Draft date: 10/30/26

2026 Fall National Meeting
Dallas, Texas

HEALTH CARE AFFORDABILITY AND MITIGATION (B) WORKING GROUP
Sunday, November 15, 2026
4:00 – 5:00 p.m.
Convention Center—Grapevine A123—Level 3

ROLL CALL

Kate Harris, Chair	Colorado	Chrystal Bartuska	North Dakota
Kevin P. Beagan, Vice Chair	Massachusetts	Kristin Cly	Ohio
Anthony L. Williams	Alabama	Michael Humphreys	Pennsylvania
Sarah Bailey/Jeanne Murray	Alaska	Carlos Vallés	Puerto Rico
Stesha R. Hodges/ Gabrielle Lessard	California	Jill Kruger	South Dakota
		Rachel Bowden/ R. Michael Markham	Texas
Howard Liebers	District of Columbia		
Weston Trexler	Idaho	Tanji J. Northrup	Utah
Alex Peck	Indiana	Todd Lovshin/ Ingrid Ulrey	Washington
Craig Van Aalst	Kansas		
Megan Mason	Maryland	Joylynn Fix	West Virginia
Amy Hoyt/Jeana Thomas	Missouri	Coral Manning	Wisconsin
Viara Ianakieva/ Margaret Pena	New Mexico		

NAIC Committee Support: Joe Touschner

AGENDA

1. Consider Adoption of its Summer National Meeting Minutes—*Kate Harris (CO)* — Attachment A
2. Consider Adoption of *State Options for Reducing Health Insurance Costs* —*Kate Harris (CO)* — Attachment B
3. Hear a Presentation from Consumer Representatives—*TBD*
4. Discuss its 2027 Activities—*Kate Harris (CO)*
5. Discuss Any Other Matters Brought Before the Working Group —*Kate Harris (CO)*
6. Adjournment

Attachment A
Draft: 8/20/26

Health Care Affordability and Mitigation (B) Working Group
Columbus, Ohio
August 13, 2026

The Health Care Affordability and Mitigation (B) Working Group of the Health Insurance and Managed Care (B) Committee met in Columbus, OH, Aug. 13, 2026. The following Working Group members participated: Kate Harris, Chair, and Debra Judy (CO); Kevin P. Beagan, Vice Chair, and Cara Libman (MA); Sarah Bailey (AK); Kelli Littlejohn Newman (AL); Andria Seip (IA); Weston Trexler (ID); Alex Peck (IN); Josh Carlson and Craig Van Aalst (KS); Patricia Dorn and Megan Mason (MD); Chrystal Bartuska (ND); Viara Ianakieva (NM); Kristin Cly (OH); Michael Humphreys and Valerie Romig (PA); Jill Kruger (SD); Daniel McAdams (TX); Shelley Wiseman (UT); Debbie Hughes (WV); and Coral Manning (WI). Also participating were: Julia Dreier (MN); Michael Muldoon and Maggie Reinert (NE); Michelle Heaton (NH); and Alice McKenney (NY).

1. Adopted its June 2, May 5, April 21, April 7, and Spring National Meeting Minutes

The Working Group met June 2, May 5, April 21, and April 7. During these meetings, the Working Group took the following action: 1) discussed its work plan for the year with a focus on developing a series of short issue briefs covering state options for improving the affordability of health care. The Working Group received updates on the work of its drafting groups and compiled a list of potential topics to cover in the issue briefs; 2) discussed the *State Options for Reducing Health Insurance Costs* document; 3) discussed a list of policy topics to focus on when developing briefs describing state options for addressing health care affordability. The Working Group conducted a poll among its members to identify the top priority affordability options; and 4) heard presentations from the Georgetown University Center on Health Insurance Reforms (CHIR) and the Health Care Affordability Lab at Yale on drivers of health care costs and strategies for controlling them.

Manning made a motion, seconded by Mason, to adopt the Working Group's June 2 (Attachment A), May 5 (Attachment B), April 21 (Attachment C), April 7 (Attachment D), and March 24 (*see NAIC Proceedings – Spring 2026, Health Insurance and Managed Care (B) Committee, Attachment* Four) minutes. The motion passed unanimously.

2. Heard a Presentation on the Impacts of the No Surprises Act Independent Dispute Resolution

Jennifer Jones (Blue Cross Blue Shield Association—BCBSA) presented on the cost impacts of the federal No Surprises Act, in particular those associated with the Act's process for independent dispute resolution (IDR).

Jones presented BCBSA's estimates of avoidable costs resulting from the federal IDR process from 2025–2030. To estimate the total cost, BCBSA added estimates of administration fees, fees to IDR entities, and award amounts in excess of qualifying payment amounts (QPAs). It then used observed IDR case growth in recent years to project continued growth through 2030. Using this formula, BCBSA projects $291 billion in avoidable costs from 2025–2030. Jones noted this projection does not include any increase in award amounts over the QPA, costs to plans, providers, and the federal Centers for Medicare & Medicaid Services (CMS), or impacts on network participation.

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Jones said that the IDR process is subject to gaming due to flawed incentives. She noted that IDR entities are paid per case, so they have an incentive to encourage providers to file more disputes. She said providers are increasingly filing disputes for high-cost services that should be excluded from the IDR process, including services scheduled in advance. She said nearly 40% of IDR cases have been identified as ineligible for the process and that more than 40% of disputes come from just three private equity-backed provider groups.

Jones offered suggestions for how state insurance regulators can reduce the impact of the federal IDR process. She said states can adopt or improve their own state processes to resolve payment disputes, shifting more cases from federal IDR to state processes. State improvements could include allowing self-insured health plans to opt in to state surprise billing processes and establishing penalties for ineligible submissions. She said states could also include additional services in their surprise billing processes and discourage defaulting to the federal process. She further recommended that state insurance regulators urge federal regulators to improve the federal process by reducing incentives for providers to submit ineligible cases and enhancing the quality of IDR entity decision-making through increased oversight and accountability.

Harris asked how many states use the federal IDR process rather than their own state process. Jones responded that there is a continuum of state-federal responsibilities, rather than a binary division. She said the federal process serves as a stopgap, resolving disputes when a state process is not applicable. She said state laws may cover certain services or medical specialties, while the federal process handles those not covered. She said all disputes arising under self-funded plans go through the federal process unless the state has created an opt-in for such plans.

Trexler asked what criteria IDR entities should use in deciding cases that they are not currently using. Jones said federal statutes lay out several required factors and allow the Secretary of Health and Human Services (HHS) to define others. She said the law seems to intend the QPA to be a primary factor, but the courts have changed the weight it can be given. She said firms representing providers use strategies to game the process—for instance by sending more than 1,000 cases on the day before a holiday, when a default decision will be entered after four business days. She cited another example of providers submitting voluminous documentation to encourage entities to make an award based on the quantity rather than the quality of the information submitted. She said IDR entities make errors, such as issuing awards for Medicare claims, Medicaid claims, or in-network claims, when none of these are eligible for IDR. Trexler asked about any audit processes to hold IDR entities accountable. Jones said CMS is currently the responsible party, and BCBSA is looking into whether states could play a larger role. She said CMS could decertify IDR entities or set up audits.

Manning asked whether BCBSA plans have made it easier for providers to join networks to avoid out-of-network payment disputes. Jones said plans have taken action to improve credentialing and streamline contracting. Jones said providers who engage in surprise billing are generally those that do not have an incentive to join networks because they are not driven by volume. They are providers with inelastic demand and are not subject to choice by consumers.

Trexler asked whether any of the recommendations for improvement can be implemented without legislation and whether any states have successfully addressed the issue. Jones said California has had the least impact from the federal IDR process. She said California uses a benchmark process before pursuing independent dispute resolution. She said other states that use benchmarks have also had success. She said the ability to act without legislation depends on a state's existing laws and rules.

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3. Heard a Presentation from Equality Arlington on Limited Benefit Plans

Amy Killelea (Equality Arlington and the Georgetown University CHIR) presented on the potential for misleading marketing and consumer harm from limited benefit plans. Killelea referenced plan types including short-term, limited-duration (STLD) insurance, fixed indemnity, Farm Bureau coverage, association health plans (AHPs), and health care sharing ministries (HCSMs). The cash pay market—including direct primary care arrangements, on-demand telehealth applications, and direct-to-consumer drug —may raise concerns similar to those with limited benefit plans.

Killelea said that consumers may misunderstand the limited nature of some plan types because of the complexity of health insurance in general and because of delibrately misleading marketing that casts limited benefit plans as comparable to Marketplace plans. Consumers may not recognize that their health status may change, making a limited benefit plan inappropriate for them.

Killelea described the potential impact of limited benefit plans on the individual market risk pool in a state. Individuals most likely to choose limited benefit plans are those who do not expect to use a significant amount of health care services. If these lower-risk consumers replace individual market coverage with limited benefit plans, the remaining risk pool will consist of higher-risk consumers and those who are more costly to cover.

Killelea shared research from the Georgetown University CHIR on the marketing of limited benefit plans. Researchers used two consumer profiles to conduct a secret shopper study in May 2026. Both profiles were for consumers in West Virginia, one eligible for premium tax credits with no pre-existing conditions and another not eligible for premium tax credits with type 2 diabetes.

Killelea reported that researchers found online searches led to lead generators who passed consumers to other screeners, agents, and brokers. Marketers often described marketplace coverage as best suited for consumers in poor health, while healthier consumers were directed to limited benefit plans. Killelea said marketers provided misleading and inaccurate information about both limited benefit plans and marketplace coverage. Marketers use aggressive tactics and work to capitalize on marketplace affordability challenges.

Killelea recommended state approaches to regulating limited benefit plans. Marketing regulation can be done under state unfair trade practice statutes. State insurance regulators can establish guardrails for limited benefit plans or prohibit the sale of certain types of plans entirely. Killelea also suggested that marketplace interventions, like a state premium subsidy wrap, could be useful to increase affordability for plans with more consumer protections.

Harris asked what types of plans were most frequently encountered in the secret shopper survey. Killelea said the report includes a chart showing how frequently different plan types came up, and the most frequent by far were fixed indemnity plans.

Commissioner Humphreys asked whether direct primary care embedded in a health care plan presents the same issues as limited benefit plans. He said the insurer can pay the monthly service fee to allow a consumer to access primary care and ultimately save money over the long term. Killelea said the research has not explored this arrangement, but the affordability benefits to both consumers and payers are clear. Killelea said stand-alone

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direct primary care is more concerning. Humphreys said direct primary care should include a disclosure that the care plan should be paired with a major medical plan.

4. Received an Update on its Drafting Groups and Collected Feedback on Draft Affordability Briefs

Harris reviewed the work of its six drafting groups. She said the drafting groups' draft affordability briefs were exposed in July for a 45-day public comment period ending Aug. 31. She said each group met in open session to gather feedback from interested parties. Harris said the drafting groups heard feedback from consumer representatives that affordability should be better defined and more clearly state how state action can improve affordability.

Harris said the drafting groups also received comments from the health insurance industry, including comments on one brief's reference to specific insurers. She said the brief on integration in health care cited specific companies as examples of integration among insurers, providers, and pharmacy benefit managers (PBMs). In some cases, only a single company was cited in a particular example. She said the Working Group received a request to remove specific company names. Harris said she supports the goal of not singling out insurers for positive or negative comments in NAIC publications. She said company names presented neutrally, factually, and with publicly available information could be included. She asked Working Group members to weigh in on whether the names of individual companies should remain in the briefs. Trexler supported including company names if the references are neutral and use publicly available information.

Stephanie Hengst (The AIDS Institute) provided comments from consumer representatives. She said consumer representatives fully support the Working Group's efforts as a whole and would provide written comments by the Aug. 31 deadline. She offered a summary of their comments, including a request to add a uniform definition of affordability that centers on consumers and takes into account both premiums and out-of-pocket costs. She said a clear and concise problem statement may help consolidate similar ideas into a single one. She encouraged the Working Group to focus on policy changes that would result in consumer savings rather than shifting costs from one party to another. She suggested adding a section on the pros and cons of each affordability option.

Kris Hathaway (AHIP) commended the Working Group for taking on the issue of affordability. She said affordability is also a priority of AHIP. She said two key cost drivers, hospital consolidation and facility fees, are not clearly included in the briefs. She said the brief on direct-to-consumer drug platforms achieved a good balance in discussing drug coupons and related issues, and she encouraged other briefs to adopt a similar balanced approach. She suggested including only enacted state legislation, not proposed legislation. In the utilization management brief, she suggested including cost savings to providers in adopting electronic prior authorization. In the integration brief, Hathway recommended paying as much attention to hospital consolidation as insurer and PBM integration and explaining the potential benefits of integration in care coordination, quality, and efficiency. She said the inclusion of references to specific companies in the brief is not necessary to explain the concepts.

Lucy Culp (Blood Cancer United) expressed support for the briefs and hoped that content and concepts from the briefs could be integrated into future work. She asked that facility fees and hospital consolidation be added to the briefs. She said that references to specific companies are not problematic if they are neutral and based on widely available information.

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

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Attachment A

Draft: 6/11/26

Health Care Affordability and Mitigation (B) Working Group
Virtual Meeting
June 2, 2026

The Health Care Affordability and Mitigation (B) Working Group of the Health Insurance and Managed Care (B) Committee met June 2, 2026. The following Working Group members participated: Kate Harris, Chair (CO); Kevin P. Beagan, Vice Chair (MA); Sarah Bailey (AK); Stesha R. Hodges and Gabrielle Lessard (CA); Howard Liebers (DC); Andria Seip (IA); Weston Trexler (ID); Alex Peck (IN); Julie Holmes (KS); Megan Mason (MD); Jeana Thomas (MO); Chrystal Bartuska (ND); Viara Ianakieva (NM); Kristin Cly (OH); Michael Humphreys (PA); Jill Kruger (SD); Rachel Bowden (TX); Tanji J. Northrup (UT); Coral Manning (WI); and Joylynn Fix (WV). Also participating was: Gio Espinosa (AZ).

5. Received Updates on Drafting Group Work

Harris reminded the Working Group that it plans to complete six briefs that describe state options for addressing health care affordability. She said six drafting groups have begun work on the briefs, and each drafting group would release an outline or other written draft and hold an open meeting to gather feedback. Drafts should be completed by August and final briefs by November. Harris asked for an update from each drafting group.

A. Drafting Group 1: Utilization Review Standardization

Beagan said the group discussed efforts to standardize and limit utilization review processes to reduce administrative costs in health insurance. The group highlighted examples, such as standardized prior-authorization forms and gold card programs, that exempt certain providers from prior authorization. The group is seeking to collect data on administrative cost savings.

Beagan noted that many states use standardized prior-authorization forms to reduce provider burden. He said Massachusetts regulations exempt certain primary and behavioral health care from prior authorization. He emphasized the goal of reducing unnecessary utilization review to lower health insurance costs.

B. Drafting Group 2: Horizontal and Vertical Integration

Cly said the group is examining horizontal and vertical integration in health care, focusing on the use of medical loss ratio (MLR) data and regulatory tools to understand and address impacts on affordability. The group is exploring how state insurance regulators can leverage existing authorities, such as rate review, to gain insights into the effects of integration, including potential areas such as facility fees and pharmacy benefit manager (PBM) integration.

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Lindsey Murtagh (Brown University) urged broad consideration of integration effects, including facility fees and PBM-pharmacy relationships. Harris emphasized the challenge for state insurance regulators in identifying mergers and the role of regulators in using tools like rate review. Mason highlighted the need to use existing regulatory levers to gather useful information on integration.

C. Drafting Group 3: State Defined Plans with Premium Reduction Targets

Beagan said the group is exploring state-defined health plans that aim to reduce premiums through options such as limited-network products, site-of-service plans, and mandate-light products. The group is collecting information on existing laws and considering the policy objectives and target populations for these plans, while maintaining quality and improving affordability.

Beagan described Massachusetts' limited-network plans that require 14% lower premiums. He noted that some states have site-of-service plans that restrict certain services in hospital settings.

Jalisa Clark (Georgetown University) emphasized the need to clarify policy objectives and target populations for these plans.

D. Drafting Group 4: Reference Based Pricing

Bailey said the group is drafting a brief on adopting reference-based pricing (RBP) to control health insurance costs, focusing primarily on commercial markets and provider/hospital reimbursement. They are reviewing state laws, researching RBP models, conducting cost-savings analyses, planning to confirm details with states implementing RBP, and aiming for a draft in late June.

Elizabeth Hagan (United States of Care) requested clarity on the drafting group's focus areas, asking whether they include prescription drugs, providers, state employee health benefit plans, and commercial payers. Harris confirmed the focus is on commercial markets and provider/hospital pricing. Hagan offered to share resources on cost savings and state experiences with RBP.

E. Drafting Group 5: Enhanced Price Transparency

Trexler said the group is working on a brief covering both consumer-facing and market-level price transparency initiatives. The group has identified successes and barriers, including legal and technical challenges, and views transparency as a tool to enable other affordability actions. It is seeking additional examples and data to support its analysis. He noted the group is looking at federal and state transparency efforts. He invited written input on transparency issues related to third-party administrators.

Clark suggested including transparency around ownership and systemic price transparency.

F. Drafting Group 6: Direct to Consumer Drug Platforms

Mason said the group is analyzing direct-to-consumer drug platforms, categorizing them by structural type and reviewing state policy options such as limits on insurer out-of-pocket cost calculations and bulk

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purchasing programs. The group is considering impacts on insured and uninsured consumers and seeking additional input to refine the brief.

Carl Schmid (HIV+Hepatitis Policy Institute) raised questions about the group's approach to affordability and insurance coverage implications. Mason confirmed the inclusion of the accumulator and maximizer program considerations.

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

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Attachment B

Draft: 5/19/26

Health Care Affordability and Mitigation (B) Working Group
Virtual Meeting
May 5, 2026

The Health Care Affordability and Mitigation (B) Working Group of the Health Insurance and Managed Care (B) Committee met May 5, 2026. The following Working Group members participated: Kate Harris, Chair (CO); Kevin P. Beagan, Vice Chair (MA); Sarah Bailey (AK); Gio Espinosa (AZ); Stesha R. Hodges and Gabrielle Lessard (CA); Howard Liebers (DC); Weston Trexler (ID); Julie Holmes (KS); Megan Mason (MD); Jeana Thomas (MO); Chrystal Bartuska (ND); Viara Ianakieva (NM); Kristin Cly (OH); Michael Humphreys (PA); Jill Kruger (SD); Rachel Bowden (TX); Tanji J. Northrup (UT); Coral Manning (WI); and Joylynn Fix (WV).

1. Heard a Presentation from the Center on Health Insurance Reforms on Site Neutral Payments

Christine Monahan (Georgetown University Center on Health Insurance Reforms) presented on the problem of excessive hospital outpatient charges and potential solutions. She said hospitals have provided a greater share of services in outpatient settings in recent years, and at the same time have acquired physician practices and turned them into outpatient departments.

Monahan shared data to indicate that hospital outpatient departments and hospital-affiliated physicians are more expensive than independent physicians for the same services. Hospital outpatient departments often use split billing, under which the hospital charges a facility fee in addition to a provider fee, which raises total costs. Split billing occurs in both Medicare and the commercial market, but price differences between hospital outpatient departments and physician offices are much larger and, overall, much higher in the commercial market due to market forces. These dynamics lead to more vertical integration, greater total spending, higher out-of-pocket costs, and potential problems with access to care.

Monahan said that Medicare has eliminated cost differentials by site of service for a small portion of its payments. States have enacted a variety of reforms, including bans on facility fees, patient billing protections, billing transparency, and reporting and notification requirements. She said the National Academy for State Health Policy (NASHP) has released model legislation on site-neutral payments.

She said that site-neutral payment policies align with several of the state options for reducing insurance costs, which are expected to be included in the Working Group's series of affordability briefs. Site-neutral policies could be considered by drafting groups focused on vertical integration, reference-based pricing, and price transparency.

2. Discussed the *State Options for Reducing Health Insurance Costs* Document

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Harris explained the Working Group's plans for completing the *State Options for Reducing Health Insurance Costs* document. She said Working Group members had been assigned to six drafting groups. She said members may choose different drafting groups than those to which they were assigned or may join any group if they were not assigned. Bailey said that Alaska had been assigned to three drafting groups but could only participate in two. Harris said the Working Group would receive brief verbal updates from the drafting groups at its next meeting, as well as feedback from interested parties. She said the drafting groups would expose outlines for comment during July and draft briefs in August. She said the Working Group expects to finalize the document containing all of the briefs by November.

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

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Attachment C

Draft: 4/28/26

Health Care Affordability and Mitigation (B) Working Group
Virtual Meeting
April 21, 2026

The Health Care Affordability and Mitigation (B) Working Group of the Health Insurance and Managed Care (B) Committee met April 21, 2026. The following Working Group members participated: Kate Harris, Chair (CO); Kevin P. Beagan, Vice Chair (MA); Sarah Bailey (AK); Stesha R. Hodges and Gabrielle Lessard (CA); Howard Liebers (DC); Weston Trexler (ID); Paula Wallin (IA); Alex Peck (IN); Julie Holmes (KS); Megan Mason (MD); Jeana Thomas (MO); Chrystal Bartuska (ND); Viara Ianakieva (NM); Kristin Cly (OH); Michael Humphreys (PA); Jill Kruger (SD); Tanji J. Northrup (UT); Todd Lovshin (WA); Coral Manning (WI); and Joylynn Fix (WV).

1. Heard a Presentation from the Health Care Affordability Lab at Yale on Hospital Costs

Zack Cooper (Health Care Affordability Lab at Yale) presented research on the drivers of U.S. health spending growth, particularly hospital and insurance market competition. He estimated that 90% to 95% of health insurance premium growth over the past 25 years was driven by health care spending growth. Hospitals account for about 40% of private health spending, and their prices have increased faster than inflation and other health care components—driving overall spending growth.

Cooper discussed the extensive consolidation in the hospital industry, with more than 1,200 mergers since 2000, many raising market concentration and prices. He explained that mergers significantly increase concentration, and this leads to price hikes, which in turn affect premiums and the broader economy. Since 2000, 238 hospital mergers raised market concentration by 200 points or more measured by the Herfindahl-Hirschman Index (HHI), often leading to price increases. Mergers that do not increase concentration generally do not affect hospital prices.

Cooper said rising hospital prices due to consolidation have negative labor market effects outside health care, including job losses and increased income inequality. Higher premiums lead employers to reduce hiring or cut jobs, especially affecting lower-income male workers, and also reduce tax revenues while increasing mortality. He said rising hospital prices cause dollar-for-dollar increases in premiums and health care spending.

Cooper described a new online tool developed by the Health Care Affordability Lab to analyze hospital market concentration and mergers nationwide. The tool uses hospital data and travel time to define markets, calculates concentration indices, and flags potentially problematic mergers to assist policymakers in evaluating hospital market dynamics and merger impacts.

Cooper demonstrated how hospital consolidation has increased market concentration and premiums, using Connecticut, New Jersey, and West Virginia as examples. He contrasted mergers with minor

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concentration changes versus those flagged as problematic, illustrating the tool's practical application for assessing merger impacts. Connecticut experienced significant hospital consolidation, with many hospitals moving into highly concentrated markets. New Jersey shows a minor increase in concentration, deemed less problematic. He cited the West Virginia University Health System merger with Independence Health System as one that will lead to large concentration increases and likely raise prices.

Cooper discussed potential policy responses to hospital consolidation, including antitrust enforcement, price regulation in concentrated markets, and promoting competition by encouraging patient travel to alternative providers. He emphasized the need for tools to screen mergers and regulate prices to control health care costs.

Cooper addressed questions about efficiency gains from mergers, potential hospital closures as a rationale for mergers, certificate of need laws, and Maryland's unique hospital pricing controls. He said there is limited evidence of efficiency or quality improvements from mergers, and he discussed regulatory approaches to address consolidation and pricing. Claims that a hospital will close without a merger are common but should be carefully scrutinized to avoid anti-competitive outcomes.

2. Discussed State Options for Reducing Health Insurance Costs

The Working Group discussed prioritizing topics for state affordability briefs, focusing on utilization review, health care integration, premium reduction plans, reference-based pricing, and price transparency. Hodges requested the addition of direct-to-consumer prescription drug platforms, and Harris agreed to add this topic to the priority list. Harris said the Working Group plans to form drafting groups, develop templates, and allow input from interested parties to produce concise, actionable briefs for policymakers.

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

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Attachment D

Draft: 4/16/26

Health Care Affordability and Mitigation (B) Working Group
Virtual Meeting
April 7, 2026

The Health Care Affordability and Mitigation (B) Working Group of the Health Insurance and Managed Care (B) Committee met April 7, 2026. The following Working Group members participated: Kate Harris, Chair (CO); Kevin P. Beagan, Vice Chair (MA); Sarah Bailey (AK); Gio Espinosa (AZ); Gabrielle Lessard (CA); Howard Liebers (DC); Paula Wallin (IA); Alex Peck (IN); Julie Holmes (KS); Megan Mason (MD); Chrystal Bartuska (ND); Viara Ianakieva (NM); Kristin Cly (OH); Michael Humphreys (PA); Jill Kruger (SD); Rachel Bowden (TX); Jane Beyer and Todd Lovshin (WA); Coral Manning (WI); and Joylynn Fix (WV).

1. Heard a Presentation on Affordability Priorities

Sabrina Corlette (Georgetown University Center on Health Insurance Reforms) presented on the root causes of high health care costs and on state options to improve the affordability of health insurance. She said high prices paid to providers drive spending rather than utilization. She said complex financial relationships and consolidation in health care also contribute to high costs.

Corlette outlined policy options, including price transparency, antitrust enforcement, and price regulation. She said price transparency is an option that requires minimal government intervention and has a low impact on costs. She said price regulation requires high government intervention and can produce greater reductions in costs. Antitrust enforcement falls in the middle of this spectrum.

Corlette highlighted several transparency and disclosure strategies, including strengthening existing transparency requirements, developing all-payer claims databases, reforming medical loss ratio (MLR) standards, and improving consumer shopping tools. Corlette discussed state roles in antitrust activities and monitoring provider-payer contracts.

Corlette identified competition and ownership reforms. Reforms within the authority of state insurance regulators include monitoring transactions, prohibiting anti-competitive clauses in payer-provider contracts, and increasing accountability for state-regulated third-party administrators.

Corlette said that price regulations can include cost-growth benchmarks, enhanced rate review and affordability standards, prohibitions on facility fees, site-neutral payment caps, No Surprises Act (NSA) reforms, and reference pricing or price caps.

Beagan asked Corlette to elaborate on MLR reform ideas regarding transparency. Corlette explained that the idea is to enhance MLR reporting to reveal financial relationships and incentives in integrated systems. Beyer added that state insurance regulators could use MLR data to compare payments to affiliated versus non-affiliated providers and investigate non-claims payments and their destinations.

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Beyer discussed Washington's pre-existing arbitration process for balance billing disputes, noting it results in fewer arbitrations and different outcomes compared to the federal NSA system. Harris asked about data on the impact of NSA arbitration on premiums. Corlette shared information from New York, attributing a 10% premium increase to independent dispute resolution processes.

2. Discussed Topics List for Affordability Options

Harris reviewed a narrowed list of 12 policy topics to focus on when developing briefs describing state options for addressing health care affordability. Manning suggested that 12 topics may be too many for in-depth coverage. Harris and Beagan suggested conducting a poll of Working Group members to identify top priorities. Working Group members discussed the feasibility of including briefs on price transparency, administrative costs, and horizontal and vertical integration in health care. Members said that horizontal and vertical integration are complex topics and suggested narrowing the scope.

Kris Hathaway (AHIP) requested that facility fees be included on the topics list. Noah Isserman (American Hospital Association) supported addressing utilization management within administrative costs and separating horizontal and vertical integration. Beyer said cost growth targets and prescription drug affordability boards have been in place in some states for years, so they may not need to be addressed by the Working Group.

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

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