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Administration Guidance on State Innovation Waivers Restricts Flexibility

The Department of Health and Human Services (HHS) and the Treasury Department released joint guidance Friday, December 11, on how they intend to review applications for state innovation waivers.¹ Under section 1332 of the Affordable Care Act (ACA), states may seek waivers from HHS and the Treasury of certain provisions of the ACA related to health insurance exchanges, federal subsidies, qualified health plans, and the individual and employer mandates. To be approved, so-called 1332 waivers must provide coverage that covers a comparable number of people at least as affordably and as comprehensively, and at no greater cost to the federal government, than would be the case without the waiver. Applications for such waivers can be submitted at any time and can be effective no earlier than January 1, 2017. The guidance explains how HHS and Treasury intend to interpret the statutory conditions for granting a waiver when they review applications.

While the statutory guardrails provide some flexibility in what types of waivers may be approved, the new guidance imposes interpretations on those guardrails that limit the types of waivers that can be approved. It appears the guidance will not impede some waivers, especially operational or technical waivers with minimal impact on the guardrails. However, HHS and Treasury say they lack the operational capacity to customize federal-facilitated Marketplace (FFM) or Internal Revenue Service (IRS) practices or procedures for particular state waivers, further restricting the feasibility of some waivers.

Executive Summary

Section 1332 permits HHS and the Treasury to grant state innovation waivers of specific provisions of the ACA—the statutory requirements for health insurance exchanges and the qualified health plans and subsidies offered on those exchanges; the individual mandate to maintain health coverage; and the large employer requirement to offer health coverage to full-time employees—but only if the waiver satisfies four guardrails. The guardrails require that the coverage that is available under the waiver be, as compared to coverage without the waiver: (1) as comprehensive; (2) as affordable; (3) cover a comparable number of people; and (4) at no increase to the federal deficit. A state can propose a section 1332 waiver in connection with waiver of Medicaid requirements, but section 1332 does not expand existing statutory Medicaid waiver authority. Waivers can be approved for five years and can be renewed.

Before the most recent guidance, HHS and the Treasury provided limited guidance on the substantive standards they intend to use in reviewing waivers, promulgating regulations that set only the procedural requirements for applying for a waiver. In the absence of federal guidance, states have considered a wide range of waiver concepts, from comprehensive rearranging of state coverage and subsidy programs (often integrating with Medicaid), to more narrow waivers. To date, only a single state, Hawaii, has released a complete waiver proposal that it intends to submit. Hawaii's waiver addresses a narrow issue that is unique to that state: the interaction of the ACA and Hawaii's pre-ACA requirement for employers to provide health coverage.

The manner in which the new guidance interprets section 1332 appears to significantly limit the types of waivers that HHS and Treasury are likely to approve:

¹ <https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-31563.pdf> The guidance will be published in the *Federal Register* on December 16, 2015.

- HHS and Treasury retain the discretion to deny a waiver application even if it satisfies all guardrails.
- When considering the impact on the federal deficit, the waiver is considered alone, without taking into account the impact of any corresponding Medicaid waiver, limiting the ability to spend more on the section 1332 waiver program based on Medicaid savings.
- When evaluating the comprehensiveness, affordability, and coverage guardrails, the state is required to consider both the impact on the state as a whole, as well as on different subgroups, such as the poor, elderly, and chronically ill. It appears the waiver cannot make coverage less available, comprehensive, or affordable for any subgroup.
- HHS says it will not be able to customize the FFM for states that use it, limiting the ability of such states to implement significant waivers while still using the FFM. Similarly, Treasury says the IRS is restricted in its ability to customize tax administration for particular states, limiting the ability of states to implement some waivers of the premium tax credits and individual and employer mandates, all of which are administered by IRS.

Taken as a whole it appears this guidance will limit states' abilities to obtain waivers that significantly reorder coverage for those without Medicare, Medicaid, or employer-sponsored coverage, especially waivers that would have reshaped the populations that receive subsidies. Nonetheless, many provisions of the guidance are written in non-mandatory language, suggesting that HHS and Treasury may be willing to approve waivers that deviate from some elements of the guidance.

Key Provisions

Legal Effect

The HHS and Treasury guidance was not published as a regulation and therefore does not have the force of law. Nonetheless, it provides guidance on how HHS and Treasury intend to review waiver applications. Future administrations will need to follow this guidance or risk being challenged for taking arbitrary and capricious action. However, should future administrations choose to revise this guidance, they are free to and could do so by publishing a notice in the *Federal Register*. HHS and Treasury are soliciting comments on the guidance but are under no obligation to respond to the comments or revise the guidance.

Coverage Guardrail

The guidance explains that, to satisfy the coverage guardrail, minimum essential coverage (the type of coverage that satisfies the ACA individual mandate) must be forecast to be provided to at least the same number of people under the waiver as without. Changes in enrollment across coverage programs would be considered, including coverage that is not directly affected by section 1332 (like Medicaid or large employer coverage) and the coverage guardrail "generally" must be expected to be satisfied each year of the waiver and for subgroups, such as the poor, elderly, and chronically ill.

Affordability Guardrail

Under the guidance, affordability would be tested by comparing the ratio of estimated total out-of-pocket cost to enrollee income, with and without the waiver. Total out-of-pocket costs include both premiums and cost-sharing (deductibles, copayments, and coinsurance). Affordability would be tested for the state as a whole, regardless of whether individuals were enrolled in coverage directly affected by the waiver, as well as for vulnerable subgroups. Waivers could also not increase the number of people without coverage that meets minimum value and affordability standards set by the ACA and Medicaid law. This guardrail "generally" must be expected to be satisfied for each year of the waiver.

Comprehensiveness Guardrail

Coverage provided under a waiver must, pursuant to the guidance, be at least as comprehensive as the ACA essential health benefits (EHB) package. At least the same number of residents must have coverage that is as comprehensive as the coverage required under each of the ten EHB benefit categories. The waiver could also not have the effect of reducing the number of residents with coverage at least as comprehensive as that under the state's Medicaid and CHIP programs. This guardrail is also tested for the state as a whole and for vulnerable populations. This guardrail also "generally" must be expected to be satisfied for each year of the waiver.

Deficit Neutrality

The deficit neutrality guardrail evaluates federal expenses and revenue, with and without the waiver. Revenue includes any changes in taxes collected due to the waiver, including changes to ACA-related taxes and credits, such as the premium tax credit, individual and employer mandate-related taxes and assessments, and the Cadillac tax. Expense changes would include the cost sharing reduction payments, Medicaid spending, and federal administration expenses. The waiver must be budget-neutral over the five-year waiver window and a required ten-year budget window. Although it appears a waiver could be approved if it were not expected to be budget neutral in any particular year, HHS and Treasury say they would be less likely to approve such a waiver. Budget projections should assume the waiver continues permanently. Savings generated by other waivers, such as Medicaid waivers under section 1115 of the Social Security Act, will not be counted for the sake of the section 1332 deficit neutrality test.

Operational Limitations

Because HHS says it cannot customize the FFM for particular states in the immediate future, states that use the FFM may not be able to implement certain waivers that could otherwise be approvable if they wish to continue using the FFM. Such as state could create its own exchange, or propose a waiver that does not rely on an exchange-like platform. Similarly, Treasury says IRS cannot modify tax administration for particular states. While a state could choose to waive an entire provision—such as eliminating premium tax credits under section 36B of the Internal Revenue Code and using the money saved for some other form of state-administered subsidy—IRS cannot implement waivers that keep but modify a tax provision.

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