NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

March 20, 2025

The Honorable Robert F. Kennedy, Jr.
Secretary of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Secretary Kennedy:

We write on behalf of state insurance regulators to share important priorities for health insurance markets this year. The National Association of Insurance Commissioners (NAIC) represents the chief insurance regulators in the 50 states, the District of Columbia, and 5 U.S. Territories. The priorities outlined below support affordable coverage, state flexibility, and effective state regulation to protect consumers and markets.

State Flexibility and Reliable Funding

Federal law has long recognized the importance of providing states with the flexibility they need to support the unique conditions of their health insurance markets. Under the Affordable Care Act (ACA), for example, states may choose to operate their own health insurance marketplaces or use the federal platform, they may develop state innovation waivers to test new ideas, and they may select the essential health benefits that will apply in the state consistent with federal guidelines. We urge the Administration to continue to support state flexibility and innovation.

We also ask that the Administration ensure Federal funding for state waivers and grants are dependable. So far, seventeen states have used state innovation waivers to implement reinsurance programs to lower health insurance premiums for their residents. The waivers are funded in part by state dollars, with the remaining funds coming from federal pass-through grants that redirect funds that would otherwise be spent on premium tax credits. Importantly, the pass-through grants do not increase federal spending. Instead of going to health insurers as premium tax credits, pass-through grants flow to state reinsurance programs and then to the insurers who enroll high-cost members, resulting in lower health insurance premiums across the individual market.

Any interruption in the pass-through grants would upend the reinsurance programs. Insurers have already set their rates in expectation of receiving reinsurance funds under approved state programs. Insurers rely on the availability of the pass-through grants, setting

their rates with the anticipation of receiving funds from the state program once the state accesses its pass-through grant. States owe tens to hundreds of millions of dollars to insurers in reinsurance payments for this year. Without the pass-through funds already authorized in state waiver approvals the reinsurance programs would not be able to meet their obligations. Not only would this have a devastating effect on insurer balance sheets and stability for this year, but it would also undermine the trust between states, state regulators, and health insurers that has helped to facilitate strong markets in many states. We urge the Administration to continue state pass-through grants for individual market reinsurance without interruption.

We also encourage the Administration to provide greater programmatic stability by avoiding significant changes year after year and providing state regulators and other stakeholders sufficient time to comment on proposed changes and to implement any final changes.

Enhanced Premium Tax Credits

We urge timely federal action on enhanced premium tax credits under the ACA. The increased size and broader availability of premium tax credits that have been available since passage of the American Rescue Plan Act of 2021 have resulted in greater enrollment in Marketplace plans in state individual health insurance markets. The greater subsidies have enhanced the affordability of coverage for families of modest means as well as those who were previously denied help with coverage costs due to income limits. Over 21 million people signed up for ACA plans in PY 2024, and potentially all of them could be affected if the enhanced subsidies expire - from very low-income individuals to high income newer enrollees and anyone in between. The economic impact of reduced coverage would extend to health care providers: hospitals, physicians, nurses, and pharmacies. And these impacts would be exacerbated if Medicaid funding is reduced.

These credits have moved the needle on access to healthcare for millions, in particular for those who need help the most, those with annual incomes under 250% of the FPL. Ending the enhanced credits at the end of this year would have a major impact on state health insurance markets. The affordability of coverage would change for millions of enrollees, and some may choose to discontinue their Marketplace coverage at the end of the year. Others may continue their enrollment, only to be caught off guard by significantly higher premium costs in 2026, when more may choose to disenroll. The enhanced subsidies have increased enrollment of the healthiest cohort, ages 18-34, who will be the most likely to drop coverage due to higher out-of-pocket premiums if the enhanced subsidies end. Losing that healthy population will adversely impact the risk pools, which will increase premiums for another significant cohort of enrollees, those aged 55-64. The end of enhanced subsidies and the return of the 400% FPL subsidy cliff together will disproportionately impact households with enrollees over age 55. These changes would not only affect access to coverage for millions, but they would also roil insurance markets as issuers and regulators adjust to a likely smaller and somewhat higher-risk overall individual market.

Further, the end of the enhanced credits would starve state reinsurance programs of the federal support they have used to reduce individual market rates overall. The reinsurance programs operated in 17 states are funded by the dollars that would otherwise flow through premium tax credits. While they do not add to federal costs, state reinsurance programs would have less funding available to lower premiums should the enhanced subsidies expire.

We know Congress must act to extend the enhanced credits and state insurance regulators have urged them to decide the issue as soon as possible. We also request guidance from the Administration on how states can address the current uncertainty surrounding PY 2026 rates and ensure accurate rates are approved and posted by the beginning of Open Enrollment. State regulators are tasked with reviewing health plans' rates and approving plans for sale each year. Open Enrollment for PY 2026 begins on November 1, 2025. To make plans available for this date, insurers must file their plans and rates with states beginning in the spring. Health insurers will need to take into account the presence or absence of enhanced subsidies in setting their rates for 2026. Without a decision on the enhanced subsidies, the rate filing and approval process will be challenging, and costly. Uncertainty regarding the continuation of the enhanced subsidies existed in 2022. That year, some states required health insurers to file two sets of rates, one assuming continued enhanced subsidies and one with subsidies returning to prior levels. Developing two sets of rates was costly and confusing for insurers and reviewing them was more complicated and resource-intensive for state regulators. In addition to complicating the rate review process, if this issue remains unresolved it may lead to higher than necessary premiums due to the uncertainty itself.

Medicare Advantage

State insurance regulators seek to work more closely with federal officials in regulating Medicare Advantage (MA) plans. While MA is a federal program, state regulators see opportunities to better serve seniors, health plans, and health providers with greater state-federal collaboration, particularly in marketing practices and provider networks. State regulators have received complaints about egregious marketing practices related to Medicare Advantage plans, some of which were detailed in a 2022 Senate report, yet lack the authority to address them. As the report concluded, greater enforcement is necessary to protect seniors. CMS has since established stronger rules on Medicare Advantage marketing, which have been helpful in curtailing some deceptive practices. Nonetheless, more action—and more enforcement—are needed. We strongly believe that enforcement should be at the state level. State regulators stand ready to partner with federal officials to enforce the federal rules on Medicare Advantage marketing—our local knowledge and investigative resources would help extend the capacity for effective enforcement.

MA network changes have also generated complaints in recent years. Providers leaving MA plan networks have unexpectedly left seniors without access to their treating doctors and hospitals. Beneficiaries should have adequate notice of changes that affect their care. Significant network changes trigger important rights for beneficiaries, and they should receive clear notice of their rights and have access to counseling to help them make appropriate choices.

As a trusted source of insurance information, state regulators would like to be able to share unbiased information with seniors on MA network changes and their effects. Federal officials with CMS have recently begun sharing more timely information with state regulators regarding significant network changes. We appreciate these efforts and request greater collaboration with more detailed information on affected beneficiaries so that state insurance department staff can offer effective assistance.

Section 1557 Nondiscrimination Rules

Updated rules to implement Section 1557 of the Affordable Care Act were finalized in 2024. Among other provisions, they limit health insurers' ability to treat enrollees differently based on age or disease status. State insurance regulators agree on the need for effective regulations under this section to better protect health insurance consumers from unfairly discriminatory practices. However, state regulators believe the 2024 rules are applied too broadly and could unnecessarily restrict Medicare Supplement, excepted benefits, and other plans.

While it is appropriate and consistent with the statute to apply section 1557 protections to health insurers' programs and activities that receive federal financial assistance, the rule goes further and applies to all the operations of health insurers when any part of the enterprise receives federal financial assistance. Because health insurers participate in some markets that receive federal financial assistance and others that do not, the rule seems to require compliance even in activities that do not benefit from federal assistance. Thus, an insurer that offers MA coverage funded by HHS would be bound by the nondiscrimination protections in all its operations. The same issuer's Medicare supplemental coverage—funded only by enrollee premiums—would be subject to the restrictions on discrimination based on age and the other provisions of the rule. We believe this interpretation goes beyond the intent of Congress. State laws often legitimately make distinctions based on age - such as for premium rating - or disease status - like making Medicare supplement plans available to those with renal disease. We urge this Administration to limit the applicability of the rule while preserving the core protections of Section 1557 for federally-supported plans.

Excepted benefits plans, short-term, limited duration insurance, and third-party administrator services to self-funded multiple employer welfare arrangements, too, may be unreasonably restricted by the broad application of the final rule. These plans operate under state laws that regulators fear could be preempted by the provisions of the final rule. A more limited application of the rule would offer more clarity and allow these plans and services to be offered without interruption.

Clear Rules on Copay Accumulator Programs

State insurance regulators seek clarification on copay accumulators and enforcement of federal rules governing their use. Litigation invalidated an HHS rule from the 2021 Notice of Benefit and Payment Parameters that gave insurers wide discretion on how they use copay accumulator programs. The court decision left a previous 2020 rule in place. Under the

2020 rule, insurers may only use copay accumulators in limited circumstances. Since 2023, however, HHS declined to enforce the 2020 rule and has promised updated rulemaking.

States have also enacted rules to allow or restrict the use of copay accumulators. State regulators ask for greater clarification from HHS on the status of federal rules so that we can provide consistent guidance to health insurers on these programs.

Short-term, Limited Duration Insurance

As federal regulation of short-term, limited duration insurance (STLDI) has tightened and loosened over the past several years, the NAIC has consistently spoken in favor of states' ability to make their own choices in regulating these products. If this Administration contemplates any changes to federal regulation of STLDI, we urge it to preserve state authority. Because the maximum length of short-term plans is not specified in federal law we believe it is more appropriate to recognize the role of states as the primary regulators of insurance products and allow states to set their own limits. The states are the more responsive regulators and know better what their individual markets can provide and what their respective consumers need.

Many states have actively considered and chosen to develop their own regulations for short-term, limited duration insurance. Some have effectively banned the products or mandated that certain benefits be covered. Several have established time limits of approximately three months, six months, one year, or until the end of the calendar year. Other states have created new regulatory structures that extend important consumer protections and rating rules to short-term, limited duration plans. Under these state laws, short-term plans serve consumers who experience gaps in other coverage sources. Allowing for different state choices is precisely why the McCarran-Ferguson Act reserves the regulation of insurance for the states. State regulators request that their flexibility to determine whether, and under what conditions, short-term, limited duration insurance plans are appropriate for their markets and consumers be retained.

Federal Support for Mental Health Parity Enforcement

We ask that HHS fund grants to states for enforcement of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Congress authorized grants to states for the enforcement of federal mental health parity laws in 2023 (section 1331 of the Consolidated Appropriations Act (CAA) of 2023). While Congress has not yet appropriated funds for these grants, the Senate Appropriations Committee has encouraged the Secretary of HHS to use already appropriated funds for this purpose.

Because of the way the federal Mental Health Parity and Addition Equity Act (MHPAEA) is structured, monitoring compliance requires more than just a comparison of benefits between mental health and substance use services and medical and surgical services. It requires a complex analysis of quantitative and nonquantitative treatment limits embedded in plans' policies, procedures, operations, and evidentiary standards. States have worked hard to develop their capacity to conduct reviews under this federal law, but more resources

are needed. Grants authorized by the CAA would allow many states to enhance their enforcement and hold more plans accountable for the MHPAEA standards.

With record numbers of Americans seeking mental health services and an ongoing epidemic of addiction, the time is right to make sure health insurers are complying with these important consumer protections. The relatively modest federal investment will support state efforts and help ensure that consumers enrolled in state-regulated health insurance are protected by MHPAEA as Congress intended.

Thank you for your consideration of these priorities. We welcome collaboration with you and your staff as we work to ensure healthy markets and protect consumers.

Sincerely,

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