The Daily Dish

ObamaCare and the States

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Eakinomics: ObamaCare and the States

The Affordable Care Act (ACA, aka ObamaCare) is hardly the center of public debate these days. But forgotten does not mean gone, and it turns out it does not mean unchanging. Recall that ObamaCare was very much a one-size-fits-all, top-down approach to insurance — in effect, a risky policy bet on a particular approach. At the time of its passage, Oregon senator Ron Wyden insisted on the inclusion of a process by which states could apply for a waiver of the ACA requirements (known as a 1332 Waiver) to allow states to offer innovative ways to meet ObamaCare's goals. In particular, the waivers had to satisfy some key requirements:

- States would get the same amount of federal dollars as without the waiver, but not more — it had to be budget neutral for the federal government;
- The plans must provide coverage that is at least as comprehensive;
- The plans must provide coverage that is at least as affordable; and
- The plans must provide coverage to a comparable number of residents.

In practice, the Obama Administration interpreted these directives so tightly — the budget dollars had to be the same every year; the coverage had to be the same not just for the total, but for a variety of target population subgroups; etc. — that the only way to match ObamaCare offerings was effectively ObamaCare offerings. There was little appetite for the 1332 waivers, which prompted lots of discussions of legislative reforms that went nowhere due to partisan gridlock.

As detailed by Tara O'Neill Hayes, this week the Trump Administration issued new regulatory guidance for 1332 waivers to replace the rigid Obama-era interpretation. In particular, it requires no increase in the federal deficit over the 5-year waiver period and

10-year budget window — but not year by year. In addition, CMS may approve a plan that could reduce the number of people covered in one year if the number covered in the long-term is not lower. The administration will also require only some form of coverage, and that coverage may include newly available types of coverage, such as a short-term limited duration plan or an association health plan. Finally, as Hayes explains, "provisions regarding comprehensiveness and affordability will be considered concurrently: Coverage options under the waiver must include plans that are both as comprehensive and affordable as without the waiver (as opposed to allowing a state to offer some plans that are comprehensive but not affordable and vice versa). That said, these requirements may be considered met if such plans are available to a comparable number of people as without the waiver, regardless of the number of people expected to enroll in them; the Trump Administration is referring to this as a new 'access standard.'"

The overall effect is to allow states to do things differently than the federal standard — the original idea behind the waiver process.

Perhaps unsurprisingly, this move has already been advertised by the left as giving the states carte blanche to assault those with pre-existing conditions (and other vulnerable populations). The logic behind this is a bit mystifying because states have just as much money as before, there still have to be available plans that are as comprehensive and affordable as without the waiver (and the only way for that to be possible for those with expensive conditions is large subsidies for comprehensive plans), and states face political pressure too. They will be loath to devote their waiver effort to subsidizing so-called "junk" insurance.

Even with the new guidance, the 1332 process is far from perfect. But that is hardly surprising. The problem is that the ACA itself was deeply flawed, and no regulation implementing it can cure those fundamental ills.