November 20, 2026

Kate Harris, Chair
Kevin P. Beagan, Vice Chair
Health Care Affordability and Mitigation (B) Working Group
National Association of Insurance Commissioners

Re: Response to State Options for Reducing Health Insurance Costs Report (November 2026)

Dear Chair Harris and Vice Chair Beagan:

NABIP appreciates the Health Care Affordability and Mitigation (B) Working Group's examination of state health insurance affordability options.

State licensed agents, brokers, consultants, and benefit advisors help individuals and employers select and manage coverage. Across the individual, employer-sponsored, Medicare, and long-term care markets, our members see firsthand how affordability challenges affect people at every stage of life—from young adults seeking coverage and working families managing premiums and deductibles to older Americans facing medical and prescription drug costs. NABIP's Healthcare Consumer Bill of Rights reflects our commitment to ensuring that consumers have access to affordable coverage, meaningful choices, transparent information, and professional assistance when making healthcare decisions.[1]

The Working Group's adopted report, "State Options for Reducing Health Insurance Costs, appropriately calls for considering total costs, cost shifts, competition, administrative burdens, and consumer access.[2] NABIP offers three recommendations for future NAIC and state regulatory work.

I. Public Options, Broker Compensation, and Nevada Implementation

Section 3 identifies lower broker costs as one way Nevada insurers may meet public option premium targets.[3] The report does not address the state's subsequent broker compensation decisions or publicly funded response.

Two of Nevada's three participating Battle Born State Plan (BBSP) insurers filed 2026 products without broker commissions. At a November 2025 legislative hearing, state officials raised concerns that consumers seeking help from brokers might not learn about BBSP plans offered without broker guidance.[4]

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[1] National Association of Benefits and Insurance Professionals (NABIP), *NABIP Healthcare Bill of Rights* (n.d.), https://nabip.org/media/9257/nabip-healthcare-bill-of-rights-final.pdf.
[2] National Association of Insurance Commissioners (NAIC), Health Care Affordability and Mitigation (B) Working Group, *State Options for Reducing Health Insurance Costs* (November 2026), introduction and secs. 3, 5, and 6, https://content.naic.org/sites/default/files/national_meeting/hcam-state-options-for-reducing-health-insurance-costs-11.26.pdf.
[3] NAIC, *State Options for Reducing Health Insurance Costs*, sec. 3, 29.
[4] Nevada Legislature, Senate Select Committee on Jobs and Economy, minutes of meeting (November 13, 2025), 21–25 (testimony of Jennifer Krupp and remarks of Sen. Nicole Cannizzaro), https://archive.leg.state.nv.us/Session/36th2025Special/Minutes/Senate/SENSCJE/Final/7.pdf.

Nevada's November 29, 2025, Senate Bill 4 appropriated $1.25 million in each fiscal years 2026 and 2027 ($2.5 million total) for broker enrollment payments. It separately appropriated $2 million for community-based enrollment assistance.[5]

The Nevada Health Authority then offered brokers a one-time $35 payment for each effectuated BBSP enrollment, including qualifying special enrollments.[6] The state-funded incentive was intended to encourage the presentation of BBSP options to consumers despite the absence of insurer-paid commissions. Unlike recurring commissions, that payment does not necessarily fund ongoing policyholder support.

During the 2026 Open Enrollment Period, BBSP enrolled 10,762 people (10.3% of the individual market). Brokers assisted with 4,393 enrollments (40.8%), involving 495 brokers. Broker participation payments were scheduled to begin after the conclusion of the 2026 Open Enrollment Period.

National enrollment data underscores the importance of access to professional assistance when consumers choose and manage coverage. In 2026, agents and brokers assisted with 76% of active HealthCare.gov plan selections.[7] MedPAC reported that among assisted Medicare beneficiaries aged 65 or older, approximately 30% in traditional Medicare and 31% in Medicare Advantage turned to agents.[8] A 2020 KFF nationwide survey of consumers assisted by brokers, navigators, and others found that 94% rated the assistance helpful[9].

NABIP asks the Working Group to examine broker participation and importance of consumer assistance before citing broker-cost reductions as a replicable strategy.

II. Direct-Pay Cost Sharing and NABIP's CREDIT Act

KFF's 2026 employer survey found that 88% of covered workers had a general annual deductible for single coverage. Among deductible plans, the average was $1,955, increasing to $2,624 at firms with 10–199 workers. Thirty-eight percent of covered workers had deductibles of at least $2,000.[10]

Section 6 identifies a common market mismatch: consumers may find lower direct-pay prescription prices, but spending outside the plan generally does not count toward deductibles or out-of-pocket maximums. These employer-market figures show why credit for qualifying direct payments matters.

A 2026 analysis estimated that direct purchasing would cost less for 15% of generic prescriptions overall. When insurance cost sharing exceeded $15, nearly 80% would have cost less through the

[5] Nevada Senate Bill 4, 36th Special Session, chap. 11, secs. 10–11 (approved November 29, 2025), https://www.leg.state.nv.us/Statutes/36thSS2025/Stats2025SS3602.html.
[6] Nevada Health Authority, *Battle Born State Plan Incentive Grant Program: Broker-Facing FAQ* (December 2025), https://nevadahealthlink.com/wp-content/uploads/2025/12/BBSP-Incentive-Grant-Program-Broker-Facing-FAQ.pdf.
[7] Centers for Medicare & Medicaid Services, *Health Insurance Exchanges 2026 Open Enrollment Report* (2026), 2, https://www.cms.gov/files/document/health-insurance-exchanges-2026-open-enrollment-report.pdf.
[8] Medicare Payment Advisory Commission, "The Complexity of Medicare Enrollment Decisions for Beneficiaries," in *Report to the Congress: Medicare and the Health Care Delivery System* (June 2026), 71–72, https://www.medpac.gov/wp-content/uploads/2026/06/Jun26_Ch2_MedPAC_Report_To_Congress_SEC.pdf.
[9] KFF, "Consumer Assistance in Health Insurance: Evidence of Impact and Unmet Need," August 7, 2020, https://www.kff.org/affordable-care-act/consumer-assistance-in-health-insurance-evidence-of-impact-and-unmet-need/.
[10] KFF, *2026 Employer Health Benefits Survey* (2026), sections on deductibles and claims-data access, https://www.kff.org/health-costs/2026-employer-health-benefits-survey/.

direct channel. For cost sharing of at least $100, median prices were $140 through insurance versus $25 directly.[11]

The Working Group report also cites research finding hospital cash prices below median commercial in-network rates in 47% of comparisons.[12] This does not mean patients always pay less in cash but helps explain interest in direct-pay services beyond prescriptions.

NABIP's Consumer Recognition for Eligible Direct Insurance Transactions (CREDIT) Act would require state-regulated, fully insured health plans to count qualifying direct payments for medically necessary covered services toward deductibles and annual out-of-pocket limits, up to the plan's in-network benchmark. Eligible services may include prescriptions, imaging, laboratories, behavioral healthcare, and outpatient procedures, whether providers are in-network or out-of-network. The insurer would not reimburse the direct payment or expand benefits; it must decide credit requests within 30 days, explain denials, and preserve appeals.[13]

The report distinguishes consumer spending from manufacturer assistance and describes Colorado and Connecticut approaches.[14] Colorado's SB 26-167 (effective 2028) credits qualifying direct-pay prescriptions, subject to documentation and plan rules.[15] Connecticut § 38a-477qq creates a related but distinct prescription credit.[16]

Nine states have enacted comparable direct-pay credit provisions varying in scope and eligibility: six for broader healthcare services and three for prescription drugs. They are summarized below.[17]

State	Law / status	What it covers
Texas	HB 2002 (2023)	Covered direct-pay healthcare services under preferred-provider benefit plans
Indiana	HB 1604 (2025)	Qualifying direct-pay covered healthcare services; also addresses prescriptions
Oregon	HB 2540 (2025)	Covered direct-pay healthcare services; excludes HMOs
Oklahoma	SB 515 (2025)	Covered direct-pay healthcare services; excludes pharmaceutical products/services

[11] John K. Lin et al., "Identifying Meaningful Patient Savings on Generics: Direct-to-Consumer Prices Versus Commercial Insurance Cost Sharing," *Annals of Internal Medicine* 179, no. 8 (2026): 1210–12, https://doi.org/10.7326/ANNALS-25-05049.
[12] NAIC, *State Options for Reducing Health Insurance Costs*, sec. 5.
[13] National Association of Benefits and Insurance Professionals (NABIP), *Consumer Recognition for Eligible Direct Insurance Transactions (CREDIT) Act* (model legislation summary), https://nabip.org/media/11429/credit-act-flyer-no-state_final.pdf.
[14] NAIC, *State Options for Reducing Health Insurance Costs*, sec. 6.
[15] Colorado General Assembly, Senate Bill 26-167 (2026), https://leg.colorado.gov/bills/sb26-167.
[16] Connecticut General Statutes § 38a-477qq (effective July 1, 2026), https://www.cga.ct.gov/2026/sup/chap_700c.htm.
[17] For general healthcare-service provisions, see Texas H.B. 2002 (2023), https://capitol.texas.gov/tlodocs/88R/billtext/html/HB02002F.htm; Indiana H.B. 1604 (2025), https://iga.in.gov/legislative/2025/bills/house/1604/details; Oregon H.B. 2540 (2025), https://olis.oregonlegislature.gov/liz/2025r1/Measures/Overview/HB2540; Oklahoma S.B. 515 (2025), https://www.oklegislature.gov/BillInfo.aspx?Bill=SB515; Idaho H.B. 929 (2026), https://legislature.idaho.gov/sessioninfo/2026/legislation/H0929/; Tennessee H.B. 1213/S.B. 1392 (2023), https://wapp.capitol.tn.gov/apps/BillInfo/Default?BillNumber=HB1213&ga=113. For prescription-specific provisions, see Conn. Gen. Stat. § 38a-477qq; Vermont H. 577/Act 132 (2026), https://legislature.vermont.gov/bill/status/2026/H.577; and Colorado S.B. 26-167.

Idaho	HB 929 (2026); effective Jan. 1, 2027	Covered direct-pay healthcare services
Tennessee	HB 1213 / SB 1392 (2023)	Certain covered direct payments, including drugs and devices, regardless of provider network status
Connecticut	PA 25-167 / § 38a-477qq (2025)	Qualifying direct-pay prescription purchases subject to statutory limits
Vermont	H.577 / Act 132 (2026)	Qualifying prescription expenses, including purchases outside plan coverage
Colorado	SB 26-167 (2026); begins Jan. 1, 2028	Qualifying direct-pay prescription purchases

NABIP is working with states to gather implementation data on utilization, consumer uptake, and measurable cost savings. We hope to share findings with the Working Group as they become available.

Implementation requires safeguards for payment verification, duplicate credits, manufacturer assistance, clinical appropriateness, and administrative or premium effects.[18] NABIP encourages the Working Group to evaluate these questions and consider extending qualifying direct-pay credits beyond prescriptions. We welcome the opportunity to present the CREDIT Act.

III. Employer Claims Transparency and NABIP's ELARA Act

Section 5 recognizes that employer claims data access under the Consolidated Appropriations Act (CAA) of 2021 can improve purchasing decisions and bargaining power. This aligns with NABIP's Employer-Level Access to Reporting & Analytics (ELARA) Act.[19]

The CAA of 2021 prohibits certain contractual gag clauses restricting health plans' access to de-identified claims data or sharing with authorized business associates.[20] State requirements can address timeliness, completeness, and usability for state-regulated insurers while respecting federal law.

KFF reports that average employer-sponsored family premiums reached $28,303 in 2026, including $7,471 paid by workers. Employers need their own claims information to evaluate plans and renewals. Among surveyed firms with at least 200 workers, KFF found that 17% reported difficulty obtaining claims data and 25% had not tried. Of those obtaining data, 95% said it helped with benefits decisions.[21]

[18] NAIC, *State Options for Reducing Health Insurance Costs*, sec. 6.
[19] NAIC, *State Options for Reducing Health Insurance Costs*, sec. 5; National Association of Benefits and Insurance Professionals (NABIP), *Employer-Level Access to Reporting & Analytics (ELARA) Act* (model legislation summary), https://nabip.org/media/11431/elara-act-flyer-no-state- final.pdf.
[20] U.S. Department of Labor, Employee Benefits Security Administration, "FAQs about Consolidated Appropriations Act, 2021 Implementation, Part 69," January 14, 2025, https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-69.
[21] KFF, *2026 Employer Health Benefits Survey*, sections on premiums and claims-data access.

A 2025 National Alliance purchaser survey found that 33% lacked complete health-data access and 42% reported that a vendor had refused full access.[22] A separate 2026 National Alliance survey associated full claim-level access with a broader range of purchasing strategies (11.9 on average, versus 7.9 among those without assured access).[23]

ELARA would require state-regulated insurers to provide standardized claims, utilization, enrollment, premium, and high-cost-claims reports within 30 days, up to twice per plan year. The model includes HIPAA-based safeguards, aggregation or de-identification, limits on use, and confidentiality protections for public employers.[24] It would not impose requirements on self-funded ERISA plans or change covered benefits or networks.

States have enacted employer claims-data disclosure requirements of varying scope. For example, Texas requires reports within 30 days and permits two requests in 12 months.[25] Ohio requires specified claims and enrollment data for qualifying groups of at least 50 full-time employees, with a 30-business-day deadline and one annual report.[26] Four close models appear below:

State / law	Law / status	Key reporting provisions
Texas	HB 2015 (2007)	30 days; 2 requests per 12 months; claims, premiums, enrollment, and high-cost claims.
Indiana	HB 1004 (2023); amended 2025[27]	15 business days; up to 4 requests yearly; claims, premiums, enrollment, and large claims.
Tennessee	SB 1270 / HB 1304 (2025)[28]	30 days; medical, dental, pharmacy claims, premiums, enrollment, and large claims.
Arkansas	HB 1771 / Act 651 (2025)[29]	Monthly claims, pharmacy, premiums, and enrollment; recurring requests.

Other states use narrower or differently structured approaches. Georgia requires claims-experience reporting for certain group policyholders; Maryland provides aggregate incurred claims for experience-rated large groups; and New Jersey requires reporting for participating public employers. Michigan requires detailed reporting for large employer groups, including specified agent, broker, consultant, and administrator compensation.[30]

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[22] National Alliance of Healthcare Purchaser Coalitions, *2025 Pulse of the Purchaser Annual Survey* (2025), 8, https://www.nationalalliancehealth.org/wp-content/uploads/Pulse-of-the-Purchaser-2025-Annual-Survey.pdf.
[23] National Alliance of Healthcare Purchaser Coalitions, "Employers with Claims Data Access Take More Action on Healthcare Costs," August 12, 2026, https://www.nationalalliancehealth.org/news/employers-with-claims-data-access-take-more-action-on-healthcare-costs-national-alliance-survey-finds/.
[24] NABIP, *Employer-Level Access to Reporting & Analytics (ELARA) Act*.
[25] Texas Insurance Code § 1215.003(a)–(c), https://statutes.capitol.texas.gov/Docs/IN/htm/IN.1215.htm.
[26] Ohio Revised Code § 3901.89(A)–(B), https://codes.ohio.gov/ohio-revised-code/section-3901.89.
[27] Indiana Code § 27-2-25.5-1 (added 2023; amended by House Enrolled Act 1004 [2025], sec. 48), https://iga.in.gov/legislative/2025/bills/house/1004/details.
[28] Tennessee Senate Bill 1270/House Bill 1304, Public Chapter 183 (2025), claims-experience reporting provisions, https://wapp.capitol.tn.gov/apps/BillInfo/Default?BillNumber=SB1270&ga=114.
[29] Arkansas House Bill 1771/Act 651 (2025), amending Arkansas Code § 23-86-119, https://www.arkleg.state.ar.us/Bills/Detail?ddBienniumSession=2025%2F2025R&id=HB1771.
[30] Georgia Code § 33-30-13.1(b)(1), https://law.justia.com/codes/georgia/2024/title-33/chapter-30/article-1/section-33-30-13-1/; Maryland Code, Insurance § 15-1411, https://mgaleg.maryland.gov/2026RS/Statute_Web/gin/15-1411.pdf; New Jersey Statutes § 52:14-17.37a, https://law.justia.com/codes/new-jersey/title-52/section-52-14-17-37a/; Michigan Compiled Laws § 500.3471(3)(a)(v), https://legislature.mi.gov/Laws/MCL?objectName=mcl-500-3471.

NABIP is gathering implementation data on request frequency, response times, report completeness, and usefulness for employer purchasing decisions. We plan to share findings with the Working Group.

NABIP requests that future affordability materials address employer access to meaningful claims experience as a distinct state policy option, evaluate experience under Texas, Indiana, Tennessee, Arkansas, and Ohio laws, and consider how reasonable reporting standards can help employers and their professional advisers make better-informed decisions without placing sensitive patient information at risk.

NABIP requests a supplemental amendment to the report of Nevada's commission decisions and state-funded initiatives, focusing on total costs and consumer access. NABIP is working with the National Council of Insurance Legislators (NCOIL) and state legislators across the country on adopting CREDIT and ELARA frameworks for direct-pay cost-sharing credits and employer claims transparency. NABIP stands ready to work with regulators on affordability measures that preserve consumer choice, professional assistance, privacy, and market stability.

Sincerely,

Mychal Walker
President
National Association of Benefits and Insurance Professionals (NABIP)