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Publications

Administration Revises State Innovation Waiver Review Standards Under Section 1332 of the ACA

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PUBLISHED
11/14/2018

SERVICES
Employers & Sponsors
Health & Welfare Programs

On October 22, 2018, The Department of the Treasury and the Department of Health and Human Services ("HHS") (jointly, the "Departments") released revised guidance regarding Section 1332 of the Patient Protection and Affordable Care Act's ("ACA") State Innovation Waiver program. The Departments will begin applying the new guidance immediately – including to any state applications currently pending or under state consideration – though comments on the guidance will be accepted until **December 24, 2018**.

This new guidance, which supersedes guidance previously issued in December 2015, is explicitly designed to provide states more flexibility, in keeping with President Trump's January 20, 2017, Executive Order directing implementing agencies to provide relief from" the ACA's regulatory requirements, "to the maximum extent permitted by law."

The guidance is in keeping with the push by the Trump Administration to offer employers and individuals alternatives to ACA compliant coverage. Regardless of whether you support or oppose the ACA, it would be fair to recognize that the Administration has made an overarching effort to deregulate health insurance markets with the idea of adding flexibility and potentially increase choice to the marketplaces as evidenced by the change to the waiver standards, and the recently promulgated regulatory measures expanding flexibility regarding short-term limited duration ("STLD") coverage, association health plans ("AHPs") and health reimbursement arrangements ("HRAs"). The new guidance regarding State Innovation Waivers has been less publicized, but could potentially allow for significantly more inter-state variation – possibly leading to an increased split between Republican and Democratic leaning states, with Republican-leaning states following a more deregulatory approach providing for wider variety of coverage and Democratic states continuing to regulate available health insurance products much more strictly.

Key Revisions

- **Coverage Availability:** The new guidance directs the Departments to assess the *availability* of comprehensive and affordable coverage: a change from past practice where the Departments assessed the coverage that residents actually purchase. Furthermore, the new guidance specifies that the

Departments will consider all forms of private coverage, including short-term limited duration insurance and association health plan coverage in making that assessment.

- **Aggregate Assessment**: The new guidance directs the Departments to assess the impact of state waiver applications in the aggregate. This change is particularly important as to affordability; in the past, the Departments have been skeptical of waiver programs that raised costs for consumers with high expected health care costs and/or those with low incomes, even if costs under the waiver might be lower in the aggregate.
- **State Law**: Under the former guidance, the Departments generally required that a state legislature pass a new state law specific to ACA section 1332 to implement a waiver program. Under the new guidance, the Departments may accept a state application if it is authorized in an executive order or other administrative action taken under the authority of pre-existing state law for the enforcement of the ACA.
- **State Benchmark Plan Comparisons**: The new guidance also aligns the Section 1332 program with other ACA requirements: in particular, the Departments will now evaluate whether a waiver program is comprehensive against the state's EHB benchmark selected by the state (or the default), any other state's benchmark plan selected solely for this purpose, or "any benchmark plan chosen by the state that the state could otherwise build that could potentially become their EHB-benchmark plan."
- **Branding:** The new guidance also refers to State Innovation Waivers as "State Relief and Empowerment Waivers." The text of the guidance, however, generally uses the former term, "State Innovation Waiver," and the guidance appears to contemplate the use of both terms interchangeably.

Background

Section 1332 of the ACA allows states to apply for a waiver of certain specified ACA provisions if the state implements a program that would provide comparable health coverage to state residents in a different manner. Section 1332 allows for the waiver of the following ACA requirements:

- premium tax credits;
- cost-sharing reduction payments;
- the individual mandate (penalty set to expire in 2019);
- the employer mandate; and
- the ACA's qualified health plan requirements.

Under Section 1332, the federal government will also pass through to the given state the funds the federal government would have otherwise spent on waived ACA programs, such as premium tax credits. States are then free to spend these funds on their waiver programs.

Under Section 1332(b)(1), in deciding whether to approve a waiver, the Departments must assess whether the proposed program meets the following guardrails:

- The new program must provide coverage at least as ***comprehensive*** as that provided under the ACA;
- The new program must provide coverage and protections against excessive out-of-pocket spending at least as ***affordable*** as that provided under the ACA;
- The new program must provide coverage to at least a ***comparable number*** of residents as under the ACA; and
- The new program must not increase the federal deficit.

Furthermore, Section 1332 requires states to comply with certain procedural requirements, including passing legislation to enact the program and supporting their applications with factual findings and data.

The Departments have enacted implementing regulations at 31 C.F.R. Part 33 and 45 C.F.R. Part 155, subpart N, that largely restate the statutory standards. The Departments also issued guidance on December 16, 2015. Dept. of Treasury, Dept. of Health and Human Services, *Waivers for State Innovation*, 80 Fed. Reg. 78131 (Dec. 16, 2015). That guidance made clear that the Departments were particularly focused on protecting "vulnerable residents" as to coverage levels, affordability, and comprehensiveness of coverage, and

also clarified that the Departments generally expected waiver programs to provide a very similar level of coverage to a similar number of state residents as provided under the ACA.

As of early November, 2018, 14 states have formally sought Section 1332 waivers, and the Departments have approved eight states' programs.[1]

Implications of the New Guidance

The new guidance explicitly supersedes the 2015 guidance and makes several key changes designed to give states more flexibility in designing waiver programs. That said, the actual impact of these changes is difficult to predict.

Affordability and Comprehensiveness

Perhaps most importantly, the new guidance clarifies that the Departments' analysis of affordability and comprehensiveness "should focus on the nature of the coverage that is made available … rather than on the coverage that residents actually purchase." Thus, while previously the Departments focused on the likely *effect* of a waiver program (including requiring that waiver programs maintain the number of residents receiving affordable, comprehensive, ACA-compliant coverage), the Departments will now shift their focus to assessing whether comprehensive, affordable coverage is available to at least a comparable number of residents as would have had access to such coverage absent a waiver. The Departments will not require the state to demonstrate that comprehensive, affordable coverage will actually be purchased by a comparable number of state residents as would have absent a waiver. Importantly, the Departments will also now include STLD and association health plan coverage options that are not required to meet certain ACA mandates in their assessment of the number of state residents for which the coverage is available. It is not clear whether coverage approved under a 1332 waiver will meet the requirements to be integrated with an employer health reimbursement arrangement under the Departments' recent HRA proposal.

Affordability for waiver purposes is measured generally by comparing out-of-pocket expenses to income, and the Departments will evaluate access to affordable, comprehensive coverage available to all citizens, without regard to the type of coverage they would have had access to absent a waiver. Comprehensiveness is measured by the scope of benefits offered, specifically, the extent to which the coverage meets the essential health benefits (EHBs) requirements. Because of the recent flexibility given to states with respect to the definition of EHBs, comprehensiveness will be evaluated based on the state's selection of a benchmark, any benchmark selected by the state for purposes of the waiver, or any benchmark plan chosen by the state that the state could otherwise build that could potentially become their EHB-benchmark plan.

These changes could have enormous consequences. States could potentially design waiver programs that explicitly facilitate the sale of cheaper, less comprehensive coverage – for example STLD coverage that is not subject to the market reform requirements – as long as at least one comprehensive plan is available. Because STLD coverage is almost certainly less expensive than coverage that meets such requirements, this change could allow states to effectively steer residents to the lower-cost, less comprehensive coverage, particularly because Section 1332 allows states to use federal funds formerly earmarked for premium tax credits or cost-sharing reductions for *any* portion of a waiver program, including STLD coverage, AHPs, or other programs, potentially including longstanding non-ACA programs such as Farm Bureau plans. Thus, it appears that states could subsidize lower-cost options and effectively steer large numbers of state residents away from plans that comply with the ACA's market reform requirements, even though Section 1332 does not specifically allow the Departments to waive those ACA requirements.

Nonetheless, it is unclear how the Departments will implement this change in practice. Notably, the new guidance also states that "it is not enough to make available some coverage that is comprehensive but not affordable, while making available other coverage that is affordable but not comprehensive."

Effect on Specific Vulnerable Populations

The new guidance also clarifies that the Departments will not necessarily deny an application simply because it might have negative effects on particular groups of residents, as long as the waiver benefits the state's residents in the aggregate. The new guidance further clarifies that the Departments will similarly assess long-term benefits against short-term drawbacks, including when assessing whether a proposed waiver program will cover a comparable number of residents. This emphasis differs from the previous guidance, which provided that the Departments would deny applications that increased "the number of state residents with large health care spending burdens" even if most residents' conditions were improved. By contrast, the new guidance provides that "a waiver that makes

coverage much more affordable for some people and only slightly costlier for a larger number of people would likely meet [the] guardrail."

Again, the impact of this shift could be significant. The former guidance made clear that the Departments would generally deny a waiver application that adversely impacted an identifiable subset of state residents, and repeatedly emphasized that reducing affordability or comprehensiveness for "vulnerable groups" would likely lead to a denied application. Even so, the previous guidance did not absolutely bar some weighing of harms in the aggregate, and the new guidance does not necessarily promise that the Departments will approve an application that justifies particularized drawbacks in terms of aggregate improvements.

Coverage

To meet the coverage guardrail, a state waiver plan must provide "meaningful" health care coverage to a comparable number of its residents would have been covered absent a waiver. The Departments note that "[f]or purposes of meeting this guardrail, in line with the Administration's priority favoring private coverage, including AHPs and STLDI plans, the Departments will consider all forms of private coverage in addition to public coverage, including employer-based coverage, individual market coverage, and other forms of private health coverage." The Departments will consider the state plan's effects on those with high expected health care costs, and whether the plan prevents gaps or discontinuation in coverage. Coverage impact will be evaluated over the course of the waiver term, and the Departments suggest that it may be possible for a state plan to be approved despite a short-term loss of coverage, if the state's plan is forecast to meet or exceed pre-waiver coverage levels within a reasonable amount of time, and any coverage reductions are offset by coverage gains.

State Executive Branch Flexibility

The new guidance will also potentially allow state governors and executive agencies more flexibility in creating waiver programs. Previously, the Departments had generally interpreted the statute to require that states enact an entirely *new* law to create waiver programs. This requirement posed a high hurdle for states: to even apply for a waiver – and with no guarantee the waiver would be approved – state legislatures were required to agree upon and pass an entirely new law providing for the program. Allowing governors and executive agencies to bypass state legislatures under color of pre-existing legislative grants of authority could make it much easier for states to apply for waivers.

Again, implementation will be key. The new guidance provides that the Departments "may" approve waiver applications grounded in state executive authority, but the Departments have outlined no specific standard. The guidance notes that the Departments will "look favorably upon" state governments' interpretations of relevant state law, but stakeholders will not necessarily know how broadly the Departments are now interpreting state executive branch authority until the Departments have reviewed an application coming from a state without a specifically enacted law. Furthermore, Section 1332(b)(2)'s statutory text arguably requires that states pass legislation specifically providing for a Section 1332 waiver programs, so this could be a potential issue for litigation.

Unchanged Standards

Finally, the new guidance does not modify some provisions that have made waiver approval challenging in the past. For example, Section 1332(b)(1)(D) requires that waiver programs "not increase the federal deficit" over the period of the waiver, or in total over the 10 year budget plan, and the Departments have interpreted this requirement very strictly: for example, even if a state waiver program was anticipated to increase overall coverage – and thus increase federal outlays through premium tax credits – the Departments would not approve the program on the ground that it would increase federal spending, even though the increased federal spending anticipated would in fact *further* the coverage goals of the ACA.

The Departments only revised the 2015 guidance to clarify that the 10-year budget plan should describe the changes in projected federal spending and changes in federal revenue attributed to the waiver for each of the 10 years. Therefore, states must still carefully design programs to avoid any increase in federal spending, even where that increase would result from coverage gains.

Conclusion

In issuing the new guidance, the Departments have sought to encourage waiver applications by seeking to refine and clarify their approach to Section 1332. The Departments' shift in emphasis could have enormous consequences, potentially allowing states to steer

large numbers of residents out of ACA-compliant plans and into more affordable, less comprehensive coverage. Ultimately, the impact of this guidance will come down to just how aggressively the Departments interpret their new position. The revisions outlined by the Departments in this guidance could lead to significant changes in the country's health insurance markets – but all of this will depend on the states' willingness to submit waiver applications.

[1] Alaska, California, Hawai'i, Iowa, Maine, Maryland, Massachusetts, Minnesota, New Jersey, Ohio, Oklahoma, Oregon, Vermont, and Wisconsin have formally applied for waivers. The Departments have approved waivers for Alaska, Hawai'i, Maine, Maryland, Minnesota, New Jersey, Oregon, and Wisconsin. Notably, Idaho attempted major changes to its state health coverage laws in 2017 and 2018. The Departments rejected those changes as non-compliant with the ACA by letter on March 8, 2018, but invited Idaho to apply for a Section 1332 waiver. Recent reports indicate that Idaho will not pursue a waiver and may potentially allow the sale of coverage that does not meet the requirements of the ACA, but also does not qualify as STLDI.