NAIC

2026 SUMMER NATIONAL MEETING
COLUMBUS, OH

Draft date: 7/29/26

2026 Summer National Meeting
Columbus, Ohio

HEALTH CARE AFFORDABILITY AND MITIGATION (B) WORKING GROUP
Thursday, August 13, 2026
10:15 – 11:15 a.m.
Greater Columbus Convention Center—Heart of It All Ballroom B—Level 1

ROLL CALL

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

NAIC Committee Support: Joe Touschner

AGENDA

1. Consider Adoption of its June 2, May 5, April 21, April 7, and Spring National Meeting Minutes—*Kate Harris (CO)* — Attachments A-E

2. Hear a Presentation on the Impacts of No Surprises Act Independent Dispute Resolution—*Jennifer Jones (Blue Cross Blue Shield Association)*

3. Hear a Presentation on Limited Benefit Plans—*Amy Killelea (Equality Arlington)*

4. Collect Feedback on Draft Affordability Briefs—*Kate Harris (CO)*
   A. Drafting Group 1—Standardizing or Limiting Utilization Review to Reduce Administrative Costs

B. Drafting Group 2—Horizontal and Vertical Integration in Health Care
C. Drafting Group 3—Develop State-Defined Plans with Premium Reduction Targets
D. Drafting Group 4—Reference-Based Pricing
E. Drafting Group 5—Enhanced Health Care Price Transparency
F. Drafting Group 6—Direct-to-Consumer Drug Platforms

5. Discuss Any Other Matters Brought Before the Working Group
—Kate Harris (CO)

6. Adjournment

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).

1. 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.

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 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.

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

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.

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 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.

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.

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.

Attachment E

Draft: 3/31/26

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

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

1. Adopted its March 10 Minutes

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

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

2. Discussed its Charges and Work Plan

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

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

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

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

Adam Fox (Colorado Consumer Health Initiative—CCHI) and Lindsey Murtagh (Brown University) presented on strategies to control hospital costs. Fox cited rising hospital costs, saying hospitals accounted for one-third of health care cost growth over the past 20 years, 61% of which is due to increased prices. He said 40% of premiums go to hospitals. Fox said nearly all metro areas have highly concentrated hospital markets, and nearly half have only one or two health systems providing inpatient care. Fox said high hospital costs drive both higher premiums and higher out-of-pocket costs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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