Section 1332 State Relief and Empowerment Waiver Concepts

Adjusted Plan Options (APO) Waiver Concept

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Section 1: Executive Summary of Adjusted Plan Options (APO) 1332 Waiver Concept

Overview: Expanding State Flexibility

The Department of the Treasury and the Centers for Medicare & Medicaid Services (CMS) in the Department of Health and Human Services (collectively, the Departments) released the Adjusted Plan Options (APO) waiver concept to encourage state innovation. The APO waiver concept provides states the opportunity to design and implement new alternatives to the Patient Protection and Affordable Care Act's (PPACA's) premium tax credit (PTC) subsidy structure to stabilize health insurance markets and address market distortions created by the PPACA in many states. The APO waiver concept is one of four waiver concepts detailed in the November 29, 2018, "Section 1332 State Relief and Empowerment Waiver Concepts: Discussion Paper" hereafter referred to as the 2018 Discussion Paper.[1] The waiver concepts are part of the Departments' effort to provide states with the ability to tailor health insurance programs to best serve the needs of state residents while still meeting the requirements of federal law, including protections for individuals with pre-existing conditions. The ultimate goal is to empower states and consumers with flexible tools to drive better coverage and increased choice and competition, resulting in more informed and cost-effective healthcare decisions. The four section 1332 waiver concepts may be used alone or in combination with other waiver concepts, state proposals, or policy changes.

The APO waiver concept is designed to empower states to establish and subsidize plan types that better address local and regional characteristics and consumer needs. States may choose to pursue this APO waiver concept to, for instance, increase Exchange enrollment, reduce the number of uninsured, or attract more issuers into the market.

Flexible Approaches

The APO waiver concept, if approved for a state, would enable a state to take advantage of the flexibility provided under section 1332 of the PPACA to increase consumer choice and affordability by allowing a state to provide state financial assistance for non-Qualified Health Plans (non-QHPs), allowing non-QHPs to be sold on the existing Exchange, expanding the availability of catastrophic plans beyond the current eligibility limitations, applying PTC to catastrophic plans and potentially certain non-QHPs sold on the Exchange, and/or other approaches. The APO waiver concept encourages states to target solutions to their unique problems or challenges in the individual and small group insurance markets, free from the constraints of certain federal requirements imposed by the PPACA.

Under the APO waiver concept, states can subsidize plans that do not necessarily include all ten essential health benefits (EHBs), as long as consumers still have the option to enroll in a plan that is as comprehensive as provided under the ACA today, like an EHB-compliant plan. Under the APO waiver concept, states can offer consumers plan designs that are driven by local market conditions and not by federal regulatory mandates.

By providing states with the flexibility to align financial assistance with the coverage needs of their residents, the Departments seek to give states tools to stimulate more competitive commercial markets, attract additional issuers, and ultimately provide greater choice of affordable plans to consumers. States are free to explore a wide range of plan designs, and the Departments encourage innovation. Innovative examples of how states might apply the APO waiver concept are outlined below. For more information, please see Section 3. The discussion here assumes all section 1332 waiver guardrails, discussed in Section 2 below, are met. Actual waivers are subject to approval by the Departments and must meet all statutory requirements.

- **Allow State Financial Assistance for non-QHPs:** States may provide state financial assistance for non-QHPs, potentially increasing consumer choice and making coverage more affordable for individuals. This option allows states the flexibility to determine what, if any, state requirements there will be for the state-specific premium subsidy to apply to non-QHPs and what types of non-

[1] Centers for Medicare & Medicaid Services. "Section 1332 State Relief and Empowerment Waiver Concepts: Discussion Paper." *CMS.gov*, 29 Nov. 2018, https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Guidance.PDF

QHP plans would be eligible for the state subsidy. Note: this builds off of the State-Specific Premium Assistance (SSPA) waiver concept.

- **Allow non-QHPs to be Sold on the Existing Federal Exchange and/or Expand the Availability of Catastrophic Plans:** States may allow advance payment of the federal PTC (APTC) for non-QHPs under certain conditions. Under this option, states could broaden the types of plans available for sale on the existing Exchange, leveraging Exchange functionality for consumer plan selection and eligibility determinations for state-specific premium subsidies or APTC. For this, the Departments would still need to evaluate the feasibility of offering a non-QHP on the FFE based on the state's specific waiver application. This option provides flexibility for states interested in offering additional plan choices to consumers while continuing to use Exchange functionality and maintaining PTC for its residents. To determine eligibility for APTC and calculate the amount of APTC available to consumers on the Federally-facilitated Exchange (FFE), issuers must continue to submit traditional silver-level QHPs for sale on the Exchange to calculate the state's benchmark plan. In addition, the Exchange must continue to perform certain eligibility activities to ensure that consumers enrolling in the non-QHP coverage generally are eligible for PTC, and must provide certain information to the IRS and to consumers about enrollment in the non-QHP.

Section 1332 Waiver Funding Options

For all section 1332 waivers, a state may receive funding equal to the amount of federal financial assistance that would have been provided to its residents absent the waiver. This funding, known as federal pass-through funding, must be used by the state for implementation and administration of the approved section 1332 waiver. States may use federal pass-through funding in addition to state contributions to fund an APO waiver concept to enhance affordability or comprehensiveness of benefits.

Take the Initial Step – Start Discussion with the Departments

The Departments are committed to empowering states to take full advantage of new opportunities to innovate in ways that will strengthen their health insurance markets and meet their unique needs. The goal is to make it significantly easier for states to apply and gain approval for all section 1332 waiver concepts, including the APO waiver concept. State engagement with CMS on section 1332 waiver concepts and applications is encouraged and welcomed.

Where to Find Out More Information

CMS encourages states that are interested in section 1332 waivers to contact the Center for Consumer Information and Insurance Oversight (CCIIO) to discuss goals and to receive technical assistance. Interested parties may send an email to StateInnovationWaivers@cms.hhs.gov for more information.

Section 2: Section 1332 Background and State Planning

Section 1332 of the PPACA permits states to request waivers of certain rules governing Exchanges under federal law to pursue innovative strategies for providing their residents with access to high quality, affordable health insurance. These waivers can be used to modify certain PPACA provisions including those related to EHBs, QHPs, the duties of a state Exchange, federal financial assistance, and the individual and employer mandates. The following table outlines the specific provisions that may be waived beginning on or after January 1, 2017.

Specific Provisions That May Be Waived	
Part I of Subtitle D of Title I	**Sections 1301-1304:** QHP and EHB requirements; Requirements for QHP issuers; Special rules related to abortion services; Insurance related definitions
Part II of Subtitle D of Title I	**Sections 1311-1313:** Exchange requirements
Subpart A of Part I of Subtitle E of Title I	**Section 1402:** Cost-sharing reductions
Internal Revenue Code of 1986	**Sections 36B, 4980H and 5000A:** PTC; Large employer coverage requirement; Individual coverage requirement

Section 1332 of the PPACA permits states to apply for waivers. The Departments may grant a waiver if a state's section 1332 waiver meets four statutory requirements (or "guardrails"). The section 1332 waiver must:

1. Provide coverage that is at least as comprehensive as the coverage defined in section 1302(b) as would be provided absent the waiver;
2. Provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as coverage absent the waiver;
3. Provide coverage to at least a comparable number of residents as would be provided absent the waiver; and
4. Not increase the federal deficit.

The Departments finalized regulations for the section 1332 statutory waivers on February 27, 2012[2], with additional guidance issued December 16, 2015 (2015 Guidance).[3] On October 24, 2018, the Departments issued updated guidance (2018 Guidance) related to section 1332 of the PPACA to expand

[2] *Application, Review, and Reporting Process for Waivers for State Innovation*. Department of Health and Human Services and Department of the Treasury, 27 Feb. 2012, https://www.govinfo.gov/content/pkg/FR-2012-02-27/pdf/2012-4395.pdf.
[3] "Waivers for State Innovation Guidance." *Federal Register*, Departments of Health and Human Services and the Department of the Treasury, 16 Dec. 2015, https://www.federalregister.gov/documents/2015/12/16/2015-31563/waivers-for-state-innovation.

state flexibility, empower states to address their unique insurance markets, and increase coverage options for their residents.[4] The 2018 Guidance, which supersedes the 2015 Guidance, provides additional flexibility on how states may meet the four guardrails. Specifically, the 2018 Guidance permits a state to meet the comprehensiveness, affordability and coverage guardrails for its residents in aggregate and by assessing the availability of affordable, comprehensive coverage, rather than only looking at the coverage people purchase. A state's waiver application will not be denied, for example, simply because people may choose a plan that is more affordable for them rather than opting to buy more expensive (but perhaps more comprehensive) coverage under current law.

State Planning for a Section 1332 Waiver

As with all new insurance program changes, states must carefully plan and design their section 1332 waiver application to meet the needs of their residents. As states design and apply for a section 1332 waiver, a thorough planning process will be critical to the waiver's approval and successful implementation. The Departments, specifically the Center for Consumer Information and Insurance Oversight (CCIIO) within CMS, will work closely with states during the comprehensive planning process. Initial planning activities, which may occur in any order, include:

- **Complete Insurance Market Study** – The Departments encourage states to leverage data-based profiles of their current health insurance market to develop effective waiver solutions. A market study may be completed by an independent vendor, or internally, and states may reach out to issuers to collect claims data. States may also look at a variety of federal and non-federal resources to gather information on their market.
- **Conduct Preliminary Stakeholder Engagement** – The Departments encourage states to begin informal conversations with issuers, consumers, providers, legislators, and other key stakeholders before finalizing a waiver approach to build consensus around goals and objectives.
- **Begin Routine Contact with CMS/CCIIO** – The designated state 1332 waiver team should establish points of contact at CMS/CCIIO, schedule periodic meetings to assess section 1332 waiver application progress and begin collaborative problem solving on key issues.
- **Draft a Section 1332 Waiver Application** – The Departments encourage states to draft a section 1332 waiver application that identifies the state's customized approach. This should include a description of challenges the waiver will address and how the waiver will alleviate those challenges. The state should also consider the implementation and section 1332 waiver application review timelines.
- **Determine Section 1332 Waiver Application Governance** – The state should determine the entity with responsibility for drafting the section 1332 waiver and administering the application phases. States may wish for this responsibility to reside in the Department of Insurance, with the State Exchange entity, the Governor's Office, or another state agency.
- **Obtain Necessary State Authority to Implement Waiver** – A key driver of waiver success is the ability to obtain timely authority to implement the waiver. States are required under the statute to enact or amend state laws to apply for and implement state actions under a section 1332 waiver. In addition, per the 2018 Guidance, the Departments clarify that in certain circumstances, existing state legislation that provides statutory authority to enforce PPACA provisions and the section 1332 waiver, combined with a duly-enacted state regulation or executive order, may satisfy the requirement that the state enact a law under section 1332(b)(2).

[4] "Waivers for State Innovation." Federal Register, Departments of Health and Human Services and the Department of the Treasury, 24 Oct. 2018, https://www.federalregister.gov/documents/2018/10/24/2018-23182/state-relief-and-empowerment-waivers

Section 3: APO Waiver Concept Description

The APO waiver concept gives states the flexibility to craft tailored solutions for ongoing challenges in the individual and small group insurance markets. The APO waiver concept allows states to provide state financial assistance for non-QHPs, allow non-QHPs to be sold on the existing Exchange, expand the availability of catastrophic plans beyond the current eligibility limitations, apply PTC to catastrophic plans and non-QHPs sold on the Exchange, and/or other approaches.

The following two policy options outlined below are provided as examples to help states conceptualize plan design choices:

Option 1: Allow State Financial Assistance for Non-QHPs

This option allows states the flexibility to determine what, if any, state requirements there are for individuals to qualify for state-administered subsidies for non-QHPs, and what types of plans would be eligible for the state subsidy. For example, states may:

- Apply a state subsidy program to plans that do not meet (or that exceed) a specific actuarial value (AV)/metal level.
- Provide state subsidies for short-term, limited-duration plans, catastrophic plans, employer-based plans, and association health plans.
- Provide state subsidies for plans that do not meet all EHB requirements but are at least as comprehensive as those that do (including non-QHP off-Exchange individual market plans).
- Provide consumer plan options such as value-based insurance design (VBID) plans; or condition-specific benefit plans that might exceed EHB requirements.

Under this option, states would request to waive provisions relating to the PTC under section 36B of the Internal Revenue Code (the Code). Provisions related to QHPs, such as PPACA section 1311(d)(2)(B)(i), which prohibits Exchanges from making available any health plan that is not a QHP would also be waived. All implementation approaches under Option 1 assume that a state is also administering its own SSPA waiver concept if it wants to offer a subsidy to non-QHPs (as described in the 2018 Discussion Paper). States considering cost sharing innovations would likely require waiving the PPACA's metal level requirements in section 1301(a)(C)(ii).

Design and Implementation Approaches

In its plan design, a state could choose how broadly or narrowly to define eligibility for the subsidies that would apply to plans that do not meet the cost sharing or AV level requirements and decide which populations to target (such as small employers or consumers eligible for a different existing state tax credit). These changes could apply across the state's entire insurance market or to a select group via a new coverage level. A state may also wish to support innovation in the benefits provided by plans, including new options for selecting an EHB benchmark plan described in the Notice of Benefit and Payment Parameters for 2019.[5]

The state's APO waiver concept should detail the enrollment process, plans for communicating information to issuers and residents on plans eligible for the state subsidy, and the strategy for notifying the public of the upcoming changes for plan options. In any option where there is a state administered subsidy program, the FFE call center would no longer be available for consumers to enroll in or select a plan, so the state will want to consider whether to offer a similar type of service. States may also want to consider the following enrollment options:

[5] "Notice of Benefit and Payment Parameters for 2019." *Federal Register*, 17 Apr. 2018, https://www.federalregister.gov/documents/2018/04/17/2018-07355/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2019

- Enable enrollment to occur directly through participating issuers or web broker websites. This option would function similarly to how small businesses enroll in the Federally-facilitated Small Business Health Options Program, how individuals are currently enrolled when purchasing coverage off-Exchange, and the direct enrollment process for consumers signing up for individual market coverage through Exchanges that use HealthCare.gov. To activate state subsidies, consumers would provide a voucher or other proof of state subsidy eligibility when enrolling. This may be more appropriate for states wishing to keep the set of state subsidy-eligible plans as broad as possible.
- Design a system where enrollment would occur through a specific website separate from the HealthCare.gov website and back-end platform used by the FFE. For example, states may consider developing their own portal and could pair this with the state's subsidy determination process and host the state subsidy eligibility application to save on administrative costs. This approach may be more appropriate for states wishing to restrict plan options to a specific plan or set of plans.

States may aggregate payment to issuers to cover appropriate levels of state subsidy payment per enrollment. States may also make payment to individuals at the time of state subsidy eligibility determination and direct the individuals to make payment to their participating issuer (similar to an Electronic Benefit Transfer (EBT) card).

Implementation approaches should also include a strong plan management component. The section 1332 waiver should address plan certification requirements and processes, identifying review tools that may be used to support plan approvals.

Administrative Expenses

States may receive federal pass-through funding associated with waived PTC under section 36B of the Code or waive 36B as well as other provisions under section 1332(a)(2) that result in savings of PTC to implement the section 1332 APO waiver. Any additional costs to fund the section waiver would be the state's responsibility. Costs could exceed expectations if the selection of plans was wide enough to attract many new subsidy-eligible consumers, or for other reasons. Please refer to the 2018 Discussion Paper for information on when states can receive federal pass-through funding, and administrative costs to the federal government associated with the waiver.

Option 2: Allow Non-QHPs to be Sold on the Existing Exchange and/or Expand the Availability of Catastrophic Plans

Under this option, states may be able to broaden the types of plans available for sale on existing Exchanges, and leverage Exchange functionality for consumer plan selection. This option provides flexibility for states interested in offering additional plan choice to consumers while continuing to use Exchange functionality and maintaining PTCs for its residents. To determine eligibility for PTC and calculate the amount of APTC available to consumers on the FFE, issuers must continue to submit traditional silver-level QHPs for sale on the Exchange in order to calculate the state's benchmark plan.

States with FFEs or with State-based Exchanges (SBE) that rely on the federal platform (SBE-FPs) that maintain the basic tenets of the PPACA QHPs may elect to make plan oversight changes that can provide additional flexibility while maintaining the technical requirements to continue use of the HealthCare.gov platform. Note that some flexibility in performing QHP certification reviews already exists for states that perform plan management functions in the FFE, and additional flexibility is available for SBEs, so a waiver may not be necessary for some changes. States are encouraged to engage with CCIIO early to determine if any fees or additional costs resulting from changes to the FFE for capabilities listed in the "State and Federal Responsibilities for Implementing a New Subsidy Structure Under a New State-Specific Premium Assistance Waiver" table within the 2018 Discussion Paper.

Design and Implementation Approaches

States interested in allowing issuers to sell plans on the Exchange that do not meet all QHP certification standards must request to waive provisions included in section 1311(c) of the PPACA. The state would

need to collaborate with CMS/CCIIO early in the process to address Exchange data structures and assure that new plans conform to the data elements required for the QHP plan templates. This option could be helpful for states that do not want to implement their own subsidy structure.

States could expand the availability of catastrophic plans beyond the current eligibility limitations by waiving section 1302(e)(2) of the PPACA, for example, to make them available to a broader group of individuals. Currently, catastrophic plans are available only to individuals under the age of thirty, or to individuals who have qualified for an Exchange affordability or hardship exemption. Catastrophic plans' risk is adjusted separately from other metal level plans. Waiving these limitations would expand plan options to more individuals.

States may also determine whether PTC could be applied to non-QHP and expanded catastrophic plans available through the Federal Exchange. Currently, individuals enrolling in catastrophic plans are not eligible for PTC. A state may choose to waive this limitation and thereby make the plans more affordable, in addition to allowing PTC to be applied to new non-QHP plans. Note that such an option may have an impact on PTC spending and premiums which would be evaluated as part of the overall waiver analysis.

Non-QHP plans offered on the Exchange for which PTC is allowable will need to ensure that consumers enrolling in the non-QHP coverage generally are eligible for PTC, and must provide certain information to IRS and taxpayers about these plans on Form 1095-A. There would need to be technical changes to allow APTC or PTC to apply to catastrophic or non-QHP plans on HealthCare.gov. This change would involve a moderate cost to the FFE for catastrophic plans and may be a higher cost depending on the type of non-QHPs offered on the Exchange. The state would be responsible for funding the technical build to adjust the HealthCare.gov system for this purpose.

Administrative Expenses

Technical changes to the FFE would be necessary in order to support changes to catastrophic plan eligibility or the application of APTC to non-QHPs. States are encouraged to reach out to the Departments with proposals early in the process for cost estimates and feasible technical timelines to be determined.

Section 1332 Waiver Administration Options

In deciding how to implement and administer their section 1332 waiver, states have a range of options. In some cases, the federal government may be able to offer support in implementing the waiver. In other cases, states may wish to leverage private sector technology and resources to create a more flexible platform for carrying out the waiver. States should work with CMS to determine the level of the FFE operations that can be utilized for the state plan based on the specifics of the state's section 1332 waiver proposal. Subject to the requirements of the Intergovernmental Cooperation Act (ICA) and OMB Circular A-97, if a waiver requires CMS to make technical changes to the federal eligibility and enrollment platform, the state will be responsible for reimbursing CMS for any costs incurred for certain technical and specialized services covered under the ICA (either with 1332 federal pass through funds and/or funds provided by the state to fully reimburse CMS). A state may administer its own information technology system, contract with a vendor(s) to outsource functions for eligibility and enrollment that the Exchange currently performs, or, where feasible, continue to utilize FFE functions that are not modified by the section 1332 waiver. States have the flexibility to structure the APO waiver concept based on the extent the state can manage the additional tasks related to direct state administration of subsidies. Under the APO waiver concept, states currently operating as an FFE that want to change the current PTC structure[6] would no longer be able to use HealthCare.gov as an application portal. Importantly, however, states may be able to use back-end FFE functionality (e.g., verification of certain eligibility factors such as citizenship and immigration) or may alternatively propose to use their own amended Medicaid system (or a third-party contractor's system) for subsidy administration services at a state level.

[6] The IRS generally cannot administer a different PTC structure for consumers in a particular state. However, the IRS may be able to accommodate small adjustments to the PTC structure, such as for consumers who get APTC and have income below 100% of FPL. Note the FFE can accommodate state requests for APTC to apply to consumers under 100% of FPL.

The Departments understand that states will have questions about the potential cost and complexity of administering a state subsidy structure and plan options that vary from HealthCare.gov. CMS is prepared to work with states to discuss this model and lay out the range of potential options available in carrying out the waiver. While states may decide to establish their own State-based Exchanges (SBEs) in order to implement the waiver, it is important to remember that the Exchanges themselves may be waived under section 1332, and that the Exchange concept may be altered to be more tailored to the state's waiver plan. States may also access FFE services in administering their waiver; any fees for accessing FFE services to carry out the 1332 waiver would be determined with each state and would depend on the requested support or changes needed.

Policy Choices for States

As states begin to think through how to design and implement the APO waiver concept, it will be important to fully understand the desired objectives, available resources, and potential overlap with existing state programs; these factors will drive the policy choices that will be necessary to effectively design an APO waiver. Policy decisions may include, but are not limited to:

- The state subsidy structure;
- Criteria for plan offerings;
- Allowable use of state subsidies;
- Administrative platform; and/or
- Potential coordination with Medicaid.

Maximizing State Flexibility to Design Innovative Waivers

States are encouraged to look at options under the APO waiver concept in conjunction with other innovative approaches introduced by CMS in the 2018 Discussion Paper. These include the flexibility to design a state's own subsidy structure; the ability to administer a defined contribution model that features a Health Expense Account (HEA); and offering solutions for high-cost claims, such as reinsurance programs or other programs to provide better care for people with complex needs. An APO waiver concept could be paired with any of the other concepts, as well as other innovative policies initiated by the state. States are also encouraged to look at additional flexibilities for section 1332 waivers as outlined in the 2018 Guidance.