
February 5, 2015

Understanding the Affordable Care Act's State Innovation ("1332") Waivers

By Jessica Schubel and Sarah Lueck

Considerable uncertainty surrounds the potential scope of the "waivers for state innovation" authorized under the Affordable Care Act (ACA), which allow states to modify how they implement key elements of health reform beginning in 2017. Also known as "1332 waivers" for the section of the ACA creating them, the waivers are attracting attention as a way states may pursue their own approaches to expand coverage, including alternatives that would represent a significant departure from the ACA's standards and requirements.¹

Many aspects of the ACA, however, cannot be waived. Moreover, the ACA establishes several conditions that states must satisfy if they diverge from ACA standards and requirements. These conditions ensure that states using the ACA's waiver authority continue to meet the overarching goals of health reform, such as extending access to affordable health coverage that provides a basic level of benefits.

In addition, section 1332 waiver authority doesn't extend to Medicaid or the Children's Health Insurance Program (CHIP). If a state wants to change these programs at the same time that it changes how it implements health reform, it can simultaneously request approval of a Medicaid or CHIP demonstration project under section 1115 of the Social Security Act. Section 1332 waivers aren't themselves "super waivers" that give states sweeping new authority over Medicaid or CHIP (or Medicare), as some have suggested.

This paper describes key elements of 1332 waivers, how states may use them, what conditions states must satisfy to receive federal approval, and how they interact with existing waiver authority related to other federal health programs.

The Origins of 1332 Waiver Authority

Federal authority allowing states to vary from the requirements of federal health coverage programs isn't new. Many states, for example, are using or have used waiver authority under section

¹ Section 1332 waivers have also been described as "Wyden waivers" because Senator Ron Wyden was the chief supporter of the original provision and as "2017 waivers" because they can first take effect in 2017.

1115 of the Social Security Act to carry out demonstration projects in Medicaid. States have used waivers to expand the use of managed care, cover individuals not otherwise eligible for Medicaid, and obtain federal matching funds for services and activities that Medicaid typically doesn't cover.

Medicare waivers related to delivery system and payment reforms are also available, though they are quite limited in scope, must be specifically authorized by legislation, and are usually administered by the federal government rather than the states. The ACA has given states some limited ability to seek Medicare waivers for changes affecting the delivery of care to “dual eligibles” — beneficiaries eligible for both Medicaid and Medicare.²

The ACA's 1332 waivers are based on a provision in the Healthy Americans Act, health reform legislation that Senator Ron Wyden, a Democrat, introduced in 2007 and 2009 with then-Senator Robert Bennett, a Republican.³ Under the final version of section 1332, the HHS Secretary may waive certain ACA provisions dealing with the health insurance marketplaces, the subsidies available through the marketplaces, the requirement for individuals to have coverage or pay a penalty, and the “shared responsibility” requirement for employers with 50 or more full-time-equivalent workers.⁴ The waiver does *not* apply to other ACA provisions. For example, states cannot use section 1332 to waive the ACA's insurance market reforms, such as the limitations on how much insurers in the individual and small-group markets can charge older people compared to younger people. Nor can states waive the ACA's risk adjustment program, designed to protect insurers in the individual and small-group markets from financial harm if they attract enrollees with higher-than-average costs.

To obtain federal approval of a 1332 waiver, a state must: (1) provide benefits at least as comprehensive as the “essential health benefits” that all plans in the individual and small-group insurance markets must cover; (2) provide cost-sharing protections and coverage at least as affordable as those in the marketplaces; (3) ensure that at least a comparable number of people have health coverage as under current law; and (4) not increase the federal deficit.

Because 1332 waivers cannot take effect until 2017, the federal government will be better able to assess the impact of state waiver proposals on coverage, affordability, and costs based on actual experience in implementing health reform. For example, federal officials will be better able to determine whether benefits provided through a waiver are as comprehensive as the benefits and cost-sharing protections in plans now provided through a state's marketplace. It also will be able to compare the number of people projected to be covered under a waiver with the number being covered under the ACA.

² Because existing Medicare waiver authority is more limited in nature and focuses primarily on ways to deliver care to specific populations, it's unlikely that states could (or will) request Medicare waivers in combination with 1332 waivers. Therefore, this paper does not address them.

³ For more on the history of these waivers, see, John E. McDonough, “Wyden's Waiver: State Innovation on Steroids,” *Journal of Health Politics, Policy and Law*, May 19, 2014.

⁴ Other federal agencies will likely also be involved in reviewing and approving 1332 state waiver requests because they have authority over provisions within the scope of section 1332. For example, the Treasury Department and the Internal Revenue Service administer the shared responsibility provisions for individuals and employers and jointly administer the provision of premium tax credits with HHS.

How 1332 Waivers Can Vary the Terms of Marketplace Coverage

Section 1332 waivers allow states to waive the following provisions:

- **Part I of subtitle D of the ACA's Title I:** This part includes the essential health benefit (EHB) requirements, which both ensure that marketplace plans cover a comprehensive array of medical benefits and limit the cost-sharing charges that enrollees must pay. This part also establishes the “metal” levels (bronze, silver, gold, and platinum) standardizing the plans that insurers may offer based on their relative generosity, sets standards for the catastrophic plans available to certain individuals, and defines which employers are in the small-group market (and thus subject to ACA requirements for small-group plans).
- **Part II of subtitle D of the ACA's Title I:** This part includes minimum federal standards for marketplace plans, such as a requirement that plans include a sufficient choice of health care providers in their networks and receive accreditation on quality measures. It also includes a list of functions that marketplaces must perform, including providing a telephone hotline and website for consumers and informing people about eligibility for various health programs such as Medicaid. And it establishes a “single risk pool” requirement under which each insurer in the individual or small-group markets must consider all of its enrollees in all of its plans (within each respective insurance market) when setting premiums. This part also requires insurers to submit a variety of enrollment and claims data to the marketplaces.
- **Section 1402 of the ACA:** This section establishes the cost-sharing reductions available to low- and modest-income people in marketplace plans. These subsidies reduce the deductibles, copayments, and overall annual out-of-pocket costs that eligible people pay under marketplace plans.
- **Section 36B of the Internal Revenue Code (IRC):** This section establishes the premium tax credit that helps people buying marketplace plans to afford their premiums, including how the credit is calculated, who is eligible, and the premium contributions that people at different income levels must make toward marketplace coverage. This section also specifies that the premium tax credit is only available to someone who has purchased a plan through the marketplace and establishes the procedure for increasing or reducing the credit at tax filing for people whose income or household size has changed since their eligibility for advance payments of the credit was determined.
- **Section 4980H of the IRC:** This section establishes penalties for employers of 50 or more full-time-equivalent workers that either do not offer health coverage or offer coverage that fails to meet certain standards. This section also defines which employers are subject to this requirement, the standards that employer-sponsored coverage must meet to be considered affordable and adequate, and the penalties for employers not providing coverage.
- **Section 5000A of the IRC:** This section includes the individual mandate, which requires most individuals to have health coverage or pay a penalty. It specifies the amount of the penalty and the categories of people who are exempt from paying it. It also defines what types of health coverage constitute “minimum essential coverage” for purposes of determining whether someone has coverage (and thus doesn't have to pay a penalty).

Many important components of the ACA aren't subject to section 1332 and thus can't be waived. For example, as noted above, the ACA's reforms to the individual, small-group, and large-group markets and/or self-insured plans are in subtitles A, B and C of Title I of the ACA, which can't be

waived. This means a state couldn't use section 1332 to waive the ACA's prohibition against insurers denying coverage or charging higher premium rates to people with pre-existing health conditions, its ban on annual and lifetime coverage limits in most plans, its requirement to cover certain preventive medical care at no charge to enrollees, or its requirement to cover adult dependents up to age 26. Nor could a state use a 1332 waiver to eliminate an array of ACA provisions that bar discrimination against people based on health status, disability status, race, age, or sex, or other factors.

Additional federal guidance is needed to fully establish whether certain other ACA requirements and standards lie within or outside the scope of 1332 waivers. For example, a state could use a 1332 waiver to modify the EHB requirements that apply to marketplace plans. But the EHB requirements also apply to individual and small-group plans offered outside the marketplace, and the provision that applies the EHB requirements outside the marketplace isn't within the scope of section 1332, so waivers of it likely will not be permissible.⁵

Waiver Standards Protect Consumers and Ensure That Waivers Meet ACA Coverage Goals

States must satisfy several conditions to obtain 1332 waiver approval. In general, the waiver can't leave state residents worse off than if they had continued to receive marketplace coverage. The conditions fall into four categories:

- **Coverage must be comprehensive.** While states may use a 1332 waiver to make changes to the EHB requirements or change which plan is used as a benchmark for determining the advance premium tax credit amount, a state must demonstrate that coverage under its waiver would be “at least as comprehensive” as marketplace coverage.⁶ Questions remain about how much leeway a state might have in providing comparable coverage and, specifically, what “at least as comprehensive” means. HHS will need to further clarify how this test will work in practice, as well as provide additional guidance on the types of data that states must include in their application to demonstrate that they meet this requirement.
- **Coverage must be affordable.** Section 1332 waiver authority appears to allow changes to the minimum requirements for marketplace plans regarding the generosity of coverage and how much enrollees must pay in premiums and cost-sharing charges. However, the state must demonstrate that, under the waiver, people will have access to coverage and cost-sharing protections that are at least as affordable as under the marketplace. The statutory language makes clear that states must continue to provide people with comprehensive benefits and protect them from excessive out-of-pocket costs. HHS will need to clarify how it will evaluate compliance with this standard.

⁵ The ACA amended the Public Health Service Act (PHSA) by adding a new section 2707 that applies the EHB requirement in section 1302(a) of the ACA — which is subject to a 1332 waiver — to all insurers in the individual or small-group market, both inside and outside the marketplace. This new section of the PHSA also requires all group health plans (including large-group plans and self-insured plans) to include the annual limitation on out-of-pocket costs described in section 1302(c). Section 2707 isn't explicitly referenced in the list of provisions subject to a 1332 waiver, so a waiver of its requirements will not likely be permitted under section 1332.

⁶ Section 1332 requires that states provide sufficient data for the Office of the Actuary of the Centers for Medicare & Medicaid Services to certify the comprehensiveness of waiver coverage.

- **A comparable number of people must have coverage.** States must ensure that the number of people receiving coverage under a 1332 waiver is at least comparable to the number who would have had coverage without the waiver. This means that, at a minimum, states must ensure that the waiver doesn't result in more uninsured individuals relative to current law. HHS will need to clarify what data and methodology it will use to determine coverage levels in the state with and without the waiver.
- **The waiver must not increase the federal deficit.** While a 1332 waiver's initial duration is five years, a state seeking a waiver must demonstrate that it will be budget-neutral to the federal government over ten years. Under the waiver, states would be able to use federal funds in ways that may not otherwise be permissible — for example, to provide premium subsidies to people at higher income levels than the ACA allows. But states would have to offset the added cost with savings in other areas. Federal guidance is needed to determine how such a budget-neutrality test would work: for example, whether states could count savings accrued in other federal health programs outside the marketplace to offset the cost of increased marketplace subsidy spending.

How Might States Use 1332 Waivers?

Federal and state officials have suggested various ways that states might use 1332 waivers. For example, some believe that a state could use a 1332 waiver to add a “public option” under which the state would offer its own plan in the marketplace to compete with private plans. A state could also use a 1332 waiver to offer in the marketplace an alternative health insurance affordability program for people with incomes too high for Medicaid — that is, a program similar to a Basic Health Program, which states can create under the ACA, but with more design flexibility.⁷

Hawaii has indicated that it may pursue a 1332 waiver to maintain its longstanding requirement that employers provide workers with health insurance, which differs from the ACA's “shared responsibility” requirement for employers.⁸ In New Mexico, a state senator recently introduced legislation to establish a task force to examine how the state might use federal subsidy funds differently under a 1332 waiver to improve health care for its residents.⁹

1332 Waivers Don't Replace Existing Medicaid Waivers

Confusion persists around how 1332 waivers would interact with Medicaid. Section 1332 doesn't give states authority to change Medicaid and CHIP. Any changes affecting beneficiaries of those programs would need to be instituted under existing Medicaid waiver authority.

⁷ The Basic Health Program is an optional coverage program states can take up to provide health insurance to individuals with incomes between 133 and 200 percent of the federal poverty line. More information on the Basic Health Program is available at <http://www.cbpp.org/files/3-13-12health.pdf>.

⁸ Presentation by Gordon Ito, Hawaii Insurance Commissioner, to the Health Care Reform Regulatory Alternatives (B) Working Group of the National Association of Insurance Commissioners (NAIC), at NAIC's 2014 Fall National Meeting.

⁹ Innovation Waiver Working Group bill, SJM 2, Jacob Candelaria, introduced December 15, 2014.

While 1332 waivers alone can't change a state's Medicaid program, states may apply jointly for a 1332 waiver and a Medicaid waiver to make changes that affect both programs. For example, a state may seek to waive certain requirements for marketplace plans and corresponding Medicaid managed care rules to achieve better continuity of care between plans offered in the marketplace and Medicaid. Such an approach could allow more managed care companies participating in a state's Medicaid program to offer coverage in the marketplace, or vice versa.

To facilitate such complementary approaches, section 1332 allows states to submit a single application for Medicaid and CHIP waivers *and* a 1332 waiver. The single application doesn't confer new waiver authority; it merely simplifies the application process by consolidating the various waiver requests into one document.

To be sure, there are some differences in application requirements. While the ACA requires HHS to issue regulations on application requirements and a process for public notice and comments for both section 1332 and Medicaid waivers, the requirements don't entirely align (see Table 1 for specifics).¹⁰ HHS will need to provide additional guidance to reconcile the different requirements concerning applications and the public notice process to create a truly coordinated process.

Conclusion

Section 1332 waivers have the potential to give states flexibility to alter certain provisions of health reform — particularly related to the health insurance marketplaces, the federal subsidies available through the marketplaces, and the ACA's "shared responsibility" requirements for individuals and employers. The waivers are limited in scope, however, and must ensure comprehensive coverage, affordability, comparable enrollment, and budget neutrality. Section 1332 doesn't directly affect Medicaid or CHIP, but 1332 waivers could help simplify a state's efforts to make cross-cutting changes to its public health insurance landscape by allowing the state to combine waiver requests for various programs into a single application.

¹⁰ Additional information on the 1332 waiver and Medicaid waiver public notice requirements can be found at <http://www.gpo.gov/fdsys/pkg/FR-2012-02-27/pdf/2012-4395.pdf> and <http://www.gpo.gov/fdsys/pkg/FR-2012-02-27/pdf/2012-4354.pdf>.

Table 1

Comparing Application Requirements for 1332 and Medicaid Waivers

Requirement	1332 Waiver	Medicaid Waiver
Application Elements	<ul style="list-style-type: none"> • Program description • Requested waiver authorities • 10-year budget plan (with supporting actuarial certifications and economic analyses) • Authorizing state legislation • Explanation of how waiver will meet ACA goals of coverage expansion, affordability, and comprehensive coverage • Explanation of waiver’s effect on individuals, insurers, employers, other ACA provisions, and efforts against fraud, waste, and abuse • Evidence of compliance with public notice requirements • Reporting plans 	<ul style="list-style-type: none"> • Program description • Requested waiver and expenditure authorities • Financing and budget neutrality information • Description of proposed health care delivery system, eligibility requirements, covered benefits, and cost sharing • Estimated annual enrollment and spending • Current enrollment data and enrollment projections • Other expected modifications to Medicaid or CHIP • Description of research hypotheses that will be tested and plan to evaluate them • Written documentation of state’s compliance with public notice requirements
State Public Comment Period	No timeframe specified	30 days
Number of State Public Hearings	No number specified	At least 2 hearings – one must be telephonic or have web capability
Federal “Completeness” Determination Period	45 days from submission	15 days from submission
Federal Public Comment Period	No timeframe specified	30 days
Final Federal Determination	180 days from determination of complete application	No timeframe specified