FROM THE NAIC CONSUMER REPRESENTATIVES

To: Health Innovations (B) Working Group
Date: February 2, 2026
Re: State Flexibility White Paper Draft

Dear Chair Grant, Vice Chair Hoyt, and Members of the Health Innovations (B) Working Group:

Thank you for the opportunity to comment on the State Flexibility White Paper draft. We write to share our thoughts on behalf of the undersigned National Association of Insurance Commissioners (NAIC) Consumer Representatives.

We appreciate the Working Group's thoughtful examination of Section 1331 and 1332 waivers, and its attention to how these provisions can be used to expand coverage and improve affordability for vulnerable populations, such as people with low incomes and immigrants in this moment of insurance market changes. We invite the Working Group to incorporate insights from the recent NAIC Consumer Representative Report, "Recommendations for States' Efforts to Mitigate Harms Caused by Federal Policy Actions," which details how states can use these provisions and other strategies to advance health coverage access and affordability.

Our comments below focus on the importance of emphasizing how Section 1333 state compacts can cause harm to consumers or result in other unintended consequences, and therefore the importance of careful state policy design and the need to maintain strict federal guardrails around their use. We believe the draft could be strengthened by:

1. **Noting legal uncertainty surrounding the use of Section 1333 compacts to preempt federal policy.**

The draft refers to section 1332 **waivers** (emphasis added) and affirms that states could use Section 1333 compacts to "minimize the impact of significant policy changes at the federal level on the individual market," echoing claims made in an American Experiment report written by Peter Nelson, now the Director of the Center for Consumer Information and Insurance Oversight (CCIIO). The American Experiment report posits that Section 1333 compacts can be used to preempt state and federal insurance law, potentially in domains that are not directly related to interstate insurance sales.

However, it is not evident that Section 1333 authorizes the Department of Health and Human Services (HHS) to approve compacts through which states waive federal insurance laws. Contrast Section 1333 with Section 1332. Both provisions include nearly identical language regarding guardrails, but where Section 1332 clearly enumerates the waivable provisions, Section 1333 does not mention any federal provisions as waivable by states at all. It is a glaring omission. Furthermore, Section 1333 includes a requirement that compact plans notify consumers that the policy might not be subject to all the laws and regulations of the state in

which the purchaser resides. Surely if Section 1333 authorized the waiver of federal law, Congress would have required the notice to mention federal law as well.

As Justice Scalia explained, "Congress…does not alter the fundamental details of a regulatory scheme in vague terms or ancillary provisions—it does not, one might say, hide elephants in mouseholes."[1] With courts giving less and less deference to federal agencies following the Supreme Court holding in *Loper Bright Enterprises vs. Raimondo*,[2] it seems improbable that a court would interpret section 1333 as giving HHS authority to allow states to waive federal insurance laws, especially those that are not even directly related to interstate insurance sales.

The white paper would be strengthened by acknowledging the legal risks and uncertainties to states of using a compact under Section 1333 to waive federal insurance laws not directly related to interstate insurance sales.

The American Experiment report also claims that, once approved, these compacts carry the weight of federal law and are subject only to future Congressional action. This is generally true for interstate compacts to which Congress has consented. However, that certainty is unlikely if HHS approves compacts under Section 1333 that reach beyond the authority Congress granted the agency. While states may appreciate the additional flexibility that the American Experiment report's interpretation of Section 1333 promises, entering into compacts that are unlikely to withstand legal scrutiny add unnecessary uncertainty and instability to state insurance markets. We are concerned about the impact on consumers if states enter into compacts that rely on an interpretation that is unsupported by the statute. The white paper would be strengthened by acknowledging the legal risks and uncertainties to states in adopting compacts that potentially exceed the scope of compacts that HHS is permitted to approve under Section 1333, specifically those that waive federal law not directly related to interstate insurance sales.

2. Discussing proposed uses of Section 1333 waivers that would weaken consumer protections, destabilize the individual market, or be redundant to existing state authority

As we noted in our comments on the white paper outline, Section 1333 compacts could potentially be employed in ways that are harmful to consumers. For example, Director Nelson and former CCIIO Director Randy Pate have publicly contemplated the following uses of Section 1333 waivers, which would either cause harm to consumers or could already be implemented through existing state authority:

- **Change network adequacy standards:** Current federal regulations set a floor for network adequacy standards for qualified health plans (QHPs). Individual states already have authority to strengthen network adequacy standards for QHPs. Loosening network adequacy standards risks harming consumers.
- **Deregulate the sale of non-ACA-compliant plans:** Non-ACA-compliant plans typically provide less comprehensive coverage at lower premiums than their ACA-compliant counterparts. Expanding the sale of non-ACA compliant plans risks segmenting the

[1] Whitman v. American Trucking Associations, Inc., 531 U.S. 457 (2001).
[2] Loper Bright Enterprises v. Raimondo, 603 US 369 (2024).

individual and small group insurance markets, as people (or firms) with fewer health care needs are likely to be drawn to lower premium, non-ACA-compliant plans. As a result, people with more health care needs, who are likely to maintain comprehensive ACA-compliant coverage, will face higher premiums, while people who purchase non-compliant plans will be exposed to high medical costs.

- **Convert the PTC to flat credits or age-adjusted credits:** This would make marketplace coverage more expensive for people with low incomes.
- **Allow the sale of specialized plans for chronic conditions:** Issuers are already able to design and sell disease-specific insurance plans, provided that enrollment in such plans is not restricted to people with a specific health condition. If the idea is to allow plans to restrict enrollment to people with certain chronic conditions, this would likely be prohibitively expensive for many people, as was the case with high-risk pools prior to the ACA. It would also prevent households with people with different chronic conditions (or households where some people have chronic conditions and others do not) from enrolling in the same health plan.

The white paper would be strengthened by acknowledging the proliferation of these policy ideas and their potential for harming consumers and undermining the stability of the individual market.

3. Highlighting potential harm to consumers if Section 1332 and 1333 guardrails are reinterpreted

The white paper notes the importance of applying Section 1332 and 1333 guardrails in ways that are consistent and that maximize state flexibility. We believe it is equally important to emphasize the role of the guardrails in protecting consumers, and potential risk to consumers if the guardrails are reinterpreted. Including discussion of potential reinterpretation of the guardrails is especially relevant, given Director Nelson's comments at the August 19 Health Innovations (B) Working Group meeting, which suggested that the Trump Administration is likely to revert to its earlier interpretation of the Section 1332 guardrails and adopt a similar interpretation for Section 1333 guardrails. If this were to happen, it could potentially enable states to enact long-term damage on the ACA marketplace under Section 1333 waivers.

We look forward to continuing to work closely with the Health Innovations (B) Working Group and its members to address the needs of consumers. Should you have any further questions, please contact Claire Heyison or Lindsey Murtagh.

Sincerely,

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