Research

PRIMER: ACA's 1332 State Innovation Waivers

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The Affordable Care Act (ACA) set substantial new federal requirements for health insurance plans and the insurers that provide them. These requirements significantly altered the way insurance is regulated, which was traditionally left to the states. The ACA included in Section 1332 the option for states to apply for a waiver from many of these regulations. The myriad stipulations tied to these 1332 State Innovation Waivers, however, limit states' ability to regain control of their own insurance regulations. Further, states have no guarantee they will be granted a waiver, even if they meet all of the ACA's requirements for obtaining one. The Trump Administration has sought to make these waivers more accessible by adding flexibility to the rules, but it is unclear how many more states will apply because of these changes.

Section 1332 Waiver Allowances

The statute limits which provisions of the ACA may be waived. States may seek waivers from any or all of the following ACA provisions: Parts 1 and 2 of Subtitle D, defining qualified health plans (QHPs) and the essential health benefits (EHBs) which must be covered by such plans, as well as the rules pertaining to the establishment of state health insurance exchanges and the required availability of plans with certain levels of actuarial value (i.e., Gold and Silver plans); reduced cost-sharing requirements for lower-income individuals; and the rules pertaining to the tax treatment of health insurance—providing refundable tax credits, mandating employers provide health insurance coverage to employees, and requiring individuals to maintain health insurance or pay a penalty. These waivers may be used in conjunction with waivers states have for other government health care programs, such as 1115 Medicaid waivers.

In addition to redefining QHPs and EHBs, states would be able to change actuarial value requirements. Accordingly, states may expand the availability of catastrophic coverage and offer financial assistance for anyone purchasing such a plan. States may change the delineating line between large and small employers (as well as the definition of a full-time employee) and the large and small group markets. States may also eliminate the employer and individual mandates altogether and may once again allow businesses to offer health reimbursement arrangements (HRAs) to their employees.

States will be able to receive the total amount of funds that would have otherwise been provided to the individuals and businesses in the state through the ACA's individual and small business tax credits and cost-sharing subsidies in order to carry out its new program. This will require some estimation because the amount states would otherwise receive is based on the premium cost of insurance plans meeting requirements that will be waived and are therefore non-existent. Amounts of the pass-through will be determined each year and estimates of what that amount should be will be based on costs in other states where the requirements have not been waived.

What May NOT Be Waived Under Section 1332

Many of the ACA's most popular provisions are excluded from those which may be waived under this section. Section 1332 does not allow to be waived any of the rules pertaining to premium rate setting, including restrictions on variations based on age, consideration of an individual's health status or the existence of pre-existing conditions. Prohibitions on denial of coverage must remain intact. Preventive services would still be required to be covered without any cost-sharing. The prohibition on annual and lifetime limits would also not be able to be waived, but because these prohibitions only apply to limits on coverage of the EHBs, which may be changed, there could be some impact in this regard.

Section 1332 Waiver Requirements

The ACA outlines a handful of requirements which must be met before a waiver may be approved under Section 1332. The primary requirements relate to the quality, affordability, and availability of coverage which will be provided under the state plan. Coverage must be at least as comprehensive as is required under the ACA's essential health benefits and as affordable in terms of out-of-pocket spending, and must cover as least as many people as would be otherwise under the ACA.

The legislation left much of the logistics of the application process to the Secretary of Health and Human Services (HHS) but did specify a number of materials which must be included. Applications must include a comprehensive description of the plan to implement the proposed changes, including state laws which have been passed to provide for this implementation. States must also provide an analysis of the 10-year budget window showing the changes would not increase the federal deficit. Applications must include actuarial and budgetary analyses along with the data and assumptions underlying those analyses.

Guidance issued by HHS in 2015 warned that the agency would impose strict interpretations of each of these requirements.[i] For example, affordability will not be considered only through average impacts but also with regard to the share of people who would have "large health care spending burdens relative to their incomes." Comprehensiveness of coverage would be evaluated in the aggregate with respect to the number of people with comparable coverage of all the EHBs as well as under each separate EHB category. HHS would also pay close attention to coverage of particularly vulnerable populations such as the poor, elderly, and those with serious health issues or at-risk of developing serious health issues; states must include in their analyses the impact on these various subpopulations. HHS will also examine any potential impact to other insurance programs (i.e., Medicaid) even if the waiver does not directly make changes to the program. When it comes to budget neutrality and the use of multiple waivers in conjunction with each other, however, budgetary effects will be considered separately. For instance, any savings which may accrue in Medicaid from a 1115 expansion waiver may not be used to cover the cost of any increases in spending which may be expected under the 1332 waiver.

Under the Trump Administration, the Centers for Medicare & Medicaid Services (CMS) released new guidance in October 2018 which replaces the 2015 guidance. The most notable change pertains to the coverage requirement: The Trump Administration will consider the requirement that a comparable number of people be covered to be met if they have *some* form of coverage, regardless of whether it is as comprehensive and affordable as coverage available without a waiver. Further, CMS will consider the comprehensiveness and affordability requirements to be met if coverage that is simultaneously both affordable and comprehensive is *available* regardless of how many individuals are expected to enroll in such coverage; this is known as the new "access standard." CMS will also no longer require assurances that each of the vulnerable subpopulations the Obama Administration targeted will be protected from any adverse changes. The new guidance states that CMS will still consider impacts to these populations, but CMS will more heavily weigh overall impacts to the

population as a whole, allowing small detrimental effects to various subgroups to be permitted if it is believed the overall benefits to the larger population will be greater. CMS will also now allow a waiver under which there may be increases to the federal deficit in a single year, so long as there is no net increase over the course of the waiver. Last, while the law requires that states pass a law authorizing such a plan, states will be able to satisfy the requirement through the combination of a state law and regulation or executive order.

The secretaries of HHS and the Treasury have six months to review applications once all necessary information has been provided. If all of the requirements are met, the waiver *may* be approved, but there is no guarantee of approval, even if all necessary conditions are fulfilled. Approved waivers will be granted for up to five years, but states may request a renewal which will, by default, be considered granted unless the Secretary of HHS provides a denial in writing within 90 days of a renewal request.

[i] https://www.gpo.gov/fdsys/pkg/FR-2015-12-16/pdf/2015-31563.pdf