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Health Innovations (B) Working Group
Minneapolis, Minnesota
August 12, 2025

The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met Aug. 12, 2025. The following Working Group members participated: Marie Grant, Chair (MD); Amy Hoyt, Vice Chair (MO); Sarah Bailey (AK); Debra Judy (CO); Scott Shover (IN); Julie Holmes (KS); Chrystal Bartuska (ND); Viara Ianakieva (NM); Craig Kalman (OH); TK Keen (OR); Glory Montalvo (PR); Debra Diaz-Lara (TX); and Joylynn Fix (WV). Also participating were: Michael Caljouw (MA); Brian Downs (OK); and Jane Beyer and Todd Lovshin (WA).

1. Adopted its June 20 Minutes

The Working Group met June 20 and took the following action: 1) heard presentations from states on their experiences in implementing Sections 1331 and 1332 of the Affordable Care Act (ACA); and 2) heard a presentation from the Center for Consumer Information and Insurance Oversight (CCIIO) on Section 1333 of the ACA.

Hoyt made a motion, seconded by Fix, to adopt the Working Group's June 20 minutes (Attachment A). The motion passed unanimously.

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

Peter Nelson (CCIIO) presented on health care choice compacts authorized by Section 1333 of the ACA. He reviewed some of the history of multi-state compacts in health insurance. Buying health insurance across state lines can mean different things. One model for health insurance compacts is that only regulations of the state in which a policy is issued would be applicable, not the laws and regulations of a consumer's home state. This model was discussed in past decades by the George W. Bush Administration and think tanks. This model would involve federal laws that preempt state laws to allow multi-state sales. Another approach was considered by smaller states. States with small markets were interested in creating a larger pool of consumers to attract more insurance issuers. The ACA adopted the latter model, which allows states to provide alternatives to the federal law.

Nelson said Section 1333 of the ACA would allow the sale of qualified health plans from one state to another. Section 1333 includes exceptions to the rule that only the issuing state's laws and regulations apply. The home state of the consumer can still apply consumer protections, including market conduct rules, unfair trade practices limits, and network adequacy rules. Section 1333 incorporates guardrails that are almost identical to those that apply to waivers under Section 1332 of the ACA. The guardrails guarantee that coverage remains available, comprehensive, and affordable and that the federal deficit does not increase. Section 1333 additionally requires that consumer protections from the consumer's home state remain in place.

Nelson said states might want to enter a compact that requires federal approval to allow the federal government to give up some of its sovereignty. Section 1333 allows the federal government to give up some sovereignty, as long as the Secretary of Health and Human Services (HHS) approves.

Nelson addressed a number of questions about Section 1333, and CMS seeks input from NAIC on all of the questions. He explained what federal laws and regulations may be waived under Section 1333. It starts with the requirements applicable to qualified health plans, identifying these requirements as an area of flexibility. States can use a compact to establish a more stable regulatory environment. Different administrations have

implemented the ACA differently, frequently reversing decisions from prior administrations. A compact would give states the power to set a consistent policy. Policy has changed from administration to administration on standardized plans and network adequacy, and these are areas where states could regulate through a compact. He requested feedback from state insurance regulators in this area.

Nelson discussed the guardrails for Section 1333. The Secretary of HHS has some discretion in interpreting the guardrails. He said it likely makes more sense to apply the guardrails in the same ways for Sections 1332 and 1333, but there could be a difference in interpretation for good reason. He invited comments on what good reasons there may be to apply the guardrails differently. For Section 1333's unique guardrail on consumer protection, the statute includes a description of what areas must be included. He cited statutory references to market conduct, unfair trade practices, network adequacy, and consumer protection standards, including rating standards and contractual disputes.

Nelson said CMS intends to issue regulations on Section 1333. CMS would do so to allow states to increase the size of their risk pools and to maintain consistent rules.

Nelson said it would be a heavy lift for states to enter a compact. States must adopt compact language into state statutes, or they could possibly defer to a state official to define the compact. There could potentially be funding for states to establish a compact. The amount available would be relatively small unless Congress decides to appropriate more funds for the purpose. CMS welcomes comments on what level of funding would be helpful for states.

Nelson said CMS would not offer specific incentives for states to enter a compact. States stand to benefit from more regulatory stability, and regulatory flexibility would encourage states to participate. However, it will be a state decision on whether to join a compact.

Nelson said CMS requirements on legislation to enter a compact would likely depend on the type of compact. States could potentially be required to ensure that guardrails are protected on an ongoing basis. 1333 compacts do not have expiration dates, unlike 1332 waivers. Because compacts are longer-term arrangements, there may need to be strong guarantees with respect to the guardrails.

Beyer asked whether Section 1333 compacts could encompass both individual and small group plans. Nelson responded that the statute clearly states that Section 1333 only applies to the individual market. Congress would have to change the law to apply it to small group coverage.

3. Heard Stakeholder Input on an Outline for a White Paper on State Flexibility Under the ACA

Adam Fox (Colorado Consumer Health Initiative) and Claire Heyison (Center on Budget and Policy Priorities) provided feedback on the outline for a white paper on state flexibility under the ACA shared by the Working Group. Fox said there have been a variety of approaches by states for each flexibility section. It is important for consumers that the guardrails for each section be protected. States have used Sections 1331 and 1332 to improve affordability, and this should be highlighted in the white paper. Some waiver concepts raise potential concerns, including those that were rejected by CMS in the past. The white paper should capture both the benefits and the cautions that exist with opportunities for state flexibility.

Heyison said regulators should ensure there are strong guardrails for Sections 1332 and 1333. Waivers should not degrade affordability, comprehensiveness, or consumer protections for the individual market overall. States should consider how they can use 1333 compacts to improve consumer protections in ways that are not already available to them and whether the waiver structure allows states to undermine federal protections.

Fox said his organization has many tools to assist consumers with state-regulated health plans. There is concern that a 1333 compact would reduce consumers' ability to push back when they are not treated appropriately by their insurer because the plan may not be regulated by the consumer's home state.

Grant requested that any additional written comments be submitted to the Working Group by Aug. 22.

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

SharePoint/NAIC Support Staff Hub/B CMTE/Health Innovations/Minutes 8.12

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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).

4. 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.

5. 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.

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

A. 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.

B. 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.

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