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Beware! New Guidance on Section 1332 Waivers Opens the Way for Serious Harm

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Under Section 1332 of the Affordable Care Act, states are allowed to apply for state innovation waivers that waive certain parts of the act's requirements[1] for private health insurance and marketplace coverage.

The statute establishes that states that waive these requirements still must show that the proposal:

> *(A) will provide coverage that is at least as comprehensive as the coverage defined in section 1302(b) [referring to essential health benefits] and offered through Exchanges established under this title as certified by Office of the Actuary of the Centers for Medicare & Medicaid Services based on sufficient data from the State and from comparable States about their experience with programs created by this Act and the provisions of this Act that would be waived;*
>
> *(B) will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title would provide;*
>
> *(C) will provide coverage to at least a comparable number of its residents as the provisions of this title would provide; and*
>
> *(D) will not increase the Federal deficit.*

The meaning of these guardrails is clear in the statute, although exactly how these statutory guardrails are measured has been set forth in guidance from the Department of Health and Human Services and the Treasury Department. In October 2018, however, the administration issued new guidance[2] that weakens or effectively eliminates these statutory guardrails through a fundamentally unsound reading of the clear legal language above. The guidance—if it stands up to potential legal challenge—can undermine key consumer protections, particularly for the most vulnerable people, including those in poor health, people with preexisting conditions, older people, and those with low incomes. It counts shoddy plans that provide few benefits to consumers as "coverage," and it paves the way for federal dollars to subsidize these plans.

The public can still weigh in, and it is important that people do so both at the federal and state levels. At the federal level, you can comment through December 24, 2018, on this new guidance and urge the federal government to better protect consumers. It is as important to watch what your state is doing. States may propose waivers that are either good for residents or bad for residents—and you can get involved as your state develops a proposal. Once a proposal

is developed, the public must be given 30 days to comment to the state before the state submits an application to the federal government. Further, if your state proposes a waiver to the federal government, besides commenting at the state level, you also can comment to the federal government about whether the proposal will help residents and should be approved, or will harm them and should be rejected.

How Does the New Guidance Undermine Each Guardrail?

1. Coverage That Is at Least as Comprehensive

A. Under previous guidance,[3] and consistent with the plain language of the statute, states had to forecast the number of residents who would have coverage that is at least as comprehensive as the state's essential health benefits package. That is, the state has a burden of proof to demonstrate that at least as many residents will have comprehensive coverage for ambulatory services, emergency services, mental health and substance use disorders, etc. Under the new guidance, comprehensive coverage must be *available*, but effective access to these benefits need not be maintained. This is intended to allow plans that are not at all comprehensive to compete directly with (and potentially destabilize) plans offering essential health benefits.

B. Under the new guidance, states can weaken even the amount of coverage they make *available* for any of these services (the "benchmark") to be the least amount of each essential health benefit that is possible under the Affordable Care Act in any state, rather than what the particular state has provided to its residents in the past. The Affordable Care Act requires essential health benefits to be equal in scope to those of a typical job-based plan as determined by the Department of Health and Human Services and the Labor Department, and it sets up a number of requirements and public input processes to make sure the benefits are balanced, meet the health care needs of various subpopulations, are nondiscriminatory, and are periodically updated to address any gaps in access to coverage or changes in the evidence base.[4] In past years, states looked at job-based plans within their state, as well as other factors, to set essential health benefit standards. A series of regulations have weakened essential health benefit standards and given states ever more flexibility to set benchmarks for essential benefits. This guidance again weakens the standards, allowing states to depart from the benchmarks the states recently set for 2020. Consumers and their advocates will have to be especially vigilant in examining proposed benefits under a 1332 waiver since this guidance does not require a separate public input process on benefit standards. Since, under this 1332 guidance, a waiver might have one standard for the generosity of benefits in the most comprehensive plan available to residents, and a much weaker standard for other plans that are offered, it is especially important that the comprehensive plan meet the needs of people in poor health. Look especially at whether benefits are in keeping with the Mental Health Parity and Addiction Act (that is, that benefits for mental health and substance use are not more limited than medical and surgical benefits), whether prescription drug coverage and drug formularies remain adequate, and whether the scope of preventive services has changed. Proposed limits to rehabilitation services and other services commonly used by people with disabilities could be harmful. The National Health

Law Program's "Step Guide to Updating States' Essential Health Benefits Benchmark Plans"[5], originally written for advocates weighing in on state benchmark updates in the summer of 2018, provides a good list of factors to review.

C. The guidance no longer guarantees no reduction in the comprehensiveness of coverage for low-income individuals, elderly individuals, those with serious health conditions, or those at greater risk of developing serious health issues. Under previous guidance, coverage to these vulnerable populations could not decrease.

D. Even though a 1332 waiver cannot directly change a state's Medicaid program, states can submit coordinated applications to alter their Medicaid programs under Section 1115 and to alter private insurance under Section 1332. Therefore, previous guidance included safeguards to make sure the Medicaid-eligible population would not be harmed in coordinated Medicaid 1115 waiver and private insurance 1332 waiver. States had to make sure there was no decrease in the number of people who had coverage for the full set of Medicaid and Children's Health Insurance Program due to the waiver. That protection is gone from this guidance. Additionally, under this guidance, a state might try to use premium tax credit dollars to provide a skimpy benefit to people with income below poverty, and cut federal premium tax expenses elsewhere, instead of expanding Medicaid to provide comprehensive coverage to low income adults. The public should beware of coordinated 1115 and 1332 waivers that would detrimentally affect the Medicaid and CHIP populations and use both waiver comment processes to raise issues at both the state and federal level. We elaborate further on Medicaid implications of the new guidance below.

2. Coverage That Is Affordable and Protects Against Excessive Out-of-Pocket Health Costs

A. Under the old guidance, and consistent with the plain language of the statute, states compared residents' net out-of-pocket spending for premiums and cost sharing under the waiver with their out-of-pocket expenses in marketplace plans absent a waiver. A waiver that reduced the number of individuals "with coverage that provides a minimal level of protection against excessive cost sharing" would be rejected. That minimum, under the previous guidance, required plans to have an actuarial value of at least 60 percent (that is, they paid at least 60 percent of a typical population's expenses). Further, plans had to cap beneficiaries' cost sharing expenses for essential benefits at a maximum of $7,350 for an individual in 2018, for example (adjusted annually for inflation). Under the new guidance, states no longer project what coverage residents *will purchase*; they only have to determine that a comparable number of people would *have access to* coverage options (whether or not they are able or likely to use those options) that are as affordable and comprehensive. This is a critical distinction, as it explicitly and avowedly will support states in making much skimpier coverage with much higher out-of-pocket liabilities available and eligible for subsidy that otherwise would not be allowed or at the very least not eligible for premium tax credits in the absence of the waiver. Since people cannot know what health care costs they will face in a year at the time they purchase coverage, marketing and federal subsidy of this skimpy pseudo-coverage will leave many people at financial risk.

B. Under the previous guidance, a waiver would fail if the overall number of people with high health care spending burdens relative to their incomes increased, even if the waiver increased affordability for many other residents. Under the new guidance, in contrast, if a waiver makes coverage much more affordable to some people and somewhat less affordable to others, it can still be approved.

C. Previous guidance required a "hold harmless" for vulnerable residents, including low-income individuals, elderly individuals, and those with serious health issues or at greater risk of developing serious health issues. Reducing affordability for those groups would cause a waiver to fail. Under the new guidance, there is no set test for when a waiver would be disapproved for either harming too many people, or harming particularly vulnerable or sick people. (Waiver applications still will have to identify how populations by income, health expense, health status, and age will be affected—so the public should review those projections to determine whether a waiver will cause harm.)

3. Coverage to a Comparable Number of Residents

A. The straightforward meaning of this guardrail in the statute is that it references the coverage and affordability guardrails—so that a comparable number of people must have coverage at least as comprehensive and affordable as they would have without a waiver. Therefore, under the old guidance, states had to forecast how many residents would have "minimum essential coverage" that met certain standards of generosity with and without the waiver. The total number of residents with this coverage couldn't decrease. States also had to show that coverage to the vulnerable populations would not decrease. Short-term, limited-duration plans are not considered minimum essential coverage.

The new guidance asserts—absurdly—that this third guardrail is entirely separate from the guardrails for maintaining comprehensiveness and affordability, and is in fact "silent" regarding the nature of the coverage in which a comparable number of people must be enrolled. Given this tendentious reading of the statutory language, the definition of what counts as coverage has been broadened to include the very limited coverage available under short-term, limited-duration plans. Thus, if the number of people with very limited coverage grows in a state and the number with comprehensive coverage decreases under a waiver, the guidance indicates it would likely still be approved. Short-term plans are allowed to deny coverage to people with preexisting conditions, or sell them a policy that does not cover treatment for preexisting conditions, undermining a basic protection under the Affordable Care Act.

In effect, even though by statute 1332 waivers cannot waive[6] the parts of the Affordable Care Act that protect people with preexisting conditions, allowing short-term plans to count as coverage undermines this protection. It allows federal pass-through funding under a waiver to be used for coverage that is denied entirely to people with preexisting conditions, priced higher for people with preexisting conditions, or excludes coverage for treatment of any conditions that they had prior to purchasing the policy.

The guidance tries to justify the administration's new position by referring to regulations on minimum essential coverage and regulations defining health coverage. However, minimum essential coverage does not include short-term plans. In fact, the preamble to rules promulgated on short-term, limited plans on August 3, 2018, says that they are neither minimum essential coverage nor individual health insurance coverage.

B. The new guidance refers to a definition of health insurance coverage that includes "medical care (provided directly, through insurance or reimbursement or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer." This could open the door to other new types of minimal contracts for medical care to count as coverage under the third guardrail, and receive pass-through funding, contrary to the plain intent of the law[7] and the other guardrails. In December 2009—during the debates over the passage of the Affordable Care Act—Sen. Ron Wyden explained[8] why he authored and championed Section 1332: "If States think they can do health reform better than under this bill, *and they cover the same number of people with the same comprehensive coverage*, they can get a waiver exempting them from the legislation and still get the Federal money that would have been provided under the bill" (emphasis added). This new guidance certainly departs from that concept.

4. Deficit Neutrality

As in previous guidance, projected federal spending net of federal revenue cannot increase under a waiver over either a 5 year or a 10 year period.

Federal Pass-Through Funding

The federal government estimates the amount it would pay to a state's residents in premium tax credits, cost-sharing reductions, and small-business tax credits absent a waiver, and subtracts any amount the federal government would instead spend under the waiver plan. This difference (minus any reduction in federal revenue attributable to the waiver) is passed through to the state. The federal money that is passed through to the state can only be used to implement the approved waiver plan.

Five New "Principles" for Waivers

Besides undermining previous protections, the guidance includes five new principles that will lead the administration to consider a waiver favorably. While the titles of these principles use inoffensive phrasing, further review and the administration's recent actions regarding Medicaid waivers demonstrate that these principles can also really harm vulnerable consumers. Thus, people should look carefully at how state waivers propose to incorporate these principles:

1. **"Provide increased access to affordable private market coverage."** As described above, the waiver guidance leaves the door open for cheap plans that cover little. "A section 1332 waiver should foster health coverage through competitive private coverage, including Association Health Plans (AHPs) and Short Term Limited Duration Insurance (STLDI) plans, over public programs," according to the guidance. It also leaves the door open for plans that can make unlimited profits and that do not have to adhere to any benefits standards.

2. **"Encourage sustainable spending growth."** Under this heading, the administration urges states to consider "eliminating or reducing state-level regulation." However, state regulation is what helps protect consumers from shoddy health plans when the federal government fails to do so.
3. **"Foster state innovation."** This could mean anything. Under this principle, the guidance only says, "States are better positioned than the federal government to assess and respond to the needs of their citizens with innovative solutions. We encourage states to craft solutions that meet the needs of their consumers and markets and innovate to the maximum extent possible under the law." But we know from the rest of the guidance that the administration is embracing the use of federal dollars to pay for inadequate coverage. Congress voted down a very similar proposal in 2017 (the proposed American Health Care Act), when the Congressional Budget Office explained that allowing waivers of benefit and price protections would destabilize markets and leave many people unable to afford care.[9]
4. **"Support and empower those in need. Americans should have access to affordable high value insurance."** Thankfully, the guidance explains, "Some Americans, particularly those with low incomes or high expected health care costs, may require financial assistance" and should receive support. The language is troubling, however, because of the way it has been used in other contexts in recent years. For example, imposing work requirements as a condition for receiving Medicaid benefits has been characterized as a way to "empower" people to move out of poverty.[10] Thus, as members of the public weigh in on state waiver requests, they should look carefully to make sure that initiatives will support people and not make it harder for them to qualify for coverage.
5. **"Promote consumer-driven health care."** Consumer-driven health care is a name given to high-deductible health plans that can be coupled with health savings accounts. Already, many people struggle to afford care until they meet their plans' deductibles. Consumers' ability to save money for their health care in a savings account varies according to their incomes, their health needs, and their other competing basic needs. We are concerned about the potential for consumer-driven health care to give favorable tax treatment to richer Americans who are able to save, to fail to help poorer Americans, and to drive health insurance deductibles even higher. Thus, the public should look carefully at how any proposed consumer-driven health plans would affect people of various income groups.

Medicaid Implications

A 1332 waiver cannot alter provisions of the Medicaid program, nor can a Medicaid 1115 waiver alter the Affordable Care Act's private insurance provisions. However, states can submit coordinated 1332 and 1115 waiver applications, and the federal government will consider each application separately. Moreover, a 1332 waiver could have indirect effects on the Medicaid population, as described here.[11] Previous 1332 guidance required states to consider whether there might be changes in Medicaid enrollment or in the number of low-income people having Medicaid coverage (or coverage at least as good) as a result of

a waiver. These safeguards are now gone. Instead, the new guidance raises the prospect that states that have not expanded their Medicaid programs could instead use a federal pass-through of premium tax credit funding under a 1332 waiver to provide a much inferior product to people with income under 100 percent of the poverty level ($12,140 for a household of one in 2018). Under this guidance, then, poor adults might get coverage less comprehensive than Medicaid. At the same time, populations with somewhat higher incomes that are eligible for the existing premium tax credit could conceivably lose premium assistance in part or entirely, with the state offsetting their loss of coverage with the gain in coverage for the expansion population. The public should be watchful and oppose waiver proposals that do not make coverage and care as affordable and as accessible as they would be if a state expanded its Medicaid program with enhanced federal match and left premium tax credits and cost-sharing reductions in place.

Waiver Application Process

It will be somewhat easier and faster for states with short legislative sessions to apply for waivers under the guidance. States can now enact laws that authorize pursuit of a waiver in broad terms, but then defer to the governor or state regulation to further spell out the parameters of the waiver. States are still required to provide public notice, hold a 30-day comment period, and consult tribes before submitting an application; the federal government is still required to accept public comment for 30 days on waiver applications that it deems complete.

We anticipate that some states will submit waiver applications to the federal government during the first three months of 2019 for implementation in 2020. It is important for consumers and their advocates to be in touch with state agencies that might be preparing waiver requests so that they can have input as a proposal is being developed, and so that they can promptly review and comment on any pending proposals.

Conclusion

The new waiver guidance is extremely concerning because it will allow states to use federal dollars to subsidize side-by-side health care systems, one that includes protections for low-income residents and people with preexisting conditions, and one that does not protect either low-income residents or those who incur high health care costs. This sort of bifurcation can destabilize health insurance and cause prices for comprehensive coverage to rise steeply. We do not know if the guidance will stand up to legal challenges given its inaccurate reading of the Section 1332 statute as detailed above.

At the state level, proposed innovations may still be **good** for residents, and take into account needs across the income, age, and health spectrum, or proposed innovations may be **bad** for state residents, and particularly for vulnerable groups with few resources and large health needs. It will be up to consumers and their advocates to watch these proposals carefully as they are developed in states, commenting to both state administrators and elected officials about what will and will not meet residents' needs.

We urge you to get in on the process early by talking to your state insurance department (and, if you have one, your state-based exchange) about whether the state is developing an innovation proposal. If your state legislature is delegating authority to pursue a waiver to the executive branch, make sure the

agency charged with developing a waiver is one that consumers trust and that the legislature sets forth at least some broad parameters to protect vulnerable consumers. If the legislature is more likely to protect consumers than the executive branch, it should not cede its authority to review and approve a waiver proposal before submission to the Department of Health and Human Services.

Also, be aware of any indirect consequences a 1332 waiver might have for the Medicaid program. States that have not yet expanded Medicaid to adults with incomes up to 133 percent of the poverty level can still get enhanced Medicaid match for doing so. If a state is tempted to use 1332 dollars to subsidize private coverage for this population instead, the state will by definition get less money overall than it would by expanding Medicaid and retaining the existing premium tax credit structure, low-income adults may have to pay more for less coverage, and moderate-income residents may lose premium tax subsidies. Besides explaining that Medicaid can better protect the very low-income population, you can explain that the increased federal dollars that come to states that expand Medicaid are an economic stimulus.[12]

Finally, remember that there are official public comment periods at both the state and federal level where you can review waiver proposals and the estimates of how they will affect coverage. Be sure to sign up for any mailing lists that will promptly alert you if your state posts a waiver for public comment. Once a state submits its application to CMS, you can also comment to the federal government about whether the application should or should not be approved.

Until December 24, 2018, you can also comment to CMS and ask the federal agencies to reconsider this new guidance to make it more protective—point out that under this guidance, waivers could undermine coverage for people with preexisting conditions and erode comprehensive coverage, which is not allowable under the Affordable Care Act.

Endnotes

[1] See Families USA's table "Private Insurance Provisions that Can and Cannot be Waived Through State Innovation Waivers Under Section 1332 of the Affordable Care Act," (2017), available online at https://familiesusa.org/sites/default/files/documents/what_can_be_waived_table.pdf. This is based on whether various provisions are in the title that can be waived.

[2] CMS and Treasury State Relief and Empowerment Waivers Guidance, 83 Fed. Reg. 53575 (Oct. 24, 2018), available online at https://www.federalregister.gov/documents/2018/10/24/2018-23182/state-relief-and-empowerment-waivers.

[3] CMS and Treasury Waivers for State Innovation Guidance, 80 Fed. Reg. 78131 (Dec. 16, 2015), available online at https://www.federalregister.gov/documents/2015/12/16/2015-31563/waivers-for-state-innovation.

[4] Patient Protection and Affordable Care Act, 42 U.S.C. §18022 (2010).

[5] National Health Law Program. (2018, May 9). *Step guide to updating states' essential health benefits benchmark plans.* Washington, DC: H. Penan. Available online at http://www.healthlaw.org/issues/health-care-reform/step-guide-states-essential-health-benefits-benchmark-plans#.W9hiXlVKjIU.

[6] For protections that are and are not in the title that can be waived, see Families USA's table, "Private Insurance Provisions that Can and Cannot be Waived Through State Innovation Waivers Under Section 1332 of the Affordable Care Act," (2017), available online at https://familiesusa.org/sites/default/files/documents/what_can_be_waived_table.pdf.

[7] U.S. Senate Committee on Finance. (Oct. 22, 2018). *Wyden slams Trump perversion of 1332 waivers* [Press statement]. Available online at https://www.finance.senate.gov/ranking-members-news/wyden-slams-trump-perversion-of-1332-waivers.

[8] The Constitutionality of Health Insurance Reform, Part II: Congressional Power: Hearings before the Senate, 111th Cong. 51852 (2009, Dec. 23) (Statement of Sen. Ron Wyden). Available online at https://www.congress.gov/congressional-record/2009/12/23/senate-section/article/s13796-4?q=%7B.

[9] Congressional Budget Office. (2017, May 4). *Congressional Budget Office cost estimate: H.R. 1628 American Health Care Act of 2017 as passed by the House of Representatives on May 24, 2017.* Available online at https://www.cbo.gov/system/files?file=115th-congress-2017-2018/costestimate/hr1628aspassed.pdf.

[10] Centers for Medicare & Medicaid Services. (2017, Nov. 7). *Remarks by Administrator Seema Verma at the National Association of Medicaid Directors (NAMD) 2017 fall conference.* Available online at https://www.cms.gov/newsroom/fact-sheets/speech-remarks-administrator-seema-verma-national-association-medicaid-directors-namd-2017-fall.

[11] Fish-Parcham, C., & Callow, A. (2016, January 14). *How could a 1332 waiver affect Medicaid and CHIP?* [Short analysis, Families USA]. Available online at https://familiesusa.org/product/how-could-1332-waiver-affect-medicaid-and-chip.

[12] See Kliff, S. (2012, July 10). *Medicaid's stimulative effect.* [Blog post, The Washington Post Wonkblog]. Available online at https://www.washingtonpost.com/news/wonk/wp/2012/07/10/medicaids-stimulative-effect/?noredirect=on&utm_term=.50281a3fdbc6. Also see the studies linked in that article.

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