# Federal Efforts to Stabilize ACA Individual Markets through State Innovation

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## ABSTRACT

Prior to full implementation of the Affordable Care Act (ACA) in 2014, states had taken the leading role in regulating individual health insurance markets. The ACA's regime of subsidies, penalties, and federal regulations made individual coverage more accessible to those with moderate incomes and those with preexisting medical conditions. Premiums for such coverage, however, doubled between 2013 and 2017, leading to turmoil in individual markets. Both Congress and the Centers for Medicare and Medicaid Services (CMS) sought to grant states more authority to stabilize their markets through a waiver process established by section 1332 of the ACA. These efforts fell short. Congress did not enact significant changes to the ACA, and few states obtained CMS approval for section 1332 waivers to stabilize their markets. This paper offers several recommendations for streamlining and improving that waiver process that would provide states with more tools to stabilize individual markets.

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The Affordable Care Act (ACA) made the federal government the primary regulator of individual and small group health insurance markets. Prior to its full implementation in 2014, states had taken the leading role in regulating these markets. The ACA established a mix of federal policies that made health insurance more accessible to two groups that had previously been largely excluded from the state-regulated market: people with relatively low incomes and those who would have been denied coverage or quoted high premiums because of their medical conditions. The result was considerable growth in the individual market in 2014 and 2015.

By 2017, however, the individual market was in turmoil. Premiums had more than doubled since December 2013, as previously uninsurable people signed up for coverage, while enrollment among young adults, a generally healthy demographic group whose participation was needed to stabilize markets, fell far short of projections.[1] Overall enrollment in individual markets began to decline as higher premiums rendered policies less attractive to millions of Americans.[2] In effect, federal intervention had made coverage more accessible to the indigent and infirm but less affordable for middle-income people in reasonably good health.

Consequently, throughout 2017, Congress and the Trump administration sought legislative and regulatory formulas that would produce more affordable coverage for the healthy and non-poor without reversing coverage gains among the poor and people with chronic medical conditions. In light of the failure of

1. Final data from the 2017 open enrollment season, for example, indicate that only 27 percent of those who selected a plan were between the ages of 18 and 34, roughly the same as in 2016 and equal to the proportion of enrollees between the ages of 55 and 64. Centers for Medicare and Medicaid Services, *Health Insurance Marketplaces 2017 Open Enrollment Period Final Enrollment Report,* March 15, 2017, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-03-15.html.
2. Mark Farrah Associates, *A Brief Look at the Turbulent Individual Health Insurance Market*, July 19, 2017, http://www.markfarrah.com/healthcare-business-strategy/A-Brief-Look-at-the-Turbulent-Individual-Health-Insurance-Market.aspx.

Congress to pass legislation to repeal and reform the ACA, a more promising approach is for states, in cooperation with the Trump administration, to take the initiative in stabilizing their markets, making full use of the flexibility provided them by section 1332 of the ACA.

A leading characteristic of proposals considered by Congress and the administration throughout 2017 was enhancing states' flexibility to stabilize fragile markets. The Centers for Medicare and Medicaid Services (CMS) solicited state applications for waivers from certain ACA requirements, which section 1332 of the statute authorizes the Health and Human Services secretary (sometimes jointly with the Treasury secretary) to issue.[3] Congress considered legislation both to expand this waiver authority and to provide the secretary with new waiver authorities.

These efforts bore little fruit in 2017. Congress failed to enact any meaningful changes to the ACA. CMS granted some state waiver applications, but states withdrew others during the fall of 2017 after the agency failed to act in time to affect 2018 premiums.

As of December 2017, individual markets in many states remain unstable. Premiums for silver plans are, on average, 37 percent higher in 2018 than in 2017, possibly auguring further enrollment declines.[4]

This paper begins by providing background on states' roles in managing individual marketplaces under the ACA and traces congressional efforts during 2017 to enlarge state authority. It also includes a detailed discussion of section 1332 of the ACA, as well as regulations and CMS guidance to states. That is followed by a discussion of state 1332 waiver requests filed during 2017. The paper concludes with specific recommendations to Congress and the administration to streamline and improve the 1332 waiver process. In particular, it recommends that CMS revise its existing guidance in order to expedite the process and redefine the budget neutrality requirements. It also recommends that Congress amend section 1332 to define budget neutrality more expansively and to facilitate state innovation.[5]

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3. Waiver for State Innovation, 42 U.S.C. § 18052 (2015).
4. HHS Office of the Assistant Secretary for Planning and Evaluation, Health Plan Choice and Premiums in the 2018 Federal Health Insurance Exchange, October 30, 2017, https://aspe.hhs.gov/pdf-report/health-plan-choice-and-premiums-2018-federal-health-insurance-exchange.
5. As of December 2017, there were several bills pending before Congress to revise the waiver process. Senate HELP Committee Chairman Lamar Alexander (R-TN) and Ranking Member Patty Murray (D-WA) released the text of a bill that would make certain changes to the 1332 process. See Bipartisan Health Care Stabilization Act of 2017, S. TAM17K02, 115th Cong. (October 19, 2017). Senators Susan Collins (R-ME) and Bill Nelson (D-FL) introduced a bill that would add a new subsection to section 1332 to facilitate waivers involving state reinsurance and "invisible high-risk pools." See Lower Premiums through Reinsurance Act of 2017, S. 1835, 115th Cong. (September 19, 2017).

## BACKGROUND: INDIVIDUAL HEALTH INSURANCE MARKETS UNDER THE ACA

The ACA enlarged federal control over the individual and small group health insurance markets. Prior to its enactment, regulation of these markets was primarily the responsibility of the states. State regulation varied widely. Most imposed requirements that insurers cover certain categories of services and providers.[6] Most states permitted medical underwriting, a practice in which insurers could charge people in poor health higher premiums than those in good health and deny them coverage entirely.[7] Many had high-risk pools.[8] A few required insurers to issue policies to all applicants and to cover their preexisting medical conditions.[9] Some states that adopted this approach also restricted premium variation based on an applicant's health status.[10]

The ACA imposed greater uniformity among states with respect to the regulation of individual health insurance coverage. The ACA's regulatory regime prohibited insurers from denying coverage or basing premiums on an applicant's medical condition. It also created premium and cost-sharing subsidies for individual coverage and levied tax penalties on the uninsured.

With some exceptions, states could permit the sale only of policies that were ACA compliant—that is, policies that met federal standards on benefits, medical underwriting, and actuarial value. States also were required to enforce federal requirements on insurers related to guaranteed issue, allowable premium variation, and the coverage of preexisting medical conditions.

These requirements largely divorced premiums from medical risk. This made coverage more affordable to people who previously might have been required to pay high premiums for individual policies, people relegated to a high-risk pool, or people denied insurance entirely. Bringing such people into

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6. Chapin White and Amanda E. Lechner, "State Benefit Mandates and National Health Reform" (Policy Analysis No. 8, National Institute for Health Care Reform, Washington, DC, February 2012).
7. One study estimated that insurers refused coverage to 18 percent of applicants before the ACA required insurers to issue policies to everyone who sought them. See Gary Claxton et al., "Preexisting Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA" (Issue Brief, Kaiser Family Foundation, Washington, DC, December 12, 2016), 2.
8. Karen Pollitz, "High-Risk Pools for Uninsurable Individuals" (Issue Brief, Kaiser Family Foundation, Washington, DC, February 22, 2017).
9. Kaiser Family Foundation Focus on Health Reform, *Health Insurance Market Reforms: Pre-Existing Condition Exclusions*, September 2012; Kaiser Family Foundation Focus on Health Reform, *Health Insurance Market Reforms: Guaranteed Issue*, June 2012.
10. Justin Giovannelli, Kevin W. Lucia, and Sabrina Corlette, "Implementing the Affordable Care Act: State Action to Reform the Individual Health Insurance Market" (Pub. 1758, Vol. 15, Commonwealth Fund, Washington, DC, July 2014).

the individual market threatened to destabilize that market. To address this concern, the ACA instituted a regime of penalties and subsidies. This included a tax penalty on the uninsured, established to induce people in relatively good health to buy a product that they may not otherwise have purchased.[11]

The ACA's penalties were coupled with a new federal entitlement to premium subsidies for those with incomes between 100 and 400 percent of the federal poverty level (FPL).[12] In addition, it provided those with incomes between 100 and 250 percent of FPL with cost-sharing reduction subsidies that increased the value of their coverage and reduced out-of-pocket expenses for covered, in-network services.[13] Premium subsidies made coverage more affordable; cost-sharing reduction subsidies reduced deductibles and other out-of-pocket costs for covered medical services. These subsidies were designed to draw people of modest means, who had disproportionately high rates of uninsurance, into the individual health insurance markets.

In short, the federal government instituted a sweeping new individual health insurance regulation regime to correct what many perceived to be a failure by states to establish robust individual health insurance markets.[14] States would henceforth enforce federal regulations, while many of their residents

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11. For details on the tax penalty on the uninsured, see Requirement to Maintain Minimum Essential Coverage, 26 U.S.C. § 5000A (2012). Assessing the effectiveness of the so-called individual mandate is difficult. The coverage models developed by the Congressional Budget Office (CBO) suggest that the tax penalty has exerted a powerful effect on enrollment in private individual coverage and in Medicaid. CBO ascribes that effectiveness to three factors: the "compliance effect" (people tend to want to comply with laws), "loss aversion" (people respond more to penalties than to subsidies), and "social norm" (the prevailing social norm directs everyone to obtain health insurance coverage). These assumptions have led CBO to conclude that, absent the mandate, 15 million people who enrolled in 2016 would have been otherwise uninsured. See Alexandra Minicozzi, "Modeling the Effects of the Individual Mandate on Health Insurance Coverage" (Presentation at the 2017 Annual Meeting of the American Academy of Actuaries, Congressional Budget Office, Washington, DC, September 15, 2017). In November 2017, CBO tempered its estimate of the coverage effects of mandate repeal, estimating that 13 million—rather than 15 million—fewer people would have health insurance coverage absent the tax penalty. That document went on to indicate that the agency was making "methodological changes to improve its estimates." Preliminary results of this undertaking, according to CBO, indicate that the coverage effects of mandate repeal "would probably be smaller than the numbers reported in this document." Congressional Budget Office, *Repealing the Individual Health Insurance Mandate: An Updated Estimate*, November 8, 2017, 4.

12. Refundable Credit for Coverage under a Qualified Health Plan, 26 U.S.C. § 36B (2011).

13. Reduced Cost-Sharing for Individuals Enrolling in Qualified Health Plans, 42 U.S.C. § 18071 (2012).

14. While the focus of this paper is individual market stability, the ACA's effects were not confined to that market. Group health plans, for example, were required to cover dependents through age 26 and could no longer impose annual or lifetime limits on coverage. The bill also extended Medicaid eligibility to nonaged, nondisabled adults and offered an enhanced federal matching rate to states that expanded coverage to this population. Discussion of the effects of those changes is beyond the scope of this paper.

would receive federal subsidies for their health insurance and out-of-pocket medical spending.

The results in the individual markets have been mixed. Data compiled by Mark Farrah Associates show that the purchase of individual policies spiked upward, beginning with the ACA's implementation in January 2014.[15] Enrollment in individual markets grew from 11.8 million in December 2013 to 17.7 million in December 2015, including both policies sold on the exchanges and those sold outside those marketplaces.[16] The enrollment trajectory started bending downward in 2016. By December of that year, enrollment stood at fewer than 17.1 million people.[17]

Enrollment in individual health insurance plans since 2014 has tended to peak during the first quarter of the year (when the ACA open enrollment period concludes) and to reach a trough in December.[18] In March 2016, for example,

15. This paper focuses on individual market enrollment, which the ACA has profoundly affected and which has attracted the most attention from policymakers. That market, however, is small relative to public coverage (chiefly Medicare and Medicaid) and group coverage (generally employer-sponsored insurance). While the ACA has affected all of those markets, a variety of factors affect overall coverage levels, including the expansion of Medicaid and economic factors such as the unemployment rate. Medicaid expansion has by far been the largest source of coverage increases since the ACA's implementation in 2014. Charles Courtemanche and coauthors estimated the ACA's coverage effects in 2014 across all public and private markets, netting out the impact of an improving economy. Charles Courtemanche et al., "Early Impacts of the Affordable Care Act on Health Insurance Coverage in Medicaid Expansion and Non-Expansion States," *Journal of Policy Analysis and Management* 26, no. 1 (2016): 178–210.

16. Edmund F. Haislmaier and Drew Gonshorowski, "2016 Health Insurance Enrollment: Private Coverage Declined, Medicaid Growth Slowed" (Issue Brief 4743, Heritage Foundation, Washington, DC, July 26, 2017).

17. Haislmaier and Gonshorowski, "2016 Health Insurance Enrollment," table 1.

18. HHS, Office of the Assistant Secretary for Planning and Evaluation, *2017 Effectuated Enrollment Snapshot*, June 12, 2017, 1. See also the unnumbered table on pages 14–15. There are several reasons why enrollment falls during the year. First, government enrollment reports at the beginning of the year are based on "plan selections" during the annual open enrollment season. That includes people who have signed up for coverage through online portals or other means, as well as those whose coverage has been renewed by their current insurer. Subsequent government reports are based on "effectuated enrollment"—people who have paid their premiums and whose coverage remains active. The first effectuated enrollment report is for March 31 of any year. The number of people enrolled at that time is ordinarily several million smaller than the number of plan selections reported at the end of open enrollment season. That suggests that many who select a plan never make the first payment and, consequently, never have insurance coverage. Second, each successive quarterly effectuated enrollment report has shown a net decline in coverage over the previous quarter. Some of that may be attributable to people getting employer-sponsored coverage or moving onto the Medicaid rolls. Additionally, once some enrollees receive medical care, they may stop paying their premiums and consequently lose coverage. That may be especially prevalent among subsidized individuals, who have a 90-day grace period during which they may retain coverage despite being delinquent in their premium payments. Once that period lapses, insurers can remove such individuals from their rolls. See HealthCare.gov, "Premium Payments, Grace Periods and Terminations," accessed February 8, 2018, https://www.healthcare.gov/apply-and-enroll/health-insurance-grace-period/.

total individual market enrollment (including both on- and off-exchange products) had exceeded 20.2 million, only to decline by more than 3 million by the end of the year.[19]

In March 2017, enrollment stood at 17.6 million, a decline of nearly 15 percent from the preceding March.[20] That decline was larger among people who did not qualify for ACA subsidies. The number of people with subsidized coverage fell by more than 5 percent (from 9.2 million to 8.7 million) between March 2016 and February 2017.[21] The number of people who paid their own premiums declined by nearly 25 percent over that same time frame, from just over 11 million to fewer than 8.9 million.[22]

The decline in enrollment coincided with the withdrawal of insurance companies from the individual market, including policies sold both on- and off-exchange. The Government Accountability Office found that the number of companies issuing policies in the individual market fell by 10.5 percent in 2014, the first year of full ACA implementation.[23] The number of issuers decreased in 46 states.[24] The resulting market concentration was more pronounced in

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19. For the number of individual market enrollees in March 2016, see Mark Farrah Associates, "A Brief Look at the Turbulent Individual Health Insurance Market," July 19, 2017. The 17.1 million figure for December 2016, which draws on data from Mark Farrah Associates, can be found at Haislmaier and Gonshorowski, "2016 Health Insurance Enrollment."
20. Farrah Associates, "A Brief Look."
21. Centers for Medicare and Medicaid Services, *2017 Effectuated Enrollment Snapshot*, June 12, 2017.
22. The Farrah Associates data report that enrollment in the individual market fell to 17.6 million in March 2017. CMS reports that in February 2017 (effectuated enrollment figures for March 2017 were not available as of September 2017), 8.7 million people had subsidized coverage. Subtracting this figure from overall enrollment in the individual market yields the number of people with unsubsidized coverage. The same sources and process were used to calculate the number of people with unsubsidized individual coverage in March 2016. Private survey data suggest that this downward trend continued through the first three quarters of 2017. The Gallup-Healthways survey found that the uninsured rate had risen to 12.3 percent as of September 2017, its highest level since the fourth quarter of 2014. See Gallup, "US Uninsured Rate Rises to 12.3 Percent in Third Quarter," Gallup-Sharecare Well-Being Index, October 25, 2017, http://www.well-beingindex.com/u.s.-uninsured-rate-rises-to-12.3-in-third-quarter. These survey data had not been confirmed by larger government surveys, which lag behind private survey data. The most recent government data come from the CDC, which reports no significant change in coverage rates between December 2016 and March 2017. Robin A. Cohen, Michael E. Martinez, and Emily P. Zammitti, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January–March 2017* (Hyattsville, MD: Centers for Disease Control and Prevention, National Center for Health Statistics, August 2017).
23. John E. Dicken, "Patient Protection and Affordable Care Act: Concentration, Plan Availability and Premiums, and Enrollee Experiences in Health Insurance Markets since 2014" (Testimony before the House Subcommittee on Health Care, Benefits and Administrative Rules, Government Accountability Office, January 2017), 7.
24. Dicken, "Patient Protection and Affordable Care Act," 6.

the individual exchanges than in the individual market more generally.[25] This reduction in the number of issuers has continued.

Insurer withdrawals have been especially pronounced in the ACA health insurance exchanges. The number of issuers participating in the exchanges declined significantly beginning in 2016. In the 39 states with federally facilitated marketplaces, the number of issuers fell by 29 percent between 2016 and 2017.[26] That number dropped further in the 2018 plan year. The US Department of Health and Human Services (HHS) reports that the number of issuers fell to 132, down from 167 in 2017 and 232 in 2016, a decline of 43 percent over the course of just three plan years.[27] Eight states have only one insurer offering exchange-based coverage for the 2018 plan year.[28]

Many insurers that have remained in the market have greatly increased their premiums, contributing to the erosion of the individual market enrollment. HHS reported that premiums for benchmark plans rose by an average of 25 percent from 2016 to 2017 in the 39 states that have federally facilitated exchanges.[29] More recently, the agency reported that premiums for individual coverage on average more than doubled between December 2013 and January 2017 in those states.[30]

Premiums in the 2018 federal marketplaces rose again for the 2018 plan year. The premiums for the so-called benchmark plan—the second-lowest-priced silver plan in an area, whose premium is used to determine premium subsidies—rose on average by 37 percent for a 27-year-old between the 2017 and 2018 plan years.[31] This followed a 24-percent increase in 2017. Overall, the average premium for a 27-year-old rose by 88 percent between 2014 and 2018.

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25. Dicken, 5.
26. US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Health Plan Choice and Premiums in the Health Insurance Marketplace*, October 24, 2016, 27.
27. US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Health Plan Choice and Premiums in the 2018 Federal Health Insurance Exchange*, October 30, 2017, 3.
28. HHS Office of the Assistant Secretary for Planning and Evaluation, *Health Plan Choice and Premiums in the 2018 Federal Health Insurance Exchange*, 3. Two hundred thirty-two issuers participated in the federal exchanges in plan year 2016.
29. US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Health Plan Choice and Premiums in the Health Insurance Marketplace*, October 24, 2016, 6.
30. US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Data Point: Individual Market Premium Changes, 2013–2017*, May 23, 2017.
31. US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Health Plan Choice and Premiums in the 2018 Federal Health Insurance Exchange*, 8. The reasons behind the 2018 premium increases are complex. When it comes to state and federal exchange participants with incomes between 100 and 150 percent of FPL, the ACA requires insurers to provide a more generous level of coverage than is available to other consumers. For example,

Subsidies, for the most part, blunt the effects of premium increases on those who qualify for them.[32] But those who pay their own premiums without government assistance are more directly affected by rate hikes, likely contributing to the decline in the number of unsubsidized people with individual coverage.

Premium increases, in turn, are in part owing to the ACA's federal regulations. The effect of these regulations on a particular individual's premiums varies by a number of factors: geography, age, health status, and income among them. The prohibition on medical underwriting, for example, increases premiums in the aggregate but reduces them substantially for people in poor health. Restrictions

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enrollees with incomes between 100 and 150 percent of FPL receive coverage with an actuarial value of 94 percent, compared with 70 percent for the standard silver plan. The federal government is supposed to compensate insurers for the additional cost of this coverage through cost-sharing reduction payments (CSRs). Congress, however, never appropriated the money for these payments, which the Obama administration continued to make throughout its tenure. A federal judge ruled in 2016 that it was unconstitutional for the administration to continue to make these unappropriated payments, but she stayed her order, pending appeal. In October 2017, President Trump announced that he would comply with the order beginning in January 2018. Insurers are still required to provide more generous coverage to low-income enrollees, but the federal government will no longer compensate them for the costs of meeting this requirement. In anticipation of this action, insurers had negotiated 2018 premium increases to compensate for the discontinuation of cost-sharing reduction payments. States handled these increases differently, with some requiring that all of the premium increases be applied to silver plans, and others directing insurers to spread the increased costs across all ACA-compliant products (i.e., gold, silver, bronze, and platinum). The Kaiser Family Foundation in October 2017 analyzed the approaches taken by 32 states and the District of Columbia. While premium increases varied by state and product, the study found that the aggregate average increase in premiums attributable to cessation of the cost-sharing reduction payments were consistent with Kaiser's earlier estimate of 19 percent. Rabah Kamal et al., "How the Loss of Cost-Sharing Reduction Subsidy Payments Is Affecting 2018 Premiums" (Issue Brief, Kaiser Family Foundation, Washington, DC, October 27, 2017).

32. The interaction of premium increases and subsidies is not straightforward. The ACA subsidy equals the difference between the premium for the second-lowest-cost silver plan (SLCSP) in a particular area and a fixed percentage of the income of an individual residing in the area. People who receive that subsidy, however, need not use it to purchase the SLCSP, or even a silver plan at all (unless they want to receive cost-sharing reduction subsidies, which are only available to people with incomes between 100 and 250 percent of FPL who purchase silver plans). A subsidy recipient can choose the cheapest silver plan, a bronze plan (for which premiums tend to be lower due to lower actuarial value), or a gold or platinum plan (for which premiums tend to be higher). Moreover, since incomes can fluctuate from year to year and subsidies are based in part on a fixed percentage of income, individuals may qualify for a higher or lower subsidy if their income declines or increases. That calculus is more complex in the 2018 plan year due to the discontinuation of CSRs to insurers. Most insurers have raised premiums to compensate for the loss of these payments. In some states, they have spread that increase across all categories of ACA-compliant products. In others, they have loaded the entire increase onto their silver plans. In those states, subsidies will rise substantially because they are pegged to the silver plan premiums. Subsidy recipients may find that they can end up paying less for a higher level of coverage (e.g., a gold plan) than for a benchmark plan in some instances. For illustrations of this anomaly, see Congressional Budget Office, *The Effects of Terminating Payments for Cost-Sharing Reduction Subsidies*, August 2017.

on varying premiums by age benefit people in their 60s but increase premiums for young adults.

The result has been that older enrollees are overrepresented in exchange-based plans and younger enrollees are underrepresented, creating an insurance pool that is older, in poorer health, and increasingly expensive to insure. A recent analysis of individual markets by the American Academy of Actuaries listed "sufficient levels" of enrollment and "a balanced risk pool" as a critical feature of a sustainable individual market.[33] The report concludes that the ACA individual markets have fallen short in that respect:

> Although the ACA has dramatically reduced uninsured rates, enrollment in the individual market has been lower than initially expected and enrollees have been less healthy than expected.[34]

## CONGRESSIONAL EFFORTS TO INCREASE STATE FLEXIBILITY

Concern about the sustainability of individual health insurance markets in many states, dissatisfaction with premium increases, and opposition to tax penalties on the uninsured were among the factors that drove Congress and the administration to entertain proposals to increase the authority of states to regulate individual health insurance policies. Lawmakers faced the formidable task of preserving coverage gains among people in poor health and of modest means, while also making coverage more affordable for younger and healthier people who did not qualify for government premium and cost-sharing subsidies.

Bills to "repeal and replace" the ACA typically contained provisions that would have invested states with authority to deviate from the law's regulatory scheme. The "repeal and replace" efforts died in the Senate, but the fragility of the individual markets—as evidenced by declining enrollment, issuer withdrawal, and rising premiums—remains a concern for policymakers.

One leading characteristic of many of these proposals was a renewed emphasis on state flexibility. Lawmakers in both parties considered proposals to provide states with more resources and more autonomy to improve their individual markets. Despite this high-level consensus, there remains considerable disagreement

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33. American Academy of Actuaries Individual and Small Group Markets Committee, *An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes* (Washington, DC: American Academy of Actuaries, 2017). The authors cited other reasons for high premiums, including an unstable regulatory environment and an underlying medical trend.

34. American Academy of Actuaries Individual and Small Group Markets Committee, *Evaluation of the Individual Health Insurance Market*, 5.

over what form this flexibility should take and the extent to which states should be permitted to deviate from the ACA's federal regulatory framework.

The next section traces the evolution of state flexibility provisions included in the House and Senate "repeal and replace" bills.

## State Flexibility in "Repeal and Replace" Bills

The failed efforts to repeal and replace the ACA occurred in an extraordinary and unexpected political context, one that was in many ways similar to the one that prevailed during the ACA's enactment in 2010. When the 115th Congress convened in January 2017, Republicans held majorities in both the House and Senate, and the Republican presidential nominee was in the White House.

As in 2009, the majority party embarked on a partisan legislative course. Republicans initially set out to use the budget reconciliation process to repeal large portions of the ACA, deferring its replacement until later in the year.[35] By the time President Trump took the oath of office, the House and Senate had taken the first step in this process by enacting a budget resolution.[36] That measure included "reconciliation instructions" to relevant committees to write a repeal bill.[37]

By that point, however, Republican congressional leaders had changed strategies, aiming to use the budget reconciliation process not only to repeal key provisions of the ACA but also to enact replacement legislation.[38] That was especially challenging in the Senate, whose rules limit the content of reconciliation bills to budgetary matters. Those rules, for example, permitted Congress to reduce the penalty for remaining uninsured to $0, but they did not allow Congress to strike the requirement that individuals buy health insurance. The former is strictly budgetary; the latter is a broad policy change that has an indirect fiscal effect and is thus subject to removal under a "Byrd rule" point of order.[39]

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35. Budget reconciliation bills cannot be filibustered and can be passed by a simple majority in the Senate. This allows the majority party in the Senate to pass such legislation without overcoming procedural obstacles that the minority party can impose. Senate rules governing the content of reconciliation bills are, however, quite stringent, as discussed at greater length below.
36. S. Cont. Res. 3, 115th Cong. (January 13, 2017).
37. S. Cont. Res. 3, § 2001 and 2002.
38. Eric Bradner, "Ryan: GOP Will Repeal, Replace Obamacare at Same Time," CNN.com, January 13, 2017.
39. The Byrd rule establishes a six-part test to determine whether a provision in a reconciliation bill is "extraneous." If a Byrd rule point of order is sustained by the presiding officer, then a motion to waive that point of order requires 60 votes. The rule is codified at 2 U.S.C. § 644.

Those limitations complicated efforts to ease ACA requirements that were driving premiums higher. Provisions in the House bill that would have allowed states to deviate from the law's "essential health benefits" requirements or to alter the law's preexisting condition mandate on insurers did not survive Byrd rule scrutiny.[40] Legislative provisions of this sort were found to have run afoul of the rule, which bars the inclusion of "extraneous" provisions (i.e., those whose primary effect is not budgetary) from reconciliation bills.

## House Proposals on State Flexibility

Seeking to legislate within these constraints proved challenging for Republicans even in the House, where the rules governing budget reconciliation bills are far less stringent. The bill the House passed in May 2017 included provisions that aimed to give states wider latitude in regulating individual insurance markets.[41] These approaches fell into two categories:

- Granting the HHS secretary broader authority to grant waivers to states to deviate from certain ACA regulatory requirements
- Creating a new program of grants to states (provisions with direct budgetary effects), coupled with flexibility on the state use of the new funds

MacArthur amendment. By far the most sweeping and controversial attempt to expand the HHS waiver authority was offered by Rep. Tom MacArthur (R-NJ).[42] The MacArthur amendment would have permitted states to obtain waivers from HHS to allow insurers to vary premiums based on an applicant's health status. To obtain such a waiver, a state would have to show that it would reduce average premiums and increase enrollment in its individual market, stabilize that market, maintain affordable premiums for individuals with preexisting medical conditions, and increase the choice of health plans available to its residents. In addition, a state would have to show that it provided financial assistance to high-risk individuals and provided insurers with incentives to stabilize premiums.[43]

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40. United States Senate Committee on the Budget, "State Waivers Largely Violate Senate Rules, According to Parliamentarian," Ranking Member's Newsroom, July 27, 2017, https://www.budget.senate.gov/ranking-member/newsroom/press/state-waivers-largely-violate-senate-rules-according-to-parliamentarian.
41. American Health Care Act of 2017, H.R. 1628, 115th Cong. (June 7, 2017).
42. H.R. 1628, § 136.
43. That last requirement could be met by participating in the "federal invisible risk-sharing program."

The MacArthur amendment was controversial from its inception, even among House Republicans. It was immediately characterized—fairly or not—as permitting states to gut the ACA's requirement that insurers cover an individual's preexisting medical conditions.

In an effort to address these concerns, the bill made $8 billion available to states that obtained a waiver to allow premiums to vary with health status.[44] States would be required to use those funds to "reduce premiums or other out-of-pocket costs of individuals who are subject to an increase in the monthly premium rate for health insurance coverage as a result of such waiver."

The MacArthur provision offered states the option to increase enrollment in individual policies by allowing premiums to vary by health status. Such variation would arguably make premiums more attractive to people in relatively good health, leading more of them to enroll. This would, in turn, create a broader risk pool that would exert a downward force on premiums. It would also, however, lead to higher premiums for those in poor health. The House bill attempted to address this, in part, by providing additional funds to waiver states that would be used to dampen the effects of these higher premiums.

Patient and state stabilization grants. This process of coupling the allocation of new federal resources with increased state flexibility was repeated elsewhere in the bill. In addition to providing $8 billion to states that obtained waivers from the ACA's community rating requirements, the bill established a new program of grants to states totaling $100 billion between 2018 and 2026.[45] States were to use these grants to help finance innovative ways to provide additional stability to their individual health insurance markets. States could use such grants for a wide range of purposes, including the following:

- Providing financial assistance to high-risk individuals
- Establishing arrangements between states and insurance companies to stabilize premiums
- Reducing costs for those who are high utilizers of healthcare and those who live in rural counties
- Increasing enrollment in individual coverage and insurance options
- Promoting preventive, vision, and dental services
- Subsidizing maternity coverage and newborn care

44. The allocation of $8 billion is contained in section 132 of H.R. 1628.
45. H.R. 1628, § 132.

- Treating mental and substance abuse disorders
- Making direct and indirect payments to healthcare providers for certain services
- Assisting consumers with their out-of-pocket costs, including copayments, coinsurance, and deductibles

This grant program looked primarily to states to devise solutions to problems that had arisen during the implementation of the ACA, including higher premiums, insurance company withdrawal from markets, and burdensome cost-sharing requirements. Instead of establishing a uniform federal remedy for these problems, the bill offered federal financing for innovative state proposals.

The process of drafting the House bill was long, checkered, and at times circuitous. Originally debated in March, the measure was withdrawn from floor consideration in advance of a vote on final passage.[46] Negotiations continued among members and the administration in the ensuing months, resulting in the addition of new provisions, including the MacArthur amendment. It cleared the House in its revised form on May 4.[47]

The changes that occurred between the bill's withdrawal in March and its passage in May were generally aimed at providing states with more federal funding and enhanced flexibility. Though the process was irregular, it yielded a product that sought to provide states with relief from some of the ACA's regulatory rigidities and new federal resources to support innovative state approaches to stabilizing their individual markets.

## Senate Proposals on State Flexibility

The Senate bill released in July 2017 also sought greater flexibility for states in the regulation of individual health insurance.[48] The draft bill included a new program of "long-term state stability and innovation" to states.[49] Similar to the House's "patient and state stabilization" grants, the bill allocated $132 billion over eight years for the program of grants to states. States could use the money in the following ways:

46. American Health Care Act of 2017, H.R. 1628, 115th Cong., 1st sess., 163 Cong. Rec. 52 (March 24, 2017): H 2441.
47. The bill passed by a vote of 217 to 213. United States House of Representatives, *Roll Call 256: On Passage of American Health Care Act–H.R. 1628*, May 4, 2017.
48. United States Senate, *Discussion Draft–Better Care Reconciliation Act, ERN17490*, July 13, 2017.
49. United States Senate, *Discussion Draft–Better Care Reconciliation Act*, § 106.

- Provide financial assistance to high-risk individuals
- Establish arrangements between states and insurance companies to stabilize premiums (states would be required to dedicate at least $5 billion in each of calendar years 2019–2021 for this purpose)
- Reduce costs for those who are high utilizers of healthcare
- Make direct and indirect payments to healthcare providers for certain services

As with the House bill, the Senate draft looked to states to devise solutions to problems attributable to the ACA regulatory regime, providing them federal resources and flexibility to explore new approaches to these problems.

The Senate bill contained a second major provision that enlarged the role of states in their individual health insurance markets. It amended section 1332 of the ACA, a provision that allows states to obtain innovation waivers.[50]

The paper discusses section 1332 at greater length below, but section 1332 generally allows states, beginning in 2017, to apply for waivers from certain ACA regulatory provisions. It also enables states to receive "pass through" payments of tax credits and cost-sharing reduction subsidies. Under the ACA, the federal government pays premium and cost-sharing subsidies to issuers of policies in which low-income people enroll. Section 1332 allows the secretary to grant waivers that would provide some or all of these payments to the state instead, if the state's waiver application meets the statutory and regulatory criteria discussed below.

The statute attaches a number of restrictions to the waivers. The Senate draft bill proposed the removal of some of these restrictions, made it easier for states to obtain waivers, and allocated $2 billion to states for planning and implementing waivers. In addition, states could combine funds from the long-term state stability and innovation grants with their innovation waivers.

A version of this provision was included in an amendment offered by Senate Majority Leader Mitch McConnell (R-KY) during Senate consideration of H.R. 1628.[51] The amendment failed passage by a vote of 49 to 51.[52]

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50. United States Senate, *Discussion Draft–Better Care Reconciliation Act*, § 207.
51. Grants for state innovation are found in section 203 of the McConnell amendment. See Amendment No. 667 to Amendment No. 267, 115th Cong. 1st sess., 163 Cong. Rec. 127 (July 27, 2017): S 4399–4400.
52. United States Senate, *Roll Call 179: On McConnell S.Amdt. 667 to S.Amdt. 267 to H.R. 1628*, July 28, 2017.

## STATE FLEXIBILITY IN THE ACA: SECTION 1332

### Statutory Provision

The Senate vote appeared to lay to rest congressional efforts to "repeal and replace" the ACA, but it did not end efforts to provide states with greater authority with respect to their individual health insurance markets.[53] Throughout much of 2017, several states sought waivers from certain federal regulatory requirements under section 1332 of the ACA.[54]

Section 1332 provides that, for plan years that began on or after January 1, 2017, a state may seek a waiver from certain federal ACA regulatory requirements. As part of the waiver, a state can elect to receive federal premium and cost-sharing subsidies that the federal government otherwise would pay directly to insurance companies on behalf of eligible individuals. The section would also require the HHS secretary to coordinate and consolidate the section 1332 waiver process with waiver requests under Medicare, Medicaid, CHIP, "and any other federal law relating to the provision of healthcare items or services." Such waivers can be requested through a single application.

Section 1332 establishes substantive and procedural requirements on waivers. A state must demonstrate that "at least a comparable number of residents" would have health coverage under its plan as under existing law.[55] That coverage must be "at least as comprehensive" and cost-sharing requirements "at least as affordable" as under current law.[56] A state must achieve these objectives without increasing the federal deficit.[57]

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53. Several senators and members of Congress continued to pursue legislation to stabilize individual health insurance markets. Senate Finance Committee Chairman Orrin Hatch (R-UT) and House Ways and Means Committee Chairman Kevin Brady (R-TX) introduced bills to appropriate cost-sharing reduction subsidy payments to insurance companies (S. 2052 and H.R. 4200). Senate HELP Committee Chairman Lamar Alexander (R-TN) and Ranking Member Patty Murray (D-WA) also announced their intention to introduce a bill to appropriate these payments: Bipartisan Health Care Stabilization Act of 2017, S. TAM17K02, 115th Cong. (October 19, 2017). The Alexander-Murray draft bill contains a number of provisions that would make it easier for states to obtain section 1332 waivers. It would remove the requirement that a state pass a law in order to apply for a waiver; soften standards related to affordability; require that waivers not increase the federal deficit over a 10-year period rather than on a year-by-year basis; require the secretary to act on waivers within 90 days (45 days in an "urgent situation") rather than 180 days; provide that waivers would last for six years, with unlimited renewals for additional six-year periods; direct the secretary to develop model waivers; and rescind existing 1332 regulations.
54. Waiver for State Innovation, 42 U.S.C. § 18052 (2011).
55. Waiver for State Innovation, 42 U.S.C. § 18052(b)(1)(C) (2011).
56. Waiver for State Innovation, 42 U.S.C. § 18052(b)(1)(B) (2011).
57. Waiver for State Innovation, 42 U.S.C. § 18052(b)(1)(D) (2011).

TABLE 1. EXAMPLES OF ACA PROVISIONS THE HHS SECRETARY MAY AND MAY NOT WAIVE

| Provisions the secretary may waive | Provisions the secretary may not waive |
|---|---|
| Definition of qualified health plan | Prohibition on annual and lifetime coverage limits |
| Essential health benefits requirement | Prohibition of rescissions |
| Annual limitation on cost-sharing | Required coverage of preventive services |
| Levels of coverage (e.g., silver, bronze) | Dependent coverage until age 26 |
| Abortion coverage limitations | Medical loss ratio requirements |
| Open enrollment periods | Prohibition of preexisting condition exclusions |
| Single risk pools | Guaranteed issue and renewal of coverage |
| Federal regulations pertaining to enrollment by agents or brokers | Prohibition of medical underwriting |
| Exclusion from exchanges of incarcerated persons and those not lawfully present in the United States | 3:1 age band |

Section 1332 places fairly stringent limits on provisions that can be waived and those that cannot. Table 1 outlines the extent and limits of the secretary's waiver authority.

## Implementing Regulation

As part of its implementation of the ACA, CMS published a regulation defining how it would administer the section 1332 waiver process. That regulation established additional criteria that states must meet to obtain a waiver.[58] For example, it requires waiver requests involving tax provisions to be reviewed by the Treasury secretary.[59] It also requires a preliminary review by the two cabinet secretaries to determine whether a state application is "complete."[60] A completed application must include a copy of the state statute detailing the waiver and a list of federal statutory provisions from which the state seeks a waiver.[61]

A state also must submit an actuarial analysis and certification that the proposed waiver will comply with requirements relating to affordability and the comprehensiveness and scope of coverage.[62] In addition, the state must develop economic analyses to that effect, along with a 10-year budget plan demonstrating that the waiver will be "deficit neutral to the federal government."[63]

58. 45 C.F.R. § 155.1300 et seq.
59. 45 C.F.R. § 155.1302(b).
60. 45 C.F.R. § 155.1308(c).
61. 45 C.F.R. § 155.1308(f)(3)(i)–(iii).
62. 45 C.F.R. § 155.1308(f)(4)(i).
63. 45 C.F.R. § 155.1308(f)(4)(ii)(A).

The completed application must explain a variety of things. It must highlight the waiver's effect on administrative burdens upon individuals, insurers, and employers; it must identify federal law provisions that the state does not seek to waive; and it must explain how the waiver will affect residents who seek medical care outside the state.[64] Once an application is deemed complete, the regulation requires the HHS secretary to decide whether to grant the waiver within 180 days.[65]

The regulation also spells out state notice-and-comment requirements, including the requirement for public hearings.[66] Furthermore, it imposes a separate federal notice-and-comment requirement.[67]

Once it has obtained a waiver, a state must conduct periodic implementation reviews, including reviews of complaints about the waiver that have been submitted to the HHS secretary.[68] The state must also hold periodic public forums on the waiver and submit quarterly and annual reports to the secretary.[69] HHS and the Treasury would conduct periodic evaluations of state waivers.[70]

Both cabinet secretaries have the "right to suspend or terminate a section 1332 waiver in whole or in part" if either "determines that a state has materially failed to comply with the terms" of its waiver.[71]

## December 2015 Guidance

Since the implementation of the ACA, states have been interested in state innovation waivers under section 1332 and have wanted a strong amount of flexibility to create the waivers. The National Governors Association wrote President Obama a letter asking for more flexibility only to have the Obama administration deny that flexibility in the December 2015 guidance.[72] While that cooled some state experimentation, states have quickly ramped up their efforts in 2017, and now half of all states have formally considered whether to seek a section 1332 waiver.[73]

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64. 45 C.F.R. § 155.1308(f)(4)(v).
65. 45 C.F.R. § 155.1316(c).
66. 45 C.F.R. § 155.1312.
67. 45 C.F.R. § 155.1316.
68. 45 C.F.R. § 155.1320(b).
69. 45 C.F.R. §§ 155.1320(c), 155.1324.
70. 45 C.F.R. § 155.1328.
71. 45 C.F.R. § 155.1320(d).
72. Letter from National Governors Association to HHS Secretary Sylvia Burwell, October 27, 2015, https://www.nga.org/cms/nga-letters/section-1332-state-innovation-waivers.
73. Richard Cauchi, "Innovation Waivers: State Option and Legislation Related to the ACA Health Law," *National Conference of State Legislatures*, accessed September 14, 2017, http://www.ncsl.org/research/health/state-roles-using-1332-health-waivers.aspx.

The December 2015 guidance gives its interpretation of the four "guardrails" in section 1332 of the ACA.[74] This guidance is extremely restrictive and in some aspects goes against the normal federal procedure on other health waivers, such as those found in Medicaid. The December 2015 guidance greatly empowers federal bureaucrats who "retain the discretion to deny a waiver application even if it satisfies all the guardrails."[75]

For example, the guidance creates special groups of people who are more important than others for purposes of determining if a waiver meets the "comparable number of people covered" prong. The guidance states that even if a state covers the same number or even more people total, the waiver violates the guardrail if fewer "vulnerable" people are covered. The guidance considers people to be vulnerable if they have a low income, are elderly, have serious health issues, or could one day have serious health issues. The guidance does not define some of these categories, such as what constitutes a low income; this ambiguity causes confusion for states given how many different federal programs use different definitions of "low income."[76]

The guidance also says that the deficit neutrality provision, along with the other guardrails, must be met each year of the waiver and not at the end of the period of the waiver. Under this interpretation, a state cannot spend more in the first year in an attempt to enroll more individuals (which could lower costs in future years) because the first year would not be deficit neutral. This interpretation is contrary to Medicaid waivers, where the program must be deficit neutral over the waiver time period and not every single year.[77]

The December 2015 guidance builds a wall between a 1332 waiver and a Medicaid waiver. The guidance states that changes to Medicaid resulting in Medicaid savings cannot be used to justify the deficit neutrality prong of the guardrail. If a state transitions people from Medicaid into private coverage, it cannot count Medicaid savings from the reduced enrollment. Instead, the state

74. Department of the Treasury, Department of Health and Human Services, Guidance: Waivers for State Innovation, 80 Fed. Reg. 241 (December 16, 2015).
75. Manatt, Phelps & Phillips, LLP, "Administration Guidance on State Innovation Waivers Restricts Flexibility," *State Health Reform Assistance Network*, December 14, 2015, http://www.statenetwork.org/wp-content/uploads/2015/12/Manatt-1332-Guidance-Summary-12-14-15.pdf.
76. Rea S. Hederman Jr. and Dennis Smith, "Returning Health Care Power to the States: The Affordable Care Act's Section 1332 Waiver for State Innovation" (Policy report, Buckeye Institute, Columbus, OH, September 21, 2016).
77. Medicaid and CHIP Payment and Access Commission (MACPAC), *Comparing Section 1332 and Section 1115 Waiver Authorities* (MACPAC Issue Brief, Washington, DC, August 1, 2016).

will need further offsets of any federal subsidy assistance to be deficit neutral.[78] The inability for states to coordinate a Medicaid waiver and an innovation waiver makes innovation waivers less appealing for states that believed innovation waivers could help change their Medicaid programs.

Interest in state innovation waivers lagged as states saw the guidance. Some states, such as Ohio, enacted a law to seek innovation waivers that would waive the individual and employer mandates and other changes to insurance regulation. Ohio has not yet moved forward with its 1332 plan in part because the guidance emerged after the passage of the law.[79]

## STATE APPLICATIONS FOR SECTION 1332 WAIVERS

Most waivers that have been formally filed with HHS include a form of reinsurance, with several new waivers being filed in the summer of 2017. Only two waivers have been formally approved, the first a waiver from Hawaii that allowed the state to waive ACA provisions that conflicted with a state-run healthcare plan. Hawaii successfully argued that its plan was more generous than the ACA, and the state was successful in administering its healthcare system. The Obama administration agreed, and Hawaii was exempt from some of the infrastructure requirements of the ACA governing how insurance was offered.[80] The Hawaii waiver is unlikely to be used by other states given Hawaii's unique preexisting insurance regulations and system.

## THE ALASKA MODEL: STATE REINSURANCE WAIVERS

The second successful waiver was for federal support for a reinsurance program in Alaska. Alaska filed a state innovation waiver in late December 2016, during the final days of President Obama's administration. The main aspect of the waiver was the creation of a state-run reinsurance program, heavily subsidized by federal dollars. The Trump administration used this waiver application to tout how 1332 waivers can reduce insurance costs, and the waiver was approved on July 11, 2017.

78. Department of the Treasury, Department of Health and Human Services, Guidance: Waivers for State Innovation, 80 Fed. Reg. 241 (December 16, 2015).
79. Ohio House Bill 64, O.R.C. § 3901.052, 131st General Assembly, June 30, 2015.
80. State of Hawaii, *Hawai'i's Proposal to Waive Certain Provisions of the Patient Protection and Affordable Care Act*, August 10, 2016.

## The Alaska Waiver Request

Alaska's reinsurance program was created by the state legislature in July 2016.[81] Legislators were concerned that the individual market was collapsing due to high premiums and a small number of participants. Under the statute, the state assessed a tax on all health insurers in the state, including those selling small group, large group, and stop-loss policies. The tax assessments financed the Alaska Comprehensive Health Insurance Fund and generated $55 million in revenue. That fund was created to pay medical claims incurred by "residents with high risk," those whose medical conditions made it likely that they would incur large medical bills. If such a resident signed up for individual health insurance coverage, the insurer would transfer that resident's premiums to the fund. The fund, in turn, would reimburse the insurer for the medical claims paid on behalf of that resident.[82]

State officials claimed that this reinsurance arrangement was responsible for holding premium increases in 2017 for individual health insurance policies to 7.3 percent, rather than the previously projected increase of 42 percent.[83] The reduced premiums were a result of the government subsidizing high-cost insurance enrollees. But it did so at a cost to the insurers outside the individual market, who did not benefit from the fund.

The bill also empowered the state to seek a waiver under section 1332 to help finance its reinsurance arrangement.[84] The key to the Alaska waiver was the request to use federal subsidies payable under the ACA to partially finance the Alaska Comprehensive Health Insurance Fund and waive the single risk pool

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81. Alaska House Bill 374, Reinsurance Program; Health Insurance Waivers, 29th Legislature (July 20, 2016).

82. Reinsurance programs give money to insurers to cover claims above a certain threshold level called the "attachment point." It is insurance for insurance companies since their total liability can be limited by the reinsurance program. A federal reinsurance program was part of the ACA in an effort to stabilize premiums. States have experimented with different methods for dealing with high-cost individuals by using different types of high-risk pools. Reinsurance programs keep high-cost individuals in a larger risk pool, whereas many high-risk pools will segment high-cost individuals into smaller risk pools. For more information on risk pools and reinsurance, see James C. Capretta and Tom Miller, "How to Cover Pre-existing Conditions," *National Affairs,* Summer 2010; and Sandy Ahn and JoAnn Volk, "What's the Difference between Reinsurance and a High-Risk Pool? Two Approaches to Insuring Those with Pre-existing Conditions," *CHIR Blog*, Georgetown University Center on Health Insurance Reforms, March 6, 2017, http://chirblog.org/whats-difference-reinsurance-high-risk-pool-two-approaches-insuring-pre-existing-conditions/.

83. Cheryl Fish-Parcham, "Alaska's Reinsurance 1332 Waiver: An Approach That Can Work," *Families USA*, August 2017, http://familiesusa.org/product/alaska-reinsurance-1332-waiver-approach-can-work.

84. Alaska HB 374, § 5.

requirement of the ACA. Alaska successfully argued that using these subsidies would reduce the cost of premiums, making insurance on the individual market more affordable. Since Alaska's waiver request dealt with federal pass-through funding under the IRS code, both the Treasury and HHS secretaries would need to approve the waiver.

Alaska's innovation waiver said that while the state would fund some of the reinsurance payments, the federal government would also fund the reinsurance program. If a state reinsurance program reduces premium increases, then federal payments will be reduced because insurance premiums are lower. Government payments based on the cost of premiums, such as Advanced Premium Tax Credits (APTCs) and Cost-Sharing Reductions (CSRs), would fall. These savings mean that the federal government is not violating the deficit neutrality guardrail, since the government would already have been making these payments and be paying even more if not for the reinsurance program. Alaska submitted actuarial evidence to support this claim.

## Federal Government Response to Alaska's Request

On March 13, 2017, HHS Secretary Tom Price issued a letter to governors that highlighted the use of reinsurance in state innovation waivers.[85] The letter stated that the Trump administration wanted to stabilize insurance markets, reduce premium costs, and increase the number of providers in the market. Secretary Price mentioned the four 1332 guardrails and steps that states needed to take to submit a waiver. The letter then specifically cited the Alaska waiver request, the reinsurance program, and the savings that resulted from the reinsurance program.

Notably, the letter stated that the administration would help guide states that wanted to use an innovation waiver like Alaska's to get more federal pass-through funding. While Secretary Price encouraged a greater use of innovation waivers overall, the letter also invited states to pursue approval of waiver proposals that include "high-risk pool/state-operated reinsurance programs."[86] This indicated that the Trump administration was favorably inclined to grant the Alaska reinsurance program and saw it as a potential model for other states to follow.

85. Letter from Thomas E. Price, Secretary of HHS, to state governors, March 13, 2017, https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/March-13-2017-letter_508.pdf.
86. Letter from Thomas E. Price to state governors.

## Other State Reinsurance Waiver Requests: Minnesota, Oklahoma, and Oregon

Less than two months later, Minnesota filed a 1332 waiver request for federal funding to support its state reinsurance plan, the Minnesota Premium Security Plan.[87] The May 2017 waiver request specifically cited Secretary Price's March letter and asked for rapid approval of the waiver request.

The Minnesota waiver was very similar to Alaska's, with the state partially funding a reinsurance plan and wanting federal dollars to fund the remaining balance. The reinsurance plan would then reimburse insurance companies for high-cost enrollees, and these payments would reduce premiums for other participants on the individual exchange. The Minnesota plan does have a trigger in place that makes the creation of the reinsurance plan contingent on the availability of federal funds for the reinsurance plan. Minnesota cites conversations with CMS staff revealing that federal approval, and hence federal funding, is contingent upon the trigger.[88] No other aspects of the ACA were waived in the Minnesota waiver, and the waiver is still in the approval process.

Less than a week after Minnesota filed its waiver, HHS published a checklist for states seeking innovation waivers.[89] The checklist cited the relevant law or regulation for every step a state must take in order to successfully complete a waiver. In the checklist, HHS also described specific actions a state would need to take in order to get approval for a reinsurance waiver. For example, the checklist mentioned that a state legislature must make its reinsurance program contingent on federal funds for the reinsurance plan, as Minnesota did with the trigger in its application. HHS cited the exact ACA sections that a state would need to waive for a reinsurance program.

As the federal ACA repeal efforts faltered, more states began moving on reinsurance waivers. In August, Oklahoma filed a 1332 waiver to create a reinsurance plan, the Oklahoma Individual Health Insurance Market Stabilization Program, on an expedited basis.[90] Like Minnesota's plan, the Oklahoma reinsurance plan is contingent upon federal approval and partial funding of the reinsurance plan. Oklahoma would also provide partial funding through a tax on Oklahoma insurers.

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87. Minnesota Department of Commerce, Minnesota 1332 Waiver Application, May 30, 2017.
88. Minnesota Department of Commerce, Minnesota 1332 Waiver Application.
89. Department of Health and Human Services, *Checklist for Section 1332 State Application Waivers, Including Specific Items Applicable to High-Risk Pool/State-Operated Reinsurance Program Applications*, May 11, 2017.
90. State of Oklahoma, 1332 State Innovation Waiver Application for the State of Oklahoma, August 16, 2017.

Later in August 2017, Oregon made a 1332 waiver request to create the Oregon Reinsurance Program, with a request for federal pass-through funding.[91] Like the other states, Oregon claims that the reinsurance plan will reduce premiums and therefore increase the take-up rate among individuals on the exchange market. In September, Massachusetts filed a 1332 waiver that would use federal funds to stabilize its individual market, but HHS has not recognized that waiver as being complete.[92] In late October, HHS informed Massachusetts that its waiver application was incomplete because the waiver was submitted too late to be reviewed and approved before the 2018 open enrollment period started in November of 2017.[93]

## Impact of the Alaska Waiver

The Alaska waiver is the first major 1332 waiver that has been approved. It redirects federal subsidies from individuals to a reinsurance plan that can help reduce premiums. Alaska also created an assessment or tax on insurance plans to help finance the reinsurance program. Other states copied the Alaska waiver for their own innovation waivers using the reinsurance model.

The early evidence is that the Alaska reinsurance program has had a positive effect in reducing premiums on the individual market. Where the national state average benchmarked premium[94] increased by 37 percent in 2017, Alaska's premium declined by 22 percent.[95]

The Alaska waiver's success also depended on taxing nonexchange plans to pay for the reinsurance program through the tax assessment. People who receive insurance through their employer will pay slightly higher premiums due to the tax assessment. Even if the statutory burden is on insurers, consumers will bear most of the incidence of the tax and see slight premium increases.

Beyond the reinsurance plan, states now have a path to consider how to utilize federal funds to fix their insurance markets. CMS agreed with the argument that if a state lowers premiums, then the state can use some of the federal

91. State of Oregon, Oregon 1332 Draft Waiver Application, August 31, 2017.
92. Commonwealth of Massachusetts, Request for a State Innovation Waiver to Stabilize Premiums under Section 1332 of the Affordable Care Act, September 8, 2017.
93. Letter from Randy Pate, director of the Center for Consumer Information and Insurance Oversight, to Louis Gutierrez, executive director of MA Health Connector, October 23, 2017, https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Preliminary-Determination-Incompleteness-MA.pdf.
94. The benchmarked premium is the cost of the second-lowest-cost silver plan.
95. Timothy Jost, "Insurer Participation Down; Premiums Up in Uncertainty-Plagued Marketplaces," *Health Affairs*, October 30, 2017.

savings to pay for insurance market improvements. States can use the same arguments to expand their waiver requests and use APTC and CSR funds for other health programs if these new programs can comply with the guardrails. If a state can determine more cost-effective ways to offer coverage, the state can use the Alaska model to request federal dollars to help provide that coverage.

## STATES THINKING BIG ON 1332: OKLAHOMA AND IOWA

Two states are thinking long term on how to utilize state innovation waivers to fix their healthcare markets. In March of 2017, Oklahoma issued a blueprint for the state on how it would seek numerous waivers over the next few years to remodel its insurance program. In the summer of 2017, Iowa issued a plan to use the 1332 waiver process to change its private insurance market. These plans have some key similarities and illuminate how other states can make changes.

These two plans seek to stabilize the individual market by moving to a flat premium assistance model and encouraging more people to buy individual insurance. The states build upon previous research that a flat tax credit can encourage people to purchase an appropriate amount of insurance.[96] A flat subsidy instead of the current ACA subsidy, which links the size of subsidy to premium costs, can increase competition among insurers and reduce insurance costs to consumers.[97]

### The Oklahoma Waiver Request

Oklahoma assembled a task force to examine how the state could utilize 1332 state innovation waivers to change its healthcare system. Oklahoma listed five key goals that guided the task force:

1. Increased flexibility at the state level
2. Reduced costs
3. Better health outcomes
4. Innovative solutions
5. Support for individual choice and freedom[98]

96. Mark Paul and Brad Herring, "Expanding Coverage via Tax Credits: Trade-Offs and Outcomes," *Health Affairs* 20, no. 1 (2001).
97. Sonia P. Jaffe and Mark Shepard, "Price-Linked Subsidies and Health Insurance Markups" (NBER Working Paper No. 23104, National Bureau of Economic Research, Cambridge, MA, January 2017).
98. Oklahoma Secretary of Health and Human Services, *A New Horizon: Recommendations for Oklahoma's Modernized Health Insurance Market*, March 2017.

The Oklahoma task force used these guiding principles in an effort "to stabilize Oklahoma's individual health insurance market."[99] The reinsurance waiver that Oklahoma filed was merely the first step in achieving this goal. The Oklahoma task force's vision is to move the state significantly toward a more market-based approach to healthcare than currently exists under the ACA.

Oklahoma's two significant, market-based approaches are (1) creating health savings accounts for individuals on the exchange and (2) changing the distribution of subsidies that are provided under the ACA. The task force also aimed to simplify the structure of the ACA by eliminating the metal tiers such as bronze, gold, and silver and changing some of the essential health benefits.

Oklahoma's blueprint is to utilize federal funds available for the APTCs and CSRs to ensure subsidies are available for individuals whose incomes are 0–300 percent of FPL, instead of going up to 400 percent as in the current law.[100] Oklahoma will also base the subsidy on both age and income, not just income. Unlike the current ACA subsidy structure, Oklahoma's premium assistance plan would not increase as insurance premiums increase. All people within a given age and income band would receive a similar subsidy that they could apply to a health insurance plan. Oklahoma increases the subsidy with age because older people pay higher premiums than younger individuals.

Under the current ACA subsidy structure, insured people on the exchange market are strongly insulated from rising premium costs if they receive a subsidy. As insurance premiums rise, the value of the subsidy also increases, which makes heavily subsidized consumers less concerned with the sticker price of insurance since they do not pay the full price.[101] Flat premium credits reduce or eliminate the perverse incentive to purchase more generous health insurance—if a premium exceeds the flat benefit, consumers would have to pay the difference.[102] Potential consumers who receive little or no subsidies are priced out of the market, and Oklahoma argues that they are no longer purchasing insurance, which makes the risk pool smaller. Research indicates that the ACA subsidy structure could increase insurance prices in Oklahoma by over 10 percent because insurers

99. Oklahoma Secretary of Health and Human Services, *A New Horizon*.
100. As previously discussed in footnote 31, CSR payments are no longer being made. This lowers the amount of funds available for any state that sought to make use of CSRs for any type of program. If payments resume, states could again request the use of CSR payments for use in the waiver process. This illustrates how fluid the source of federal dollars could be for states trying to use the waiver program.
101. Jonathan Gruber and Ebonya Washington, "Subsidies to Employee Health Insurance Premiums and the Health Insurance Market," *Journal of Health Economics* 24 (2005): 253–76.
102. Katherine Baicker, "Tax Treatment of Health Insurance" (Testimony before the Senate Finance Committee, Harvard School of Public Health, Boston, MA, July 31, 2008).

left the market and reduced competition.[103] In other states, rising subsidies could encourage families to purchase bronze or even gold insurance. Oklahoma's plan to eliminate metal tiers would preclude families or individuals from buying gold or bronze plans and would instead offer a single actuarial value plan.[104]

Oklahoma's waiver request is unique in how it seeks federal funding. Currently, federal subsidies flow to a state's eligible residents only if they are enrolled in qualified health insurance. But Oklahoma argues that it should receive federal dollars based on eligibility alone, regardless of whether or not the eligible residents are enrolled in an insurance plan. Oklahoma state officials estimate that less than one-third of the state's eligible population obtains subsidized insurance on the federal exchange market.[105]

Oklahoma will use some of the federal subsidy dollars to create a state-based health savings account. The federal subsidies will pass through this "consumer health account" to insurance plans, providing the consumer with qualified insurance under the ACA. The consumer will be able to keep any remaining money in the account to pay for health expenses.

Oklahoma would rely on consumer preference and competition to lower prices and make healthcare more affordable. Consumers who choose plans that cost less than their subsidy and utilize fewer services could see their health savings balance grow. Lower utilization in the short term could help stabilize premiums in the short term, but if preventative care is neglected, then prices could increase in the long run.[106]

It is unknown whether the federal government will approve Oklahoma's claim for federal funding for all eligible subsidy recipients. The statute is unclear, and Oklahoma's interpretation is a valid reading of the text. Whether the federal government will agree that these additional funds are legal under the deficit neutrality guardrails is unknown. If the federal government agrees, then states will receive a significant increase in funding, with Oklahoma receiving about twice as much as it now receives.

If Oklahoma succeeds with this argument, federal spending on health exchange subsidies will increase as other states will likely follow suit. This new spending will put pressure on the federal government to find savings in other

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103. Jaffe and Shepard, "Price-Linked Subsidies."
104. See footnote 31 for more discussion of how a family or individual could receive a gold plan for less than the silver plan, especially after cost-reduction payments are no longer being made.
105. Oklahoma Secretary of Health and Human Services, *A New Horizon*.
106. Mary Charlton et al., "Effects of Health Savings Account-Eligible Plans on Utilization and Expenditures," *American Journal of Managed Care* 17, no. 1 (2011): 79–86.

areas or run higher deficits. For this reason, the federal government is going to be reluctant to approve a waiver that will greatly increase federal spending.

Oklahoma makes a case that many people do not acquire insurance because the premiums are too high even with some federal subsidies. This is particularly true of younger, healthier individuals age 19–34 who make up almost half of all uninsured Oklahomans.[107] If the Oklahoma waiver reduces the price of insurance, some of these uncovered individuals would purchase insurance and thus receive subsidies for which they are eligible.

Oklahoma estimates the impact of its reform solutions using the designations "low," "moderate," and "high." Each reform is targeted toward a specific problem. If the problem is a low enrollment or take-up rate, a high-impact reform would affect over 75 percent of the eligible population. The state estimates that a consumer savings account will reduce prices and increase enrollment for over 75 percent of the population. The state will also abolish all retail tiers for non-high-deductible plans and establish one benefit level of 80 percent of actuarial value, the current level of the silver plan. This is expected to reduce premiums and make it easier to shop.

Oklahoma also wants to change age-rating bands that are currently restricted at 3:1 under current law and potentially create a new rating band of no more than 5:1. Since the state's subsidy will vary not only with income but also with age, the impact on older consumers can be mitigated while reducing insurance costs for the younger consumers who are needed to balance the risk pool. Some older residents could see higher premium payments if increased subsidies and reduced insurance costs are not enough to offset the higher premiums that result from the age band change.

## Iowa 1332 Waiver Proposal

On June 12, 2017, Iowa proposed a 1332 waiver that the state considered a stopgap to fix its failing individual market. The initial waiver request did not have any of the required material such as actuarial analysis. Instead, appendix A of the waiver was an inauguration day order from President Donald Trump that called for agencies to minimize the harm of the ACA.[108] Iowa declared that the waiver was necessary "to avoid total collapse of Iowa's individual insurance market."[109]

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107. Charlton et al., "Effects of Health Savings Account-Eligible Plans on Utilization and Expenditures."
108. Exec. Order No. 13765, 3 C.F.R. §§ 8351-8352 (2017).
109. Iowa Insurance Division, *The State of Iowa's Proposed Stopgap Measure for the Individual Health Insurance Market*, June 12, 2017, https://iid.iowa.gov/documents/the-state-of-iowa%E2%80%99s

Iowa's June waiver was not accepted as an official waiver. Iowa then resubmitted the final waiver on August 21 with actuarial analysis and public comment in the state.[110] On September 19, HHS accepted the Iowa waiver as being complete.[111]

As mentioned earlier, several problems of the ACA had contributed to a crisis in the Iowa individual market. Iowa cited the fact that premiums on the individual market had increased between 70 and 100 percent. As a result, enrollment was weak and insurers had dropped out of the market. In the spring of 2017, Iowa had strong concerns that the 72,000 enrollees in the individual market would not have a single insurer offering an insurance product.

Like many other states, Iowa created a reinsurance program in an attempt to lower costs. Iowa wants to use the APTC. Iowa's waiver asks that insurance companies not have to pay CSRs, citing the current court challenges to the legality of the current funding of CSRs.[112] However, if CSRs are funded, then Iowa would utilize the CSR funding in the same way that it plans to use the APTC funds.[113]

Iowa's August 2017 waiver also cites the rapidly escalating cost of insurance, which increases federal payments to the state. Iowa also wants to use federal funding to pay for a per-member-per-month premium assistance credit, like the Oklahoma credit. The premium assistance credit would be allowed to change in value based on age (where older enrollees receive a higher credit) and income (where low-income enrollees receive more support than higher-income enrollees). The income categories are 133–150 percent FPL, 150–200 percent FPL, 200–250 percent FPL, 250–300 percent FPL, 300–400 percent FPL, and greater than 400 percent FPL. Premium assistance within those bands varies with age, where someone who is 40 will receive a smaller premium than someone who is 50. The premium age adjustment offsets higher premium costs for older enrollees. The premium assistance is transferred to the insurer, who bills the consumer for the remaining premium, if any.

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-proposed-stopgap-measure-for-the-individual-health-insurance-market.

110. Iowa Insurance Division, Iowa Stopgap Measure, August 21, 2017, https://iid.iowa.gov/documents/state-of-iowa-1332-waiver-submission.

111. Letter from Randy Pate, director of the Center for Consumer Information and Insurance Oversight, to Doug Ommen, Iowa Insurance Commissioner, September 19, 2017, https://iid.iowa.gov/documents/iowa-completeness-letter.

112. US House of Representatives v. Burwell, 185 F. Supp. 3d 165 (D.D.C. 2016).

113. CSRs are currently not being funded. See footnote 31 for a fuller discussion of CSRs and the impact on premiums. Ironically, since CSRs are not being funded, the value of premium tax credit subsidies will increase to the extent that the elimination of CSRs increases the price of the benchmark silver plan, which determines the value of the tax credit subsidy.

The flat premium means that consumers in areas with a more expensive premium plan will contribute more toward their insurance plan than consumers in a less expensive area. To ensure that the insurance premiums remain affordable, Iowa's actuarial analysis stated that many Iowans would pay either the same or less than projected premiums under current ACA law. Future premiums are reduced due to reinsurance and a broader and healthier risk pool. Iowa also submitted statements that insurers would again offer coverage on the individual market if the risk pool stabilized. These additional insurers would help constrain future premium increases by making the individual market more competitive.

Iowa believes that this funding stream will be budget neutral to the federal government—federal subsidies are expected to decline as the Iowa program stabilizes the individual market. Unlike Oklahoma, Iowa will be using only federal dollars to fund the reinsurance and subsidy programs; Iowa will not be spending any state dollars. By relying solely on federal dollars, the Iowa 1332 plan runs the risk of being inadequately funded with the revenue stream outside state control.

Like Oklahoma, Iowa seeks to eliminate the metal tiers and require insurers to offer a plan of one actuarial level, which is between 68 and 72 percent (the equivalent of silver's 70 percent). Iowa will not seek to change essential health benefits in the current waiver.

Iowa's credit is very different because it is available to all consumers. Where Oklahoma went up to 300 percent of FPL, all Iowans buying on the individual market can receive the flat credit, even consumers above 400 percent of FPL. All consumers over 400 percent of FPL would receive the same premium with the only variance being age. The premium assistance does decline by almost 75 percent compared with premium assistance for those in the 300–400 percent FPL category. For example, everyone who makes over 400 percent of FPL at age 40 would receive a monthly credit of approximately $94.[114] Iowa believes that this, instead of just a subsidy based on income and the price of an insurance premium, will attract a healthier risk pool mix that can lower premiums. Iowa also asked the federal government for the funding to ensure that the subsidy will last, even as new consumers enter or reenter the market to purchase health insurance. Iowa believes that this subsidy structure can meet the neutrality guardrail over the long term because the flat subsidy will grow more slowly and be smaller than the current APTC and CSR subsidies.

Iowa has a striking request in its official waiver, asking HHS to approve a waiver that falls outside the statutory guardrails. Iowa notes that, under President

114. Iowa Insurance Division, Iowa Stopgap Measure, August 21, 2017.

Obama, HHS bent the rules, particularly with plans that were considered grandfathered or grandmothered. Many of these plans would have been disqualified under the ACA rules; but HHS allowed these plans to continue to operate in an effort, Iowa speculates, to boost popularity of the ACA. Many people were unhappy with having to obtain a different form of insurance or a different provider net. The "grandmothered" plans meant fewer people would have to change their insurance.

The result was that many people did not enter the individual market, driving up premium costs. Citing precedent established under the Obama administration, Iowa asks the Trump administration to likewise make an exception to the text of the statute. Iowa's official waiver request states,

> CMS previously displayed its ability to be flexible in its adherence to the provisions of the ACA in its continued extensions of the transitional relief program requested by former President Barack Obama as related to grandmothered plans. CMS created a "transitional policy" allowing for health insurance carriers to continue to offer certain non-compliant ACA policies to existing consumers. This continued policy position demonstrates that CMS does have authority to be accommodating and adaptable in its interpretation and implementation of the ACA.[115]

It is unknown whether HHS will accept the argument that a second wrong would make Iowa's insurance system right. If HHS does accept Iowa's argument, it would greatly empower the executive branch's ability to interpret and even alter the law of the ACA.

## Oklahoma and Iowa Waiver Requests Withdrawn

In a four-week period between September 29 and October 23, 2017, both Iowa and Oklahoma formally withdrew their waiver applications. Both states cited frustration with the waiver process, with Oklahoma being particularly disappointed.

Oklahoma's initial 1332 was the reinsurance plan that was needed for the 2018 open enrollment period. The state of Oklahoma worked with the federal government and believed that the plan would be approved in time for the state to prepare for open enrollment. However, the federal government told Oklahoma that its waiver would not be approved by Oklahoma's deadline and did not

115. Iowa Insurance Division, Iowa Stopgap Measure, August 21, 2017.

indicate when the federal government would approve the reinsurance waiver. As a result, Oklahoma formally withdrew to allow insurers to prepare for a 2018 enrollment period with no reinsurance program.[116] Oklahoma did state that it would continue to pursue a future innovation waiver.

Iowa's waiver was to use federal dollars from premium tax credits and possible CSRs to create a new flat subsidy to purchase insurance. The federal government could not tell Iowa the amount the state could receive under its waiver application. Without enough federal dollars, Iowa could not create its new state subsidy in time for the 2018 period. The reluctance of the federal government to accept Iowa's claim that federal subsidies could save money in the long run and inhibit premium growth makes it difficult for these types of waivers to move forward. If a state wants to emulate Iowa in the future, the state's assumptions on federal subsidies and premium growth should be more conservative to help pass federal scrutiny.

After hearing the federal skepticism on the amount of money available to Iowa for its new health credit, Iowa withdrew its waiver in a short letter saying "Section 1332 Waivers in the Affordable Care Act are unworkable. Section 1332 Waivers are not designed to fix collapsing individual health insurance markets created by the Affordable Care Act."[117]

## MASSACHUSETTS MANDATE WAIVER

The state of Massachusetts has told HHS it plans to seek a waiver to eliminate the individual mandate.[118] The state wants a transition plan so it is no longer bound by the mandate, believing the mandate is not needed to ensure compliance with the ACA guardrails. Massachusetts had an employer mandate that predated the ACA, and Massachusetts believes its previous state mandate is better than the ACA employer mandate. Massachusetts Governor Charles Baker wants to waive the federal mandates in order to create state-specific mandate legislation that would better serve the state.

116. Letter from Terry Cline, Oklahoma Secretary of Health and Human Services, to Treasury Secretary Steven Mnuchin and HHS Secretary Tom Price, September 29, 2017, https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/OK-Withdraw-1332.pdf.
117. Letter from Doug Ommen, Iowa Insurance Commissioner, to Secretary Mnuchin and Acting HHS Secretary Eric Hargan, October 23, 2017, https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/IA-Letter-Withdraw-1332-Waiver.PDF.
118. Letter from Massachusetts Governor Charles D. Baker to Secretaries Mnuchin and Price, September 8, 2017, https://www.mahealthconnector.org/wp-content/uploads/Gov-Baker-Employer-Mandate-Relief-Letter.pdf.

## CHANGES TO IMPROVE STATE INNOVATION WAIVERS

The Trump administration should rescind old guidance and issue new guidance on 1332s. The Obama-era guidance is too restrictive and hampers the ability of states to innovate. States that wanted to combine Medicaid reform and private insurance options are going to struggle to use a 1332 waiver because of the wall between Medicaid and 1332 waivers. The new guidance should also clarify that a waiver is successful if it meets the statutory criteria, instead of being left to the discretion of officials in HHS. At a minimum, the Trump administration should clarify how savings from the Medicaid program could be used to offset deficit neutrality.

The Alaska reinsurance waiver illustrates a current problem with the deficit neutrality guardrail under section 1332(a)(3). The pass-through funding from the federal government is fixed at the amount going to the state for subsidies, minus any net changes in the federal budget; under current guidance, there can be no adjustments that would increase federal deficits in any given year even if deficit neutrality exists over the life of the waiver. For example, if more people enroll due to lower premiums, fewer mandate penalties are collected. As a result, the federal payments to Alaska are reduced by the forgone mandate penalties collected. Alaska is then forced to pay more for covering more people, which can make states more reluctant to innovate.

An improvement would be for Congress to alter the text of section 1332(a)(3) to make clear that a state may include all savings from a waiver instead of the current limited savings amount.[119] For example, if a state uses reinsurance to reduce premiums, it could count more savings from other reductions in government spending owing to reductions in Medicaid or uncompensated care spending. Currently, a state's waiver budget could be reduced, because it is successful in covering more people, some of whom would have paid a mandate penalty.

Another improvement would be to allow for an expedited waiver process.[120] While Iowa calls for an immediate waiver, the Trump administration should be capable of rapidly approving waivers that have been filed by several states, such as the various reinsurance waivers. This can allow states to more quickly get approval to fix their insurance markets. Several states that have withdrawn their 1332 waivers cited the lengthy timeline needed to obtain a waiver.

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119. Jason Levitis and Stuart M. Butler, "Elements of a Compromise on State Innovation Waivers" (*Up Front*, Brookings Institute, Washington, DC, September 19, 2017).
120. Tammy Tomczyk, "Stabilizing Premiums and Helping Individuals in the Individual Insurance Market for 2018: State Flexibility" (Testimony before the Senate Committee on Health, Education, Labor, and Pensions, September 12, 2017).

Several proposals in the Senate are currently being discussed. The first is Alexander-Murray, which is a bipartisan proposal that would appropriate federal money to cost-sharing reductions in return for more flexibility on 1332 guardrails.[121] A broader proposal is a discussion draft from Senate Finance Chair Orrin Hatch with Senator Mike Crapo. This discussion draft would replace the guardrails and call for new guidance on 1332s from the Trump administration.[122] Senators Susan Collins and Bill Nelson have introduced legislation that would amend section 1332 to expedite state waivers to establish reinsurance and "invisible high risk pool" programs.[123] It also would allocate $4.5 billion over two years to states that establish such programs.

Congress also should recognize the central role of states, rather than the federal government, in stabilizing their individual markets. Uniform federal rules have yielded disparate results. Some states have tolerated the ACA's federal regulatory regime better than others. In addition to variations among states, there are variations within them, with rural counties often less able to attract insurers willing to offer coverage at affordable rates.

States are better positioned than federal policymakers to address these complex issues. As the Alaska reinsurance waiver has demonstrated, section 1332 empowers states to strengthen fragile markets by directing federal resources in more effective ways that can lower premiums. For example, states can funnel federal money that would otherwise have been paid directly to insurers in the form of premium and cost-sharing subsidies into risk mitigation programs that make insurance more affordable for those who are ineligible for such subsidies.

More important, section 1332 obviates the need for Congress to allocate additional federal money to stabilize individual health insurance markets. States with troubled markets can use the section 1332 waiver process to reduce market turbulence at no additional cost to the federal government.

## CONCLUSION

The ACA's federal scheme of regulation, subsidies, and penalties has had mixed results in the individual market. That market is larger than it was before the ACA's implementation, but it is also more turbulent. While the ACA has made insurance

121. See footnote 53 for more discussion of Alexander-Murray.
122. Joe Williams, "Governors' Obamacare Waiver Power Would Broaden under GOP Proposal," *Roll Call*, November 8, 2017, https://www.rollcall.com/news/policy/proposal-would-allow-governors-to-exempt-states-from-obamacare.
123. Lower Premiums through Reinsurance Act of 2017, S. 1835, 115th Cong. (September 19, 2017).

more affordable for people with low to moderate incomes and those with chronic medical conditions, coverage is increasingly unaffordable for middle-income people in reasonably good health. The products have proven especially unattractive to younger people. Tax penalties on the uninsured have not induced a sufficient number of them to buy insurance. Because the law guarantees favorable enrollment terms for those who wait to buy insurance until they are sick (i.e., insurers must issue them policies, must cover medical conditions they acquired before they bought insurance, and cannot charge them higher premiums), the decision to remain uninsured is an economically rational one for those who do not expect to incur sizable medical bills.

Congress attempted to address these problems through legislation to "repeal and replace" the ACA. Much of this effort involved providing states with more federal resources and authority to obtain waivers from the ACA's regulatory regime. Those efforts failed.

Section 1332 of the ACA gives states authority to do what Congress could not: calm the market turbulence that Congress itself created with the enactment of the ACA. That provision enables states to deploy existing federal resources in a more cost-effective way, obviating the need for new federal spending.

States, in cooperation with the Trump administration, should take the initiative in stabilizing their markets, making full use of the flexibility provided them by section 1332. For states to be able to fully utilize innovation waivers, new guidance is needed from HHS, and the waiver process should be streamlined so states can receive timely responses from HHS.

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