Draft date: 8/8/25

2025 Summer National Meeting
Minneapolis, Minnesota

HEALTH INNOVATIONS (B) WORKING GROUP
Tuesday, August 12, 2025
11:00 a.m. – 12:00 p.m.
Hilton Minneapolis—Grand Ballroom ABC—Level 3

ROLL CALL

Marie Grant, Chair	Maryland	Viara Ianakieva/ Margaret Pena	New Mexico
Amy Hoyt, Vice Chair	Missouri	Chrystal Bartuska	North Dakota
Anthony L. Williams	Alabama	Kristin Cly	Ohio
Sarah Bailey/Jeanne Murray	Alaska	TK Keen	Oregon
Debra Judy	Colorado	Carlos Vallés	Puerto Rico
Howard Liebers	District of Columbia	Rachel Bowden/ R. Michael Markham	Texas
Alex Peck	Indiana	Tanji J. Northrup	Utah
Andria Seip	Iowa	Todd Lovshin	Washington
Julie Holmes	Kansas	Joylynn Fix	West Virginia
Robert Wake	Maine		

NAIC Support Staff: Joe Touschner

AGENDA

1. Consider Adoption of its June 20 Minutes—*Marie Grant (MD)* Attachment A

2. Discuss a Request from the Federal Centers for Medicare & Medicaid Services (CMS) for Consultation on Health Care Choice Compacts —*Marie Grant (MD)*
   - Peter Nelson (Center for Consumer Information and Insurance Oversight)

3. Hear Stakeholder Input on an Outline for a White Paper on State Flexibility Under the Affordable Care Act (ACA)—*Marie Grant (MD)*

4. Discuss Any Other Matters Brought Before the Working Group —*Marie Grant (MD)*

5. Adjournment

Draft: 7/2/25

Health Innovations (B) Working Group
Virtual Meeting
June 20, 2025

The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met June 20, 2025. The following Working Group members participated: Marie Grant, Chair (MD); Amy Hoyt, Vice Chair (MO); Sarah Bailey (AK); Debra Judy (CO); Andria Seip (IA); Alex Peck (IN); Julie Holmes (KS); Viara Ianakieva (NM); Daniel Bradford (OH); Jesse O'Brien (OR); R. Michael Markham (TX); and Tanji J. Northrup (UT). Also participating were: Weston Trexler (ID); and Jane Beyer (WA).

1. Adopted its April 24 Minutes

The Working Group met April 24 and heard presentations on three sections of the Affordable Care Act (ACA) that provide flexibility to the states.

Hoyt made a motion, seconded by Holmes, to adopt the Working Group's April 24 minutes (Attachment XX). The motion passed unanimously.

2. Heard a Presentation on Health Care Choice Compacts under Section 1333 of the ACA

Peter Nelson (Center for Consumer Information and Insurance Oversight—CCIIO) presented on health care choice compacts authorized by Section 1333 of the ACA. He said the Trump Administration is considering the impacts of health care choice compacts. He said such compacts could give states more choice and stability in their insurance markets. Nelson requested input from states as the federal government considers the effects of the compacts. He said a letter would soon go to the states to solicit input. He said the law directs the federal Centers for Medicare & Medicaid Services (CMS) to consult with the NAIC and issue regulations on Section 1333 compacts. He reviewed past comments from the NAIC, which he said concluded that new regulations were unnecessary because of existing state authority to enter into compacts. He said states have had success under existing compacts and agreed that states have authority outside of Section 1333 to enter multistate compacts.

Nelson said the biggest benefit of compacts in health insurance is that they create efficiencies in regulation and allow insurers to operate in a standardized way across states. He said states can already enter a compact outside of Section 1333, but it requires approval from U.S. Congress (Congress) if the compact impinges on federal sovereignty. He said Section 1333 offers new opportunities and allows the sale of health insurance across state lines. A Section 1333 compact would allow insurers to offer plans in multiple states while abiding by the laws and regulations of the state where the policy is written. He said the law includes protections for consumers.

He said Section 1333 has guardrails similar to Section 1332 with regard to affordability, coverage, comprehensiveness, and deficit neutrality. In addition, he said Section 1333 also requires the maintenance of consumer protections, such as network adequacy, in a consumer's home state.

Nelson said that in the coming months, he would like to focus on what else a Section 1333 compact could mean for states, including how states can take control over insurance markets back from the federal government. He said taking back federal control is how Section 1333 differs from other compact authorities. He said CMS is working to determine which federal authorities can be transferred to states. Qualified health plan (QHP) certification requirements represent one possibility. Nelson said federal policy has vacillated as federal administrations have changed. He said states would benefit from more stability, and a compact would allow them to decide together how to regulate QHPs.

Nelson said that states in a compact have a voice in regulatory decisions they do not have when federal officials make decisions. He said there are benefits, especially for smaller states, to create an attractive market for insurers to do business.

Commissioner Grant asked whether states need specific statutory authority for a Section 1333 compact. Nelson confirmed that states are required to pass legislation and added that state legislation can take different shapes. He said some legislation might include the compact language in its entirety, while other examples might authorize a state executive to sign onto a compact.

Seip asked about compacts for rate setting or benefit design, given that states have different statutory requirements. Nelson said that issuers must be licensed in every state where they sell, regardless of a compact. He said different benefits could create adverse selection issues. He said examples like this are where states have struggled in the past to set up compacts because it required them to give up some control. He said that, alternatively, the compacting states could establish a compact commission with representation from each state to sort through these issues. Seip asked whether the same would apply to rates. Nelson said each state could have its own rate review process or could allow the compact to take on certain duties to gain efficiencies. He said states would need to retain certain authorities as spelled out in Section 1333, including consumer protections.

Beyer asked whether a compact would create a single risk pool across multiple states. Nelson said it would be up to compacting states—they could each maintain a separate risk pool, but it may make sense to combine risk pools to gain efficiency. He said any compact arrangement would be a heavy lift, as decisions like these would need to be made across states.

Hoyt asked whether there would be one compact or separate compacts among different groups of states. Nelson said multiple compacts could exist between contiguous or non-contiguous states.

Commissioner Grant asked whether Section 1332 and Section 1333 could be used together. Nelson said the two sections could be used together. He said Section 1332 involves approval from the U.S. Department of the Treasury (Treasury Department) and potentially state pass-through funds. He said it could be

argued that similar funding could be available under Section 1333, but it may be more efficient to make use of both sections to access pass-through funds.

3. Heard Presentations on State Experiences with Flexibility Under Sections 1332 and 1331 of the ACA

4. Section 1332

Trexler presented on Idaho's experience seeking state innovation waivers under Section 1332 of the ACA. He reviewed the guardrails that states must meet for waiver approval.

Trexler said Idaho began considering Section 1332 waivers in 2019. The initial coverage choice waiver would have allowed individuals to keep commercial coverage rather than enrolling in expanded Medicaid coverage. He said some individuals may have preferred commercial coverage due to network availability, fluctuating income, or a desire to keep an entire family on one plan. He said Idaho submitted an application showing how it met the four guardrails, but it was not approved because the federal government determined it would add to the federal deficit. He said a second attempt relied on authority under a governor's executive order. That waiver did not receive approval because state legislation is required.

Trexler said the legislature authorized a reinsurance waiver in 2022. He said this waiver application moved much more smoothly because several states had already gone through this process, and Idaho followed the same path. He said the waiver was approved and went into effect for plan year 2023. He said Idaho uses a portion of its premium tax to fund the state share of the reinsurance costs. He said the program has led to 12%–20% lower premiums compared to what they would be without the waiver.

Trexler said that this year, the legislature has renewed interest in a coverage choice waiver. A new waiver plan would allow individuals the choice to opt out of Medicaid and select a qualified health plan with tax credits. He said Idaho is working to develop a new waiver application to implement this direction from the legislature. He said Idaho does not want to jeopardize the state's existing reinsurance waiver. He said the state seeks to waive the definition of "coverage month" in federal law.

5. Section 1331

O'Brien and Clare Pierce-Wrobel (Oregon Health Authority—OHA) presented on Oregon's basic health plan, called the Oregon Bridge Plan (OBP). O'Brien said Section 1331 allows Oregon to repurpose 95% of premium tax credit funds for a certain population to offer a new health plan. He said the OBP aims to keep people covered despite the return to Medicaid eligibility redeterminations following the COVID-19 pandemic and to minimize churn between coverage sources.

O'Brien said insurance regulators in Oregon had three main concerns with the basic health plan. First, rates may be affected due to a smaller individual market risk pool. He said potential increases in rates were offset by higher morbidity in the population, leaving the individual risk pool. Second, the basic health

plan removes the majority of consumers who are eligible for cost-sharing reductions, meaning the need for silver loading is greatly reduced. This, in turn, reduces silver premiums and the tax credit available for some consumers. Third, the expiration of enhanced premium tax credits reduces the amount of funding available for the basic health plan and potentially compounds the other premium effects.

Pierce-Wrobel reviewed data on health insurance coverage by income level. She said the highest rate of uninsurance prior to the pandemic was individuals between 138% and 200% of the federal poverty level (FPL), which makes up the group that would be covered by the basic health plan. She said the state established a task force to develop the plan, and it met extensively with marketplace carriers. She said the task force recommended using existing Medicaid plans to deliver the program so that enrollees did not need to change plans moving between Medicaid and the OBP.

Pierce-Wrobel said actuarial analysis indicated that there would only be a small impact on silver loading. She said the biggest impact the state worked to control was the net premium increase for consumers at some income levels. She said individuals are expected to move to the OBP over three years. She said a small number of individuals who remain in the individual market would face premium increases, concentrated among those over 400% of the FPL. She said the impact on consumers at lower income levels was $50 or less per month.

Pierce-Wrobel said Oregon considered some ways to mitigate these premium effects. She said the state considered an additional state subsidy, but it was not possible because the state uses the federal marketplace platform. She said the state considered using gold plans as the premium tax credit benchmark, but this also had operational limitations and policy concerns. She said the state considered a Section 1332 waiver to establish a basic health plan look-alike and access pass-through funds. Pierce-Wrobel said the state determined that the pass-through funding would not be sufficient for this purpose. She said enrollment in the OBP has been lower than expected, so the impacts on the individual market have been less than expected.

Pierce-Wrobel said the federal reconciliation legislation would potentially impact basic health plans, including Medicaid eligibility rules and work requirements. She said that, for other states, switching to the basic health plan could be accelerated if automatic re-enrollment in marketplace plans is prohibited through federal law. She said that despite the uncertainty, there are benefits to having a basic health plan, including offering a plan for those who lose Medicaid eligibility, more financial protection for those who would lose enhanced premium tax credits, and mitigating the effect of the end of silver loading at the federal level.

Commissioner Grant said the Working Group has been charged with developing a white paper on the state flexibility sections. She said the Working Group would meet in regulator-to-regulator session in July to discuss an outline of the paper and in open session at the Summer National Meeting to solicit stakeholder input on the outline.

Having no further business, the Health Innovations (B) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/B CMTE/Health Innovations/Minutes 6.20