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

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.

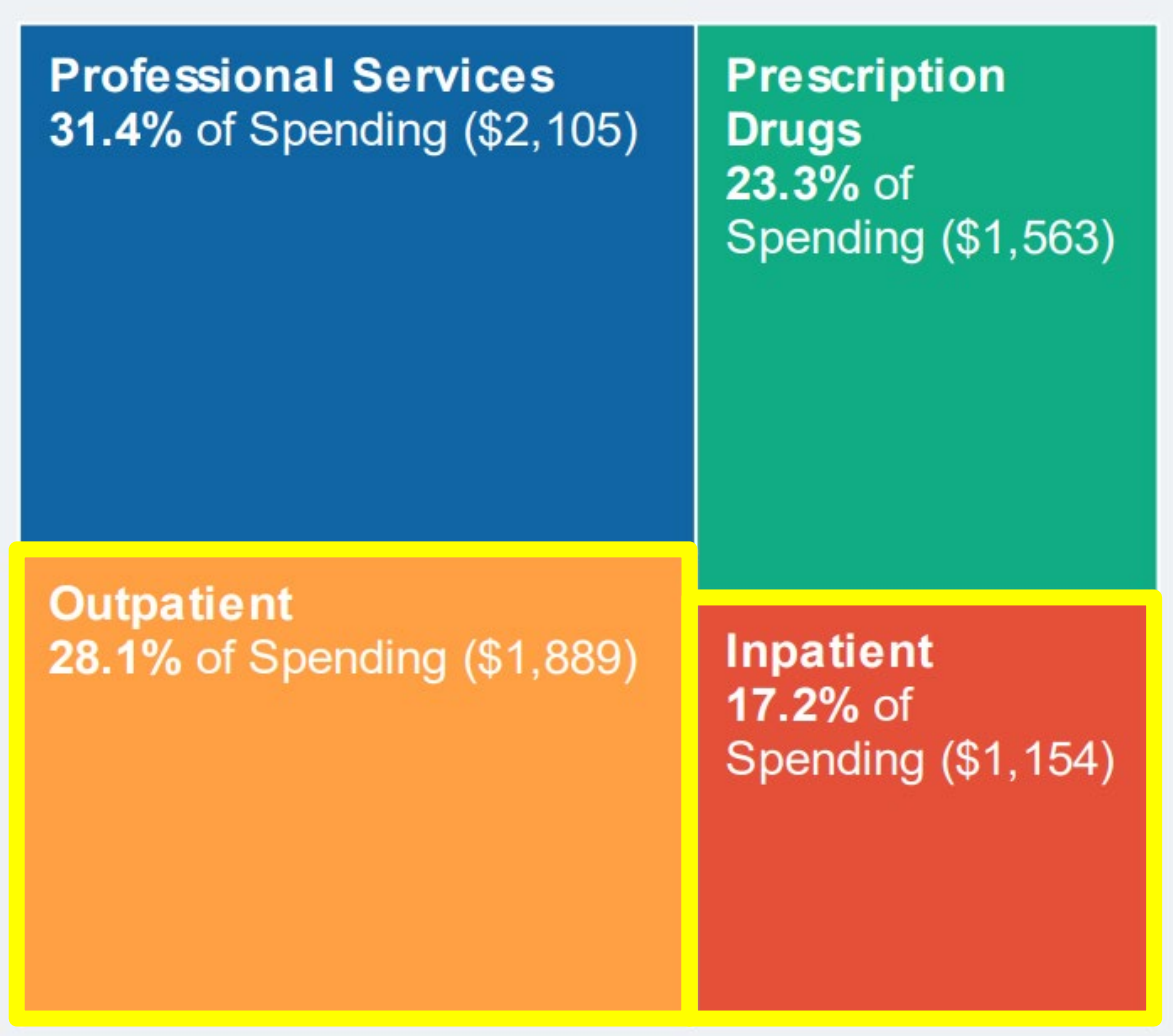
Setting the Stage

HEALTH CARE COST DRIVERS

Commercial Health Care Spending by Service Type

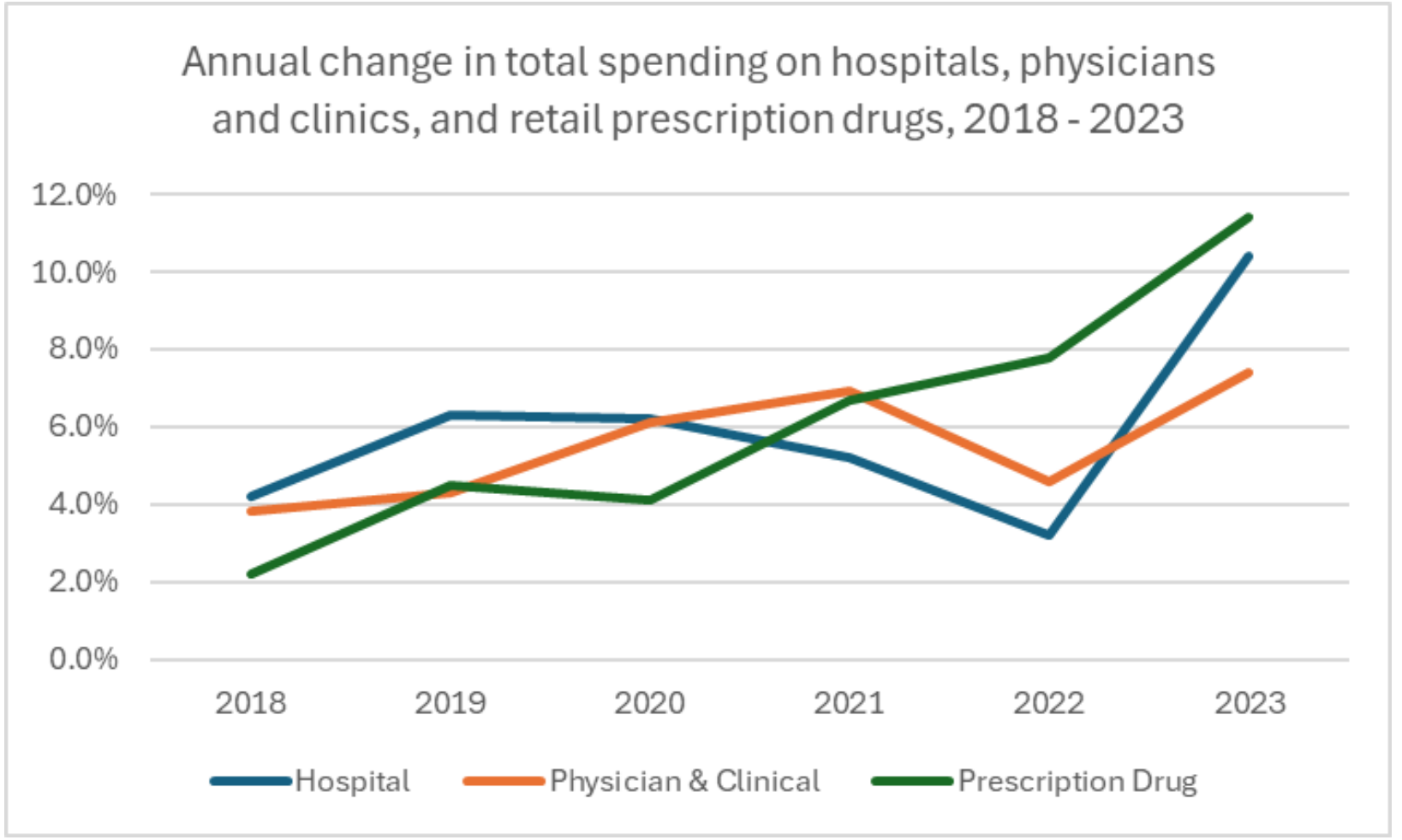
- Nationally, **hospital spending makes up nearly half of total health care spending**.
- For this reason, states are focusing much of their attention on hospitals.

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

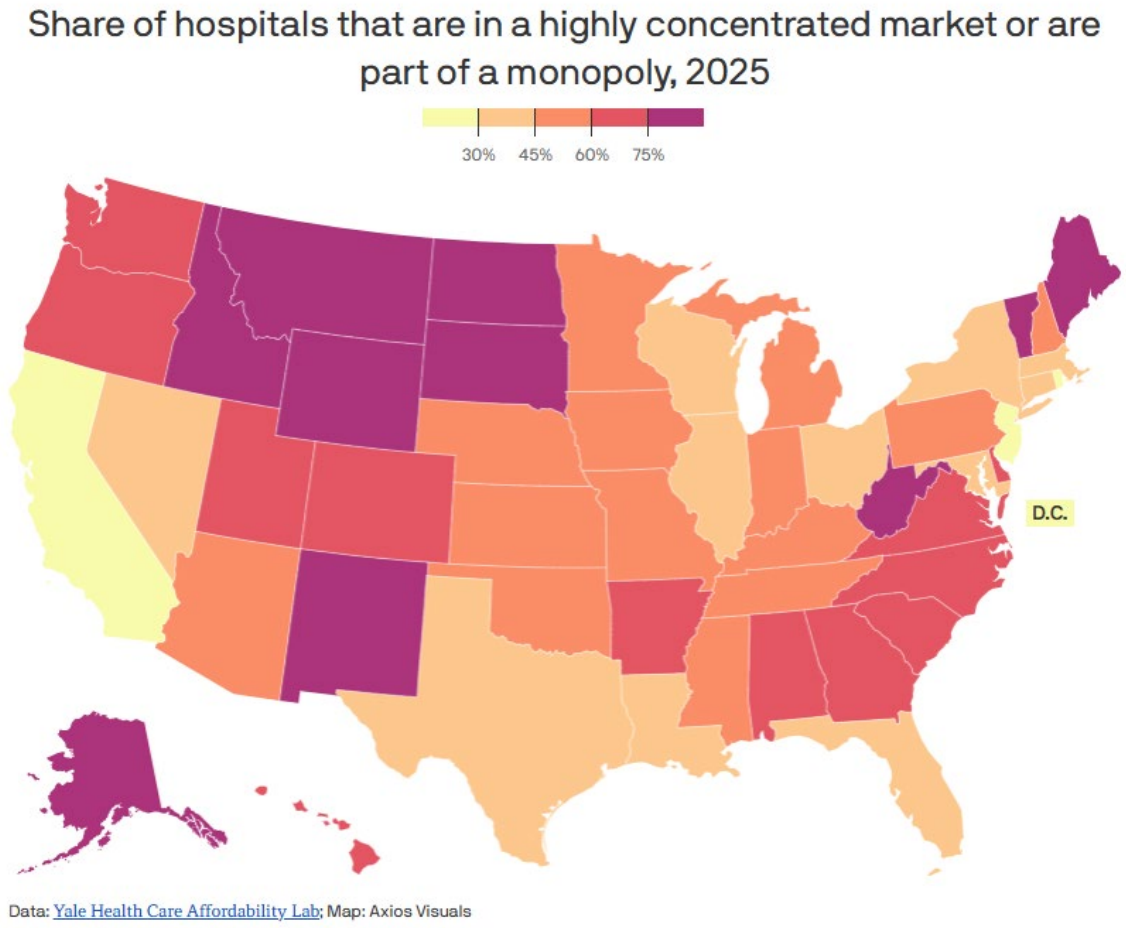
Increasing Health Plan Competition

- **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!

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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)