New 1332 Guidance Gives States More Flexibility

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On October 22nd, 2018 the Trump Administration released new guidance on 1332 waivers that in many ways reshapes and expands the policies that states can have approved as part of a 1332 waiver. This paper will examine what the guidance does, how this affects potential 1332 waivers, and what are things to keep an eye out for in the future.

What is Section 1332 of the ACA?

Section 1332 of the Affordable Care Act allows states to waive certain provisions of the ACA. These provisions include Exchange requirements, APTC/CSR requirements, and Mandate requirements, among a few others. They do not include the market reform rules such as guaranteed issue or community rating. Waivers must meet four specific guard rails in order to be considered for approval. The coverage in a post-waiver state would need to:

1. Provide as comprehensive coverage,
2. Provide as affordable coverage,
3. Provide comparable number of coverage, and
4. Does not increase the Federal deficit.

Both the Secretaries of HHS and Treasury would need to approve any waiver and each have the option of declining.

How Have 1332 Waivers Worked to Date?

The Obama Administration released guidance in 2015 that set the basic rules for 1332 approval. The guidance set forth specific conditions for a waiver approval such as the Federal deficit condition needed to be met in every year and vulnerable populations would need to be protected. Eight states have had approved waivers and excluding Hawaii's waiver, all have focused on implementing a reinsurance focused waiver.

New Guidance: State Relief and Empowerment Waivers

The new guidance[1] by the Trump Administration replaces the previously existing guidance and is effective immediately. The guidance lays out five principles that will guide the two Departments as to if they will approve future 1332 waivers. New waivers should explain how the waiver proposal would advance some or all of these principles:

1. Provide increased access to private market coverage,
2. Encourage sustainable spending growth (promote cost-effective care and restrain growth in federal commitments),
3. Foster state innovation,
4. Support and empower those in need (i.e., low income or high expected health care costs), and
5. Promote consumer-driven health care.

New waiver proposals should explain how the waiver would advance some or all of the principles in the new guidance.

What Are the New Flexibilities the New Regulations Provide?

The guidance changes fundamentally how the coverage and affordability provisions are interpreted. In particular, 1332 waivers will be evaluated as to if individuals have access to comprehensive and affordable coverage, not if they are enrolled in coverage. Furthermore, vulnerable populations do not have to be explicitly accounted for. Instead the comprehensiveness and affordability will be judged in aggregate. For example, under the previous rules if high cost or low-income enrollees would see their premiums or cost-sharing increase, the waiver would not be approved. In other words, if any subset of people were hurt the waiver would not have been approved. The new guidance instead focuses, in theory, on the totality of costs. For example, one can imagine that if APTCs were directed towards cheaper short-term plans, healthier enrollees would see their total out of pocket expenses decrease while costlier (unhealthy) enrollees would see their out of pocket costs increase. Under the old guidance this would not be allowed since unhealthy enrollees are financially harmed but under the new guidance, if the healthier enrollees affordability gains offset the affordability losses by sicker enrollees, it would be allowed.

This change in what can be considered "affordable coverage" is further driven home by the change in what counts as "coverage". The guidance allows enrollment in non-minimum essential coverage (such as short-term limited duration plans) to count as coverage. Consequently, states would be able to subsidize individuals purchasing short-term limited duration plans through a 1332 waiver.

While not explicit, the focus on private coverage options does hint that the Administration will not look favorably upon 1332 waivers that attempt to expand public coverage in the form of Medicaid-Buy In programs or other universal health options. HHS does not have to accept and the new guidance provides ready-made criteria for rejecting public option type waivers.

[1] https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-23182.pdf

A few additional flexibilities were also included, namely:

- The waiver cannot increase the Federal deficit over the course of the waiver. It can increase the Federal deficit in any one year. For example, an approved waiver could add to the Federal deficit in the initial year provided in the later years, Federal savings are such that over the entire waiver (five years) the waiver does not add to the Federal deficit.
- Changes in state Medicaid coverage that result from a 1332 waiver, can be included in the coverage (although changes in Medicaid savings cannot be included in the deficit calculations).
- States, for a fee, would be able to leverage the Healthcare.gov and other CCIIO operational infrastructures to implement their 1332 waiver. The IRS, under very limited circumstances, may also be able to make changes. For example, a waiver that provides APTC funding for those under 100% FPL could use both Healthcare.gov and the IRS systems.
- States have increased flexibility on what counts as 1332 specific legislation. In certain circumstances, states may use existing legislation if it provides statutory authority to enforce the ACA or the state plan and combine with a regulation/executive order. States are encouraged to reach out to CMS if they are uncertain if their existing legislation is sufficient.

Pass-Through Uncertainty

One key thing to flag that also changed for states is that while the pass-through amount (what the Federal government sends states) is calculated annually, the Federal government reserves the right to update the pass-through amount AT ANY TIME to reflect changes in state or federal law (including regulation and sub-regulatory guidance). This increases uncertainty for states as the amount of funds available could be different than what issuers or states thought they had available when rates were set.

Next Steps

The new guidance, specifically the portions that open up the types of waivers that will be accepted, would affect the 2020 market at the earliest. States are encouraged to submit waiver applications during the first quarter of the year prior to the year health plans would be affected. States should keep an eye out for “waiver concepts” that CMS will be releasing in the near future that may provide insights into the type of waivers that will be well received. Finally, given the significantly divergent interpretation of the statutory guard rails, it is likely that some of the new waiver concepts will be challenged in court.

Please contact Michael Cohen at michael.cohen@wakely.com with any questions or to follow up on any of the concepts presented here.