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Overview of CMS' 1332 Waiver Concepts

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As **we previously discussed**, in October the Trump Administration **issued guidance** related to 1332 waivers. This guidance outlines how the Trump Administration interprets the ACA 1332 waiver guardrails. On November 29th, **CMS built off that guidance and outlined four concepts** that states can utilize in 1332 waivers. Below is a discussion of these concepts and their potential effects.

The Affordable Care Act created 1332 waivers for states to seek additional flexibility to pursue various strategies that provide high quality and affordable health coverage within a defined set of guardrails. Specifically, Section 1332 waivers were created to waive provisions within the ACA, including the possibilities of eliminating the individual and employer mandates, changing the subsidies structure, waiving exchange coverage provisions, and combining 1332 waivers with Medicaid 1115 waivers.

The ACA also included guardrails on what a 1332 waiver must include. Specifically, those guardrails required the waiver to be deficit neutral, cover a comparable number of individuals, and have coverage and affordability equitable to that under the ACA. In 2015, the Obama Administration issued guidance on what would be considered under a 1332 waiver and how they would interpret the guardrails. The October guidance from the Trump Administration is a significant deviation from the Obama Administration's approach to these waivers.

First, while the 2015 guidance focused on the number of individuals actually estimated to receive coverage, the new guidance focuses on the availability of coverage. (Through this change the Trump Administration is focusing on access to coverage, rather than the number of people that actually purchase insurance.) Next, the new guidance focuses on the total aggregate effects of a waiver rather than requiring that the coverage guardrail be met for specific sub-populations. (Meaning if some sub-populations lose coverage, but other sub-populations gain coverage, and the aggregate coverage effects are neutral, then the waiver can be approved.) Additionally, this guidance expands the definition of coverage to include more forms of coverage, including short-term plans and association health plans. The guidance also removes the requirement that 1332 waiver applications be approved/implemented by state legislative authority. Instead, they can be enacted by state regulation or executive order.

The guidance also notes that CMS would issue four concepts that states can utilize to design new approaches to provide access to health insurance. These concepts were published in a **CMS factsheet**. The four concepts are:

- **Account-Based Subsidies:** Under this waiver concept, a state can direct public subsidies into a defined-contribution, consumer-directed account that an individual uses to pay for health insurance premiums or other health care expenses. The account could be funded with pass-through funding made available by waiving the Premium Tax Credit (PTC) or the small business health care tax credit. The account could also allow individual and employer contributions.
- **State-Specific Premium Assistance:** States can use the State-Specific Premium Assistance waiver concept to create a new, state-administered subsidy program, and design the subsidy structure. States may receive federal pass-through funding by waiving the PTC to help fund the state subsidy program.
- **Adjusted Plan Options:** Under this waiver concept, states would be able to provide financial assistance (i.e., federal subsidies) for non-ACA plan options (i.e., STLDI, AHPs, etc.).
- **Risk Stabilization Strategies:** This waiver concept gives states more flexibility to implement reinsurance programs or high-risk pools.

If it wasn't already clear from the October guidance, the four concepts now clearly demonstrate that CMS is serious about giving states large amounts of flexibility in offering health insurance. And with that increased flexibility comes the rolling back of essentially all of the ACA requirements surrounding coverage and consumer protections. This can create the opportunity for more consumer options at a cheaper cost, but in turn it also allows actual coverage of services and consumer protections to decrease or vanish. (Of note, CMS Administer Seema Verma noted in her speech today, which outlined the four concepts, that pre-existing condition protections cannot be waived.)

Democrats in Congress have little ability to change or require CMS to scale back its guidance and/or concepts. With Democrats taking control over the House, they can develop and pass messaging bills that would prevent CMS and states from implementing these concepts. But without the Senate and the President, no bills on the subject can go forward. However, we could see legal action as state begin to implement these concepts in 1332 waivers.

And the state role here is one of the most important things to keep in mind. States are not required to make any of these changes. States would have to actively pursue, develop, and submit a 1332 waiver to

implement any of these concepts. What’s next is in the states' hands.

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