1332 State Innovation Waivers
Waiver Requirements and Recent Administrative Actions

Section 1332 of the Affordable Care Act (ACA) allows states to seek a waiver of key private coverage provisions in the law, including the coverage of essential health benefits, cost-sharing limits and network adequacy standards, and experiment with different health coverage models. Section 1332 was intended to give states the opportunity to pursue broad health care reform initiatives, as well as less comprehensive modifications of various aspects of the law’s coverage requirements to meet the needs of their residents. Waivers can affect the scope and structure of coverage for children and families in the individual and small group insurance markets, as well as their coverage in the broader commercial market.

States can seek a Section 1332 waiver in conjunction with a Section 1115 Medicaid waiver, but cannot use a Section 1332 waiver to change Medicaid program requirements. States with an approved waiver receive the federal funds that would have been provided to their residents through premium tax credits and cost-sharing reductions as “pass through” funds to support the state innovations.

To date, the Centers for Medicare & Medicaid Services (CMS) and the Department of Treasury have approved eight waivers from Alaska, Hawaii, Maine, Maryland, Minnesota, New Jersey, Oregon and Wisconsin. All of these states, except for Hawaii\(^1\), have used 1332 waiver authority to establish reinsurance programs. Additional states have submitted waiver applications or have passed authorizing legislation to do so.

Statutory language under the ACA and subsequent regulatory and subregulatory guidance from the Obama administration delineated the criteria that a waiver must meet in order to be approved. On Oct. 22, 2018, the Trump administration issued new guidance that renames the waivers as “State Relief and Empowerment Waivers” and gives states substantially more flexibility to pursue alternative approaches to private coverage under the ACA, including the promotion of less comprehensive and affordable coverage options, such as Association Health Plans (AHPs) and Short-Term Limited Duration Insurance (STLDI) plans. The new guidance takes effect immediately and will apply to waivers beginning in the 2020 plan year.

STATUTORY AND REGULATORY WAIVER REQUIREMENTS

ACA Statutory Requirements
Section 1332 of the ACA specifies which aspects of the law’s coverage provisions can and cannot be waived, as well as the procedures states must use to apply for and implement the waiver.

- **ACA provisions that may be waived**
  - States may waive all or any of the following ACA provisions:
    - The individual and employer mandates.
    - The requirements related to the establishment of a health insurance Exchange.

\(^1\) In January 2017, CMS approved Hawaii’s 5-year waiver application that allows the state to replace its Small Business Health Options Program with an alternative business model.
The coverage standards for the qualified health plans sold through the Exchanges, including essential health benefits (EHBs), cost-sharing limits, network adequacy standards, and actuarial value requirements.

The structure of the federal subsidies and cost-sharing reductions.

ACA provisions that may not be waived
States may not waive the private insurance protections enacted under the ACA, including:
- Prohibition on pre-existing conditions exclusions and medical underwriting.
- Prohibition on annual/lifetime limits on the dollar value of coverage.
- Dependent coverage for children until the child turns 26.
- Coverage without cost-sharing of recommended preventive services and immunizations.
- Prohibition on the rescission of coverage.

State waiver application and certification requirements ("guardrails")
States interested in applying for a waiver must:
- Certify that coverage under the waiver will be comparable to the coverage provided through the ACA. Specifically, the waiver must:
  - Provide coverage that is at least as comprehensive and affordable as provided absent the waiver.
  - Cover a comparable number of residents of the state as would be covered absent a waiver.
  - Not increase the federal deficit.
- Pass authorizing legislation and provide for a public notice and comment period, including public hearings.

Regulatory Requirements to Enforce Guardrails
Regulatory and subregulatory guidance from the Obama administration added strict requirements for states to demonstrate their compliance with the statutory guardrails. Under the guidance, state waiver applications were required to include:
- An assessment of how the waiver would affect vulnerable populations, including low-income individuals and those with high health care needs and risks.
- Assurances that people will not experience coverage gaps or lose coverage entirely under the waiver.
- Assurances that the waiver does not inadvertently decrease the number of people that have coverage for the full set of services covered under the state’s Medicaid and/or Children’s Health Insurance Programs, even though a state cannot use a 1332 waiver to change Medicaid policy.

The October 2018 Trump administration guidance significantly loosens those requirements and emphasizes a new focus on waivers that advance five core principles:
- Favoring affordable private market coverage (e.g. AHPs and STLDIs) over public plans (e.g. Medicaid and CHIP).
- Encouraging sustainable funding growth, including reducing state regulation of the market.
- Fostering state innovation.
- Supporting and empowering those in need.
- Promoting consumer driven health care.

A comparison of prior state waiver requirements under the Obama administration with the new requirements of the October 2018 Trump administration guidance is provided in the following chart.
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<thead>
<tr>
<th>Guardrail</th>
<th>Previous Requirements</th>
<th>New Guidelines</th>
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<tbody>
<tr>
<td><strong>Comprehensiveness:</strong></td>
<td>• Waiver cannot result in a decrease in the # of individuals with coverage that meets the statute’s EHB requirements.</td>
<td>• Comprehensive coverage must be available even if a comparable # of residents don’t purchase it.</td>
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<td>• Plans will be evaluated for comprehensiveness through a comparison with the state’s EHB benchmark, any other state's benchmark or any benchmark that the state chooses to build.</td>
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<td><strong>Affordability</strong></td>
<td>• Defines affordability as net out-of-pocket spending compared to income.</td>
<td>• Defines affordability as expected out-of-pocket spending.</td>
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<td>• Waiver cannot increase the # of residents with a large health care spending burden even if affordability is retained in the aggregate.</td>
<td>• State must demonstrate that a comparable # of residents have access to affordable coverage even if they don’t purchase the affordable coverage.</td>
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<td>• Places special emphasis on affordability protections for vulnerable populations.</td>
<td>• The waiver can make coverage substantially more affordable for some residents and slightly less affordable for others.</td>
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<td>• The analysis of affordability must address the empowerment of consumers, including those with high health care costs.</td>
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<td><strong>Covered Lives</strong></td>
<td>• Defines coverage (for the purposes of assessing the # of covered lives) as “minimum essential coverage,” which includes ESI and Exchange plans and excludes STLDIs and limited benefit plans.</td>
<td>• Allows coverage that does not meet the minimum essential coverage definition, such as STLDIs, to be considered when determining # of covered lives.</td>
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<td>• Waivers cannot decrease the # of covered lives over the course of the waiver or in any single year.</td>
<td>• Allows a temporary reduction in # of residents covered, if state provides a rationale and if the reduced coverage is balanced out by eventual gains.</td>
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2 The 2019 Notice of Benefit and Payment Parameters changed the EHB benchmark process to provide states and insurers more flexibility in the design of their EHBs. That flexibility is reflected in this guidance.
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<td>Waivers must not reduce # of residents with coverage that meets at least the ACA 60% minimum actuarial value (AV).</td>
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<td>• Eliminates requirement that a comparable # of residents must have coverage that meets at least the ACA minimum AV.</td>
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<td>Waiver cannot reduce coverage for groups of individuals, including individuals with low-incomes, the elderly and those with serious health issues.</td>
<td>• Waiver cannot reduce coverage for groups of individuals, including individuals with low-incomes, the elderly and those with serious health issues.</td>
<td>• Does not require a separate assessment of impact on coverage of different groups of individuals – some groups may lose coverage if it’s balanced out by gains in coverage among other groups.</td>
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<td>Changes in Medicaid enrollment caused by waiver count towards # of covered lives.</td>
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<th>State Authority to Submit Waiver</th>
<th>State legislature must enact new law specifically authorizing the state to submit a waiver application.</th>
<th>State may pursue waiver by executive order or regulation if state legislation already exists to give the state broad authority to implement the ACA, even if it doesn’t specifically authorize a waiver.</th>
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<td><strong>State must pass authorizing legislation</strong></td>
<td>• Cannot increase the deficit over the period of the waiver or in any single year of the waiver.</td>
<td>• May increase the federal deficit in any year so long as the total impact of the proposed waiver is budget neutral.</td>
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<td><strong>Must be deficit-neutral</strong></td>
<td>• Budget neutrality is calculated based on changes in federal spending for Exchange financial assistance, waiver administrative costs, and Medicaid spending.</td>
<td>• Budget neutrality calculations do not include changes in Medicaid spending.</td>
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**REINSURANCE PROGRAM AND HIGH-RISK POOL WAIVER CHECKLIST**

On May 11, 2017, CMS released a [checklist](#) for states interested in using a Section 1332 waiver to establish a high-risk pool or reinsurance program for their individual and small group private insurance markets. The checklist identifies the general procedural requirements that states must meet to secure, a waiver, as well as specific requirements to develop a high-risk pool or reinsurance program. The October 2018 guidance does not impact this checklist.

For more information, contact [Jan Kaplan](#).