Draft date: 2/25/26

2026 Spring National Meeting
San Diego, California

REGULATORY FRAMEWORK (B) TASK FORCE
Tuesday, March 24, 2026
12:00 – 1:00 p.m.
Manchester Grand Hyatt—Grand Hall A—Level 1

ROLL CALL

NAIC Member	Representative	State/Territory
Marie Grant, Chair	Marie Grant	Maryland
Allan L. McVey, Vice Chair	Joylynn Fix, Vice Chair	West Virginia
Mark Fowler	Sanjeev Chaudhuri	Alabama
Heather Carpenter	Jeanne Murray	Alaska
Peter M. Fuimaono	Elizabeth Perri	American Samoa
Charles Bassett	Fausto Burruel	Arizona
Michael Conway	Debra Judy/Lila Cummings	Colorado
Joshua Hershman	Tricia Davé	Connecticut
Trinidad Navarro	Susan Jennette	Delaware
Karima M. Woods	Howard Liebers	District of Columbia
Michael Yaworsky	Alexis Bakofsky	Florida
John F. King	John F. King	Georgia
Dean L. Cameron	Dean L. Cameron	Idaho
Ann Gillespie	Shannon McNally	Illinois
Holly W. Lambert	Alex Peck	Indiana
Doug Ommen	Andria Seip	Iowa
Vicki Schmidt	Julie Holmes	Kansas
Sharon P. Clark	Shaun Orme	Kentucky
Michael T. Caljouw	Christopher Joyce	Massachusetts
Grace Arnold	Julia Dreier	Minnesota
Angela L. Nelson	Melissa Panettiere	Missouri
Eric Dunning	Martin Swanson	Nebraska
Ned Gaines	Ned Gaines	Nevada
Susan Ochs	Susan Ochs	New Jersey
Remedio C. Mafnas	Remedio C. Mafnas	Northern Mariana Islands
Judith L. French	Laura Miller	Ohio
Glen Mulready	Mike Rhoads	Oklahoma
TK Keen	TK Keen	Oregon
Michael Humphreys	Richard L. Hendrickson	Pennsylvania
Larry D. Deiter	Jill Kruger	South Dakota
Amanda Crawford	Rachel Bowden	Texas

Jon Pike	Tanji J. Northrup	Utah
Scott A. White	Julie Blauvelt	Virginia
Patty Kuderer	Jane Beyer	Washington
Nathan Houdek	Coral Manning	Wisconsin

NAIC Committee Support: Jolie H. Matthews/Jennifer R. Cook/Joe Touschner

AGENDA

1. Consider Adoption of its Feb. 13, 2026, and 2025 Fall National Meeting Minutes—*Commissioner Marie Grant (MD)* — Attachment One

2. Receive Status Updates on and Consider Adoption of the Reports of its Working Groups—*Commissioner Marie Grant (MD)*
   A. Employee Retirement Income Security Act (ERISA) and Alternative Health Coverage (B) Working Group—*Andria Seip (IA)*
   B. Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group—*Chrystal Bartuska (ND)*
   C. Prescription Drug Coverage (B) Working Group—*Joylynn Fix (WV)*

3. Hear an Update on Recently Enacted Federal Pharmacy Benefit Manager (PBM) Legislation—*Joe Touschner (NAIC)*

4. Discuss and Possibly Consider Adoption of the Revised State Flexibility White Paper—*Commissioner Marie Grant (MD)*

5. Discuss Any Other Matters Brought Before the Task Force —*Commissioner Marie Grant (MD)*

6. Adjournment

Agenda Item #1

Consider Adoption of its Feb. 13, 2026, and 2025 Fall National Meeting Minutes
—Commissioner Marie Grant (MD)

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

Regulatory Framework (B) Task Force
Hollywood, Florida
December 10, 2025

The Regulatory Framework (B) Task Force met in Hollywood, FL, Dec. 10, 2025. The following Task Force members participated: Grace Arnold, Chair (MN); Allan L. McVey, Vice Chair, represented by Joylynn Fix (WV); Heather Carpenter represented by Sarah S. Bailey (AK); Mark Fowler represented by Yada Horace (AL); Maria Ailor represented by Fausto Burruel (AZ); Michael Conway represented by Debra Judy and Lila Cummings (CO); Jared Kosky (CT); Karima M. Woods represented by Howard Liebers (DC); Michael Yaworsky represented by Alexis Bakofsky (FL); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Shannon Hohl (ID); Holly W. Lambert represented by Alex Peck (IN); Vicki Schmidt represented by Craig VanAalst (KS); Sharon P. Clark represented by Shaun Orme (KY); Michael T. Caljouw represented by Kevin P. Beagan (MA); Robert L. Carey represented by Robert Wake (ME); Angela L. Nelson represented by Jo A. LeDuc (MO); Mike Causey represented by Robert Croom (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning represented by Martin Swanson and Maggie Reinert (NE); D. J. Bettencourt represented by Michelle Heaton (NH); Ned Gaines (NV); Judith L. French represented by Laura Miller (OH); Glen Mulready and Andy Schallhorn (OK); TK Keen (OR); Michael Humphreys represented by Lindsi Swartz (PA); Larry D. Deiter represented by Jill Kruger and Gretchen Brodkorb (SD); Cassie Brown represented by Rachel Bowden (TX); Jon Pike represented by Tanji J. Northrup (UT); Scott A. White represented by Julie Blauvelt (VA); Patty Kuderer represented by Jane Beyer (WA); and Nathan Houdek represented by Coral Manning (WI).

1. Adopted its Oct. 20, Sept. 22, and Summer National Meeting Minutes

The Task Force met Oct. 20 and Sept. 22. During these meetings, the Task Force took the following action: 1) discussed the Aug. 29 comments received on the July 18 draft of the *Prior Authorization White Paper*; and 2) adopted its 2026 proposed charges and the 2026 proposed charges of its working groups.

Croom made a motion, seconded by Manning, to adopt the Task Force's Oct. 20 (Attachment One), Sept. 22 (Attachment Two), and Aug. 11 minutes (*see NAIC Proceedings – Summer 2025, Regulatory Framework (B) Task Force*). The motion passed unanimously.

2. Adopted the Reports of its Working Groups

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

3. Adopted the *Prior Authorization White Paper*

Commissioner Arnold reminded everyone that the Health Insurance and Managed Care (B) Committee and NAIC leadership directed the Task Force to develop a white paper on prior authorization (PA) frameworks. She discussed the Task Force's work in developing the *Prior Authorization White Paper*, which was before the Task Force for adoption at this meeting.

Commissioner Arnold stated that as discussed during 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 period ending Aug. 29. The Task Force met Sept. 22 to discuss the comments received. She stated that following the Sept. 22 meeting, the PA

Drafting Group, which developed the initial white paper draft, reviewed the comments to consider which, if any, to incorporate into a revised 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 draft before the Task Force for adoption today is a revised draft that includes non-substantive revisions to the Oct. 28 draft, as suggested in some of the Nov. 19 comments. She noted that the non-substantive changes are in tracked, redlined language.

Commissioner Arnold asked for comments from Task Force members and interested regulators. There were no comments. She asked for comments from interested parties. Lucy Culp (Blood Cancer United), speaking on behalf of the NAIC consumer representatives, said the NAIC consumer representatives support the white paper draft. She said they believe it captures the different perspectives on PA. She urged the Task Force to think of next steps, such as developing a new model law and regulation addressing PA and appropriate referrals related to PA enforcement to the Market Regulation and Consumer Affairs (D) Committee.

Beyer made a motion, seconded by Beagan, to adopt the *Prior Authorization White Paper* (*see NAIC Proceedings – Fall 2025, Health Insurance and Managed Care (B) Committee, Attachment Six*). The motion passed unanimously.

Commissioner Arnold said the Health Insurance and Managed Care (B) Committee will consider adoption of the white paper during its Dec. 11 meeting. She said that following Committee adoption, she anticipates additional discussion among NAIC leadership on next steps.

4. Heard a Presentation from the NCQA on 2026 Updates to its UM Standards

Kristine Toppe (National Committee for Quality Assurance—NCQA) and Alan Immelman (NCQA) discussed updates to the NCQA's utilization management (UM) standards for 2026. Toppe said the NCQA's presentation outlines how the NCQA is supporting both federal and state goals for improving the care experience of individuals and their providers by addressing the hurdles in the UM process chain that result in delays in care, provider dissatisfaction, and administrative inefficiencies. She stated that the NAIC's focus on PA, and the recently adopted *Prior Authorization White Paper* reinforce the importance that has been collectively placed on addressing this problem.

Toppe provided an overview of the NCQA's work, explaining that it offers more than 20 accreditation, certification, and recognition programs, which are all focused on helping organizations improve and deliver quality health care. She said the NCQA has the most widely used standardized performance measurement tool in health care: the Healthcare Effectiveness Data and Information Set (HEDIS).

Immelman discussed the NCQA's UM management program suite, which includes health plan accreditation (HPA) UM requirements, UM accreditation, and behavioral organization accreditation. He noted that the NCQA's standards apply across all lines of business for health plans, including Medicare, Medicaid, commercial, and Affordable Care Act (ACA) exchange plans. Immelman discussed the NCQA's UM requirements, which include policies and procedures for PA, timely decision-making, appeals and grievance processes, and qualified clinical staff involvement. He discussed the key 2026 UM standard updates, which include updates related to: 1) UM data collection and trends analysis; 2) evaluation and measurement of effectiveness when interventions are implemented; 3) the availability of UM criteria to practitioners at the point of care; and 4) the timeline for UM decision making for non-urgent requests. Immelman said these changes collectively: 1) build trust with providers; 2) build trust with members; 3) mitigate risk; 4) facilitate process improvement; 5) strengthen internal benchmarking; and 6) demonstrate value.

Toppe stated that the updated UM standards are effective July 1, 2026. She said the NCQA produces its standards and any updates to standards in advance of the year to give organizations time to prepare their data systems and

processes. She said that once the updates are effective, plans and organizations accredited with the NCQA will begin collecting data consistent with the updated requirements.

Commissioner Arnold said that one of the best practices noted in the *Prior Authorization White Paper*, particularly if a state has just enacted PA legislation, is data collection and learning from the information collected. She acknowledged that the NCQA does not make the UM data it collects public, but she asked, despite this, whether the NCQA has a way of informing state insurance regulators and other state regulators when there could be an issue with an accredited plan. Toppe said the NCQA strives to support state insurance regulators. She said that in a situation like the one Commissioner Arnold described, involving an NCQA-accredited plan that is required to be accredited by the state, the NCQA would be happy to provide a briefing to the state on an individual basis or to states collectively.

Heaton asked Toppe and Immelman about the potential for duplicate UM data collection requirements when states have their own UM data collection requirements. Toppe said the NCQA will certainly review New Hampshire's data collection requirements to eliminate any duplication of efforts for NCQA-accredited plans in New Hampshire, which is one of the things the NCQA accreditation team already does.

Beagan said Massachusetts tracks UM request denials, approvals, and modifications. He asked how the NCQA tracks UM request modifications because he believes it is important to track this data as well. Immelman said the NCQA also tracks UM request modifications as part of its data information integrity requirements, which has been a UM accreditation standard requirement for the past few years.

Beyer asked how the NCQA's updated UM accreditation standards compare with the federal PA data reporting requirements, which will be effective next year. Immelman said that as part of its updating process, the NCQA spends a considerable amount of time and effort making sure that any new time frames or new data elements it plans to introduce in its standards do not conflict. He said that, specifically regarding the new federal PA data reporting requirements, the NCQA's updated UM accreditation standard requirements do not conflict.

5. Received an Update on the ERISA (B) Working Group's Work

Wake said that during the ERISA (B) Working Group's meeting at the Summer National Meeting, the Working Group asked for volunteers to participate in an ERISA Pharmacy Benefit Manager (PBM) Drafting Group to discuss developing guidance for state insurance regulators looking at ERISA preemption of state PBM laws since the *Rutledge v. Pharmaceutical Care Management Association (PCMA)* U.S. Supreme Court decision. He said the goal is to develop guidance, based on current case law, to assist insurance regulators in determining what PBM laws may be more or less vulnerable to ERISA preemption.

Wake said the ERISA PBM drafting group, which is made up of state insurance regulators from Iowa, Maine, Massachusetts, Missouri, Nebraska, North Dakota, Virginia, Washington, and West Virginia, has been meeting every other week since late September to develop an initial draft of the guidance document. He said the ERISA PBM Drafting Group is making progress. It has an initial draft and is currently working on refinements to it. Its next meeting is Dec. 22. Wake said he anticipates forwarding an initial draft of the guidance document to Working Group members for their review and comment by the end of this year or early next year and exposing a draft of the guidance document for public comment early next year.

Wake said the Working Group is also working to complete its assignment from the Health Insurance and Managed Care (B) Committee and NAIC leadership to develop guidance on level-funded plans and other alternative arrangements as related to the small group market. He said that to obtain more information on, and a better understanding of, level-funded plans, the Working Group heard a presentation from the National Association of Benefits and Insurance Professionals (NABIP) on level-funded plans during the Summer National Meeting. He said

that after that meeting and presentation, it became clear the Working Group needed to gather additional perspectives to draft guidance that thoughtfully examines level-funded plans in relation to the small group market. Wake said the Working Group has had trouble finding presenters willing to speak on the topic. He said that recently, however, the Self-Insurance Institute of America Inc. (SIIA) agreed to speak to the Working Group on the issue of stop-loss insurance, including its use in level-funded plans. Wake said he anticipates the Working Group scheduling a meeting early next year to hear the presentation.

Given his anticipated retirement from the Maine Bureau of Insurance early next year, Fix thanked Wake for his contributions to the work of the ERISA (B) Working Group and the NAIC as a whole. She said he will truly be missed. Commissioner Arnold also thanked Wake for his many contributions.

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

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/RFTF/National Meetings/2025 Fall Meeting/RFTF 12-10-25 MtgMin.docx

Agenda Item #2

Consider Adoption of its Working Group Reports—*Commissioner Marie Grant (MD)*

- *Employee Retirement Income Security Act (ERISA) and Alternative Health Coverage (B) Working Group—Andria Seip (IA)*
- *Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group —Chrystal Bartuska (ND)*
- *Prescription Drug Coverage (B) Working Group—Joylynn Fix (WV)*

2026 Spring National Meeting
San Diego, California

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) AND ALTERNATIVE HEALTH COVERAGE (B) WORKING GROUP
Tuesday, March 24, 2026
12:45 – 1:45 p.m.

Meeting Summary Report

The ERISA and Alternative Health Coverage (B) Working Group met March 24, 2026. During this meeting, the Working Group:

1. Adopted its Feb. 26 minutes. During this meeting, the Working Group took the following action:
   A. Discussed its name change and new charge.
   B. Heard preliminary feedback on the draft *Guidance Document: ERISA Preemption and State Pharmacy Benefit Manager (PBM) Laws*.
   C. Discussed next steps, which would likely involve discussing comments received on the draft *Guidance Document: ERISA Preemption and State Pharmacy Benefit Manager (PBM) Laws* at the Spring National Meeting.

2. Discussed and agreed that a drafting group would revise the *Guidance Document: ERISA Preemption and State Pharmacy Benefit Manager (PBM) Laws* based on the comments received.

3. Discussed the drafting of a paper on level-funded plans and requested volunteers to join a drafting group.

4. Discussed its charge to monitor, analyze, and report, as necessary, developments related to excepted benefits coverage; short-term, limited-duration (STLD) coverage; health sharing ministry coverage (HSMC); and coverage that is offered and marketed as a substitute for, or an alternative to, comprehensive major medical coverage. The Working Group requested feedback on what it would like to focus on to begin addressing this charge by April 30.

2026 Spring National Meeting
San Diego, California

PRESCRIPTION DRUG COVERAGE (B) WORKING GROUP
Monday, March 23, 2026
11:45 a.m. – 12:45 p.m.

Meeting Summary Report

The Prescription Drug Coverage (B) Working Group met March 23, 2026. During this meeting, the Working Group:

1. Adopted its 2025 Fall National Meeting minutes.

2. Adopted its Dec. 15, 2025, minutes. During this meeting, the Working Group took the following action:
   A. 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.

3. Heard presentations from the National Health Law Program (NHeLP) and the HIV+Hepatitis Policy Institute on prescription drug formularies, consumer protections, and state enforcement. The presentations highlighted the importance of nondiscriminatory prescription drug benefit design for consumers and the need for more transparency into how formularies are developed and how their requirements are used when consumers try to access their prescription drug coverage.

4. Heard a presentation from the Alabama Department of Insurance (DOI) on prescription drug discount cards and how they work. The presentation also discussed topics related to discount cards, including copay and prescription drug assistance programs and copay accumulators.

Agenda Item #3

Hear an Update on Recently Enacted Federal Pharmacy Benefit Manager (PBM) Legislation
—Joe Touschner (NAIC)

Pharmacy Benefit Manager Provisions

Consolidated Appropriations Act 2026

Group Health Plans
(Self and Fully Insured)

- PBMs must pass through rebates and discounts
- PBM may charge only flat service fee
- Transparency: PBMs report to plans on drug costs, spreads, benefit designs, use of affiliated pharmacies
- Effective for plan years after August 2028

Pharmacy Benefit Manager Provisions

Consolidated Appropriations Act 2026

Medicare Part D Prescription Drug Plans

- PBMs must pass through rebates and discounts
- PBM may charge only flat service fee
- Strengthens "any willing pharmacy" provisions
- Transparency: PBMs must explain manufacturer contract provisions to plans
- Greater oversight from HHS
- Effective January 1, 2028

MINTZ Blogpost Feb. 6, 2026

Congress Passes Landmark PBM Reform in 2026 Spending Bill

By Theresa C. Carnegie, Bridgette A. Keller, Hassan Shaikh, Abdie Santiago

On February 3, 2026, Congress passed – and the President signed – the Consolidated Appropriations Act, 2026 (2026 CAA). The legislation includes a long-anticipated and far-reaching package of PBM reforms. These reforms draw from the PBM Reform Act of 2025 and other legislative proposals and will significantly reshape PBM operations across the commercial market and Medicare Part D beginning in 2028–2029.

The reforms center on **rebate pass-through**, **increased transparency**, **standardized reporting**, and **expanded federal oversight**. Stakeholders should begin preparing for material operational and contractual changes well ahead of the effective dates. This post summarizes the key changes below.

Commercial Market – Group Health Plans and Health Insurance Issuers Offering Group Health Insurance Coverage

The law requires PBMs that provide services to group health plans or health insurance issuers offering group health insurance coverage to comply with new requirements taking effect in 2028-2029, including:

- **100% Pass-Through of Rebates.** The 2026 CAA requires that entities providing pharmacy benefit management services (PBMs) remit to plan clients 100% of rebates, fees, alternative discounts, and other remuneration received from manufacturers, GPOs, and rebate aggregators in connection with the plan's drug utilization or drug spending (collectively referred to throughout this post as "Rebates"). Congress does not define "pharmacy benefit management services" in the commercial market section of the law.

1. **Remittance of Rebates.** The new law requires that PBMs remit Rebates to their plan clients on a quarterly basis, no later than 90 days after the end of each quarter. In addition, the law requires PBMs to structure their rebate aggregator and GPO contracts to require those upstream entities to pass through 100% of Rebates to the PBM within 45 days of each quarter, enabling the PBM to meet its 90-day remittance obligations.
2. **Disclosure of Rebates to Plans.** The 2026 CAA requires PBMs to fully disclose all Rebates to their plan clients.

3. **Audits.** At least once per plan year, PBMs are required to make Rebate records, including Rebate contracts, available to their plan clients for audit. The Secretary of Labor will establish reasonable confidentiality restrictions for audited Rebate contracts. The plan fiduciary selects the auditor, and the PBM may not pay for the auditor, directly or indirectly. Accordingly, plans may not use PBM credits or allowances to pay for a Rebate audit.
4. **Enforcement.** If a PBM violates the law's Rebate requirements, the PBM's contract becomes "unreasonable" under ERISA Section 408(b)(2)(B) and constitutes a prohibited transaction.

The new law directs the Secretary of Labor to issue regulations governing the procedures for Rebate remittance, audits, and disclosures. We expect the Secretary to publish additional details as the industry prepares to implement these Rebate pass-through requirements.

- **Transparent Compensation.** The law expands the definition of "covered service providers" under ERISA, requiring PBMs to make a variety of disclosures, including those required under the Consolidated Appropriations Act of 2021. The law makes clear that PBMs may receive and retain reasonable payments for bona fide services, provided the fees are transparent and quantifiable to the plan.

The Department of Labor released proposed rules that overlap with and expand on the 2026 CAA transparency and disclosure requirements. We are analyzing the impact of the proposed rule, keep a lookout for our next alert!

In addition, PBMs will face new transparency and reporting requirements, including:

- **Plan-Level Reporting.** The law requires PBMs to provide plans with detailed reports on a semiannual basis – or quarterly upon plan request – covering the following categories of information:
    - Gross and net prescription drug spending by the plan
    - Manufacturer rebates, fees, and other remuneration the PBM receives in connection with the plan's drug utilization
    - Spread pricing arrangements with network pharmacies and pharmacy network reimbursement amounts, including drug-level detail and the type of pharmacy (e.g., retail, mail, specialty) dispensing each drug
    - Formulary structure and prescription drug benefit design
    - Drug dispensing through PBM-affiliated pharmacies, including an explanation of any benefit design parameters that encourage or require members to fill prescriptions at mail order, specialty, or retail pharmacies
    - Member out-of-pocket cost metrics

    - Summary documents, tailored by plan-client type, for plan clients to provide to their members

The Secretaries of Health and Human Services (HHS), Labor, and the Treasury will establish a standard reporting format and issue additional rulemaking as necessary to implement these requirements.

- **Contractual Requirements**. PBMs may not enter into contracts that limit the PBM's ability to provide these required reports, and must include provisions in their upstream contracts requiring each counterparty to furnish all information required by the PBM to prepare and deliver the reports.
- **Enforcement.** The Secretary of HHS or the Secretary of Labor may impose civil monetary penalties, and the Secretary of the Treasury may enforce parallel excise taxes under the Internal Revenue Code, if a PBM fails to comply with the law's reporting requirements.

Medicare Part D Market

The 2026 CAA provisions governing PBM services for Medicare Part D plans largely mirror the legislative framework Congress advanced in 2025. CMS will implement the Medicare PBM reforms by updating its standard PDP and MA-PD contracts and by issuing uniform reporting formats. Beginning with the 2028 plan year, PDP and MA-PD sponsors (PDP sponsors) are required to comply with and enforce the new PBM standards.

The new law introduces the following changes:

- **Definition of PBM.** For purposes of the Medicare Part D provision of the 2026 CAA,the law defines "pharmacy benefit manager" broadly to extend beyond traditional PBMs and include rebate aggregators, group purchasing organizations, and utilization management entities. The definition specifically states, *"[s]uch term includes any person or entity that carries out one or more of the activities described in the preceding sentence, irrespective of whether such person or entity calls itself a 'pharmacy benefit manager.'"*
- **Delinked, Transparent Compensation and Pass-Through of Rebates.** PBMs that act on behalf of PDP Sponsors may receive compensation related to Part D drug utilization only in the form of a bona fide service fee (BFSF). The law prohibits PBMs from receiving any other income tied to Part D drug utilization.

The statute defines a BFSF as: (1) a flat fee; (2) consistent with fair market value ("FMV"); (3) for a service actually performed by the PBM or its affiliate on behalf of the PDP Sponsor; (iv) that is not passed on to a client or customer; and (v) does not vary based on drug price, Rebates, coverage or formulary decisions, or the volume or value of referrals or business generated between the PBM and the PDP Sponsor. In addition:

- Incentive payments (as determined by the Secretary) that PDP Sponsors pay to PBMs qualify as BFSFs if the payments meet certain requirements.
- Rebates that Manufacturers pay to PBMs, even when calculated as a percentage of a drug's price, do not violate the BFSF requirements if the PBM fully passes through the Rebates to the PDP Sponsor and reports the Rebates in accordance with applicable DIR requirements.
- The law requires PBMs to pass through to the PDP Sponsor any PBM remuneration that fails to meet the BFSF definition requirements.

The law's BFSF definition differs materially from the BFSF definition used under existing Medicare Part D law. In particular, the requirement that a BFSF be both a flat fee and consistent with FMV creates immediate practical tension, as PBMs and PDP Sponsors often cannot predict service volume with certainty at the time they enter PBM agreements. The Secretary of HHS will review certain components of PBM remuneration arrangements to confirm that they are consistent with FMV.

- **Additional PBM Agreement Requirements**. To evaluate PBM performance against pricing guarantees and other Rebate-related cost measures, the new law requires PDP Sponsors and PBMs to structure their agreements so that PBMs: (1) define, interpret, and apply key terms in a transparent and consistent manner (e.g., generic drug, brand drug, specialty drug, rebate, and discount); (2) clearly identify any claims or price concessions that the agreements exclude from pricing guarantees or other performance measures; and (3) calculate and provide a WAC-based equivalent when an agreement bases a pricing guarantee or cost-performance measure on a benchmark other than WAC.
- **Standardized Reporting Requirements.** Beginning in 2028, and no later than July 1 of each year, PBMs are required to submit detailed standardized annual reports to PDP Sponsors and HHS. These reports include, among other information:
    - Comprehensive drug-level and aggregate data, including pricing, reimbursement amounts, enrollee out-of-pocket spending, Rebates, and manufacturer-derived revenue (including BFSFs), attributable to each drug and that the PBM or its affiliates retain
    - Dispensing activity by PBM-affiliated pharmacies, including transparency into PBM reimbursement practices and dispensing of 340B drugs
    - Formulary and benefit design information related to generics and biosimilars
    - Aggregate spending metrics, including total spending by the PDP Sponsor; total amounts the PBM retains in connection with covered Part D drug utilization (including BFSFs); and total spending on covered Part D drugs net of Rebates and DIR

    - Benefit-design parameters that encourage plan enrollees to fill prescriptions at PBM-affiliated pharmacies
    - Broker or consultant compensation that the PBM or its affiliates pay in connection with PBM services provided to PDP Sponsors

  In addition, PBMs are required to provide PDP Sponsors with a written explanation of Rebate contracts within 30 days of finalizing each contract.

- **Audits.** PDP Sponsors may audit their PBM's compliance with applicable legal requirements on an annual basis. The law also requires PBMs to provide all requested audit information within 6 months after the PDP Sponsor initiates the audit. In practice, many PDP Sponsors already maintain audit rights in their agreements that require faster turnaround times.
- **Remedies.** PBMs will be responsible for any civil monetary penalties imposed on a PDP Sponsor due to a PBM's noncompliance with these new requirements, as well as other punitive remedies for noncompliance. The Secretary of HHS will establish a mechanism for reporting PBM noncompliance, and the law includes anti-retaliation protections related to such reports. In addition, PDP Sponsors are required to submit to HHS an annual certification of compliance with all PBM contractual requirements.
- **Any-Willing-Pharmacy Contract Standards.** Medicare Part D includes long-standing "any-willing pharmacy" (AWP) requirements that require PDP Sponsors to allow any pharmacy to participate in a plan's or PBM's network if the pharmacy agrees to accept the PDP Sponsor's standard terms and conditions. Those terms must be "reasonable and relevant" to the pharmacy services provided. In practice, PBMs that manage pharmacy networks offer pharmacies requesting to participate in the PBM's network the PBM's standard contract and reimbursement terms. Many pharmacies have raised concerns that, although these terms are standard, they do not always align with a pharmacy's specific business model.

  The new law responds to these concerns and strengthens existing AWP requirements by directing CMS to establish standards defining "reasonable and relevant" pharmacy contract terms and conditions. CMS will issue a request for information (RFI) by April 2027 to solicit stakeholder input and finalize the standards by April 2028, with the standards taking effect for the 2029 plan year.

  In addition, CMS will create a process that allows pharmacies to submit allegations of PBM noncompliance with the AWP contract standards. PDP sponsors that fail to offer contracts consistent with the CMS established standards will face civil monetary penalties.

- **Essential Retail Pharmacies.** Beginning with plan year 2028, CMS will identify, track, and report on non-PBM-affiliated pharmacies that play a critical role in Medicare

beneficiary access to pharmacy services (referred to as “essential retail pharmacies”). CMS will publish an annual list of essential retail pharmacies and will issue periodic public reports analyzing reimbursement, network participation, cost-sharing, and dispensing trends for essential retail pharmacies compared with non-essential retail pharmacies. Industry stakeholders expect this CMS oversight to help preserve beneficiary access by supporting the financial sustainability of these essential retail pharmacies.

What About Medicaid?

Unlike prior proposals, the 2026 CAA does not make direct changes to PBM services under the Medicaid program. Instead, Congress directs the GAO to study price-based PBM compensation across both Medicaid and Medicare, laying the groundwork for potential future federal standards or state-level action.

Key Takeaways for Stakeholders

The 2026 CAA marks the most comprehensive federal effort to regulate the pharmacy benefit management industry to date. Although many of the law’s provisions have delayed effective dates and depend on future regulatory guidance, the legislation clearly advances Congress’s policy priorities—greater transparency, rebate pass-through, and enhanced disclosure.

- ***Start early.*** *Significant new data, reporting, and operational requirements begin in 2028.*
- ***Review PBM contracts.*** *Many agreements will require substantial restructuring, particularly around compensation, definitions, reporting, and audit rights.*
- ***Assess data infrastructure.*** *The new reporting standards demand more granular, drug-level and pharmacy-specific data.*
- ***Prepare for increased regulatory oversight.*** *HHS, DOL, and Treasury will play expanded enforcement roles.*

Agenda Item #4

Discuss and Possibly Consider Adoption of the Revised State Flexibility White Paper
—Commissioner Marie Grant (MD)

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

State Flexibility White Paper - Draft

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

Contents

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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, ~~F~~federal law preempts state insurance laws ~~only~~ 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. ~~continue to make coverage as affordable and comprehensive to as many people as would be covered under the waived provisions of the ACA., while also not increasing federal deficits~~ 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 ~~benefits packages~~ 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~~s~~ 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 ~~is generating~~ 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. ~~Consumers eligible for premium tax credits pay a set percent of their household income for benchmark plans, whether or not a reinsurance program is in effect.~~

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~~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~~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~~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~~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

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

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]:

> 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

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

[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/.

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 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 ~~Combining risk pools could~~ potentially add to ~~improve~~ market

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

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

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 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 ~~input into~~ ability to set QHP standards and certification processes, even without a state-based marketplace. ~~A Section 1333 compact could be the vehicle through which states could provide that input.~~ 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~~, including~~ 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~~, the interpretation of the five guardrails,~~ 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 ~~certain higher-income residents~~individual market participants above 200~~X~~% 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

[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.

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 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 ~~and technical assistance would greatly help~~ could assist states in taking~~take~~ 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.

[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/.

Agenda Item #5

Discuss Any Other Matters Brought Before the Task Force
—Commissioner Marie Grant (MD)