REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-I-17

Subject: Affordable Care Act Section 1332 Waivers
(Resolution 206-I-16)

Presented by: Paul A. Wertsch, MD, Chair

Referred to: Reference Committee J
(Peter C. Amadio, MD, Chair)

At the 2016 Interim Meeting, the House of Delegates referred Resolution 206, "Advocacy and Studies on Affordable Care Act Section 1332 (State Innovation Waivers)," which was sponsored by the Medical Student Section. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2017 Interim Meeting. Resolution 206-I-16 asked:

> That our American Medical Association (AMA) advocate that the "deficit-neutrality" component of the current US Department of Health and Human Services (HHS) rule for Section 1332 waiver qualifications be considered only on long-term, aggregate cost savings of states' innovations as opposed to having costs during any particular year, including in initial "investment" years of a program, reduce the ultimate likelihood of waiver approval; and
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> That our AMA study reforms that can be introduced under Section 1332 of the Affordable Care Act (ACA) in isolation and/or in combination with other federal waivers to improve healthcare benefits, access and affordability for the benefit of patients, healthcare providers and states, and encourages state societies to do the same.

This report provides background on Section 1332 waivers, outlines regulatory activity on Section 1332 waivers, highlights Section 1332 waiver applications and approvals, summarizes relevant AMA policy, and presents policy recommendations.

BACKGROUND

Section 1332 of the ACA established a new waiver supporting state innovation in order to enable states to experiment with and implement different models to provide health insurance coverage to their residents. Under Section 1332, some of the ACA's private insurance and coverage provisions can be waived, including those pertaining to premium tax credits and cost-sharing reductions for plans offered through the marketplaces, the individual and employer responsibility requirements and standards for health insurance marketplaces and qualified health plan standards. Other sections of the ACA cannot be waived under Section 1332, including those addressing guaranteed issue and community rating, the law's prohibition against insurers denying coverage or charging higher premiums to people with pre-existing conditions, the ban on annual and lifetime limits, and the ability of adult dependents up to age 26 to be covered on their parents' health plans.

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Under Section 1332, the Secretaries of HHS and the Treasury are granted the authority to approve a request for a Section 1332 waiver only if the proposal meets the following four criteria:

1. The proposal will provide coverage to at least a comparable number of the state's residents as would be provided absent the waiver;
2. The proposal will provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable for the state's residents as would be provided absent the waiver;
3. The proposal will provide coverage that is at least as comprehensive for the state's residents as would be provided absent the waiver; and
4. The proposal will not increase the federal deficit.

If a Section 1332 waiver is approved, a state may receive funding equal to the amount of forgone federal financial assistance that would have been provided to its residents enrolled in marketplace coverage pursuant to the ACA, a process referred to as pass-through funding. Pass-through funding is capped at the amount of forgone marketplace subsidies and does not account for any other changes in federal spending or revenues as a result of the waiver.[1] Accordingly, pass-through funding is especially essential for Section 1332 waivers under which individuals and/or small employers in the state would no longer qualify for premium tax credits, cost-sharing reductions and/or small business credits for which they would otherwise be eligible. For such waivers, the aggregate amount of such credits or reductions that would have been paid on behalf of consumers in the marketplaces had the state not received such waiver would instead be paid to the state to implement its Section 1332 waiver. Section 1332 waivers, which have been available since the beginning of this year, may be approved for periods up to five years and can be renewed.[2]

REGULATORY ACTIVITY ON SECTION 1332 WAIVERS

A final regulation addressing the application, review, and reporting process for Section 1332 waivers was issued in February 2012. Under the final regulation, a state submitting an application for a Section 1332 waiver must provide actuarial analyses and certifications, economic analyses, data and assumptions, targets, an implementation timeline, and other necessary information to show the proposed waiver's compliance with the ACA criteria for Section 1332 waivers as noted above. Specific to deficit reduction, the economic analyses submitted by the state are required to include a detailed 10-year budget plan that is deficit neutral to the federal government. The final regulation also allows states to submit a single application for a Section 1332 waiver along with existing waivers applicable to Medicare, Medicaid and the Children's Health Insurance Program (CHIP), which could include Section 1115 (of the Social Security Act) waivers, which currently allow states to implement experimental, pilot, or demonstration projects in the Medicaid and CHIP programs.[3]

In December 2015, the Centers for Medicare & Medicaid Services (CMS) and the Department of the Treasury released guidance that addressed how the agencies will evaluate state applications for Section 1332 waivers. Addressing the ACA's deficit neutrality requirement, the guidance stated that waivers must not increase the federal deficit over the period of the waiver or in total over the ten-year budget plan submitted by the state. Pertinent to referred Resolution 206-I-16, the agencies stated in the guidance that "a waiver that increases the deficit in any given year is less likely to meet the deficit neutrality requirement." In addition, the guidance stated that although a state may submit a coordinated waiver application, in such a case each waiver will be evaluated independently according to applicable federal laws. Importantly, the guidance stated that there would be limitations to Section 1332 waiver applications for states that use healthcare.gov for their marketplaces, as the federal platform cannot accommodate different rules for different states.

Therefore, the agencies note that states contemplating waivers that include changes to the calculation of marketplace financial assistance as well as plan management, for example, may consider establishing and administering their own platform.[4]

In March 2017, HHS Secretary Price sent a letter to governors encouraging states to submit Section 1332 waiver proposals, including proposals for high-risk pool/state-operated reinsurance programs. In the letter, Secretary Price referenced Alaska's waiver application, which was approved in July 2017, and sought federal support for a state-managed reinsurance program. The Secretary noted that if a state's plan under its waiver proposal is approved, a state may be able to receive pass-through funding to help offset a portion of the costs for the high-risk pool/state-operated reinsurance programs.[5]

In May 2017, CMS released a checklist for Section 1332 waiver applications, which also included specific items pertaining to applications that include high-risk pool/state-operated reinsurance programs. Pertaining to deficit neutrality, the checklist states as part of waiver applications, states must include an economic analysis to support the state's finding that the waiver will not increase the federal deficit over the five-year waiver period or in total over the ten-year budget period. Additionally, the checklist stipulates that the deficit analysis submitted by the state should show yearly changes in the federal deficit due to the waiver.[6]

SECTION 1332 WAIVER APPLICATIONS AND APPROVALS

As Section 1332 waivers have only been available starting this year, activity on waivers has been relatively limited. At the time that this report was prepared, nine states had submitted waiver applications – Alaska, California, Hawaii, Iowa, Massachusetts, Minnesota, Oklahoma, Oregon and Vermont. The waiver applications of three states - Hawaii, Alaska and Minnesota - have been approved. Of note, Minnesota's waiver was approved with less federal pass-through funding than was requested by the state. The waiver applications of California and Oklahoma were withdrawn, while Vermont's was put on hold.[7] Hawaii's Section 1332 waiver allowed the state to keep its longstanding employer coverage provisions resulting from the state's Prepaid Health Care Act, which requires employers to provide more generous coverage than is required under the ACA. As such, Hawaii's waiver sought to waive the ACA requirement that a Small Business Health Options Program (SHOP) marketplace operate in Hawaii and other provisions related to SHOP marketplaces, including the requirement that the small business tax credits could only be available through the SHOP.[8,9]

Alaska's waiver allows the state to implement the Alaska Reinsurance Program (ARP) for 2018 and subsequent years. The ARP will cover claims in the individual market for individuals with one or more of 33 identified high-cost conditions to help stabilize premiums. As a result, insurers will relinquish both premiums received for such individuals as well as claims they would have paid absent the waiver. As a result of the ARP, it is expected that premiums will be 20 percent lower in 2018 than absent the waiver, and 1,460 additional individuals will have health insurance coverage. Because the ARP will lower premiums, the second lowest cost silver plan premium is reduced, which results in the federal government spending less on premium tax credits.[10] The waiver application of Minnesota would create the Minnesota Premium Security Plan, which was estimated to yield a 20 percent reduction in average premiums in 2018.[11] While Minnesota's waiver was approved, the full amount the state requested in its waiver for federal pass-through funding to financially support its reinsurance program was not approved. Only federal pass-through funding reflecting savings from less spending on premium tax credits and cost-sharing reductions was approved, not the amount also requested by the state that reflects federal savings due to lower premiums for plans under the state's Basic Health Program.[12] The waiver application of Oregon,

which was still under review when this report was prepared, anticipates that its waiver to establish the Oregon Reinsurance Program will reduce premiums, including those for the second-lowest cost silver plan, by 7.5 percent in 2018 (net of the premium assessment), with an increase in enrollment in the individual market by approximately 1.7 percent in the same year.[13]

Likewise, Iowa's waiver application includes a reinsurance program. However, due to concerns at the time of its waiver application that there would be no insurers participating in the state's marketplace in 2018, Iowa also proposed to make substantive changes to ACA requirements, and cited the need for "emergency regulatory relief." Iowa's Section 1332 waiver proposal calls for the creation of a single Proposed Stopgap Measure plan that would be the only plan offered by insurers in the marketplace, and provide coverage similar to that offered by a standard silver plan. In addition, the initial waiver application proposes replacing the ACA's premium tax credits with flat premium subsidies based on age and income, as well as eliminating cost-sharing reductions (CSRs).[14] In response to concerns over the state's waiver application eliminating cost-sharing reductions, Iowa submitted a supplement to its waiver application in order to provide additional cost-sharing support to individuals with incomes between 133 and 150 percent of the federal poverty level (FPL), to be implemented similarly to how cost-sharing reductions are currently provided to this population.[15] Of note, cost-sharing reductions are currently provided to individuals with incomes up to 250 percent of the FPL under the ACA. In addition, the state has requested that HHS waive the requirements that Section 1332 waivers include actuarial analyses, actuarial certifications, and economic analyses, including those which support the state's finding that the waiver will not increase the federal deficit over the period of the waiver or in total over the 10-year budget period.[16] At the time that this report was prepared, Iowa no longer has any counties at risk of having no insurer participating in the state's marketplace in 2018.[17]

In response to the market volatility the uncertainty about continued funding for CSRs has caused, Massachusetts submitted a waiver request that requested waiver of CSRs and instead create a Premium Stabilization Fund that would make payments to health plans equivalent to those that would be made under federal CSR payments. Massachusetts requested expedited review of its waiver, which if approved would be effective January 1, 2018 for an initial period of at least one year, and likely blunt premium increases that would otherwise occur in the marketplace due to the uncertainty as to whether federal CSR funding will continue.[18]

RELEVANT AMA POLICY

Policy D-165.942 advocates that state governments be given the freedom to develop and test different models for covering the uninsured, provided that their proposed alternatives meet or exceed the projected percentage of individuals covered under an individual responsibility requirement while maintaining or improving upon established levels of quality of care, ensure and maximize patient choice of physician and private health plan, and include reforms that eliminate denials for pre-existing conditions. Policy H-165.845 supports outlined principles to guide in the evaluation of state health system reform proposals, including:

- Health insurance coverage for state residents should be universal, continuous, and portable. Coverage should be mandatory only if health insurance subsidies are available for those living below a defined poverty level.
- The health care system should emphasize patient choice of plans and health benefits, including mental health, which should be value-based. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as references when considering if a given plan would provide meaningful coverage.

- The delivery system should ensure choice of health insurance and physician for patients, choice of participation and payment method for physicians, and preserve the patient/physician relationship. The delivery system should focus on providing care that is safe, timely, efficient, effective, patient-centered, and equitable.
- The administration and governance system should be simple, transparent, accountable, efficient, and effective in order to reduce administrative costs and maximize funding for patient care.
- Health insurance coverage should be equitable, affordable, and sustainable. The financing strategy should strive for simplicity, transparency, and efficiency. It should emphasize personal responsibility as well as societal obligations.

Policies D-165.966 and H-165.855 advocate that state governments be given the freedom to develop and test different models for improving coverage for patients with low incomes. Policy D-165.966 also supports changes in federal rules and federal financing to support the ability of states to develop and test such alternatives without incurring new and costly unfunded federal mandates or capping federal funds.

DISCUSSION

The AMA has long advocated that state governments be given the freedom to develop and test different models for improving coverage for patients with low incomes. The Council believes that Section 1332 of the ACA provides states with a unique opportunity to build upon the progress that has been made in expanding health insurance coverage and choice under the ACA. With Section 1332 waivers, states could devise new and innovative approaches to provide quality health insurance coverage to more people, as well as make health insurance coverage more affordable. The Council believes that it is imperative that approved State Innovation Waivers follow the criteria outlined in Section 1332 of the ACA and related regulations: that Section 1332 waiver proposals will provide coverage to at least a comparable number of the state's residents as would be provided absent the waiver; provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable for the state's residents as would be provided absent the waiver; provide coverage that is at least as comprehensive for the state's residents as would be provided absent the waiver; and not increase the federal deficit.

However, additional actions should be taken, either administratively or legislatively, to make Section 1332 waivers more workable for states, and be potentially more advantageous for state residents. Under current law, Section 1332 waivers are required to not add to the federal deficit, and current guidance states that waivers must not increase the federal deficit over the period of the waiver or in total over the ten-year budget plan submitted by the state. However, the language in the federal guidance from 2015 also stated that "a waiver that increases the deficit in any given year is less likely to meet the deficit neutrality requirement." The Council believes that there could be unintended consequences for states seeking to innovate to require deficit neutrality in each individual year of a Section 1332 waiver. The Council recognizes that it would be reasonable for some waivers to project deficits in years one or two of a waiver as a result of start-up and other costs, and savings in subsequent years that offset the earlier deficits. The Council believes it is essential for Section 1332 waivers to remain deficit neutral over the period of the waiver (which may not exceed five years unless renewed), as well as in total over the ten-year budget plan submitted by the state.

The Council also believes that federal pass-through funding provided to states to implement their Section 1332 waivers should capture all federal budgetary savings achieved by the waiver. Under current law, the amount of federal pass-through funding is equal to an annual estimate of forgone

marketplace subsidies and financial assistance that would have otherwise been provided pursuant to the ACA. If a Section 1332 waiver creates additional federal savings outside of the scope of marketplace subsidies, such as reducing the cost of the tax exclusion for employer-sponsored coverage, such savings should also be included in the amount of federal pass-through funding provided to the state to finance its Section 1332 waiver.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 206-I-16, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) support the criteria outlined in Section 1332 of the Affordable Care Act for the approval of State Innovation Waivers:

    a. The waiver proposal will provide coverage to at least a comparable number of the state’s residents as would be provided absent the waiver;
    b. The waiver proposal will provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable for the state's residents as would be provided absent the waiver;
    c. The waiver proposal will provide coverage that is at least as comprehensive for the state’s residents as would be provided absent the waiver; and
    d. The waiver proposal will not increase the federal deficit. (New HOD Policy)

2. That our AMA support the deficit neutrality requirement of Section 1332 waivers being enforced over the period of the waiver and in total over the ten-year budget plan submitted by a state, not in each individual year of the waiver. (New HOD Policy)

3. That our AMA support legislation to allow other federal savings projected to be achieved as a result of a Section 1332 waiver, including any reductions in the cost of the tax exclusion for employer-sponsored coverage, to be included in the amount of federal pass-through funding provided to a state to subsidize state innovations. (New HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

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