, as well as address emerging issues in health care delivery and affordability." The revisions also rename the Health Innovations (B) Working Group to the Health Care Affordability and Mitigation (B) Working Group and add a new charge taken from the Committee's charges to "examine factors that contribute to rising health care costs and insurance premiums, as well as coverage losses. Review state initiatives to address cost drivers, consumer affordability, disparities in coverage, and coverage continuity." The motion passed unanimously.

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

Draft: 3/6/26

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

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

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

The Committee and Task Force conducted a joint e-vote to revise the Task Force's 2026 charges. The revisions add a new charge taken from the former Health Innovations (B) Working Group to "gather and share information, best practices, experience, and data to inform and support state flexibility options through the Affordable Care Act (ACA) and other health insurance-related policy initiatives." This transferred charge allows the Task Force to complete the Health Innovations (B) Working Group's work to develop a state flexibility white paper, which will outline state flexibility options under ACA Sections 1331, 1332, and 1333. The revised Task Force charges also revise the name of the Employee Retirement Income Security Act (ERISA) (B) Working Group to the Employee Retirement Income Security Act (ERISA) and Alternative Health Care Coverage (B) Working Group to reflect its new charge taken from the Task Force's charges to "monitor, analyze, and report, as necessary, developments related to excepted benefit coverage, short-term, limited-duration (STLD) coverage, health care sharing ministry (HCSM) coverage, and coverage that is offered and marketed as a substitute for, or an alternative to, comprehensive major medical coverage."

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

Draft Pending Adoption

Draft: 12/15/25

Health Insurance and Managed Care (B) Committee
Hollywood, Florida
December 11, 2025

The Health Insurance and Managed Care (B) Committee met in Hollywood, FL, Dec. 11, 2025. The following Committee members participated: Glen Mulready, Chair (OK); Ann Gillespie, Co-Vice Chair, represented by Adam Flores (IL); Grace Arnold, Co-Vice Chair (MN); Trinidad Navarro represented by Susan Jennette (DE); Dean L. Cameron (ID); Marie Grant (MD); Anita G. Fox (MI); D.J. Bettencourt (NH); Alice T. Kane represented by Viara Ianakieva and Alejandro Amparan (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); Peter M. Fuimaono (AS); Sterling Gavette (AZ); Martin Sullivan (GA); Doug Ommen (IA); Michael T. Caljouw (MA); Robert L. Carey (ME); Angela L. Nelson (MO); and Cassie Brown (TX).

1. Adopted its Nov. 20 and Summer National Meeting Minutes

The Committee met Nov. 20. During this meeting, the Committee took the following action: 1) adopted its 2026 proposed charges, including the 2026 proposed charges for the Consumer Information (B) Working Group and the Health Innovations (B) Working Group; and 2) adopted the 2026 proposed charges for the Health Actuarial (B) Task Force, the Regulatory Framework (B) Task Force, and the Senior Issues (B) Task Force.

Commissioner Arnold made a motion, seconded by Commissioner Pike, to adopt the Committee's Nov. 20 (Attachment One) and Aug. 13 minutes (*see NAIC Proceedings – Summer 2025, Health Insurance and Managed Care (B) Committee*). The motion passed unanimously.

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

Commissioner Arnold made a motion, seconded by Fix, to adopt the following task force and working group reports: 1) Consumer Information (B) Working Group, including its Oct. 31 (Attachment Two), Oct. 23 (Attachment Three), Oct. 3 (Attachment Four), and Aug. 11 (Attachment Five) minutes; 2) Health Innovations (B) Working Group; 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 *Prior Authorization White Paper*

Commissioner Arnold said the Regulatory Framework (B) Task Force met Dec. 10. During this meeting, the Task Force adopted the *Prior Authorization White Paper*, which the Committee and NAIC leadership directed the Task Force to develop by the end of this year. She discussed the Task Force's work in developing the white paper.

Commissioner Arnold said that, as discussed at the Task Force's meeting at the Summer National Meeting, the Task Force exposed an initial white paper draft in July for a public comment ending Aug. 29. The Task Force met Sept. 22 to discuss the comments received. She said that following the Sept. 22 meeting, the Prior Authorization (PA) Drafting Group, which developed the initial white paper draft, reviewed the comments to consider which, if any, to incorporate into a revised white paper draft. She said that, in October, the Task Force exposed a revised white paper draft reflecting the Aug. 29 comments received for a public comment period ending Nov. 19. She said the white paper adopted by the Task Force incorporates some of the suggested revisions included in the Nov. 19 comments.

Commissioner Arnold stated that the white paper before the Committee for adoption today provides a comprehensive overview of PA in healthcare, detailing: 1) its purpose; 2) its processes; 3) consumer, provider, and insurer perspectives on PA; 4) state PA reform efforts; and 5) PA regulatory frameworks. She said the Task Force intends for the white paper to guide state insurance regulators in understanding legislative options to reform PA processes and believes the white paper will serve as an informative resource for regulators, policymakers, and industry stakeholders aiming to understand and improve PA systems to balance cost containment, patient safety, and administrative efficiency. Commissioner Arnold explained that the white paper does not extensively cover artificial intelligence (AI) in PA but offers support for future AI-related discussions.

Commissioner Arnold said that since the Task Force adopted the white paper on Dec. 10, she has heard from some states that the section in the white paper highlighting state PA reform efforts does not include information about their state's PA laws. She acknowledged the white paper is a snapshot in time and, as such, will not include state PA reform efforts moving forward. She said she will work with NAIC committee support to develop a way to track and update, as needed, information on state PA reform laws.

Director Fox made a motion, seconded by Jennette, to adopt the *Prior Authorization White Paper* (Attachment Six). The motion passed unanimously.

4. Heard a Presentation from the CHIR on State-Level Actions to Mitigate Projected Coverage Losses and Premium Impacts from H.R. 1 and Other Federal Changes Impacting the Individual Market

Lucy Culp (Blood Cancer United) said the NAIC consumer representatives are pleased to share a new report titled *Recommendations for States' Efforts to Mitigate Harms Caused by Federal Actions* with the Committee. She said that Blood Cancer United, on behalf of the NAIC consumer representatives, contracted with the Center on Health Insurance Reforms (CHIR) to conduct research and develop the report. Culp said the report examines the impact of federal policy changes on health insurance access and affordability. She said that, as many of the Committee members know, the federal Congressional Budget Office (CBO) is estimating that, between legislative and regulatory changes at the federal level, 10 million people are expected to lose either Medicaid or Affordable Care Act (ACA) Marketplace coverage. Over the next decade, the CBO anticipates that another four million will lose coverage and become uninsured. Culp said the report details how state insurance regulators can mitigate those harms in meaningful ways, protecting consumer access to affordable, high-quality coverage and access to care.

Sabrina Corlette (CHIR) discussed the federal changes that will lead to unprecedented coverage losses for consumers. She said the first change, which will lead to coverage losses, is the loss of enhanced premium tax credits if Congress allows those credits to expire at the end of the year. She said that without these credits, some consumers will not be able to afford coverage. She said other changes, such as new documentation requirements for Special Enrollment Periods (SEPs), shorter open enrollment periods (OEPs), and the end of automatic re-enrollment, will lead to coverage losses because of the increased red tape.

Corlette described the options the states have to mitigate those losses, including: 1) providing state financial help through subsidy wraps, which 11 states and the District of Columbia currently provide; and 2) establishing a Basic Health Program (BHP), which three states and the District of Columbia have established. Corlette said that for states that operate their own ACA Marketplace (i.e., state-based marketplaces [SBMs]), other options they can take are through changes in ACA Marketplace policies, such as establishing facilitated enrollment, flexible enrollment opportunities, and standardized plans. She also discussed other options states can take to mitigate coverage losses through insurance regulation, such as preventing insurers from denying coverage solely because of past-due premiums and continuing to require plans to price for cost-sharing reductions via on-Marketplace silver plans (or silver loading). Corlette discussed other state options involving consumer communications and engagement and market oversight.

5. Heard a Presentation from Wakely on the Emerging 2025 Individual Market Risk Pool

Michelle Anderson (Wakely Consulting Group—Wakely) and Michael Cohen (Wakely) discussed: 1) the 2026 market framework; 2) the 2025 individual market framework morbidity; 3) medical trends in the individual market and commercial market; and 4) key considerations and uncertainties going forward.

Anderson provided a snapshot of the 2026 market and the drivers causing the highest premium rate changes since 2018. Those drivers include: 1) 2025 emerging experience and a sicker population; 2) trend patterns; 3) inflation; 4) rate correction from prior years; 5) regulatory changes, including the enhanced premium tax credit expiration; 5) expensive medications, such as glucagon-like peptide-1s (GLP-1s); and 6) uncertainty.

Anderson next discussed the 2025 changes in morbidity in the individual market. She said Wakely's analysis of the changes supported many health carrier findings. For the 2025 period analyzed (January through July of 2025), Wakely continues to see a dramatic increase in overall relative risk of 6.8% from 2024 to 2025, with the federally facilitated marketplaces (FFMs) having higher increases. She said ACA Marketplace enrollment continued to increase, but morbidity continues to increase, which she said could be due to the impacts from Medicaid redeterminations, which were required when Medicaid continuous enrollment ended in April 2023 due to the end of the public health emergency (PHE) declared for the COVID-19 pandemic. She noted that historically, higher enrollment increases are correlated with lower morbidity. Anderson discussed the change in the percentage of enrollees with claims from July 2024 to July 2025. She noted that this is a distinct change from the trend in the reduction in the number of people with claims that occurred since the introduction of the enhanced premium tax credits.

Cohen discussed the general drivers of trends from 2024 to 2026. He explained that persistent inflationary pressure on provider costs, especially hospital labor and supplies, continues to push the unit cost trend upward across all years. He noted that the pharmacy trend remains highly influenced by specialty drugs and GLP-1s. Cohen discussed the implications of these trends for 2027.

Director Cameron asked Anderson about the differences between the SBMs and FFMs regarding the changes in relative risk and changes in the percentage of enrollees with claims. Anderson said that a possible driver of that difference is the availability of more no-cost gold plans and low-cost silver plans in the FFMs. However, because of the type of data collected, Cohen said Wakely cannot be certain if those are the drivers because it could also be the disproportional impact of Medicaid redetermination on the FFMs, rather than the SBMs. He said there could also be operational differences between FFMs and SBMs that cause this difference, or something else Wakely has not been able to pinpoint at this time. The Committee discussed this issue and decided that it merited follow-up with Wakely in the future, once more data has been collected.

Gavette asked about the trend in overall pharmacy utilization. Cohen said the 2024 data show an overall 9% trend increase, with GLP-1s and specialty drugs driving the trend. He stated that when it obtains the full data for 2026, Wakely plans to re-examine the numbers.

Superintendent Carey asked how much confidence Wakely has in the numbers to date because they only reflect data from the first six months of 2025. Anderson said there are a lot of caveats when looking at partial-year data. She noted, however, that, like what happened in 2025, even the partial year data shows that there were significant shifts and deviations from what carriers nationally had assumed. She stated that, regardless, it is more of an art than a science in making these assumptions. Cohen said that, in addition, the Committee should keep in mind that, when thinking about 2027, there is a two-year lag, and the starting point is 2025.

Commissioner Mulready asked for clarification on rate corrections. Cohen said that when carriers set rates in 2025, they were using 2023 data and assumptions. As such, carriers make corrections later. Superintendent Carey

suggested that with Wakely's assistance, the Committee should consider developing a common data template that the states can use for their individual markets.

Director Fox asked about Wakely's funding sources. Anderson said carriers fund Wakely for its risk adjustment project. She said carriers voluntarily submit their data to Wakely. She discussed the parameters of such data collection to ensure its credibility. Anderson said she believes Wakely's data is representative of national numbers.

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 federal Centers for Medicare & Medicaid Services' (CMS's) recently released enrollment snapshot. He said the 2026 enrollment snapshot, which was released Dec. 5, showed that nearly 950,000 consumers who do not currently have health care coverage through plans in the individual market ACA Marketplace have signed up for coverage in 2026, since the start of the Marketplace OEP on Nov. 1. Existing consumers are also returning to the Marketplace to actively renew their coverage, and anyone who does not actively renew will be automatically re-enrolled for 2026. Over 4.8 million existing consumers have already returned to the Marketplace to select a plan for 2026.

Nelson explained that the proposed federal U.S. Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2027 rule has been delayed, but he is hopeful that it will be released soon. Nelson also discussed the CCIIO's work to stabilize the individual market. He urged state insurance regulators to think about using the flexibility and state innovation opportunities provided through ACA waivers, such as the Section 1332 and Section 1333 waivers, to also stabilize their individual markets.

Director Fox asked how the CCIIO identifies individuals to be removed from the Marketplace rolls because they have no claims, under the assumption that they did not know they had coverage. She said there are individuals who have no claims because they are young and healthy, and others who, because of other situations, do not seek care but still want coverage. She also asked how the proposal to provide health savings accounts (HSAs) to individuals would work because HSAs are typically associated with group coverage. Nelson said the CCIIO uses the same processes it has used in the past to identify these individuals, such as through consumer complaints and periodic data matching for Medicaid. He said that with respect to the question about HSAs, it is envisioned that access to HSAs would be coupled with catastrophic plans or bronze plans, which would create a new level of affordability for some consumers.

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

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Agenda Item #2

Consider Adoption of its Working Group and Task Force Reports
—Commissioner Grace Arnold (MN)

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Virtual Meeting

CONSUMER INFORMATION (B) WORKING GROUP
Wednesday, March 4, 2026

Summary Report

The Consumer Information (B) Working Group met March 4, 2026. During this meeting, the Working Group:

1. Discussed its potential activities for 2026, which included several potential projects, including its annual update to the *Frequently Asked Questions About Health Care Reform* document and collaborating with the federal Centers for Medicare & Medicaid Services (CMS) to update its *Choosing a Medigap Policy* guide.

2. Decided to finalize what projects the Working Group would work on in 2026 based on the results of a poll of the Working Group members.

Draft: 3/17/26

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

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

1. Discussed its Leadership Transition

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

2. Discussed its Potential Activities for 2026

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SharePoint/NAIC Support Staff Hub/B CMTE/Consumer Information/Minutes 3.4

2026 Spring National Meeting
San Diego, California

HEALTH CARE AFFORDABILITY AND MITIGATION (B) WORKING GROUP
Tuesday, March 24, 2026
10:00 – 11:00 a.m.

Meeting Summary Report

The Health Care Affordability and Mitigation (B) Working Group met March 24, 2026. During this meeting, the Working Group:

1. Adopted its March 10 minutes. During this meeting, the Working Group took the following action:
   A. Discussed its 2026 charges and work plan.
   B. Discussed state affordability and mitigation activities.

2. Discussed its 2026 work plan, including whether to focus on a shorter list of topics in greater depth or to address a longer list with less depth.

3. Heard a presentation from the Colorado Consumer Health Initiative (CCHI) and Brown University on hospital costs and strategies for controlling them.

4. Heard a presentation from Georgians for a Healthy Future (GHF) and the Center on Budget and Policy Priorities (CBPP) on state-based marketplaces and their tools for improving affordability.

2026 Spring National Meeting
San Diego, California

HEALTH ACTUARIAL (B) TASK FORCE
Sunday, March 22, 2026
3:30 – 5:00 p.m.

Meeting Summary Report

The Health Actuarial (B) Task Force met March 22, 2026. During this meeting, the Task Force:

1. Adopted its 2025 Fall National Meeting minutes.

2. Discussed its 2026 work plan.

3. Heard an update from the federal Center for Consumer Information and Insurance Oversight (CCIIO) on the 2027 Notice of Benefits and Payment Parameters (NBPP), Actuarial Value Calculator updates, and Uniform Rate Review Template (URRT) changes.

4. Heard an update on Society of Actuaries (SOA) Research Institute activities.

5. Heard an American Academy of Actuaries (Academy) professionalism update.

6. Heard an update from the Academy Health Practice Council, including 2026 health policy priorities.

7. Heard an update on the artificial intelligence (AI) systems evaluation tool pilot.

2026 Spring National Meeting
San Diego, California

REGULATORY FRAMEWORK (B) TASK FORCE
Tuesday, March 24, 2026
12:00 – 1:00 p.m.

Meeting Summary Report

The Regulatory Framework (B) Task Force met March 24, 2026. During this meeting, the Working Group:

1. Adopted its 2025 Fall National Meeting minutes.

2. Adopted its Feb. 13 joint minutes with the Health Insurance and Managed Care (B) Committee. During this meeting, the Task Force and Committee took the following action:
   A. Adopted the Task Force's revised 2026 charges, which included adding a new charge taken from the former Health Innovations (B) Working Group to "gather and share information, best practices, experience, and data to inform and support state flexibility options through the Affordable Care Act (ACA) and other health insurance-related policy initiatives." The revisions also change the name of the Employee Retirement Income Security Act (ERISA) (B) Working Group to the Employee Retirement Income Security Act (ERISA) and Alternative Health Care Coverage (B) Working Group to reflect its new charge taken from the Task Force's charges to "monitor, analyze, and report, as necessary, developments related to excepted benefit coverage, short-term, limited-duration (STLD) coverage, health care sharing ministry (HCSM) coverage, and coverage that is offered and marketed as a substitute for, or an alternative to, comprehensive major medical coverage."

3. Received status updates on the work and 2026 planned work of its working groups: 1) ERISA and Alternative Health Coverage (B) Working Group; 2) Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group; and 3) Prescription Drug Coverage (B) Working Group.

4. Adopted the report of the ERISA and Alternative Health Coverage (B) Working Group, which met March 24. During this meeting, the Working Group took the following action:
   A. Discussed comments received on the draft *Guidance Document: ERISA Preemption and State Pharmacy Benefit Manager (PBM) Laws* and next steps in developing a revised draft based on those comments.
   B. Discussed its planned work on guidance related to level-funded plans. The Working Group decided to form a drafting group to develop an initial draft.
   C. Discussed potential work related to its new charge to monitor, analyze, and report, as necessary, developments related to excepted benefit coverage; short-term, limited-duration (STLD) coverage; health care sharing ministry (HCSM) coverage; and coverage that is offered and marketed as a substitute for, or an alternative to, comprehensive major medical coverage. The Working Group received suggestions related to this charge from Working Group members,

interested regulators, and interested parties. The Working Group asked that any additional suggestions be submitted to the Working Group by April 30.

5. Adopted the report of the MHPAEA (B) Working Group. The Working Group plans to meet April 2 to discuss its activities for 2026.

6. Adopted the report of the Prescription Drug Coverage (B) Working Group, which met March 23. During this meeting, the Working Group took the following action:
   A. Adopted its 2025 Fall National Meeting minutes.
   B. Adopted its Dec. 15, 2025, minutes. During this meeting, the Working Group took the following action:
      i. Heard a presentation from the Pharmaceutical Research and Manufacturers of America (PhRMA) on the 340B Drug Pricing Program and anticipated changes beginning Jan. 1, 2026.
   C. Heard a presentation from the National Health Law Program (NHeLP) and the HIV+Hepatitis Institute on prescription drug formularies, consumer protections, and state enforcement.
   D. Heard a presentation from the Alabama Department of Insurance (DOI) on prescription drug discount cards and topics related to them, such as co-pay and prescription drug assistance programs and copay accumulators.

7. Heard an update on recently enacted federal PBM legislation.

8. Adopted the revised *State Flexibility White Paper*, which the Health Insurance and Managed Care (B) Committee will consider for adoption during its March 25 meeting.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Adopted by the Regulatory Framework (B) Task Force, March 24, 2026

State Flexibility White Paper

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

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Washington, DC 1101 K Street NW, Suite 650, Washington, DC 20005-7032 p | 202 471 3990

Kansas City 1100 Walnut Street, Suite 1000, Kansas City, MO 64106-2197 p | 816 842 3600

New York One New York Plaza, Suite 4210, New York, NY 10004 p | 212 398 9000

www.naic.org

Introduction: State and federal roles in regulating health insurance

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

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

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

In 2010, the passage of the Affordable Care Act (ACA) introduced extensive new federal regulations for individual health insurance markets. While maintaining markets in each state,

the ACA established requirements in each state's market related to risk pools, enrollment periods, coverage tiers, benefits, and consumer protections. It also created Marketplaces for consumers with coverage supported by federal premium tax credits (PTCs) for eligible individuals.

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

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

Section 1331 Basic Health Programs

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

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

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

Population eligible

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

Summary of federal statute, regulations, and guidance

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

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

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

[3] Id.

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

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

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

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

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

State experiences

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

Minnesota

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

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

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

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

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

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

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

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

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

[8] Id.

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

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

New York

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

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

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

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

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

[10] Minnesota Management and Budget

Oregon

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

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

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

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

District of Columbia

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

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

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

Considerations for consumers, states, and insurance markets

Basic Health Programs have the potential to impact consumer costs both for those who enroll in the BHP and for Marketplace consumers who do not. BHPs require administration by state agencies and potential investment from the state budget. States evaluating the establishment of a BHP should weigh a range of considerations to determine the most appropriate choice given state-specific circumstances and priorities.

Consumer coverage impacts

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

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

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

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

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

State considerations

Budget

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

States have been able to offer more affordable and more robust coverage through BHPs than is available in their Marketplaces by using provider payment rates closer to those used

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

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

Medicaid and Marketplace roles in implementation

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

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

BHPs have the potential to ease coverage transitions for consumers whose eligibility shifts between Medicaid, BHP, and Marketplace coverage. This may be most likely to be achieved in a state with a state-based Marketplace, so Medicaid, BHP, and Marketplace systems can more easily coordinate with each other. Nonetheless, Oregon has implemented a BHP while using the federal platform for Marketplace eligibility.

Individual market effects

States, especially state insurance regulators, should consider the effects of a BHP on a state's market for individual coverage. BHPs serve individuals who would otherwise be eligible for Marketplace coverage and for cost-sharing reduction plan variations since their incomes are

between 138% and 200% of the federal poverty level. Covering this population in a BHP removes them from the individual market risk pool and can affect costs and market stability for the remaining risk pool.

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

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

Section 1332 State Innovations Waivers

Summary of statutes, regulations, and guidance

Section 1332 of the Affordable Care Act (ACA) allows states the flexibility to pursue innovative approaches to high-quality health care coverage by waiving certain ACA provisions. These waivers, referred to as State Innovation waivers, allow states to adapt coverage options to meet the needs of their states while still retaining the ACA's basic

consumer protections. Section 1332 of the ACA provides that "State legislation" must grant the authority to implement the law.[11]

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

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

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

Guardrails and the limitations they introduce

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

- **Comprehensiveness:** Coverage must be at least as ***comprehensive*** as coverage without the waiver.
- **Affordability:** The state plan must provide coverage and cost-sharing protections as ***affordable*** as coverage available to people absent the waiver.
- **Comparable Number of Insured:** ***The number of people with health coverage must be comparable*** with the waiver in place to without the waiver.
- **Deficit-Neutrality:** The waiver must be ***deficit-neutral*** to the federal government over ten years.[12]

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

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

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

the guardrails, it is subject to HHS and Treasury discretion on whether to approve a state's application.

Funding and applications

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

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

State experiences

Twenty-one states have applied for and successfully received section 1332 waivers – in fact, some states have multiple waivers. Most states have waivers leveraging federal pass-through funds to support reinsurance programs for individual market stability. A handful of states have sought further market reforms through section 1332 waivers – including Colorado, Washington, Nevada, and New York (New York's waiver and its current status are discussed in more detail above as part of the 1331 Section). However, several states have been denied section 1332 waivers for proposed reforms, or have received determinations that their applications were incomplete.

Reinsurance waivers and related state choices

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

As of 2025, 19 states operate state-based reinsurance programs by waiving the single risk pool requirement under section 1312(c)(1) of the ACA to the extent that it would otherwise require excluding total expected state reinsurance payments when establishing the market-

wide index rate.[13] Most states use a claims-based model, where qualifying insurers are reimbursed for a percentage ("coinsurance rate") of an enrollee's claims costs exceeding a specified threshold ("attachment point") and up to a specified ceiling ("reinsurance cap"). Alaska uses a conditions-based model, where insurers are reimbursed for all medical and prescription drug costs of enrollees with one or more of pre-determined high-cost conditions. Idaho uses a hybrid conditions and claims cost-based model for its section 1332 state-based reinsurance program.[14,15]

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

Reinsurance Example: Colorado

Colorado's approved 1332 waiver consists of two programs that reduce individual market premiums. Program one, the reinsurance program, has operated under a Section 1332 waiver since 2020. Program two, the Colorado Option program, began implementation in Plan Year 2023 and includes a standardized health insurance plan and required premium reduction targets. Colorado generated $339,125,752 in 1332 waiver pass-through funding in 2025.

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

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

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

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

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

Reinsurance Example: Wisconsin

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

Other Approved 1332 Waivers

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

Colorado Option Program

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

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

Health insurance companies are also required to reduce premiums on Colorado Option plans. These premium rate reduction requirements, which rely on the 1332 waiver authority, are incorporated into "target premiums" each year for issuers. These targets establish the

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

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

Waivers Applied for But Not Approved

A handful of states have applied for section 1332 waivers that have not been implemented – either due to the state withdrawing the application, the federal government determining that an application was incomplete or could not be approved, or receiving a suspension of the waiver. Examples of these applications are below.

Georgia

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

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

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

subsequently moved to establish Georgia Access as a state-based Marketplace, which was approved in September of 2024.[19]

Iowa

On August 21, 2017, Iowa submitted a 1332 State Innovation Waiver application, known as the Iowa Stopgap Measure, to the U.S Treasury Department and the U.S. Department of Health and Human Services. The Iowa Stopgap Measure was designed to stabilize Iowa's Affordable Care Act (ACA)–compliant individual market through a series of modifications: (1) a requirement that all insurers in the individual market offer a single standard plan, similar to the ACA's silver plan; (2) elimination of CSR subsidies for those with incomes between 200 and 250 percent of the federal poverty level (FPL); (3) a new premium tax credit structure (tax credits would vary by age and income and would be extended to individual market enrollees with incomes above 400 percent of the FPL); and (4) federally funded reinsurance on all annual individual market claims above $100,000.[20]

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

Considerations for consumers, states, and insurance markets

Reinsurance

Consumer coverage impacts

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

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

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

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

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

Budget

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

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

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

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

Other waiver types

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

1332 can be used for specific state objectives, provided the state meets the guardrails established in federal law.

Section 1333 Health Care Choice Compacts

Background

Summary of statute and 2019 request for information

Section 1333 of the Public Health Service Act, codified at 42 USC §18053, establishes statutory authority for states to create "health care choice compacts" (HCC Compacts)". The law directs HHS/CMS, in consultation with NAIC, to issue regulations for the creation of these compacts. The regulations are required under section 1333 to authorize two or more states to enter into an agreement where a qualified health plan could be sold in the individual markets of all the states and only be subject to the laws and regulations of the state where the plan is written or issued. Section 1333 clarifies that such health care choice compacts are also subject to the following requirements:

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

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

CMS released a Request for Information on HCC Compacts in March 2019. At that time, NAIC commented that states already have authority to permit sales of non-domiciled plans to their residents and thus, separate federal authority to do so was not needed. The comments noted concern about the risks of market instability if plans were sold across state

lines and stated that federally-directed sales of health insurance coverage across state lines would frustrate the ability of state insurance regulators to fulfill one of their central obligations—to provide protection and counsel to insurance consumers in their states. CMS did not at that time follow up with proposed regulations.

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

Comparison with other multi-state compact authority

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

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

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

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

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

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

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

In the years following the passage of the Affordable Care Act, an organization called "Competitive Governance Action" proposed a "Health Care Compact."[24] The purpose of the Health Care Compact was to restore "authority and responsibility for health care regulation to the member states."[25] It would allow member states to enact legislation to suspend the operation of all federal laws, rules, regulations and orders regarding health care that are inconsistent with the laws and regulations adopted by the member state pursuant to the compact. It would also give member states the rights to federal funds in an amount equal to total spending on health care in the member state during federal fiscal year 2010.[26] Nine

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

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

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

states[27] adopted legislation authorizing them to enter into the Compact, but no further action to receive Congressional consent or otherwise stand up the compact has taken place.

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

Considerations for consumers, states, and insurance markets

Potential areas of regulation impacted by HCC compact

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

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

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

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

Pros and cons for states

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

In its October 2025 consultation letter to CMS, the NAIC noted that state flexibility and input will be paramount in making Section 1333 waivers effective. NAIC cautioned against federal

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

regulations that limit how states work together to harmonize differing rules, how a compact is governed, and how a compact is funded.

Given the extensive federal regulation of qualified health plans under the ACA, states may value greater ability to set QHP standards and certification processes, even without a state-based marketplace. As noted in the NAIC's 2025 letter to CMS, flexibility is very important to states when discussing both section 1332 and section 1333 waivers. Consumer protection is of paramount importance to state insurance regulators, and a key element of the Section 1333 compact is that plans offered across state lines would continue to be subject to important consumer protection laws in each state in which they are offered.

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

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

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

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

The biggest unknown about the Section 1333 compact today is the lack of federal regulations outlining specifics. States would gain greater clarity if CMS defines the scope of flexibility granted, specifies whether the four guardrails shared with Section 1332 will be

interpreted the same way, and provides more information on the guardrail on consumer protections. States will also require details about the approval process by CMS, funding, and procedural issues. These outstanding questions are also a significant deterrent to states that may be contemplating a compact under Section 1333.

Discussion, including combining state flexibilities

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

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

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

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

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

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

waiver would also be needed for states pursuing such an option. Clear federal guidance is needed on several issues before states can consider further pursuing these compacts.

Pursuing any of these flexibility options, alone or in combination, requires long-range planning and cooperation between governors, state agencies, and legislatures, as well as funding for actuarial modeling and venues for robust stakeholder engagement. Careful design is needed to avoid anti-selection and prevent risk pool fragmentation. Federal technical assistance and funding for planning could assist states in taking further advantage of the ACA's state flexibility provisions.

Conclusion

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

2026 Spring National Meeting
San Diego, California

SENIOR ISSUES (B) TASK FORCE
Tuesday, March 24, 2026
8:15 – 9:45 a.m.

Meeting Summary Report

The Senior Issues (B) Task Force met March 24, 2026. During this meeting, the Task Force:

1. Adopted its 2025 Fall National Meeting minutes.

2. Discussed the Medicare Supplement Insurance (Medigap) birthday rule and Medigap for those under 65.

3. Discussed long-term care (LTC) riders on life insurance products and variable plans.

4. Heard a presentation from the Coalition Against Insurance Fraud (Coalition) on long-term care insurance (LTCI) fraud.

5. Heard from NAIC consumer representatives on their newly published report on long-term care LTC.

Agenda Item #3

Hear a Presentation on Health Insurance Affordability and State Options to Address It
—Michael Bailit (Bailit Health)

State Strategies for Addressing the Affordability Crisis in the Commercial Market

Michael Bailit

NAIC Health Insurance and Managed Care (B) Committee

March 26, 2026

bailit health

Setting the Stage

THE PROBLEM OF HIGH AND RISING COMMERCIAL HEALTH CARE COSTS

High Health Care Costs Can Have Dire Consequences

- Roughly 36% of adults in the U.S. say they have skipped or postponed needed health care due to cost in the last year; one in five have not filled a prescription.
- Four in ten adults report having debt resulting from medical or dental bills.
- About half of U.S. adults says they would not be able to pay an unexpected medical bill of $500 in full without accumulating some form of debt.
- Medical bills are the leading cause of personal bankruptcy in the U.S., contributing to roughly two-thirds of all filings.

Other sources: https://www.kff.org/health-costs/americans-challenges-with-health-care-costs
https://pmc.ncbi.nlm.nih.gov/articles/PMC6366487/

The Impact on Consumers is Terrible

Americans skip meals to afford health care

Life forced to be put on hold as premiums rise

By Daniel Wu
WASHINGTON POST

Americans are driving less, skipping meals, and putting off big life moves, like buying homes or having children, to keep up with health care costs, according to two Gallup polls released Thursday.

Roughly one-third of Americans are cutting back on daily spending to cover medical costs, and about half of middle-income

to climb and destabilizes stock markets.

"People are making sacrifices, and they're angry," said Tim Lash, president of the health care nonprofit group West Health, which conducted the research in partnership with Gallup.

The second Gallup poll found that nearly 1 in 10 Americans reported postponing retirement in the past four years due to health care costs, and 6 percent said they postponed having or adopting a child.

"Seeing that health care is now impacting those decisions and the ability to kind of attain

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Local News

Wisconsin couple sues Walgreens, Optum Rx, saying son died after sudden $500 price spike for asthma meds

Updated on: February 6, 2025 / 6:15 PM CST / AP

Add CBS News on Google

A Wisconsin couple is suing Walgreens and a pharmacy benefits management company, alleging that their son died because he couldn't afford a sudden $500 spike in his asthma medication.

Shanon and William Schmidtknecht, of Poynette, filed their lawsuit in federal court in Milwaukee on Jan. 21, a year to the day that their son Cole died at age 22.

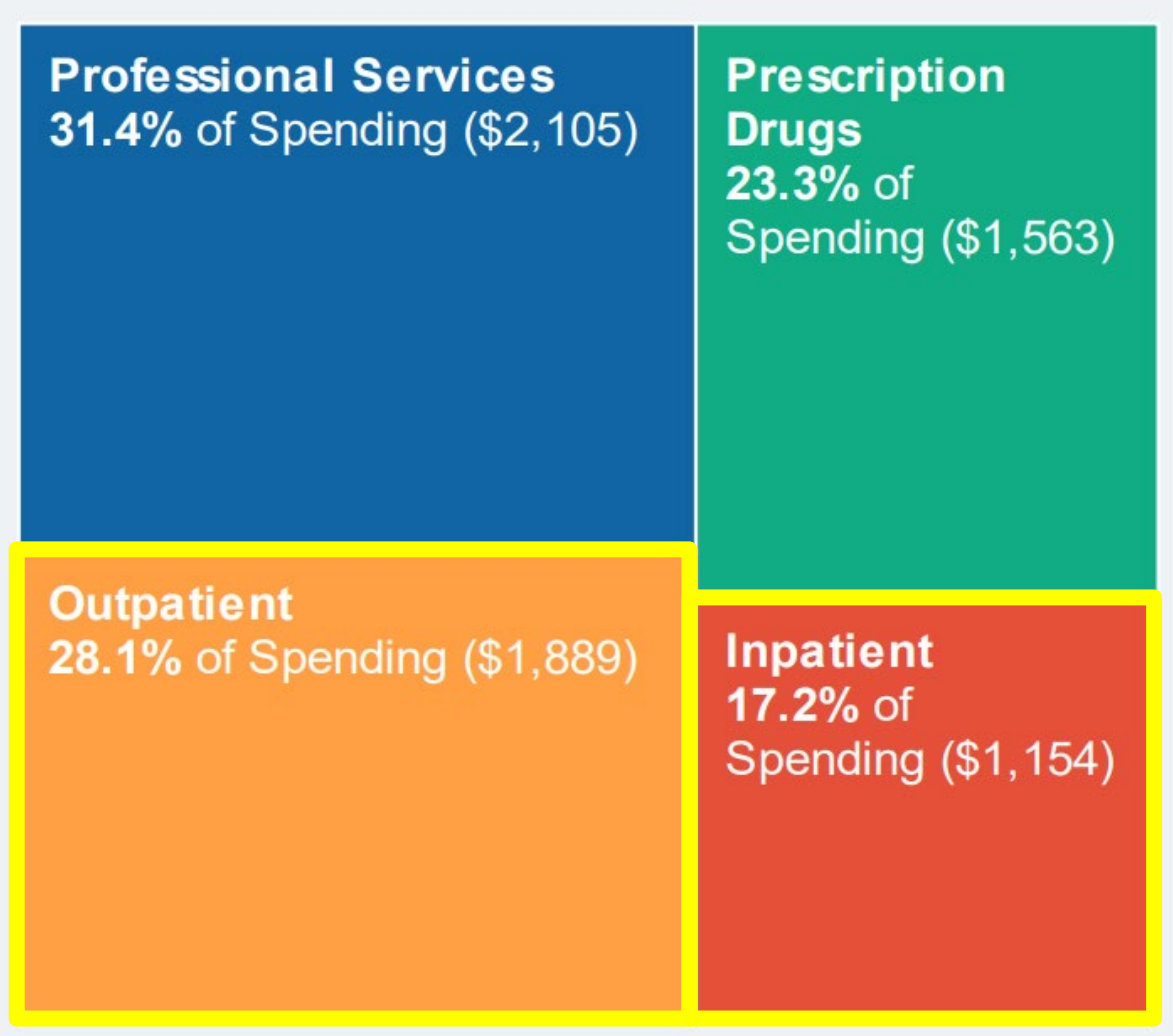
Setting the Stage

HEALTH CARE COST DRIVERS

Commercial Health Care Spending by Service Type

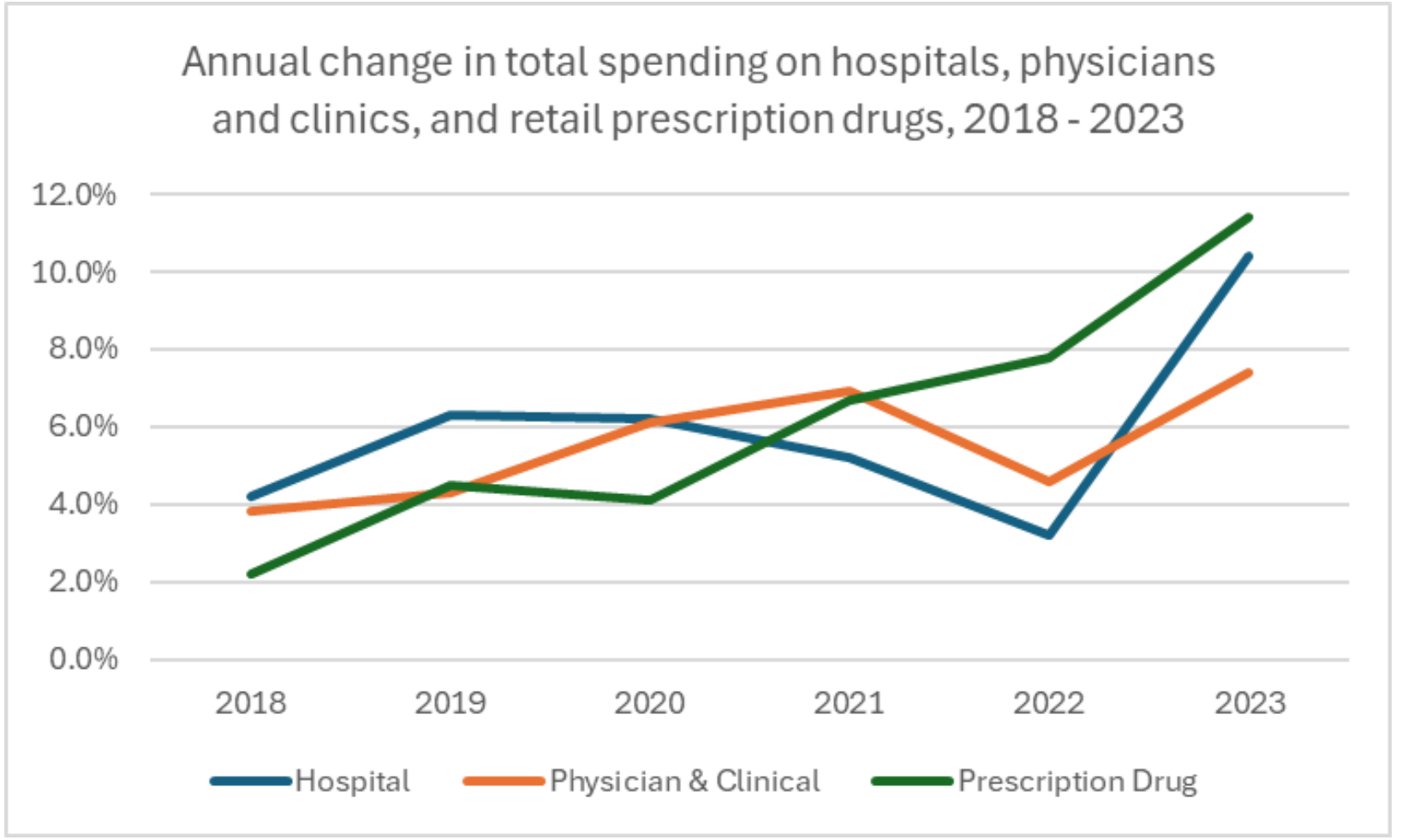
- Nationally, **hospital spending makes up nearly half of total health care spending**.
- For this reason, states are focusing much of their attention on hospitals.

Share of Per Capita Spending in 2022



Source: Health Care Cost Institute. 2022 Health Care Cost and Utilization Report. April 2024.

High Health Care Spending Growth in Recent Years



Source: KFF analysis of National Health Expenditure (NHE) data

STATE STRATEGIES FOR MANAGING HEALTH CARE COST GROWTH

State Options for Addressing Cost Growth

States have been considering and pursuing many different options to address the problem of commercial market affordability. Just some include…

- Measurement and transparency
- Hospital and prescription drug price caps
- Site-neutral payments and facility fee bans
- Hospital and prescription drug price growth caps
- Enhancing market competition
- Reinsurance programs
- Limiting consolidation, vertical integration and/or private equity
- Investments in primary care, prevention and non-medical drivers of health

A Key Strategic Question

- Many believe that the lack of a functioning market for health care is part of the problem.

"*This is not a free market. There is no competition, there is no transparency*."

- Rep. Julie McGuire, Indiana (R)

- Why has this happened?
  - Provider market consolidation
  - Lack of transparent information on cost and quality
  - Patients don't act like rational consumers
- Can health care work as a market? Some think yes, others believe no.

Reviewing State Strategies

- On the following slides I will describe strategies that have been adopted by a wide array of states.
- Most address **hospital and pharmacy** prices, and data analysis has shown these to have been the primary forces driving up health care spending – and commercial premiums – for the past decade or more.

MEASUREMENT, TRANSPARENCY AND COLLABORATION

Measuring Drivers and Identifying Opportunities

- Several states have initiatives to measure annual cost growth across markets, identify cost drivers and collaboratively develop strategies for improving affordability. Examples include:
  - Rhode Island Spending Accountability and Transparency Program: a program managed by the Office of the Health Insurance Commissioner, operating since 2018
  - Minnesota Center for Health Care Affordability: a program within the Department of Health, created in 2023
  - One Utah Health Collaborative: a public/private initiative to address health care quality and affordability, launched in 2025

PRICE CAPS

Overview of Hospital Price Cap

- A price cap, also referred to as a *payment limit*, *payment cap,* and *provider-based reference pricing*, limits the payment amounts for hospital or other services.
  - These limits are established in reference to an external payment benchmark, usually a percentage of Medicare.
  - They typically apply to inpatient and outpatient hospital services, although the scope of services could vary.

Hospital Price Cap: State Options

States have three options for implementing a price cap:

1. **State purchasing authority:** The state caps prices for care purchased through public programs (e.g., the state employee health plan).
2. **Insurance regulation:** The state regulates maximum reimbursement rates for services covered by fully insured private plans.
3. **Provider price regulation:** The state limits prices providers can charge.

Hospital Price Cap Examples: Indiana and New Mexico

- **Indiana** – Uses state nonprofit status as a lever to push prices toward the state average, with a focus on the largest hospital systems in the state.
  - Hospitals whose prices remain above the state average by mid-2029 forfeit their non-profit status for at least one year.
  - Threshold of $2 billion in net patient revenue results in a focus on the state's five largest not-for-profit hospital systems.
  - See House Enrolled Act No. 1004. 2025 Session.
- **New Mexico** – Capped hospital prices in the state employee health plan effective, July 2025
  - In-network capped at 200% of Medicare; out-of-network capped at 175% of Medicare
  - Limited to urban hospitals
  - See Senate Bill 376

Pharmacy Price Cap Example : Colorado

- **Colorado** was the first state to set an upper payment limit on a high-cost drug.
  - Colorado's Prescription Drug Affordability Board created by the legislature in 2021 capped the price of Enbrel at $31,000 per year (the average insurance prices exceeded $50,000).
  - The cap will be effective in 2027.
  - See Senate Bill 21-175

SITE-NEUTRAL PAYMENTS AND FACILITY FEE BANS

Overview of Site-Neutral Payments

- Site-neutral payment policies reduce the prices for certain services delivered within a hospital-owned or affiliated setting and those that can be safely provided in a lower-cost setting.
  - NASHP 2025 model law, Establishing Site-Neutral Commercial Payment for Select Outpatient Health Care Services, applies across fully-insured and self-insured markets by prohibiting providers from charging amounts that exceed the applicable payment cap defined as a percentage of Medicare's non-hospital rates
  - States can exempt certain hospitals based on financial or other factors
- **New York** has proposed prohibiting payers from charging more than the lesser of 150% of the Medicare non-hospital rate or the existing rate for certain outpatient hospital services
  - Savings expected to exceed $1 billion
  - See Fair Pricing Act S705

Overview of Facility Fee Bans

- Facility fee bans limit higher prices charged when hospitals acquire physician practices and shift services that were billed at office-based rates to outpatient hospital rates
  - Limits authorized through legislation are typically applied to providers, creating savings across fully-insured and self-insured markets
  - State laws may limit facility fees in all outpatient settings, or may apply to offsite from a hospital's main campus
  - States could exempt certain hospitals based on financial or other factors
- **Indiana** prohibits facility fees for care provided in an off-campus office setting owned in whole or in part by a nonprofit hospital system with annual patient service revenue exceeding $2 billion
  - Effective July 2025
  - See House Bill 1004 (2023)

PRICE GROWTH CAPS

Overview of Hospital Price Growth Cap

- A price growth cap limits how much provider payments can grow each year; the cap can be linked to an economic indicator such as Consumer Price Index (CPI) or gross state product (GSP) growth.
  - It can be applied to all hospitals, or to certain classes of hospitals where price growth has been problematic.
  - It can be applied differentially based on relative baseline prices.
  - It can be applied to each provider contract individually or across all of a given payer's contracted providers.
  - It is usually implemented and enforced through insurance regulation.

Hospital Price Growth Cap: Delaware

- In 2021, **Delaware** developed provisional affordability standards.
- Rate filing requirements limit commercial insurers' hospital unit cost growth for non-professional services.
  - Current hospital price growth cap level: the greater of 2% and CPI +1%.
  - Caps are effective from 2024 – 2026; extension is pending legislation
  - See Senate Bill 120
- The State enforces the hospital price growth cap through health insurer rate review.
- In RI, insurers negotiate on behalf of fully insured business and self-insured/third party administrator business together, so the cap extends to the self-insured market in practical application. This has not happened in Delaware, however.

Pharmacy Price Growth Cap: Connecticut

- **Connecticut's** 2025 biennial state budget bill prohibits any pharmaceutical manufacturer or wholesale distributor from selling a generic prescription drug at a price above the wholesale acquisition cost after adjusting for any increase in the Consumer Price Index.

STRATEGIES TO INCREASE COMPETITION AND ADDRESS MARKET CHANGES

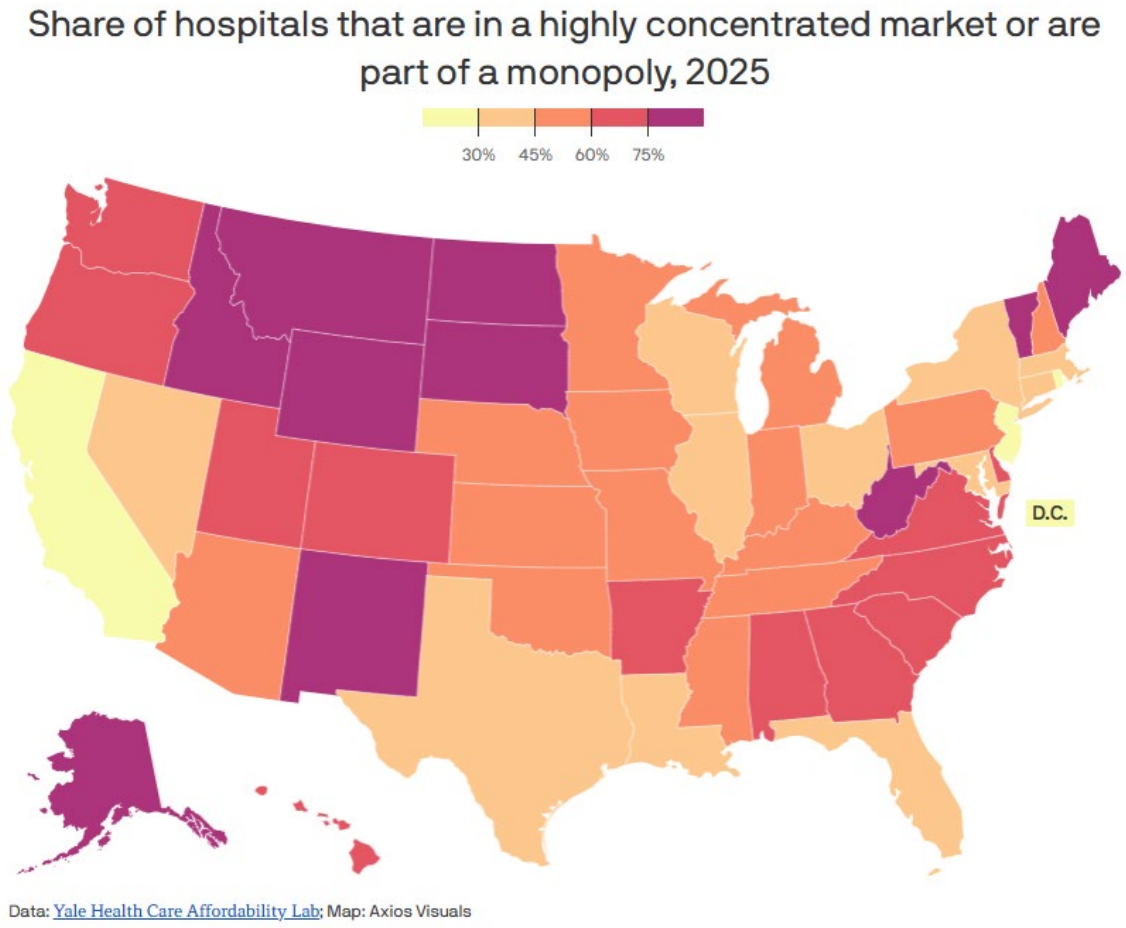
Increasing Health Plan Competition

- **Nevada:** Launched a public option on their health insurance exchange in January 2026
  - Premium growth is limited to the Medicare Economic Index
  - Premiums must be at least five percent lower than reference premium tied to second lowest cost silver plan
  - Provider reimbursement cannot be lower than Medicare in aggregate
  - Legislation created a Public Option Trust Fund administered by the state treasurer with funds to help lower premiums.
  - See Senate Bill 420.

Source: https://nashp.org/nevada-enacts-a-public-option/

Market Changes are Driving Health Care Cost Increases

- Health care ownership changes are driving up health care costs
  - Hospital consolidations reduce competition on cost and quality of care
  - Private equity focus on volume and profit
  - Vertical integration of payers and providers disincentivizes cost containment



Source: https://www.axios.com/2026/03/09/hospital-concentration-states-health-costs

State Strategies to Address Market Changes

Strategy	State Examples
Broadening reviews of transactions across health care entities to mitigate potential harm to patients or providers, with the ability to prevent or condition certain behaviors	• California • Massachusetts • Oregon
Increasing transparency through ownership reporting requirements and expanded financial disclosures	• Indiana • Massachusetts • Washington
Preserving professional autonomy by strengthening Corporate Practice of Medicine protections	• Arkansas • California • Montana • Oregon
Address anticompetitive contracting practices of dominant insurers with providers, such as all-or-nothing and anti-steering provisions in contracts	• Connecticut • Indiana • Massachusetts • Nevada

Source: State Strategies to Improve Health Care Market Oversight (Peterson-Milbank)

Additional Resources

- State Hub for Hospital Pricing Strategies - Supported by The Commonwealth Fund
- Peterson-Milbank Program for Sustainable Health Care Costs
- Health Care Affordability Lab at Yale

THANK YOU!

Michael Bailit
mbailit@bailit-health.com

Agenda Item #4

Hear Remarks on Improving State/Federal Coordination on Issues Related to the Medicare Advantage Program—*Alec Aramanda (Federal Centers for Medicare & Medicaid Services [CMS])*

Agenda Item #5

Hear an Update from the Federal Center for Consumer Information and Insurance Oversight (CCIIO) on its Recent Activities—*Peter Nelson (CCIIO)*

Agenda Item #6

Discuss Any Other Matters Brought Before the Committee
—Commissioner Grace Arnold (MN)