Update on the Section 1332 State Innovation Waivers
April 2017

Section 1332 of the Patient Protection and Affordable Care Act (ACA) allows states to seek State Innovation Waivers of certain ACA provisions beginning in 2017.

ACA Sections that may be Waived under Section 1332

Subtitle D, Part I	Sections 1301-1304: Qualified Health Plan (QHP) and Essential Health Benefits requirements; Requirements for QHP carriers; Special rules related to abortion services; insurance-related definitions
Subtitle D, Part II	Sections 1311-1313: Exchange requirements
Subtitle E, Part 1	Section 1402: Cost-sharing reductions
Internal Revenue Code of 1986	Sections 36B, 4980H and 5000A: Premium tax credits; Individual coverage requirement; Large employer coverage requirement

In order to receive a Section 1332 Waiver, states must apply in accordance with the process set forth in 45 CFR 155.1300 through 155.1328 and 31 CFR 33.100 through 33.128, which may be done jointly with Section 1115 Medicaid Waivers. In the waiver application, the state must demonstrate that the waiver meets comparability requirements:

- It will provide coverage to at least a comparable number of the state's residents as would be provided without the waiver;
- It will provide coverage and cost-sharing protections that are at least as affordable as would be provided without the waiver;
- It will provide for coverage that is at least as comprehensive as would be provided without the waiver; and
- It will not increase the federal deficit.

States are increasingly looking to Section 1332 Waivers as a way to expand upon or customize the ACA to best address the unique circumstances within the state. As outlined below, a number of states have either submitted Section 1332 Waiver requests or begun the process of designing a Section 1332 Waiver. The new administration reminded states of the opportunity under Section 1332 in a letter sent to Governors in March. The letter highlighted the ability to use Section 1332 Waivers to further address access, affordability, choice and stabilizing the health insurance pools, and specifically noted the reinsurance focus of the waiver submitted by Alaska, as outlined below.

As you will see below, the waivers that are being considered in states and may be of value to other states are very much state-specific and directly tied to: the existing context in the state; the needs of the state; and what flexibility may benefit the state. Therefore, understanding challenges currently affecting the health care system in the state and what sections can be waived is a crucial first step in considering whether and how to leverage Section 1332 Waiver authority. However, below is an overview of waivers being pursued or considered in states and examples of other ways in which Section 1332 Waiver authority could be leveraged in an effort to demonstrate what sort of flexibility may be possible.

Overview of State Section 1332 Waivers[1]

Alaska

Seeking support for the state reinsurance program

Alaska submitted a Section 1332 Waiver application in December of 2016 with the goal of seeking federal funding to support the state-based reinsurance program.

In response to projections that premiums in the state's individual healthcare market were projected to increase 42 percent for 2017, the state created the Alaska Reinsurance Program, which pays claims for individuals with high-cost conditions, removing those claims from the insurance risk pool. State funds were appropriated to fund the program only for 2017. As a result of the program, rates increased an average of only 7.3 percent.

[1] See Table 1 at the end of the paper for a detailed list of each state's specific waiver requests.

Via the waiver, the state is seeking federal funding from the savings the federal government accrues in premium tax credits because the reinsurance program has prevented what was projected to be a significant rise in premiums.[2] In addition, enrollment in individual market health insurance in the state is projected to increase generally, with more healthy individuals entering the market, which is also projected to result in premium savings. The state projects premiums to actually decrease up to 4 percent for 2018, saving the federal government $51.6 million in premium tax credits.[3]

The state meets all comparability requirements because coverage rates are projected to increase while premiums decrease and cost sharing and benefits stay the same. The federal funding will come from savings to the federal government, with the state funding any delta between that funding the cost of the program.

The state also seeks to waive the opportunity to establish CO-OPs in Alaska. The state believes it is not feasible that a successful CO-OP could be established in the state and, therefore, projects that the introduction of a CO-OP could ultimately cause disruption to the market.

Oklahoma

Comprehensive individual market / Marketplace and subsidy waivers

Following legislation directing the exploration of waiver opportunities and creation of a Waiver Task Force, Oklahoma published a Section 1332 concept paper in March of 2017. While many of the ideas in the paper are not fully fleshed out or even concrete proposals, the paper starts the public discussion in the state regarding options for advancing state-based reform. The paper is expected to be followed-up with a data-driven report in June 2017 and then a rolling implementation starting in 2018.

The primary focus of the state's efforts is a fledgling individual insurance market. In particular, the state's individual insurance market is reportedly suffering from:

- Low enrollment, due to Medicaid crowd-out, lack of awareness, and lack of affordability
- High churn, with enrollees commonly dropping coverage after they receive care or due to missed payments
- Lack of competition in the market, as a result of the low enrollment and poor risk
- Plan designs that do not meet the needs of consumers
- Lack of state involvement in oversight

[2] Those individuals that are eligible for tax credits have their required premium contribution limited to a set percentage of their annual income, with the tax credits paying what remains of the premium for the second lowest-cost Silver plan. Therefore, tax credits are calculated based on – and directly impacted by – the cost of premiums.

[3] While the application does not detail expected savings from cost-sharing reductions, to the extent the reinsurance pays for a portion of claims, cost-sharing reductions will not be needed for those services, also reducing that federal expenditure.

The goal of the proposed waivers is to stabilize the individual market by increasing state flexibility, competition, and choice while reducing costs and improving health outcomes. As outlined in greater detail in Table 1, the state primarily proposes to do this by:

- Eliminating the metallic coverage levels under the ACA in lieu of one actuarial value for plans other than high deductible health plans;
- Introducing state-specific requirements focused on payment and delivery system reform for Qualified Health Plans and reducing the Essential Health Benefits;
- Increasing administrative simplification for QHP carriers;
- Ending use of the Federally-Facilitated Marketplace (FFM) and instead utilizing an existing state-based coverage portal;
- Revisiting the dates of the Open Enrollment Period (OEP) and tighten rules for Special Enrollment Periods (SEPs);
- Adjusting eligibility for federal financial assistance to those under 100% of the Federal Poverty Level (FPL) that are currently in the gap between Medicaid coverage and tax credits, tightening grace period rules, and enabling auto-enrollment;
- Establishing and utilizing Health Savings Accounts (HSAs) as a vehicle for financial assistance; and
- Eliminating certain exemptions from the individual coverage requirement.

Further, the Task Force has proposed pursuing other flexibility unrelated to 1332 waivers at the same time, including:

- Assuming greater state responsibility over rate review and QHP certification;
- Expanding age ratios to a maximum of 5:1 (not currently allowed); and
- Exploring creation of a reinsurance pool, high risk pool, or hybrid model using federal funding

Hawaii

Maintaining its state-based employer coverage requirements

Hawaii is the first state with an approved Section 1332 Waiver, having received approval in December of 2016. The state sought the waiver to allow its long-standing small group health coverage law – the Prepaid Health Care Act - to remain intact. The law was enacted in 1974 as a result of an ERISA exemption and requires most small employers to offer coverage that meets state standards to their employees that work 20 hours or more a week and provides premium assistance for doing so. Under Hawaii law, employers are required to offer coverage that is more affordable and comprehensive than most plans that would be available through the SHOP.

Via the waiver, Hawaii is released from the requirement to operate a small group Marketplace (also known as the Small Business Health Options Program or SHOP) and related provisions so that employers can continue to purchase more generous coverage outside of the Marketplace with state assistance without requiring the state to build a platform that would go largely unused in the state or allow employers to access a FF-SHOP which may lead to lack of awareness of state-based obligations. The waiver also allows for the pass-through of tax credit amounts that would have otherwise been paid to small employers that purchased coverage via the SHOP and met eligibility requirements. That funding is used, in turn, to support a state fund for small businesses that offer health insurance.

The waiver also includes flexibility as to which state agencies can carry out responsibilities for the Marketplace.

Under the waiver, there is not projected to be any decrease in coverage or change in affordability or benefits. Nor will it increase any federal expenditures.

Vermont
Maintaining small group direct enrollment

In March of 2016, Vermont submitted a Section 1332 Waiver seeking to waive the requirement to set up a SHOP to allow for continued direct enrollment through insurers. The Centers for Medicare and Medicaid Services informed the state that its submission was incomplete (missing required data and actuarial analysis) in June and there has been no public correspondence since.

Vermont has merged its individual and small group markets and requires all coverage to be sold on the Marketplace but allows for small groups to enroll directly through insurers. Insurers must make all of their plans available to employees, and employers can choose to offer employee choice across plans from all carriers by administering plan selection internally. With that structure, Vermont reports having the largest small group enrollment of all State-Based Marketplaces in 2014. Vermont sought to maintain this successful structure without having to invest in an internet portal.

California
Expanding coverage options for immigrants

While California ultimately rescinded its waiver application, it had applied in December of 2016 with the aim of offering a new health insurance option to individuals excluded from enrollment in QHPs through the Marketplace due to their immigration status (undocumented immigrants and individuals granted Deferred Action for Childhood Arrivals). California south to create “California Qualified Health Plans” (CQHPs), which would mirror and meet all the requirements of existing QHPs, and allow such individuals to enroll in those plans via the state Marketplace. This would allow mixed status families to access coverage through the streamlined Marketplace process. Such individuals would remain ineligible for financial assistance.

California reported that its proposal met comparability requirements by increasing coverage without impacting affordability or benefits and that there would be no federal cost.

Table 1: Specific Waiver Requests

Waivable ACA Sections	Key Provisions	Alaska (Reinsurance) Waiver Proposals	Oklahoma (Individual Market) Waiver Proposals	Hawaii (SHOP) Waivers	Vermont (SHOP) Waiver Proposals	California (Immigrant Coverage) Waiver Proposals	Examples of other ideas that are being or could be considered *(not intended to be an exclusive list)*
Subtitle D Part I Sections 1301-1304	• Defines QHPs, including the requirement that they be certified by the Marketplace • Defines Essential Health Benefits (EHBs) and requires QHPs to include them • Outlines requirements for QHP carriers (must sell at least one Silver and one Gold plan; must charge the same premiums on- and off-Marketplace) • Outlines coverage levels and actuarial value (AV) requirements and catastrophic plans • Establishes CO-OPs	• Eliminates the opportunity to establish CO-OPs in Alaska	• Eliminate ACA coverage levels and AV requirements and instead require all "standard" (non-HDHP) to have an AV of 80%; state to validate AVs • Establish state-based QHP requirements related to value-based payment, quality metrics, and care coordination • Reduce EHBs • Establish consumer and plan incentives related to HSA-like accounts (see below)	• Eliminates the reference to SHOP in the definitions of QHPs and CO-Ops and multi-state plans • Eliminates the requirement that carriers offer Silver SHOP plans • Eliminates the provision regarding continued participation in the SHOP for growing small employers			• Add another EHB service or substitute an EHB category across the Marketplace or in certain coverage levels (straight eliminations would not meet comparability requirements) • Decrease cost-sharing limitations (increases would not meet comparability requirements) • Eliminate requirement that carriers offer Gold and Silver plans to encourage participation • Add a new coverage level or eliminate one or more coverage levels • Allow catastrophic plans to be purchased by a broader population • Allow unique plans to be offered to specific populations
Subtitle D Part II Sections 1311-1313	• Sets forth provisions relative to the creation and duties of Marketplaces • Outlines QHP		• Eliminate use of the FFM and instead piggy-back on the Insure Oklahoma platform (offers reduced-cost	• Eliminates the state requirement to establish a SHOP (and the federal establishment of a FF-SHOP); **passes through amounts**	• Eliminate the requirement that the state establish a SHOP. Also eliminate requirements	• Waive the requirement that the Marketplace only offer QHPs for the limited purpose of	• Waive individual Marketplace (replaced with direct enrollment or private exchanges) • Allow rate setting by the Marketplace

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	certification criteria and requirements • Sets forth Marketplace consumer support tools • Sets OEP and SEPs • Sets forth requirements related to consumer choice in the Marketplaces and SHOPs including the right to continue to purchase insurance off-Marketplace • Sets forth the requirement for a single risk pool and allows states to merge their individual and small group markets • Sets forth eligibility requirements for purchasing through the Marketplace • Sets forth requirements related to		insurance for certain low-income individuals and small employers); **request funds that currently support the FFM in Oklahoma** • Establish state-based QHP requirements (see above) • Establish state-based fixed-cost description of benefits • Change the OEP (consider aligning with date of birth) • Increase pre-verification for SEP eligibility • Administrative simplification for QHPs (including related to risk mitigation, eligibility and enrollment) • Enable auto-enrollment (eg those found ineligible for Medicaid) • Establish consumer and plan incentives	**that would otherwise be available for small buiness tax credits through the SHOP to support state subsidies** • Waives employee choice • Waives the definition of "qualified employer" • Allows flexibility as to which state agencies can carry out responsibilities for the Marketplace.	that the following be available through a SHOP: rates, enrollee satisfaction system, enrollment portal, plan certification, consumer assistance, quality ratings, employee choice (this is all done through the individual market Marketplace which offers the same plans)	allowing it to offer CQHPs	• Adapt QHP criteria for all plans or a subset of plans offered to a limited population to promote better integration with Medicaid (including to allow premium assistance programs to be more seamlessly integrated on the Marketplace) • Allow the state to maintain a merged market while allowing unique rules for enrollment and rate changes (MA) • Expand the role of agents and broker to allow them to assist with financial assistance applications • Expand the SHOP to only a subset of large businesses • Allow employers to offer vouchers for purchasing on the individual market Marketplace

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	Marketplace financial integrity (record-keeping, reporting, audits)		related to HSA-like accounts (see below) • Change grace period rules (see below)				
Subtitle E Part 1 Section 1402	Establishes and sets forth eligibility and requirements related to cost-sharing reductions (CSRs)		• Change eligibility for subsidies to 0-300% FPL; "gap" populations are eligible • Establish HSA-like accounts using federal subsidy dollars for use for premiums and cost-sharing; include incentives for continuous coverage and healthy behaviors • Reduce the grace period for non-premium payment for subsidy-eligible to 30 days (currently 90 days); require premium payment for reenrollment • If CHIP is not reauthorized, move kids to the Marketplace with federal financial assistance • **Request pass-**				• Change CSR amounts • Allow CSRs to be used outside of the Silver level via a benchmark plan approach • Allow CSRs to be funded through HSAs and applied to plans outside of the Marketplace • Provide CSRs for certain employer-sponsored plans • Provide CSRs for standalone dental (MN)

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			through funding for CSRs				
Internal Revenue Code of 1986 Section 36B Section 4980H Section 5000A	• Establishes and sets forth eligibility and requirements related to premium tax credits • Outlines the large employer coverage requirement • Outlines the individual coverage requirement	• **Request for pass-through funding from savings related to lower premiums due to the state reinsurance program to fund the program**	• Establish HSA-like accounts (see above) • Move CHIP kids to the Marketplace with federal financial assistance (see above) • Change eligibility for tax credits to 0-300% FPL (currently 100-400% FPL); "gap" populations are eligible • Eliminate calculation of eligibility for tax credits based on one family member ("family glitch") • Calculate tax credits solely based on age and income • **Request pass-through funding for premium tax credits** • Limit hardship exemptions for the individual mandate				• Change premium tax calculation • Eliminate the "family glitch" (MN) • Allow premium tax credits to be administered at the family level • Allow those who are income-eligible for premium tax credits to use them toward employer-sponsored plans that exceed affordability • Include standalone dental premiums in the calculation for premium tax credits (MN) • Smooth the subsidy continuum (CA) • Further adjust the employer penalty for those employers that offer "skinny" plans • Redefine seasonal employees • Replace the individual mandate with another continuous coverage incentive (premium assessment, auto-enrollment) • Adjust the individual penalty for those who purchase inadequate plans

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			• **Request access to federal revenues collected as a result of the individual and large employer coverage requirement**				