AMERICAN EXPERIMENT

Section 1333 Health Care Choice Compacts

Opportunities for states to improve the individual health insurance market through state compacts under the Affordable Care Act

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Introduction

The Patient Protection and Affordable Care Act (ACA) is now 14 years old. Since its passage, the law has survived numerous legal and political challenges to overturn or repeal it. Nonetheless, the law remains mired in political controversy. A clear divide has emerged between Democrat and Republican policy positions on how the law should be administered. While the ACA included some popular features and expanded access to coverage, the law also introduced problems that increased health care costs and upset health insurance markets. Division over how to address the problems and strengthen the positives the ACA introduced has led to substantial regulatory instability. During the short history of ACA implementation, a pattern has already emerged of major regulations getting implemented in one presidential administration only to be quickly reversed in the next administration under new political leadership.

This unstable, seesawing regulatory environment creates obvious problems. Regulatory efficiency clearly suffers when both regulators and health plans must devote resources to enact and implement these regulatory changes. Health plans must also account for uncertainty in the market by raising premiums. Consumers, therefore, face higher premiums simply because insurers must price a certain amount of regulatory uncertainty into their premiums. Much of the policy differences between Democrats and Republicans represents honest differences over the best way to regulate health care. But, to the extent this seesawing represents political positioning, the policy suffers and never has time to prove its merit.

Courts have largely upheld these regulatory reversals, citing the substantial discretion the ACA gives to federal regulators. Therefore, this seesawing regulatory environment appears to be the inevitable product of how the ACA was drafted. If this regulatory instability is baked into federal law, then there is no reason to think anything will change without a change in federal law. Right now, Congress does not appear prepared to address this problem. The ACA, however, does include an opportunity for states to stabilize health insurance regulation through interstate compacts. In addition to stabilizing how the ACA is administered, a compact also gives states the opportunity to adopt alternatives to the ACA. This can allow states to address deeper structural problems with the law that would otherwise require congressional action.

Under section 1333 of the ACA, Congress approved Health Care Choice Compacts to allow qualified health plans to be sold across state lines subject to the laws and regulations of only one state. As a compact created under the Compact Clause of the U.S. Constitution, these agreements become federal law. Ultimately, that means a Section 1333 Health Care Choice Compact (hereinafter, 1333 compact) can fundamentally change federal regulatory requirements for the sale of qualified health plans under the ACA and allow states to adopt alternative regulatory approaches that would otherwise be preempted by the ACA. States can also take more modest steps to simply restore regulatory stability by taking control over administering the ACA's requirements. This report details how states can take advantage of 1333 compacts to improve the regulation of the individual health insurance market.

Section I: Ongoing ACA Challenges

The requirements of the ACA aimed to solve several longstanding problems with state insurance markets. Prior to 2014 — the year these ACA requirements took full effect — insurers in the individual health insurance market could deny coverage to people with preexisting conditions. Millions of low-income people could not afford coverage. Higher income people and small businesses also complained about high costs. Unfortunately, ACA policies pushing to positively expand access for low-income people also pushed health insurance markets in negative directions that undermined access, affordability, and quality in other ways.

ACA impact on premiums, issuer participation, and enrollment

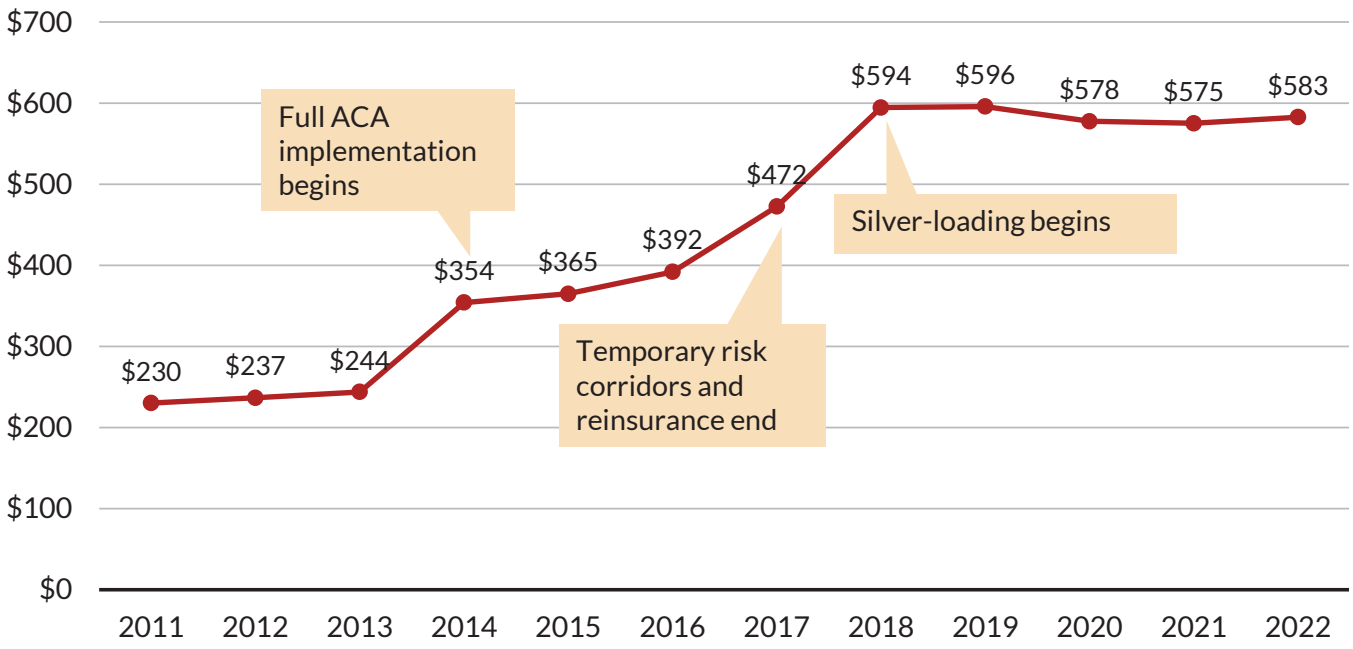
Immediately after the main ACA requirements launched in 2014, individual premiums skyrocketed. After several years of stable premiums, Centers for Medicare & Medicaid Services (CMS) data in Figure 1 show that average monthly premiums on the individual market increased from $244 in 2013 to $354 in 2014 — a 45 percent jump. By 2017 — the last year an annual rate review was administered by the Obama administration — premiums had increased to $472.

This adds up to a 94 percent increase over 2013 rates. Issuers needed to raise premiums to offset the substantial losses they experienced from higher-than-expected claims costs. Some issuers could not manage these losses. "As a result," according to a CMS report on issuer competition, "many issuers decided to reduce their service areas or leave the Exchanges altogether."[1] Moving into 2018, over half of all counties in America had only one issuer participating on the Exchanges.[2]

Average monthly premiums stabilized after 2018. However, as Figure 1 shows, they stabilized at a very high level. The figure also points out key events that impacted premium levels. The first event happened in 2014 when the ACA's main requirements took effect. The ACA then included two temporary policies — risk corridors and reinsurance — to address the difficulty health insurers might have in predicting how to price premiums when the ACA's new regulations took effect in 2014.[3] Premiums jumped in 2017 when these policies ended. The ACA also required insurers to reduce cost sharing for people with lower incomes. However, after

Figure 1

Average Monthly Premiums for Plans on the Individual Market, 2011 to 2022



Sources: Centers for Medicare & Medicaid Services, Medical Loss Ratio Data; and Centers for Medicare & Medicaid Services, HHS Risk Adjustment Program State-Specific Data.

Note: This figure shows the average monthly premiums for plans purchased on the individual market. Prior to 2014, this figure reports average monthly premiums from medical loss ratio data. From 2014 forward, this figure reports average monthly premiums from risk adjustment data for ACA compliant plans purchased through the individual market single risk pool. These two data sources provide the best comparison of the average premium for a plan that was available for anyone to purchase on the individual market before and after the full implementation of the ACA. This follows the same methodology CMS used to compare premiums before and after the ACA's market rules took effect

1 Centers for Medicare & Medicaid Services, *Increasing Competition on the Exchanges to Improve Consumer Choice and Affordability* (October 2020), available at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Issuer-Participation-in-the-Marketplace.pdf

2 Centers for Medicare & Medicaid Services, County by County Analysis of Plan Year 2018 Insurer Participation in Health Insurance Exchanges (Oct. 20, 2017), at https://www.cms.gov/marketplace/about/exchange-coverage-maps.

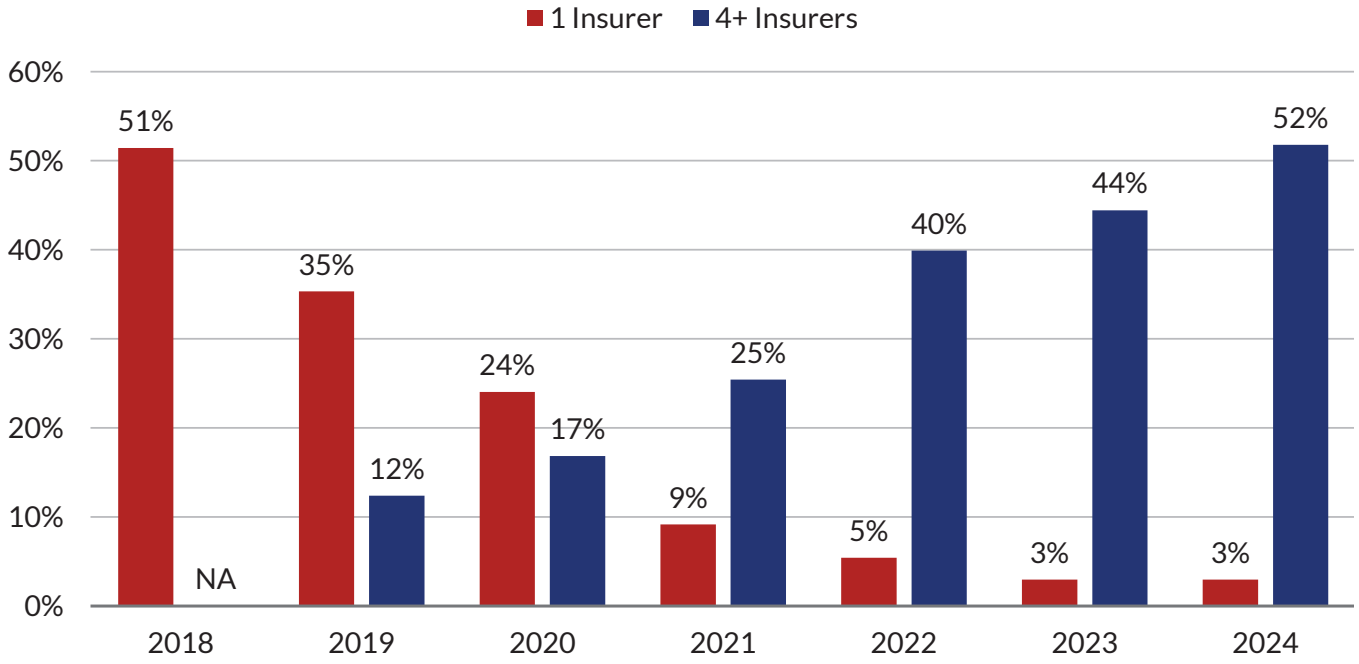
3 Risk corridors transferred unexpectedly large profits from some health plans to cover unexpectedly large losses for others. Reinsurance paid insurers a portion of the claims cost for people who experienced higher claims. Each of these programs were limited to the first three years of the ACA's new market rules.

a federal judge ruled the ACA never appropriated funding to pay for cost sharing reductions, these payments ended in the fall of 2017. As discussed in more detail later, this led insurers to implement a strategy called "silver loading" to replace the loss of cost sharing payments with higher premium tax credit subsidies. This, in turn, led to higher average premiums in 2018.

Since 2018, Figure 2 shows how the portion of single issuer counties has steadily dropped year after year. Today, only three percent of counties offer just one issuer and over half of counties offer four or more issuers. Though issuers may have come back to the market, persistently high premiums created a serious and ongoing affordability challenge for people who do not qualify for federal premium subsidies. Prior to COVID-19 emerging in 2020, unsubsidized enrollment had dropped by 2.8 million people from 2016 to 2019 — a 44 percent decline over just three years.[4] Wide regional variations in affordability meant some areas of the country experienced a real death spiral — a cycle where healthier people leave the market resulting in a higher cost risk pool the next year — among the unsubsidized portion of the market. From 2016 to 2019, 15 states lost over 60 percent of their unsubsidized enrollment.[5]

Figure 2

Percent of Counties with One Versus Four or More Insurers



Source: Centers for Medicare & Medicaid Services, Health Insurance Exchange Coverage Maps, available at https://www.cms.gov/marketplace/about/exchange-coverage-maps.

4 Centers for Medicare & Medicaid Services, *Trends in Subsidized and Unsubsidized Enrollment* (Oct. 9, 2020), available at https://www.cms.gov/cciio/resources/forms-reports-and-other-resources/downloads/trends-subsidized-unsubsidized-enrollment-by18-19.pdf.

5 Id. Today, there are far too many areas of the country where premiums are only affordable to people who qualify for subsidies. CMS estimates that the average premium for the lowest-cost silver plan in the highest-cost quintile of counties in America would on average cost a 60-year-old $17,652 per year in 2020. That is 35.3 percent of income for someone earning just above the premium subsidy eligibility threshold. By contrast, a 60-year-old living in the lowest-cost quintile of counties would pay $9,444, which is still 18.9 percent of income for people on the other side of the subsidy cliff. In response to the pandemic, the American Rescue Plan Act of 2021 temporarily smoothed this subsidy cliff by extending premium tax credits subsidies to people above 400 percent of the federal poverty level. These enhanced subsides are set to expire at the end of 2025 and, therefore, revert to the ACA's original subsidy cliff. Centers for Medicare & Medicaid Services, *Affordability in the Marketplaces remains an issue for Moderate Income Americans*, CCIIO Data Brief Series (January 2021), available at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Impact-Premium-Affordability.pdf.

ACA continues to pose structural problems for markets

The structure of the ACA poses ongoing challenges for state insurance markets. The following list itemizes major problems the ACA creates which states could help resolve if given the opportunity.

- **Premium inflation.** The law's premium subsidy structure inflates premiums by fully subsidizing any premium increase for large segments of the subsidy-eligible population. By using federal tax dollars to pay the full cost for premium increases, there's little pressure on insurance companies or regulators to keep premiums down for subsidized people. As the portion of the unsubsidized market shrinks, the inflationary pressure grows.[6]
- **Adverse selection.** The ACA aims to protect people with preexisting conditions by requiring insurers to 1) guarantee coverage and 2) not vary premiums by health status. Alone, these requirements create an "adverse selection" problem because they allow people to select the timing of enrollment in health coverage to when they need care. This timing harms the risk pool and raises premiums. The law included provisions to mitigate adverse selection, but the ACA still led to higher premiums. Today, these higher premiums continue to price some people with preexisting conditions out of the market.
- **Narrow networks.** Before the ACA, people shopping on the individual market tended to have choices between narrower and broader networks. The ACA, however, led to narrower provider networks. Between 2014 and 2021, the percent of silver plan offerings with more restrictive Health Maintenance Organization (HMO) or Exclusive Provider Organization (EPO) plans increased from 43 percent to 85 percent.[7] This means individual market consumers often don't have access to centers of excellence.[8] Narrowing networks ended up being one of the few cost-containment tools health plans could use to keep premiums in check after the ACA closed other avenues.
- **High cost-sharing.** Alongside narrowing networks, increasing cost sharing was the only other obvious lever health plans could pull to quickly address rising premiums. Therefore, average deductibles have been rising. Average deductibles for a bronze plan increased by 35 percent from 2014 to 2021.[9] Out-of-pocket (OOP) limits also increased. So, even if lower deductible plans are offered on the market, the market may still be limited to higher total OOP limits. Losing lower cost-sharing options can be a particular problem for younger people and others who might not have had time to save for future health care costs.
- **Poor coverage for people with chronic health conditions.** Narrow network, high cost-sharing plans tend to work well for healthy people and not so well for people with chronic, high-cost health conditions. Unfortunately, the ACA's structure moves markets toward one-size-fits-all health plan offerings. Strict requirements on essential health benefits, networks, and using health

6 *See* Peter Nelson, "Three Steps To Achieving More Affordable Health Insurance In The Individual Market," *Health Affairs Forefront*, Aug. 19, 2021, at https://www.healthaffairs.org/content/forefront/three-steps-achieving-more-affordable-health-insurance-individual-market. Due to the ACA's premium subsidy structure, unsubsidized people are the only people in the market who are price sensitive to rising premiums. That's because the federal premium subsidies are tied to the amount of premium as a percentage of income. Once the premium amount triggers subsidy eligibility, the subsidy rises lockstep with the rise in premiums. Because the government generally pays the full cost of any premium increase, there's little pressure on insurance companies to keep premiums down for subsidized people. Economic theory and research show this type of subsidy inflates premiums. As the portion of the unsubsidized market shrinks, the inflationary pressure grows. The American Rescue Plan Act (ARPA) enacted in March 2021 temporarily expanded premium subsidies to people above 400 percent of the federal poverty level. While this might provide some temporary premium relief for middle income people, it also aggravates the ACA's premium inflation problem. *See also*, Sonia Jaffe and Mark Shepard, "Price-Linked Subsidies and Imperfect Competition in Health Insurance," *American Economic Journal: Economic Policy* (August 2020), available at https://www.aeaweb.org/articles?id=10.1257/pol.20180198.

7 Edmund Haislmaier and Abigail Slagle, *Premiums, Choices, Deductibles, Care Access, and Government Dependence Under the Affordable Care Act: 2021 State-by-State Review*, (The Heritage Foundation Nov. 2, 2021), available at https://www.heritage.org/health-care-reform/report/premiums-choices-deductibles-care-access-and-government-dependence-under.

8 For instance, MD Anderson in Houston specifically warns people on their website that they "are not included as a 'Participating Provider' for any 'Individual' insurance plans on or off the marketplace in Texas (i.e., ACA plans)." MD Anderson, "Insurance Plans," at https://www.mdanderson.org/patients-family/becoming-our-patient/planning-for-care/insurance-billing-financial-support/insurance-plans.html (accessed on June 6, 2024).

9 Edmund Haislmaier and Abigail Slagle, *Premiums, Choices, Deductibles, Care Access, and Government Dependence Under the Affordable Care Act: 2021 State-by-State Review*, The Heritage Foundation (Nov. 2, 2021), available at https://www.heritage.org/health-care-reform/report/premiums-choices-deductibles-care-access-and-government-dependence-under.

status-related eligibility factors make it harder to tailor plans to specific disease conditions. The annual nature of insurance contracts and approach to risk adjustment undermine incentives for health plans to identify health care needs upfront and manage health conditions for better long-term results.

- **Unfunded cost-sharing reduction subsidies.** As discussed previously, the ACA requires health plans participating on the Exchange to provide plans with a cost-sharing reduction (CSR) to eligible people with incomes up to 250 percent of the federal poverty level. The federal government initially paid health plans to cover the cost of CSRs. However, a federal judge ruled that Congress did not appropriate funding for CSRs and so CSR payments ended in the fall of 2017.[10] To compensate for the lack of funding, health plans have been allowed to increase premiums. Most states have allowed a strategy called "silver loading" where the premium increase targets the silver-level benchmark plan used to set premium tax credit subsidies. This helps ensure the premium increase is born by the federal taxpayer through higher premium subsidies and not spread across the entire market. However, this is an imperfect solution that inevitably still distorts pricing in the market.

Unstable regulatory environment

These challenges are not being ignored. Year after year state and federal lawmakers take steps to make the ACA work better. While the ACA allows states to continue regulating insurance and expects states to lead enforcement,[11] states cannot implement laws or regulations that conflict with federal regulations.[12] Therefore, state-level solutions are limited. In contrast, the ACA gives federal regulators substantial policy discretion over how to implement key aspects of the law.

This policy discretion led to a very unstable regulatory environment for health insurers over the past decade. Federal discretion inevitably led to an unstable set of federal regulations that seesaw from liberal to conservative with changes in presidential leadership. Here are some of the most significant regulatory swings from Obama to Trump to Biden.

- **Enrollment periods:** After the first few years of enrollment experience, the Obama administration expressed a commitment "to avoiding any misuse or abuse of special enrollment periods" and implemented a pilot program to test pre-enrollment verifications which were set to begin in June 2017.[13] But the Obama administration remained hesitant to impose strong verification standards. The

Federal discretion inevitably led to an unstable set of federal regulations that seesaw from liberal to conservative with changes in presidential leadership.

Trump administration quickly concluded Obama's weak enrollment period rules required strengthening and, therefore, moved beyond a pilot and added permanent verifications for special enrollment periods.[14] In addition, Trump reduced the length of the annual open enrollment period.[15] The Biden administration reversed many of these Trump-era rules and recently established a permanent monthly special enrollment period that effectively allows certain low-income people to enroll at any time during the year.[16]

10 Press Release, U.S. Department of Health and Human Services, "Trump Administration Takes Action to Abide by the Law and Constitution, Discontinue CSR Payments," Oct. 12, 2017, available at https://public3.pagefreezer.com/browse/HHS.gov/31-12-2020T08:51/https://www.hhs.gov/about/news/2017/10/12/trump-administration-takes-action-abide-law-constitution-discontinue-csr-payments.html.
11 42 U.S.C § 300gg–61(a).
12 *See* 42 U.S.C. §§ 300gg–62(a), 18031(k), and 18041(d).
13 Centers for Medicare & Medicaid Services, Pre-Enrollment Verification for Special Enrollment Periods (Dec. 12, 2016), available at https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/pre-enrollment-sep-fact-sheet-final.pdf.
14 Patient Protection and Affordable Care Act; Market Stabilization, 82 Fed. Reg. 18346, 18355-59 (Apr. 18, 2017).
15 Id at 18353-55.
16 Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures;

- **Standardized plans:** The Obama administration implemented a framework for requiring health plans to offer standardized plan designs to help people compare plans.[17] This framework envisioned imposing limits on non-standardized plan offerings to reduce choice overload through future rulemaking. The Trump administration removed this framework, arguing that it undermines the consumer benefits from market competition.[18] The Biden administration then reversed and fully implemented standardized plan requirements[19] and went further by placing strict limits on the number of non-standardized plans that can be offered.[20]
- **Network adequacy:** The Obama administration began implementing "time-and-distance" network adequacy standards for provider networks but moved slowly in adopting any nationwide standard "[i]n recognition of the traditional role States have in developing and enforcing network adequacy standards."[21] The Trump administration then eliminated federal network adequacy reviews that duplicated state reviews to return oversight to states, arguing that states are better positioned to evaluate network adequacy.[22] After concluding state reviews might fall short, the Biden administration reversed this policy and implemented federal network adequacy requirements which exceed the requirements under Obama.[23]
- **1332 waiver guidelines:** The Obama administration issued guidance[24] on approving Section 1332 State Innovation Waivers (hereinafter, 1332 waivers) that, according to some observers, applied a "stricter-than-expected interpretation."[25] The Trump administration then issued new guidance[26] and eventually, new rules to give states broader flexibility to waive certain ACA requirements,[27] which the Biden administration quickly reversed.[28] The Biden administration also effectively rescinded a 1332 waiver the Trump administration approved for Georgia,[29] as well as several Medicaid waivers.[30] These actions set a new precedent for a sitting presidential administration not honoring waivers approved under a prior administration.
- **Essential health benefits:** Both the Obama and Trump administrations endorsed a regulatory policy to give states flexibility in setting their essential health benefits (EHBs).[31] While states were given flexibility, there are still limits on the scope of benefits. The Biden administration recently finalized rules to allow states to substantially increase the scope of benefits by adding routine adult dental and removing requirements on states to defray the cost of new health benefit mandates which are

Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program, 89 Fed. Reg. 26218, 26320-23 (June 4, 2024).
17 Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017, 81 Fed. Reg. 12204, 12289-93 (Mar. 8, 2016).
18 Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019, 83 Fed. Reg. 16930, 16974-75 (Apr. 17, 2018).
19 Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023, 87 Fed. Reg. 27208, 27310-23 (May 6, 2022).
20 Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024, 88 Fed. Reg. 25740, 25847-65 (Apr. 27, 2023).
21 Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017, 81 Fed. Reg. 12204, 12301 (Mar. 8, 2016).
22 Patient Protection and Affordable Care Act; Market Stabilization, 82 Fed. Reg. 18346, 18371-72 (Apr. 18, 2017).
23 Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023, 87 Fed. Reg. 27208, 27322-34 ((May 6, 2022)
24 Waivers for State Innovation, 80 Fed. Reg. 78131 (Dec. 16, 2015).
25 Heather Howard and Dan Meuse, "New Section 1332 Guidance A Mixed Bag For States," *Health Affairs Forefront*, Feb. 29, 2016, at https://www.healthaffairs.org/content/forefront/new-section-1332-guidance-mixed-bag-states.
26 State Relief and Empowerment Waivers, 83 Fed. Reg. 53575 (Oct. 24, 2018).
27 Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022; Updates to State Innovation Waiver (Section 1332 Waiver) Implementing Regulations, 86 Fed. Reg. 6138, 6157-65 (Jan. 19, 2021).
28 Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond, 86 Fed. Reg. 53412, 53457-88 (Sept. 27, 2021).
29 Letter from Chiquita Brooks-LaSure, Administrator, Centers for Medicare & Medicaid Services, to Grant Thomas, Georgia Governor's Office of Planning and Budget (Aug. 9, 2022) (suspending Part II of Georgia's section 1332 waiver), available at https://www.cms.gov/cciio/programs-and-initiatives/state-innovation-waivers/downloads/1332-ga-suspension-letter-of-ga-access-model-for-py-2023.pdf.
30 Phil Galewitz and Andy Miller, "Skirmish Between Biden and Red States Over Medicaid Leaves Enrollees in the Balance," *KFF Health News*, Feb. 10, 2022, at https://kffhealthnews.org/news/article/skirmish-between-biden-and-red-states-over-medicaid-leaves-enrollees-in-the-balance/.
31 Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12834, 12840-42 (Feb. 25, 2013) (establishing state flexibility to choose EHB from a selection of benchmark plans); and Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019, 83 Fed. Reg. 16930, 17008-21 (Apr. 17, 2018) (giving states more options to select an EHB benchmark plan).

currently included in the state's EHB.[32]

- **Short term, limited duration insurance (STLDI):** The Obama administration reduced the term for STLDI — a largely unregulated, less costly alternative to individual market policies — from less than 12 months to less than three months.[33] They viewed this as an important protection against healthier people leaving the individual market risk pool and opting for what they have deemed "junk" insurance plans. The Trump administration viewed this as an abandonment of a 20-plus year policy on the definition of STLDI that undermined access to affordable coverage and quickly reversed the policy.[34] Just recently, the Biden administration finalized new regulations to enforce similar limits as Obama required.[35]

Regulatory instability inevitable

Given the recent shifts in federal electoral outcomes, the level of policy discretion the ACA gives federal regulators made this seesawing regulatory environment inevitable. That's because this discretion involves areas of fundamental disagreement between the left and the right over the role of government and markets in health care. To what extent can the government intervene in health care markets to promote public purposes without severe unintended consequences? To what extent can health care markets deliver the benefits of competition without undermining consumer protections? What priority should policymakers give to solving problems over access versus cost versus quality?

The ACA gives federal regulators wide discretion on policies tied closely to these fundamental questions. This includes discretion over adding entirely new certifications requirements for qualified health plans (QHPs) to be sold on Exchanges, deferring regulation to states, scaling the flexibility and rigor for several major requirements, and waiving certain requirements entirely. When regulatory changes touch on such fundamental questions, they naturally and inevitably trigger a strong response. So, it is no surprise that each change in presidential leadership has led to major policy shifts and reversals. This result is baked into the structure of the law.

Section II: 1333 Compact Statutory Framework

If regulatory instability is baked into the law, then there is no reason to think it will change without a change in federal law. Generally, this would require Congress to enact new, more detailed laws that limit regulatory flexibility. However, the ACA itself includes a framework to shift a substantial portion of regulatory authority back to the states. Section 1333 of the ACA approves a framework for states to create a Health Care Choice Compact, which gives states substantial flexibility to enact an "alternative" to the ACA.[36] As a congressionally approved compact, a 1333 compact can, in effect, change federal law and shift certain authority from the federal government to states.

> **The ACA itself includes a framework to shift a substantial portion of regulatory authority back to the states.**

Under section 1333 of the ACA, the federal government may approve a compact under which two or more states agree to allow individual market health insurance to be sold across all participating states and, with certain exceptions, "only be subject to laws and regulations of" one participating state.[37] The exceptions to this general choice of law agreement would still subject insurers to certain laws and regulations from the state where the consumer lives. Because the terms of this

32 Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program, 89 Fed. Reg. 26218, 26264-69 and 26342-49 (June 4, 2024).
33 Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance, 81 Fed. Reg. 75316 (Oct. 31, 2016).
34 Short-Term, Limited-Duration Insurance, 83 Fed. Reg. 38212 (Aug. 3, 2018).
35 Short-Term, Limited-Duration Insurance and Independent, Noncoordinated Excepted Benefits Coverage, 89 Fed. Reg. 23338 (Apr. 3, 2024).
36 42 U.S. Code § 18053. The ACA includes Health Care Choice Compacts under Part IV of Subtitle D of Title as one of the opportunities for "State flexibility to establish alternative programs."
37 42 U.S. Code § 18053(a)(1)(A).

compact specifically apply *only* to state laws and regulations, an approved compact removes the federal regulatory role over the laws and regulations covered by the compact. The federal government, however, retains substantial discretion over whether to approve a compact and may only approve a compact that meets certain statutory guardrails. As such, while a compact can amend the requirements of federal law, any amendment must still achieve the same coverage goals as the ACA would absent the compact.

The Health Care Choice Compact

Specifically, section 1333(a)(1)(A) authorizes the Secretary of Health and Human Services to approve agreements between two or more states under which "1 or more qualified health plans could be offered in the individual markets in all such States but, except as provided in subparagraph (B), only be subject to the laws and regulations of the State in which the plan was written or issued."[38] This statutory language effectively permits states to waive all federal laws and regulations related to the sale of QHPs in the individual market under a compact. The use of the term "only" plainly allows a plan to be subject to the laws and regulations of just one state except for the laws itemized in subparagraph (B) from the state where the purchaser resides. Therefore, subject to the minimum standards set forth in section 1333's guardrails, federal laws and regulations would not apply.

Exceptions ensure certain requirements remain with the state where the purchaser lives

There are limits to just how much a 1333 compact can streamline regulation under the rules of just one state. Section 1333 recognizes the potential harm in states giving up too much regulatory responsibility and, therefore, includes exceptions to the general flexibility for a compact to allow only one state's laws and regulations to regulate a health plan sold in a different state.

One criticism of the ACA centers on how federalizing insurance regulation weakens the responsiveness of state regulators to the consumers they serve. State insurance regulators are closer to consumers than federal regulators and can therefore be more responsive to consumer issues and complaints. This is true because state regulators are both closer in geography and political accountability. A 1333 compact that shifts too much regulatory authority to a different state through a compact could similarly weaken the responsiveness of regulators to consumers.

State insurance regulators are closer to consumers than federal regulators and can therefore be more responsive to consumer issues and complaints.

To strike the right balance between streamlining insurance regulations and maintaining strong consumer protections, section 1333(a)(1)(B) includes exceptions that keep each participating state directly responsible for certain requirements that benefit from the more localized expertise of the state where the purchaser lives. Under these exceptions, a 1333 compact must require a health plan to meet three additional requirements:

- The health plan must be subject to the "market conduct, unfair trade practices, network adequacy, and consumer protection standards (including standards relating to rating), including addressing disputes as to the performance of the contract, of the State in which the purchaser resides;"
- The health plan must be licensed in each state in which it offers a plan; and
- The health plan must notify consumers that the policy they sell may not be subject to all of the laws and regulations in the state where the consumer resides.

Together, these exceptions ensure that consumers retain robust protections from the state regulators who are the closest and most directly accountable to them through the

38 Id.

democratic political process. The specific areas of oversight that remain with the state where the consumer lives all require more intimate knowledge of what is happening within the state, including knowledge of regional health care pricing trends, local provider markets, and individual consumer experiences.

In addition to these exceptions, Section 1333(a)(2) also requires that each state enact a law that specifically authorizes the state to enter into a 1333 compact. This ensures the adoption of a compact receives the same level of local oversight and democratic accountability provided by each state's legislative process.

Federal approval and statutory guardrails

As previously noted, the Compact Clause requires Congress to approve an interstate compact when it encroaches on federal sovereignty and power. Congress provided this approval for Health Care Choice Compacts by enacting the framework for states to adopt such a compact under section 1333 of the ACA. The authority for Congress to approve a compact *in advance* in this manner is discussed in the legal background on compacts later.

The congressionally approved 1333 compact framework gives the Secretary of the Department of Health and Human Services (HHS) substantial discretion over whether to ultimately approve or reject a compact. The law specifically provides that "[t]he Secretary *may* approve interstate health care choice compacts …."[39] However, under section 1333(a)(3), the Secretary may only approve a compact if the Secretary determines that it will meet the following five conditions, often referred to as guardrails.

- The compact will provide coverage that is at least as comprehensive as the essential health benefit coverage required by the ACA and offered through the Exchanges established under the ACA;
- will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of the ACA would provide;
- will provide coverage to at least a comparable number of its residents as the provisions of the ACA would provide;
- will not increase the Federal deficit; and
- will not weaken enforcement of state laws and regulations kept in place by the exceptions required under section 1333(a)(1)(B).

Together, these guardrails work to ensure that any alternative path that states follow will lead to a similar destination as the ACA without the compact. Here, Congress makes clear that states cannot abandon the ACA under a compact. In short, to be approved, a compact must provide coverage that is at least as comprehensive and affordable to a comparable number of people as the ACA would provide.

Section 1333 guardrails mirror section 1332

The 1333 compact guardrails largely mirror the guardrails that must be met for the Secretary to approve state innovation waivers under section 1332 of the ACA. Section 1332 offers another opportunity for states to establish an alternative to the ACA by waiving a limited portion of the ACA's health coverage requirements. Because 1332 waivers and 1333 compacts both allow states to establish an alternative set of regulations, they both include a set of guardrails to ensure the alternative regulatory approach achieves similar coverage goals as the ACA would meet without the waiver or compact.

There are only two differences between the section 1332 and 1333 guardrails. First, the comprehensiveness guardrail for a 1332 waiver requires a certification from the CMS Office of the Actuary. Second, section 1333 adds a guardrail that requires a compact to not weaken the enforcement of the insurance requirements that must remain with the state where the purchaser resides. Aside from these two differences, the 1332 waiver and 1333 compact guardrails are exactly the same.

39 42 U.S. Code § 18053(a)(3) (emphasis added).

The contours of 1333 compact guardrails

While 1333 compacts have been largely ignored, there has been substantial interest and activity around implementing 1332 waivers. As such, there's already a body of work interpreting and applying the 1332 waiver guardrails from federal rulemaking and processing of waiver applications. Because the 1332 and 1333 guardrails are nearly identical, this work largely defines the contours of the guardrails for 1333 compacts.

Together, these guardrails work to ensure that any alternative path that states follow will lead to a similar destination as the ACA without the compact.

As previously discussed, the application of the 1332 waiver guardrails has seesawed from less flexible under the Obama administration to more flexible under Trump and back to less flexible under Biden. In December 2015, CMS issued guidance on how the Obama administration planned to apply the section 1332 guardrails.[40] At the time, two writers for *Health Affairs Forefront* characterized the guidance as a "stricter-than-expected interpretation" and outlined how it "considerably limits [State] flexibility."[41] For many people, this more limiting interpretation failed to deliver the flexibility Congress intended.[42] The Trump administration issued updated guidance in October 2018, which replaced the 2015 guidance to give states significantly more flexibility.[43] The main elements of this 2018 guidance were later codified in federal regulation through the more formal rulemaking process.[44] After these rules were finalized, the Biden administration quickly moved to repeal and replace them with new rules that largely follow the Obama administration's guidance.

The way the Obama and Biden interpretations of the 1332 waiver guardrails differ from the Trump administration centers on the use of the word "provide" in the first three guardrails on affordability, comprehensiveness, and coverage numbers. To meet these guardrails, the Secretary must determine that the state innovation waiver or compact "will provide coverage" that is 1) "at least as comprehensive" and 2) "at least as affordable" to 3) "at least a comparable number of [state] residents" as the ACA would provide. The Obama and Biden administrations have applied these three guardrails to 1332 waivers using an *accounting* standard where "provide" means "projected to provide."[45] This means the 1332 waiver must be projected to cover the same number of people with coverage that meets the same level of affordability and comprehensiveness as the ACA requires.

In contrast, the Trump administration applied an *access* standard where "provide" means "to supply or make available" in line with the Merriam-Webster dictionary definition of provide.[46] This standard requires a 1332 waiver to provide access to "coverage that is as comprehensive and affordable as would occur without a waiver," but does "not require that people actually purchase and enroll in this

40 Waivers for State Innovation, 80 Fed. Reg. 78131 (Dec. 16, 2015).
41 Heather Howard and Dan Meuse, "New Section 1332 Guidance A Mixed Bag For States," *Health Affairs Forefront*, Feb. 29, 2016, at https://www.healthaffairs.org/do/10.1377/hblog20160229.053456/full/.
42 *See e.g.*, Rea S. Hederman Jr. and Dennis G. Smith, *Returning Health Care Power to the States: The Affordable Care Act's Section 1332 Waiver for State Innovation*, (The Buckeye Institute Policy Brief, Sept. 21, 2016), available at https://www.buckeyeinstitute.org/library/doclib/1332.pdf (arguing the "[Obama] administration's guidance conflicts in part with the ACA, complicates waiver approval, and imposes arbitrary restrictions on states.).
43 State Relief and Empowerment Waivers, 83 Fed. Reg. 53575 (Oct. 24, 2018), available at https://www.federalregister.gov/documents/2018/10/24/2018-23182/state-relief-and-empowerment-waivers.
44 Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022; Updates to State Innovation Waiver (Section 1332 Waiver) Implementing Regulations, 86 Fed. Reg. 6138 (Jan. 19, 2021), available at https://www.federalregister.gov/documents/2021/01/19/2021-01175/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2022.
45 Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond, 86 Fed. Reg. 53412, at 53463 (Sept. 27, 2021), available at https://www.federalregister.gov/documents/2021/09/27/2021-20509/patient-protection-and-affordable-care-act-updating-payment-parameters-section-1332-waiver.
46 Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022; Updates to State Innovation Waiver (Section 1332 Waiver) Implementing Regulations, 86 Fed. Reg. 6138, 6162 (Jan. 19, 2021).

coverage".[47] This ensures that people retain access to the same type of coverage available under the ACA's requirements even if the waiver provides access to other coverage options "at different price points and benefit levels."[48] However, this rule does not apply the access standard in the same way to the coverage guardrail even though it relies on the same use of the word "provide" in the statute. While people would be allowed more coverage options, the rule made the policy choice to still require a waiver to actually cover a comparable number of residents. This policy protected against a waiver that might increase the uninsured rate.

This history of applying 1332 waiver guardrails helps predict how a future administration will enforce the nearly identical 1333 compact guardrails. States can expect a Democrat-led administration to continue to apply a similar accounting standard to the section 1333 affordability, comprehensiveness, and coverage guardrails. A Republican-led administration would likely apply the same access standard. However, to align more closely with the statutory text and give states more flexibility, a Republican administration might consider applying the access standard to the coverage guardrail as well. However, it's unlikely any state would want to pursue a waiver that forecasted a drop in the number of covered people and an offsetting increase in the number of uninsured.

There are important differences between a 1332 waiver and a 1333 compact which demonstrate how Congress intended to give states far more flexibility and permanence under a 1333 compact.

Because the deficit neutrality guardrail was applied largely the same way across all three administrations for 1332 waivers, any future administration would likely apply this guardrail in a similar way to a 1333 compact.

Section 1333's additional guardrail against weakening state enforcement of certain requirements could lead to some variations on how a Democrat versus Republican administration might apply it. However, any difference will not likely be as large as the affordability, comprehensiveness, and coverage guardrails. So long as each state continues to enforce the laws covered by this guardrail, then the guardrail will likely be considered met. However, a question may arise over whether a state can outsource enforcement under a compact to achieve a more comprehensive approach to streamlining insurance regulations across participating states.

Differences between 1332 waivers and 1333 compacts

The way the guardrails are mirrored between sections 1332 and 1333 in the ACA reflects how Congress intended them to operate similarly, giving states flexibility to create alternative approaches under the ACA. However, there are important differences between a 1332 waiver and a 1333 compact which demonstrate how Congress intended to give states far more flexibility and permanence under a 1333 compact. Here are the main ways a 1333 compact differs from a 1332 waiver in the statute.

- **Broader state regulatory authority.** The fundamental purpose of an interstate compact, which needs federal approval, is to change or limit how federal law applies in the states participating in the compact. As discussed in more detail later, the U.S. Constitution requires Congress to approve interstate compacts only when a compact encroaches on federal sovereignty. Therefore, it follows that Congress intended to allow states to take back a large measure of their long-held jurisdiction over health insurance regulation under a 1333 compact. Section 1333 does not itemize specific federal laws that can be waived like section 1332 does. This effectively permits the federal government to approve a compact,

47 Id.
48 Id.

subject to the guardrails, that shifts far more regulatory authority back to the states than a 1332 waiver can.

- **No specific application procedures.** Section 1333 does not include any specific application procedures that a state must follow to get a compact approved. As a result, there is no specific requirement for a state or the federal government to engage in a process for public notice and comment. There's also no requirement for a state to provide specific plans to ensure the compact complies with the guardrails or a process of periodic evaluation by the federal government.

  While there is no specific application procedure outlined in the statute, states should expect HHS to use their discretion to impose some similar application procedures. As noted previously, HHS has not adopted regulations to implement section 1333, despite a statutory requirement to issue regulations by July 1, 2013. Regulations will need to be issued before HHS can approve a compact.

- **No periodic evaluation reports.** Section 1333 also does not require states to submit periodic implementation and evaluation reports to the federal government. Section 1332 includes this requirement because a waiver operates as an ongoing agreement between the federal government and the states that requires renewal. Therefore, a 1332 waiver includes stated terms and conditions which operate as a contract between the federal government and the states. In contrast, a 1333 compact operates primarily as a contract between states. The federal government retains the responsibility for approving the compact, but the federal government is not necessarily a party to the contract. The federal government may participate in the compact — several interstate compacts do include direct federal participation — but this participation is not necessary. Therefore, section 1333 does not specifically give the federal government the same ongoing oversight responsibility.

- **No limit to the term.** Section 1332 limits the term of a waiver from extending over a period longer than five years unless a state requests a continuation. This gives HHS an opportunity to review the waiver and the discretion to deny it after five years. Section 1333 does not limit the term period of a compact or give the Secretary the authority to deny the continuation of a compact. Therefore, a 1333 compact provides an opportunity for a more permanent transfer of regulatory authority to states. This permanence follows from the nature of a state compact. As discussed in more detail later, congressional consent transforms a compact into a federal law which then requires an act of Congress to modify or withdraw it.

- **No specific requirement to provide pass-through funding.** Section 1332 requires the federal government to provide states with pass-through funding to fund any reduction in federal premium tax credit or cost sharing subsidy that would have been paid to state residents absent the waiver. Just as section 1333 does not specify what can be waived, it does not specify how to account for impacts on federal funding, except that a compact cannot increase the federal deficit.

Section III: Historical Context

To more fully understand why Congress approved 1333 compacts in the ACA, how a compact works and the potential benefits of such compacts, it's helpful to review some historical context. States have historically been the primary regulators of insurance and federal law continues to keep states in a lead role. In the years leading up to the passage of the ACA, several states had been studying opportunities to streamline health insurance regulation and improve state health insurance markets through state compacts. At the time, policies to permit people to buy insurance across state lines also featured prominently in Republican health care platforms.

Expanding federal regulatory role

Historically, health insurance has mainly been regulated at the state level. Prior to 1944, health insurance was exclusively regulated at the state level because insurance was not considered commerce. However, in *United States v.*

South-Eastern Underwriters Ass'n, the U.S. Supreme Court held insurance is in fact commerce which gave Congress the power to regulate it under the Commerce Clause of the U.S. Constitution.[49] To alleviate concerns that this holding removes states' authority to regulate insurance, Congress quickly passed the McCarran-Ferguson Act to expressly permit states to continue regulating insurance.[50] This largely kept the status quo in place for decades.

In the years leading up to the passage of the ACA, several states had been studying opportunities to streamline health insurance regulation and improve state health insurance markets through state compacts.

Beginning with the Employee Retirement Income Security Act of 1974 (ERISA), the passage of major federal legislation over the past 50 years has shifted significant aspects of health insurance regulation to the federal level. ERISA preempts states from regulating most private sector employer health plans but keeps states responsible for regulating the business of insurance, including group health insurance that employers purchase. Congress then passed major health care legislation in the mid-1980s to give people certain rights to keep employer coverage after they leave their job and to ensure access to emergency services regardless of an individual's ability to pay.[51] Nothing in these laws altered the states' primacy over the regulation of health insurance.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) represents the first major federal action to adopt national health insurance standards. HIPAA restricted group health insurers from discriminating against people based on health status and set national standards for the portability and renewability of health insurance in the group and individual markets.[52] Shortly after HIPAA passed, Congress enacted additional health insurance requirements related to mental health services,[53] hospital maternity care,[54] and mastectomies.[55] These new federal health insurance requirements still relied largely on state laws and regulations for enforcement. HIPAA permitted each state to enforce the law's health insurance provisions and only resorted to federal enforcement in cases where "a State has failed to substantially enforce" them.[56] After completing a review of state enforcement in 2001, the federal government found that Missouri was the only state to have not passed legislation in conformance with HIPAA.[57] In addition, only four states had yet to conform with hospital maternity care or mastectomy requirements.[58]

The passage of the ACA in 2010 introduced the next and most substantial shift of health insurance regulatory authority from states to the federal government. While HIPAA added several national health insurance requirements, state standards — especially in the individual market — remained the foundation for health insurance regulation. In contrast, the ACA enacted a comprehensive set of national health insurance standards that are broad enough to largely govern the individual and small group markets without state standards. Despite the breadth of the ACA, the law carried forward the same HIPAA policies that rely on state enforcement. The ACA also expected states to take responsibility for establishing Exchanges.

49 United States v. South-Eastern Underwriters Assn., 322 US 533 (1944).
50 McCarran-Ferguson Act, Pub. L 79-15, ch. 20, 59 Stat. 33 (1945).
51 Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99-272, 100 Stat. 82 (1986); and Emergency Medical Treatment and Active Labor Act, Pub. L. 99-272, § 9121, 100 Stat. 164 (1986).
52 Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936 (1996).
53 Mental Health Parity Act of 1996, Pub. L. 104-204, §§ 701-703, 110 Stat. 2944 (1996).
54 Newborns' and Mothers' Health Protection Act of 1996, Pub. L. 104-204, §§ 601-606, 100 Stat. 2935 (1996).
55 Women's Health and Cancer Rights Act of 1998, Pub. L. 105-277, §§ 901-903, 12 Stat. 2681-436 (1998).
56 Health Insurance Portability and Accountability Act of 1996, Pub. Law 104-191, § 102 (1996).
57 Memo to the Honorable James M. Jeffords, "Private Health Insurance: Federal Role in Enforcing New Standards Continues to Evolve," U.S. Government Accountability Office, May 7, 2001, available at https://www.gao.gov/products/gao-01-652r.
58 Id.

Some people may conclude that expecting this level of cooperation from states reveals a remarkable level of hubris from Congress. After all, why would states acquiesce in simply carrying out federal requirements that they did not themselves see fit to enact? That may be true to a degree, but this reliance on states clearly flows from the deference Congress has given to state health insurance regulators since the passage of the McCarran-Ferguson Act. The experience with implementing HIPAA showed Congress how a federal partnership with states can set national standards while still letting states retain substantial control and flexibility.

The ACA's ongoing deference and reliance on states shows how federal law continues to view states as trusted partners and often better situated to develop, implement and enforce health insurance policies than the federal government. Within this context, it makes sense how Congress decided to give states substantial flexibility to adopt alternative programs within the guardrails that govern the approval of 1332 waivers and 1333 compacts under the ACA.

Federal proposals to authorize insurance sales

Leading up to the passage of the ACA, most leading Republican platforms featured policies permitting the sale of insurance across state lines. Rep. John Shadegg and Sen. Jim DeMint introduced identical bills to allow this in May 2005.[59] President George W. Bush featured it in a comprehensive health care agenda published in concert with his 2006 State of the Union address.[60] Sen. John McCain featured it in his 2008 presidential bid.[61] These proposals aimed to create a national health insurance marketplace that allowed people to shop for insurance sold in other states and subject to the other states' regulations. According to Sen. McCain: "Opening up the health insurance market to more vigorous nationwide competition, as we have done over the last decade in banking, would provide more choices of innovative products less burdened by the worst excesses of state-based regulation."[62] These federal proposals worked by preempting state insurance laws in the state where the insurance was sold.

The ACA's ongoing deference and reliance on states shows how federal law continues to view states as trusted partners and often better situated to develop, implement and enforce health insurance policies than the federal government.

Critics of these federal proposals argued it would result in a race to the bottom and lead to insurance with only the most minimal consumer protections.[63] In addition, critics argued the cost differences between states largely reflected local provider costs and utilization rates, not the differences in each state's regulatory environment. These critics downplayed the accumulation of costly benefit mandates and often ignored the complete lack of choice in several states. However, they correctly noted how buying insurance across state lines would not let you buy into another state's lower cost risk pool. Insurers would still account for local factors in setting premiums. They also correctly noted how, even if allowed, health insurers would not necessarily offer insurance across state lines. Insurers would still need to set up provider

59 Health Care Choice Act of 2005, H.R. 2355, 109th Cong. (2005); and Health Care Choice Act of 2005, S.1015, 109th Cong. (2005). *See also* Congressional Budget Office Cost Estimate, H.R. 2355 Health Care Choice Act of 2005, Sept. 12, 2005, available at https://www.cbo.gov/publication/17145.
60 National Economic Council, *Reforming Health Care for the 21st Century* (February 2006), available at https://georgewbush-whitehouse.archives.gov/stateofheunion/2006/healthcare/; and Press Release, The White House, Office of the Press Secretary, "State of the Union: Affordable and Accessible Health Care," Jan. 31, 2006, available at https://georgewbush-whitehouse.archives.gov/news/releases/2006/01/20060131-7.html.
61 John McCain, "Better Care at Lower Cost for Every American," *Contingencies* (Sept/Oct 2008),available at https://web.archive.org/web/20081009182650/https://contingencies.org/septoct08/mccain.pdf.
62 Id.
63 Linda J. Blumberg and John Holahan, *An Analysis of the McCain Health Care Proposal* (The Urban Institute Health Policy Center 2008), available at https://www.urban.org/sites/default/files/publication/32011/411755-an-analysis-of-the-mccain-health-care-proposal.pdf (arguing that, under the McCain proposal to allow the sale of insurance across state lines, "[s]tate regulatory environments would become a race to the bottom, since no insurer would be able to compete by pooling risk broadly if those whose health care risk was better than the average in their state pool could get a better deal elsewhere.").

networks, which tends to be the largest obstacle to entering a new health insurance market.

State compact approaches to interstate sales

In the mid-2000s, several states were considering a different strategy to allow the sale of insurance across state lines through a state compact approach. While proposals to amend federal law aimed to create a national insurance market by preempting state insurance laws, a state compact did not necessarily need any federal involvement. States have always been able to create a compact on their own so long as the compact does not encroach on federal sovereignty.

The idea of a state compact enjoys broader bipartisan interest because it aims to address a problem that several left- and right-leaning states share. States like Rhode Island and Wyoming have always struggled to attract insurers because of their small populations. A state compact offers these smaller states an opportunity to increase the size of the insurance market to attract more insurance choice and competition for their residents. This represents a different focus from federal proposals which gave more emphasis on giving people opportunities to buy lower cost coverage in states with a lower regulatory burden.

The compact approach also enjoys bipartisan interest because it allows purchasing insurance across state lines through state cooperation, not a federal mandate. States interested in a compact tend to look for state partners with similar regulatory environments. Rhode Island enacted a law in 2008 to study developing a compact with other New England states.[64] Wyoming passed a law just days before the ACA passed in March 2010 which authorized the commissioner to explore reciprocity for the approval of health insurance with "like-minded states."[65] In 2012, Kentucky passed a similar law to explore establishing a compact with "contiguous states."[66] Most recently, Oklahoma gave its insurance commissioner more open-ended authority to negotiate compacts with other states to allow insurers domiciled in the compacting state to sell health insurance policies in Oklahoma.[67] While this law did not direct the Oklahoma insurance commissioner to negotiate with any particular type of state, any state willing to negotiate would need to be like-minded.

Similar to a compact, Wyoming,[68] Georgia,[69] and Maine[70] also all passed laws authorizing the sale of health insurance approved in other states. This, in effect, allows the sale of insurance across state lines without a compact between states. Wyoming limits approval to states "with insurance laws sufficiently consistent with Wyoming laws" and Maine limits approval to other New England states. Like the Oklahoma compact, the Georgia authorization is open to any state, but limited to the discretion of the Georgia insurance commissioner.

The idea of a state compact enjoys broader bipartisan interest because it aims to address a problem that several left- and right-leaning states share.

This cooperative approach allows states to streamline regulations in a way that allows the purchase of insurance across state lines without creating any serious conflicts or forcing big changes to their current regulatory environment. In addition, because states look to partner with similar states, a state compact approach largely avoids concerns over a

64 An Act Relating to Insurance – Health Insurance Market Expansion, ch. 99, 2008 R.I. Pub. Laws., available at https://webserver.rilegislature.gov/PublicLaws/law08/law08099.htm.
65 Health Insurance-Interstate Purchase, ch. 86, 2010 Wyo. Sess. Laws 384, available at https://wyoleg.gov/2010/Session%20Laws.pdf.
66 Act of April 12, 2012, ch. 144, § 10, 2012 Ky. Acts 1089, 1255, available at https://apps.legislature.ky.gov/law/acts/12RS/actsmas.pdf.
67 Health Care Choice Act, ch. 362, § 3, 2017 Okla. Sess. Laws, available at https://www.sos.ok.gov/documents/legislation/56th/2017/1R/SB/478.pdf.
68 Health Insurance-Interstate Purchase, ch. 86, 2010 Wyo. Sess. Laws 384, available at https://wyoleg.gov/2010/Session%20Laws.pdf.
69 Act of 2011 Ga. Laws 249, §1.
70 An Act To Modify Rating Practices for Individual and Small Group Health Plans and To Encourage Value-based Purchasing of Health Care Services, ch. 90, 2011 Me. Laws 114, 124, available at https://legislature.maine.gov/ros/LOM/LOM125th/125R1/LOM125R1Vol1.pdf.

"race to the bottom." While a state may still have concerns about giving up some authority, each participating state retains ultimate control over its insurance market. States participating in the compact need to agree to the insurance regulations that apply to their residents and would be free to leave the compact.

Interstate Insurance Product Regulation Compact

At the same time several states were investigating state compacts for health insurance in the mid-2000s, a large portion of the country was in the process of implementing the Interstate Insurance Product Regulation Compact. This compact created the Interstate Insurance Product Regulation Commission (the Commission) which now serves as a multi-state public entity that "promotes uniformity through application of uniform product standards embedded with strong consumer protections."[71] The compact covers four insurance product lines — life, annuity, long-term care, and disability income — and focuses on improving "the efficiency and effectiveness of the way insurance products are filed, reviewed, and approved."[72] The Commission's inaugural meeting was in June 2006, and by 2009, 36 states had enacted laws to join the compact.[73]

Minnesota helped lead the launch of the Commission as one of three states elected to the permanent Management Committee established at the Commission's first annual meeting. After a positive experience with this compact, Minnesota Gov. Tim Pawlenty proposed to establish an Interstate Health Insurance Compact "modeled after the successful Interstate Insurance Product Regulation Compact."[74] The proposed compact "would allow states to join and share common regulatory standards to facilitate the purchase of health insurance across state lines."[75] Notably, Pawlenty offered this proposal in October 2009 at the same time Congress was updating draft legislative text to approve 1333 compacts.

ACA opted for the state compact approach

Initial drafts of the ACA emerged in 2009 with some conservative input from the Senate Finance Committee's bipartisan "Gang of Six."[76] Sen. Chuck Grassley — a Republican member of the Gang of Six — regularly expressed support for allowing consumers to buy insurance across state lines.[77] In September 2009, Sen. Max Baucus — a Democrat member of the Gang of Six who chaired the Senate Finance Committee — introduced the committee's health reform framework which included "'health care choice compacts' to allow for the purchase of non-group health insurance across state lines."[78] This proposal evolved and eventually became law under section 1333 of the ACA.

This historical context demonstrates how section 1333 fits squarely within the health policy discussions happening at the time the law passed. By approving 1333 compacts, Congress put in place a bipartisan policy to expand insurance markets and streamline insurance regulations

71 Interstate Insurance Product Regulation Commission (Compact), "About," at https://www.insurancecompact.org/about (accessed on June 6, 2024).
72 Id.
73 Interstate Insurance Product Regulation Commission (Compact), "Compact History," at https://www.insurancecompact.org/compact-history (accessed on June 6, 2024)
74 Press Release, Office of the Governor, Tim Pawlenty, "Governor Pawlenty Outlines Health Care Reform Initiatives," Oct. 13, 2009, available at https://www.leg.mn.gov/docs/2010/other/101583/www.governor.state.mn.us/mediacenter/pressreleases/2009/PROD009692.html. *See also*, Tim Pawlenty, "Five steps to health reform," *Washington Post*, Feb. 14, 2010.
75 Press Release, Office of the Governor, Tim Pawlenty, "Governor Pawlenty Outlines Health Care Reform Initiatives," Oct. 13, 2009, available at https://www.leg.mn.gov/docs/2010/other/101583/www.governor.state.mn.us/mediacenter/pressreleases/2009/PROD009692.html.
76 National Public Radio, "What The 'Gang Of Six' Wants From Health Care Bill," Sept. 9, 2009, at https://www.npr.org/2009/09/09/112222617/what-the-gang-of-six-wants-from-health-care-bill
77 *See, e.g.*, News Release, "Transcription Of Senator Grassley's Capitol Hill Report," Oct. 29, 2009, available at https://www.grassley.senate.gov/news/news-releases/transcription-senator-grassleys-capitol-hill-report-9.
78 U.S. Senate Committee on Finance, "Proposed Framework for Health Care Reform," Sept. 9, 2009, available at https://www.finance.senate.gov/chairmans-news/proposed-framework-for-health-care-reform. The House also included Health Care Choice Compacts in their health reform bill introduced the following month. However, the House version focused on providing federal funding to facilitate compacts that states could agree to without a federal approval. Affordable Health Care for America Act, H.R. 3962, 111th Cong. § 309 (introduced Oct. 29, 2009), available at https://www.congress.gov/bill/111th-congress/house-bill/3962/text/ih#toc-H636E07EA677B48348CB8B0DB5212ADDB.

for people to buy insurance across state lines. Congress recognized the importance of assigning one regulatory regime and entrusted states with the sole regulatory authority. When Gov. Pawlenty proposed the compact approach in 2009, he noted that he would ask Congress to approve the plan.[79] This recognized how a successful state compact would likely need to streamline both state and federal regulations. Congress responded in real time by providing that approval through section 1333 just two months after Pawlenty offered his proposal.

By approving 1333 compacts, Congress put in place a bipartisan policy to expand insurance markets and streamline insurance regulations for people to buy insurance across state lines.

Section IV: Legal Background

Congress enacted section 1333 in accordance with the Compact Clause of the U.S. Constitution. Under the Compact Clause, "No State shall, without the Consent of Congress, … enter into any Agreement or Compact with another State …."[80] Supreme Court Justice Felix Frankfurter and James Landis published a seminal article on compacts in 1925 that federal courts continue to cite for authority.[81] They begin with a discussion of the need for statecraft to address certain disputes among the colonies that frames the legal purpose behind the Compact Clause. Understanding the Compact Clause within the context of this history, they conclude: "The framers thus astutely created a mechanism of legal control over affairs that are projected beyond State lines and yet may not call for, nor be capable of, national treatment. They allowed interstate adjustments but duly safeguarded the national interest."[82]

While the framers may have astutely understood how interstate agreements can negotiate judicious legal accommodations where purely state or purely federal lawmaking falls short, they did not provide any direction on how compacts must be structured. U.S. Supreme Court Justice Powell once colorfully noted how the Constitutional Convention records "are barren of any clue as to the precise contours of the agreements and compacts governed by the Compact Clause."[83] Therefore, later case law establishes the rules that govern how the Compact Clause applies today. The following rules cover key issues related to the implementation and legal force of a 1333 compact.

Compacts operate as contracts between states

U.S. Supreme Court opinions consistently hold "that interstate compacts 'are construed as contracts under the principles of contract law.'"[84] Last year the U.S. Supreme Court provided the latest instruction on how to apply contract law to interstate compacts in a dispute between New York and New Jersey over whether New Jersey could unilaterally withdraw from an interstate compact.[85] In this case, the compact did not expressly address whether New Jersey could unilaterally withdraw. The Court held that New Jersey could unilaterally withdraw and supported this holding primarily by applying the default contract-law rule that either party can terminate a contract when it calls for ongoing and indefinite performance.

Because background contract-law principles apply to interstate compacts, this should be familiar territory for states to operate under when drafting and negotiating a 1333

79 Minnesota Public Radio, "Pawlenty proposes interstate insurance compact," Oct. 21, 2009, at https://www.mprnews.org/story/2009/10/21/pawlenty-insurance-compact.
80 U.S. Const., art. I, § 10, cl. 3.
81 Felix Frankfurter and James M. Landis, "The Compact Clause of the Constitution – A Study in Interstate Adjustments," *Yale Law Journal* (May 1925).
82 Id. at 695.
83 U.S. Steel Corp. v. Multistate Tax Commission, 434 U.S. 453, 461 (1978).
84 New York v. New Jersey, 156 S. Ct. 922 (2023).
85 Id.

compact. Moreover, it gives states substantial flexibility in how a 1333 compact can be structured. However, as a contract, a 1333 compact is binding on participating states. Federal courts will have jurisdiction related to any legal disputes over the performance of the compact.[86] The U.S. Supreme Court has original jurisdiction over disputes between states.[87] As a contract, a state challenging the breach of a compact can seek specific performance as a remedy.[88]

States can delegate their sovereignty under a compact

In *New York v. New Jersey*, the Court noted that principles of State sovereignty also support their holding. Specifically, they explained how courts interpret interstate compacts with the understanding "that a State does not easily cede its sovereignty …."[89] Because "the Compact involves the delegation of a fundamental aspect of a State's sovereign power," the Court concluded this was something "New Jersey did not permanently give up …."[90] This holding offers important instruction on how ambiguities under a Compact should generally be resolved to uphold state sovereignty.

However, a state can still delegate a state's traditional state sovereignty under a compact. As the Court noted in *New York v. New Jersey*, "States can propose language expressly allowing or prohibiting unilateral withdrawal if they wish to do so."[91] State sovereignty only became relevant in that case because the compact was silent on unilateral withdrawal. The Court dealt squarely with the question of state sovereignty in *West Virginia ex rel. Dyer v. Sims*. Here, the Court held that West Virginia could delegate state power to an interstate water sanitation commission created by a state compact.[92] In delegating state sovereignty, a compact operates as one of the few exceptions to the general rule that a state legislature cannot bind a future legislature.[93]

Therefore, states need to be alert to how the terms of a 1333 compact could potentially give up state sovereignty. Here, the main concern will likely focus on a state's ability to amend or withdraw from the compact. Because the main subject matter of a 1333 compact involves regulatory authorities over health insurance that currently rests with the federal government, the state will likely not be giving up much sovereignty in this area. The state, however, will be sharing sovereignty with participating states.

Congressional consent is only needed when a compact encroaches on federal sovereignty

A literal reading of the Compact Clause would require congressional consent to "any" and, therefore, all agreements and compacts between two or more states.[94] However, the U.S. Supreme Court has consistently held that congressional approval is only required for compacts "that would enhance the political power of the member States in a way that encroaches upon the supremacy of the United States."[95] Under this approach, congressional consent is not necessary when the compact only works to increase states' influence. The compact must also not encroach on federal supremacy. Therefore, the Supreme Court has held that a state compact that increased the bargaining power and influence of member states against corporations under their taxing jurisdiction did not require congressional consent.[96]

86 Cuyler v. Adams, 449 US 433, 438 (1981) ("Because congressional consent transforms an interstate compact within this Clause into a law of the United States, we have held that the construction of an interstate agreement sanctioned by Congress under the Compact Clause presents a federal question.").
87 The U.S. Supreme Court granted the motion to file the complaint in New York v. New Jersey, 156, S. Ct. 922 (2023) in its original jurisdiction. U.S. Supreme Court, Orders of the Court - Term Year 2021, June 21, 2022, available at https://www.supremecourt.gov/orders/courtorders/062122zor_0pl1.pdf. *See also* Kentucky v. Indiana, 281 US 163 (1930).
88 Kentucky v. Indiana, 281 US 163 (1930).
89 New York v. New Jersey, 156 S. Ct. 922, at 925 (2023) (quoting *Tarrant Regional Water Dist. v. Herrmann*, 569 US 614, 631 (2013)).
90 Id.
91 Id. at 926.
92 341 U.S. 22 (1951).
93 *See* Jill Elaine Hasdat, Interstate Compacts in a Democratic Society: The Problem of Permanency, *Florida Law Review*, at 2 (January 1997).
94 United States Steel Corp. v. Multistate Tax Comm'n, 434 US 452, 459 (1978).
95 Id. at 472-73 (1978).
96 Id.

Based on this long-held interpretation of the Compact Clause, a 1333 compact clearly authorizes states to take back a measure of power over health insurance regulation from the federal government. Because states can freely compact in ways that do not encroach on federal power, the only reason for Congress to enact section 1333 is to allow states to make a compact which does encroach on federal power. Congress did this in the context of the ACA's substantial expansion of federal power over health insurance regulation. Section 1333 recognizes states' traditional sovereignty in this area and creates an alternative for States to limit this substantial expansion of federal power.

Congress may approve compacts in advance

Congress has substantial discretion over the process for giving consent to state compacts. The most common and straightforward type of congressional consent involves Congress enacting a law that gives express consent to a specific compact after each participating state has agreed to it. Using this process, the authorizing legislation generally includes the full text of the compact and any amendments require further congressional consent.[97] However, Congress may also give consent in advance for a compact before the compact is even drafted or even considered by a state.

In one of the earliest cases interpreting the Compact Clause, Justice Story explained how "the constitution makes no provision respecting the mode or form in which the consent of Congress is to be signified, very properly leaving that matter to the wisdom of that body …."[98] With this discretion, the Supreme Court has concluded that "Congress may consent to an interstate compact by authorizing joint state action *in advance* or by giving expressed or implied approval to an agreement the States have already joined."[99]

Consent in advance operates as a congressional invitation to interstate cooperation.[100] By giving states more clarity on what the federal government will allow, it encourages states to invest the time and resources necessary to establish a compact. As the Congressional Research Service notes,

> **Consent in advance operates as a congressional invitation to interstate cooperation.**

Congress "has given approval in advance to *broad classes* of compacts."[101] For examples, they cite congressional consent in advance for compacts for crime prevention and enforcement,[102] disposal of low-level radioactive waste,[103] and controls for flooding and pollution along waterways.[104]

Congress has taken several different approaches to provide consent in advance. The following list itemizes several examples of how Congress has provided consent in advance.

- **Blanket consent:** Congress has provided blanket consent for states to agree to compacts for specific purposes without specifying the details of the compact. The first example of this type of advanced consent occurred in 1911 when Congress allowed states to enter into compacts to conserve a state's forest and water supply.[105] This compact, however, did impose one significant condition to protect federal authority which restricted the state compact from being "in

97 *See e.g.,* Pub. Law 106-287, 114 Stat. 909 (October 10, 2000) (approving the Kansas and Missouri Metropolitan Culture District Compact); and Pub. Law 85-653, 72 Stat. 609, (August 14, 1958) (approving the Tennessee-Tombigbee Waterway Development Compact).
98 Green v. Biddle, 21 U.S. 1, 85-86 (1823).
99 Cuyler v. Adams, 449 US 433, 441 (1981) (emphasis added).
100 *See* Frederick L. Zimmerman and Mitchell Wendell, *The Interstate Compact Since 1925* (The Council of State Governments 1951), 57-58.
101 Congressional Research Service, *The Constitution of the United States of America: Analysis and Interpretation* (2023), available at https://www.govinfo.gov/collection/constitution-annotated.
102 4 U.S.C. § 112.
103 42 U.S.C. § 2021d(a)(2).
104 33 U.S.C. § 567a.
105 Weeks Act of 1911, Act of Mar. 1, 1911, ch. 186, §1, 36 Stat. 961, incorporated into 16 U.S.C. 552 (giving states consent "to enter into any agreement or compact, not in conflict with any law of the United States, with any other State or States for the purpose of conserving the forests and the water supply of the States entering into such agreement or compact"). *See also*, Frederick L. Zimmerman and Mitchell Wendell, *The Interstate Compact Since 1925* (The Council of State Governments 1951), at 57.

conflict with any law of the United States."[106] In 1934, Congress gave states blanket consent to enter into compacts for the purpose of crime control without any conditions or qualifications.[107]

- **Standards-based consent:** Congress has provided consent in advance for compacts so long as they meet a set of standards that provide further parameters governing the provisions of the compact. For instance, Congress provided consent to tobacco regulation compacts so long as they met the following standards: Each state law in authorizing such compacts must be "essentially uniform and in no way conflicting"; must be "in conformity" with agreements referred to in a law passed by Virginia; must not fix prices, create or perpetuate monopolies, or promote regimentation; and must "enable growers to receive a fair price for such tobacco."[108]
- **Consent subject to Secretarial approval:** Consent in advance has been provided under the condition that the compact receives final approval from a department head in the executive branch. In 1936, Congress provided this type of consent for flood control compacts that required further approval and cooperation from the Secretary of War to take effect.[109]
- **Consent subject to a concurrent resolution veto:** The Federal Civil Defense Act of 1950 provided consent in advance to permit Interstate Civil Defense Compacts to permit mutual aid for civil defense in the event of an attack.[110] Here, Congress provided consent in advance under a framework where consent was deemed granted after 60 calendar days of a continuous session of Congress after it was submitted to Congress, but only if Congress does not disapprove of the compact through a concurrent resolution before the 60 days expires. Unlike a joint resolution, a concurrent resolution is not submitted to the President for approval and so this operates as a mechanism for Congress to retain the sole veto power over the compact.[111]
- **Consent with time for reconsideration:** The Interstate Civil Defense Compact was repealed in 1994 and replaced by a similar Interstate Emergency Preparedness Compacts which permitted mutual aid compacts in the event of a hazard.[112] However, Congress did not retain the power to reject this compact through a concurrent resolution and instead deemed consent to be granted upon the expiration of the 60-day period beginning the day the compact is transmitted to Congress.[113] By establishing a 60-day period between the presentment of the compact to Congress and the approval date, this approach gives Congress time to pass legislation to stop the compact from becoming federal law if they identify any problems.

106 Id.

107 Crime Compact of 1934, Act of June 6, 1934, 48 Stat. 909, incorporated into 4 U.S.C. § 112 by section 129(b) of Act May 24, 1949 ch. 139, § 129(b) (giving states consent "to enter into agreements or compacts for cooperative effort and mutual assistance in the prevention of crime and in the enforcement of their respective criminal laws and policies, and to establish such agencies, joint or otherwise, as they may deem desirable for making effective such agreements and compacts"). The substantial flexibility offered by this level of blanket consent led to multiple state compacts aimed at crime control. For instance, the U.S. Supreme Court held the Interstate Agreement on Detainers, which 48 states agreed to between 1951 and 1981, was a congressionally sanctioned compact under the Crime Control Consent Act of 1934. Cuyler v. Adams, 449 U.S. 433 (1981). Applying this precedent, the 3rd Circuit held the Interstate Compact for Adult Offender Supervision was also a congressionally sanctioned compact. Doe v. Pennsylvania Bd. of Probation and Parole, 513 F. 3d 95 (3rd Cir. 2008). Like the Interstate Compact for Adult Offender Supervision, the text of the Interstate Compact for Juveniles specifically relies on the congressional grant of authority at 4 U.S.C. § 112. *Compare* Minn. Stat. § 243.1605 (2023) *with* Minn. Stat. § 260.515 (2023).

108 Tobacco Control Act of 1936, Act Apr. 25, 1936, ch. 249, 49 Stat 1240. This compact was repealed by Pub. L. 108–357, title VI, §611(c), Oct. 22, 2004, 118 Stat. 1522.

109 Act of June 22, 1936, ch. 688, § 4, 49 Stat. 1571, currently codified at 33 U.S.C § 701d. In 1937, President Franklin D. Roosevelt sent a letter to Rep. William M. Citron explaining why a proposed flood control compact needed further consent from Congress because it violated the requirements of the Flood Control Act of 1936 and encouraged the state legislatures to, instead, approve a compact under Section 4 of the Flood Control Act to allow the Secretary of War to move forward without further congressional consent. Franklin D. Roosevelt, Letter on Interstate Compacts for Controlling Floods on the Merrimack and Connecticut Rivers, Aug. 26, 1937, available at https://www.presidency.ucsb.edu/node/208715.

110 Federal Civil Defense Act of 1950, Pub. L. 920, ch. 1228, § 201(g) (1951).

111 John V. Sullivan, *How Our Laws Are Made* (Office of the Parliamentarian of the U.S. House of Representatives, 2007), available at https://www.congress.gov/help/learn-about-the-legislative-process/how-our-laws-are-made. Note that since Congress established this concurrent resolution veto for state compacts, the U.S. Supreme Court considered the constitutionality of giving either house of Congress the power to veto a decision of the executive branch in *INS v. Chada*, 462 U.S. 919 (1983). The Court held that this congressional resolution veto violated the Constitution's requirements for legislation to be passed by both houses of Congress and presented to the President. While this case did not involve a concurrent resolution that would require bicameral passage, it does call into question the constitutionality of using the concurrent resolution to veto state compacts.

112 National Defense Authorization Act for Fiscal Year 1995, Secs. 3411 (authorizing Emergency Preparedness Compacts) and 3412 (repealing Civil Defense Compacts).

113 42 U.S.C. § 5196(h).

Each of these different approaches to provide consent in advance shows how Congress adapts their consent to the needs of the compact and the level of federal oversight Congress deems appropriate under each circumstance. While the section 1333 approach to consent in advance is somewhat unique, it is consistent with prior compacts where advanced consent was standards-based or subject to secretarial approval.

Congress can impose conditions on consent

When Congress provides consent, Congress may impose conditions. In *James v. Darvo Contracting Co.*, the Supreme Court referenced the Compact Clause as an example where "[i]t can hardly be doubted that in giving consent Congress may impose conditions."[114] For instance, Congress approved a compact to create the Pacific Marine Fisheries Commission on the condition that the commission provide an annual report to Congress.[115] The tobacco regulation compacts previously discussed provide a clear example of Congress providing approval in advance to a compact with conditions.

Under section 1333, Congress set important conditions that govern the approval of a 1333 compact. As outlined previously, a compact must meet five guardrails. In sum, these guardrails require a compact to 1) provide equivalent coverage options as the ACA; 2) not increase the federal deficit; and 3) keep the state where the purchaser resides responsible for enforcing certain requirements. Congressional consent also requires a compact to be approved by the Secretary of HHS. Congress assigned the Secretary as the federal authority for determining whether a compact meets the statutory guardrails.

Congress gave the Secretary broad authority to approve or not approve a 1333 compact at their discretion. By giving the Secretary additional discretion to approve a compact, Congress also granted the Secretary the authority to impose additional conditions so long as they are tailored to support the purposes of the compact.[116]

Approved compacts become federal law

The Supreme Court has regularly affirmed that "the consent of Congress transforms the States' agreement into federal law under the Compact Clause."[117] As federal law, an approved 1333 compact takes on important characteristics.

- Future presidential administrations must faithfully execute the terms of the compact.[118] This creates the opportunity for a stable and enduring transfer of regulatory authority from the federal government to the participating states.
- As a corollary to an administration's faithful execution of the compact, a future administration cannot revoke the approval. As discussed in the next section, Congress is the only federal entity that can repeal or amend an approved compact. This puts 1333 compacts on a much firmer foundation than 1332 waivers.
- A compact supersedes and preempts prior state laws.[119] As previously noted, states need to fully understand the sovereignty they may give up under a compact.
- Any legal controversies will be resolved in federal

114 302 US 134, 148 (1937). In this case, the Supreme Court addressed whether West Virginia can impose conditions on giving the federal government approval to buy land within its borders under Article I, Section 8, Clause 17 of the Constitution. In addition to citing to the Compact Clause, the Court also cited how a State may "'may prescribe the terms and conditions on which it consents to be sued'" and how the Senate may include reservations to its consent to treaties. This case references an earlier case involving the Boulder Canyon Project Act of 1928 which "approved the Colorado River Compact subject to certain limitations and conditions …." Arizona v. California, 292 US 341, 345 (1934).

115 Act of July 24, 1947, Pub. L. 80-232, ch. 316, §2, 61 Stat. 419.

116 As the Supreme Court instructs in *Dravo Contracting Co.*, "[n]ormally, where governmental consent is essential, the consent may be granted upon terms appropriate to the subject and transgressing no constitutional limitation." 302 US 134, 148 (1937). For instance, in exercising the spending power to approve grants, Congress can generally impose conditions on a grantee so long as they are related to the purposes for which the grant is made. South Dakota v. Dole, 483 US 203, 208-09 (1987). Similarly, cities may impose conditions on a property owner before approving a permit, but the conditions must relate to the exercise of its land-use power being exercised. *See* Nollan v. California Coastal Comm'n, 483 US 825, 836-37 (1987) (concluding "unless the permit condition serves the same governmental purpose as the development ban, the building restriction is not a valid regulation of land use but 'an out-and-out plan of extortion.'").

117 Cuyler v. Adams, 449 US 433, 439-440 (1981).

118 U.S. Const., art. II, § 3.

119 Hinderlider v. LaPlata River & Cherry Creek Ditch Company, 304 U.S. 92, 106 (1938) (holding that the apportionment of water rights under a compact "is binding upon the citizens of each State and all water claimants, even where the State had granted the water rights before it entered into the compact.")

court and the Supreme Court will have original jurisdiction over controversies between states.[120]

Congress can always amend or repeal consent

Congressional consent to a compact can nearly always be taken back.[121] As the Supreme Court explains in *Cuyler v. Adams*, by requiring congressional consent and the authority to impose conditions, "the Framers sought to ensure that Congress would maintain ultimate supervisory power over cooperative state action that might otherwise interfere with the full and free exercise of federal authority."[122] Therefore, states should expect that Congress will continue to supervise a 1333 compact. Like any other federal law, the compact will be subject to future congressional action.

Section V: Legal Questions and Issues

Within this constitutional, statutory and contractual legal framework, there are several legal questions that states and the federal government may eventually need to address. Whether these become serious questions will depend on how a 1333 compact proposal seeks to amend the requirements of the ACA. In the future, the answers to these questions should be outlined in federal regulation.

Scope of regulation subject to a compact

A 1333 compact represents the type of compact where Congress gives states advanced consent to enter into a compact that covers a specific field of regulation. There will be questions over the breadth of regulations that a 1333 compact can cover. Section 1333 allows states to enter into agreements where a QHP could be offered in the individual markets in all participating states but "*only* be subject to the laws and regulations of the State in which the plan was written or issued" (emphasis added). This raises a specific question about what it means for a QHP to be subject to the laws and regulations of "only" one state.

QHPs must fully comply with all individual market laws and regulations. In addition, a QHP must comply with another layer of laws and regulations that apply to plans sold on Exchanges. The statutory text does not differentiate between the laws and regulations that apply to only QHPs and those that apply to the entire individual market. For a QHP to be subject to the laws and regulations of "only" one state as section 1333 allows, a compact would need to cover the entire field of laws and regulations related to the individual market. Therefore, section 1333 can be read to provide congressional consent for a compact to cover the entire field of individual market laws and regulations. As such, a compact can cover the sale of QHPs and every other individual market health insurance plan that is subject to the same laws and regulations.

This conclusion fits with the legislative history of the ACA and the historic deference Congress gives to states to regulate health insurance. Moreover, it fits with how Congress drafted other areas of the ACA. Section 1334 of the ACA adopts standards for the sale of multi-state qualified health plans overseen by the Office of Personnel Management (OPM) which specifically reference the continued applicability of "all requirements of State law not inconsistent" with federal requirements on the individual market.[123] If section 1333 intended a compact to maintain consistency with other federal requirements

120 *Supra* notes 88 and 89.

121 When approving a compact, Congress nearly always expressly reserves the right to alter, amend, or repeal its provisions. However, even without an express reservation, the right to approve a contract is generally viewed to also include the right to alter, amend, or repeal the compact at a later date. Emanuel Celler, "Congress, Compacts, and Interstate Authorities," *Law and Contemporary Problems*, at 685 (Autumn 1961) ("Since the compact clause imposes on Congress a constitutional responsibility to safeguard both national interests and the interests of non-compacting states, congressional power cannot be limited to passing on a compact in the first instance, alone. The power must also include ability subsequently to alter, amend, or repeal the consent that has been given."). Boundary compacts may be the one exception to Congress's power to subsequently change a compact. *See* Jill Elaine Hasdat, "Interstate Compacts in a Democratic Society: The Problem of Permanency," *Florida Law Review*, at 16 (January 1997).

122 Id.

123 Patient Protection and Affordable Care Act § 1334, 42 U.S.C § 18054 (2010). The initial drafts of the ACA introduced in both the Senate Finance Committee and the House included "Authority for Nationwide Plans" in the paragraph following the authorization of Health Care Choice Compacts. This allowed health insurers to offer a nationwide plan which was exempt from state benefit mandates. Both the Senate and House versions continued to specifically apply all federal

on the individual market, then Congress would have drafted similar instructions.

An early summary and report from the Urban Institute — a policy organization that tends to advocate for the ACA's centralized federal approach to insurance regulation — asserts health plans would still be subject to federal minimum requirements under a 1333 compact.[124] These statements are not supported by any legal analysis of the statute. However, given this view, if state interest in section 1333 grows, opponents of state flexibility will undoubtedly advance legal arguments for a narrower interpretation of the statute.

However, even under the Urban Institute's more narrow interpretation, a 1333 compact can still transfer substantial regulatory authority to states. When the Urban Institute refers to a "national regulatory floor," they likely mean the health insurance market reforms included in section 1201 of the ACA. This includes the major requirements on insurers to guarantee coverage to everyone and not discriminate against people based on health status. However, most of the major discretionary regulatory changes seesawing from one presidential administration to the next fall outside section 1201. This includes most of the changes states must otherwise work to accommodate each year in the Payment Notice — the annual federal rule that updates standards on health insurance and exchanges.

Authority to include additional, related subject matter in a compact

States may also be interested in controlling other aspects of the health insurance market that have a relationship with individual market plans but are not directly regulated by federal individual market rules. For instance, the federal rules related to short-term limited-duration insurance, association health plans, and excepted benefit plans all impact the individual market. The Obama and Biden administrations specifically justified tightening regulations in these areas due to their impact on individual markets and QHPs.

Can state agreements to allow the sale of individual market health insurance plans across state lines cover the regulation of other health insurance products that relate to and impact these sales? States may conclude that a consistent regulatory approach across these types of insurance products would support the success of a 1333 compact. A compact could certainly incorporate agreements between states in these areas that do not conflict with federal law and regulations. But could states agree to something in these areas that is inconsistent with federal law within the framework of a 1333 compact?

Waiver of federal premium and cost sharing subsidy requirements

Any insurance requirement that states can waive through a 1332 waiver can be waived through a 1333 compact. However, section 1332 also allows states to waive requirements related to premium tax credits, small business tax credits, and cost sharing reductions. Furthermore, the federal government must provide pass-through funding to states to replace any part of a 1332 waiver program that reduces the amount of federal funding people would otherwise be eligible to receive through tax credits or cost sharing reductions.

Can a state reform the ACA's premium and cost sharing subsidy structure or receive pass-through funding under a 1333 compact? The Compact Clause certainly allows Congress to authorize states to reform the ACA's subsidy structure and facilitate pass-through funding under an interstate compact. Section 1333 can be read to provide this consent because the ACA's subsidy structure is an essential part of the ACA's program to provide access to QHPs. State efforts to subject QHPs to the laws and regulations of just one state might involve a whole new set of laws and regulations on how insurers must administer subsidies.

requirements for plans sold on the individual market. The language used in the House is similar to language that became section 1334 of the ACA. The Senate version only allowed QHPs to be sold on the individual market, which helps explain why Section 1333 specifically references QHPs.

124 Linda J. Blumberg, *Does the Patient Protection and Affordable Care Act Permit the Purchase of Health Insurance Across State Lines?* (Urban Institute, August 13, 2010), available at https://www.urban.org/research/publication/does-patient-protection-and-affordable-care-act-permit-purchase-health-insurance-across-state-lines.

There may still be questions on whether a 1333 compact can adjust the amount of premium tax credits available under the tax code. While the tax code primarily governs individual taxpayers and not QHPs, some may argue that a 1333 compact cannot adjust the subsidy amounts because those amounts are part of the tax code and, as such, these amounts regulate individual taxpayers, not insurers. However, these tax credit amounts are still an essential part of how the ACA regulates access to QHPs and the viability of the market for QHPs. The availability of tax credits for QHPs have been referred to as an essential feature of the overall regulatory structure of the individual market.[125] For instance, without such subsidies, healthier low-income people would be more likely to not buy insurance. This could fuel a death spiral in the market where rising premiums push healthy people out of the market and make the market unaffordable to everyone.

Pass-through funding

If a 1333 compact makes any changes to the ACA that would substantially reduce the amount of federal funding currently going to member states, then states will want to negotiate how to get pass-through funding to keep the same level of federal funding. Without pass-through funding, it will be difficult for a 1333 compact to meet the guardrails if it reduces federal funding that currently increases health care access.

HHS should have authority to negotiate pass-through funding under the general authority Congress gave them to approve a compact. Under section 1333, Congress established the framework for a compact but, unlike section 1332, did not set detailed parameters. As such, Congress did not spell out what ACA requirements can be waived under an interstate compact and likewise did not spell out how the federal government would fund an alternative state program. However, by establishing nearly the exact same guardrails as a 1332 waiver requires, Congress certainly envisioned how they might operate similarly. Silence on the exact parameters of a 1333 compact suggests Congress gave advanced consent to HHS to negotiate these parameters, which should include federal payments for pass-through funding.

Note that including pass-through funding in a 1333 compact would require ongoing involvement and oversight from the federal government. As such, this type of compact would likely need to include the federal government as a party to the compact to administer the payment of federal funds to states.

Coordination with 1332 waivers

To the extent a 1333 compact does not cover the full scope of what a 1332 waiver allows, states may want to coordinate a 1332 waiver with their 1333 compact. This might occur if future HHS regulations implementing section 1333 do not copy the same flexibilities available under section 1332 — e.g., the compact cannot restructure premium tax credit subsidies — or states choose a 1333 compact that does not take advantage of specific flexibilities allowed under section 1332. While coordinating a 1332 waiver with a 1333 compact will add complexity, there should be nothing stopping a state from pursuing a coordinated approach. A state may also want to coordinate a 1333 compact with a Medicaid waiver. Note, however, participating states would also be free to agree to negotiate a compact that restricts this type of coordination if there were any concerns that other waivers could negatively impact the success of the compact.

Interstate compact commission

Most interstate compacts that streamline regulations across state lines transfer a certain amount of authority to a commission to administer the compact. Whether or not to establish a commission will be an important issue to address. A compact could be simple enough to not need a commission, but there would likely still be enough ongoing coordinating functions to warrant a commission even for a simpler compact.

There may also be questions over whether states should empower a commission to regulate aspects of insurance across all participating states. Under this arrangement, the compact would set the laws governing insurance for all participating states and the commission would set and enforce the regulations implementing the compact. In this way, plans would only be subject to the laws and regulations of the "State

125 *See e.g.*, Jonathan Gruber, *Health Care Reform Is a "Three-Legged Stool": The Costs of Partially Repealing the Affordable Care Act* (Center for American Progress, August 2010), available at https://www.americanprogress.org/article/health-care-reform-is-a-three-legged-stool/.

in which the plan was written or issued" as section 1333 allows, but each participating state would share the same laws and regulations.

Historically, states have not been willing to give up authority over health insurance. Due to the more localized nature of health insurance and health care delivery, states tend to oppose giving up regulatory authority in this insurance space compared to other types of insurance. But the way the ACA took authority away from states may have fundamentally changed how states view the future of health insurance regulation. Moreover, the section 1333 exceptions that require states to retain certain consumer protection authorities may keep what should be local about health insurance regulation local. Thus, states may be willing to give up the remaining authorities to a commission, especially considering the state would still participate in the commission's policy decisions.

Secretary's discretion to impose additional conditions

In the same way that the Constitution's provision of congressional consent gives Congress the authority to impose conditions, giving HHS discretion to approve a 1333 compact gives them the authority to impose conditions. However, the conditions will need to relate to the subject matter of the compact. There may also be questions over how the Administrative Procedure Act would apply to the approval of a compact and any ongoing oversight of the compact.

Section VI: State Implementation Considerations

States that want to pursue a 1333 compact can choose from several different approaches. As Congress enacted section 1333 to give states the flexibility to create "alternative programs," the most robust 1333 compact could offer a comprehensive alternative to the ACA's regulatory structure. This approach could potentially remove federal regulatory authority over the individual health insurance market. A more modest 1333 compact could keep the ACA's requirements entirely in place but transfer portions of the administration and enforcement of these requirements from the federal government to the states. This would create the opportunity for states to reclaim control over and stabilize the regulations that are now seesawing between presidential administrations. When deciding on a strategy to pursue, states should keep several considerations in mind.

Enacting a law to authorize a compact

Section 1333 requires states to enact a law that specifically authorizes the state to enter into an agreement under section 1333. Section 1332 includes a similar requirement to enact a law for state waivers. In this context, some states started by enacting laws to provide funding to develop 1332 waiver proposals. Other states enacted laws to authorize specific 1332 waivers. Most of these laws authorized states to use section 1332 to establish reinsurance programs. Georgia enacted a law that gave the governor broad discretion to submit and implement a waiver proposal.[126]

As Congress enacted section 1333 to give states the flexibility to create "alternative programs," the most robust 1333 compact could offer a comprehensive alternative to the ACA's regulatory structure.

Following the example of state laws that authorize specific reinsurance waivers, states could enact a compact that adopts a very specific approach. Consistent with this approach, several compacts create agreements between participating states by each state passing identical legislation. However, states can also consider giving their governor or insurance commissioner more general authority to negotiate a compact. Without general authority, Georgia's Governor Brian Kemp would likely not have had the time or flexibility necessary to

126 Patients First Act, 2019 Ga. Laws 106, available at https://www.legis.ga.gov/legislation/54962.

gain federal approval for the state's section 1332 and Medicaid waivers before President Trump's first term ended. However, because compacts create long-term and binding contracts, state legislators should consider retaining final approval of any negotiated compact.

Dividing federal and state authority

A compact could entirely remove the federal government from administering all of the laws and regulations governing the sale of QHPs. This would protect states from any regulatory instability that can occur after a transfer of power to a new presidential administration. However, states may want to leave the federal government responsible for certain aspects of the ACA over which it has particular expertise and experience. For instance, states will likely, at least initially, want to leave the federal government responsible for the risk adjustment program. To achieve the goal of regulatory stability, a simpler minimalist compact only needs to administer the ACA requirements that have substantial discretionary elements.

Dividing state authority

Compacting states will need to distribute the state laws that apply to health insurers between the state where the insurance is written or issued and the state where the insurance consumer lives. The first step in this process will be to ensure the division of authority under the compact complies with the requirements of section 1333 and, in particular, the exceptions that keep certain responsibilities with the state where the consumer lives. States may want to consider keeping more responsibilities with the state where the consumer lives. A compact may be simpler to administer and negotiate if the state where the health plan purchaser resides maximizes control over the requirements it traditionally administers.

Meeting the guardrails

The amount of analysis that the federal government will need to assess whether a compact will meet the guardrails will vary substantially based on the extent to which the compact proposes to modify the ACA's requirements.

By using a minimalist approach to focus on regulatory stability, the 1333 compact should already be structured to fully satisfy the statutory guardrails. By design, this compact will meet the guardrails because it will fully apply the ACA's requirements. The first three guardrails focus on ensuring a compact provides coverage to a comparable number of people that is at least as affordable and comprehensive as under the statute. Because the statute is the standard and not any given administration's application of the statute, a compact that fully enforces the statute should, per se, meet this standard. This means any variations in how the compact applies the statute from how the federal government currently applies it should not impact whether it meets the guardrails. Importantly, this also means compacting states could seek approval without needing to undertake in-depth economic and actuarial analyses.

More robust compacts will need to undertake these analyses. States can expect these analyses to be at least as rigorous as the analyses needed to qualify for a 1332 waiver. However, the longer term, binding nature of a compact may demand even more rigorous analyses to ensure it can reasonably be expected to meet or exceed the coverage goals of the ACA's current framework.

Establishing an interstate health insurance commission

Interstate compacts often create a commission to support the compact. For a more robust compact, a commission can operate as an administrative body with the power to regulate and enforce the requirements of the compact. Under this model, states delegate a certain amount of authority to the commission. For instance, the Ohio River Valley Sanitation Compact established a commission with the authority to issue compliance orders on treating sewage and industrial waste discharges into streams flowing across states.[127]

A commission can also provide services to the compacting states. The Interstate Insurance Product Regulation Commission discussed previously operates this way. Under this compact, the commission "serves as a central point

127 West Virginia ex rel. Dyer v. Sims, 341 US 22, 24-25 (1951).

of electronic filing for certain insurance products" for all the member States. Under this approach, a commission could streamline certain administrative processes, such as the collection of form and rate review submissions. A commission could also, for example, administer a risk adjustment program for all participating states.

States can also consider establishing a third type of commission that operates as a planning and oversight body without any regulatory or service delivery roles. A 1333 compact offers states enormous opportunities to improve health insurance markets and connect people with better, more affordable health care. States may be well positioned to succeed where Congress has failed. A commission assigned to research ways to expand or better administer an existing compact would provide a valuable planning resource and forum to start the interstate negotiation process.

A 1333 compact offers states enormous opportunities to improve health insurance markets and connect people with better, more affordable health care.

Conclusion

No matter how simple, a Section 1333 Health Care Choice Compact will require a significant amount of time and political energy from states. This is especially true for any approach that makes any substantial changes to the current requirements of the ACA. However, even a compact that keeps the ACA's requirements will, by its nature, involve difficult decisions and negotiations on how to distribute state control over insurance regulation. Historically, states have avoided those negotiations. Today, however, every state should have a strong interest in stabilizing the ACA's seesawing federal regulatory environment. A 1333 compact may be the only solution.

As Justice Flexis Frankfurter and James Landis concluded nearly 100 years ago: "The imaginative adaptation of the compact idea should add considerably to resources available to statesmen in the solution of problems presented by the growing interdependence, social and economic, of groups of States forming distinct regions."[128] Considering the difficulty of advancing any meaningful reform in Congress, a 1333 compact creates a real opportunity for states to join together in the imaginative statesmanship necessary to address ongoing problems with the ACA and expand access to better, more affordable health coverage. ■

128 Felix Frankfurter and James M. Landis, "The Compact Clause of the Constitution – A Study in Interstate Adjustments," *Yale Law Journal*, at 729 (May 1925).

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