

# Section 1332 State Relief and Empowerment Waiver Concepts

## State-Specific Premium Assistance (SSPA) Waiver Concept

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# Section 1: Executive Summary of State-Specific Premium Assistance (SSPA) 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 State-Specific Premium Assistance (SSPA) waiver concept to encourage state innovation. The SSPA 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 SSPA 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.<sup>1</sup> 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 SSPA waiver concept illustrates the flexibility available to states under federal law to innovate new ways to target health insurance premium subsidies that better meet its individual market needs. Even though income, Medicaid eligibility, plan availability, and underlying healthcare costs vary greatly across the country, current Exchange premium subsidies provided through the federal PTC are allocated using the same formula in all fifty states and the District of Columbia. The SSPA waiver concept is designed to free states from this "one-size-fits-all" approach, by illustrating how states can design and implement a new state subsidy structure in lieu of the PTC structure.

## Flexible Approaches

The SSPA 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 design a state subsidy structure that meets the unique needs of its population in order to achieve a number of important goals, including providing more affordable healthcare options to a wider range of individuals, attracting more young and healthy consumers into the market, or addressing structural issues that create perverse incentives, such as the "subsidy cliff" (the point at which a consumer's income changes and they are ineligible for PTC).

The SSPA waiver concept encourages states to target solutions to well-known structural problems in the health insurance markets. For example, in 2017, 15.6% of adults ages 26-34 were uninsured, the highest of any age group, according to the *U.S. Census Bureau*.<sup>2</sup> The SSPA waiver concept provides states with the opportunity to waive federal PTC provisions and establish its own state subsidy structure, in a deficit neutral fashion, to reduce the cost burden and attract these consumers. The SSPA waiver concept may also be used to address other distortions and inequities engendered by the current structure, such as subsidy cliffs that sharply decrease financial assistance when income rises.

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 SSPA waiver concept are outlined below. For more information please see Section 3. The discussion here assumes all section 1332 waiver guardrails, discussed in

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<sup>1</sup> 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>

<sup>2</sup> Berchick, Edward R., et al. Health Insurance Coverage in the United States; 2017. United States Census Bureau, Sept. 2018, [www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf](http://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf).

Section 2 below, are met. Actual waivers are subject to approval by the Departments and must meet all statutory requirements.

- **Close Coverage Gaps and Address Subsidy Cliffs:** States may wish to replace the federal PTC structure with a more flexible state framework designed to prevent subsidy cliffs that lead to sudden loss of affordable coverage. More specifically, states may broaden the eligibility criteria for the state subsidy program compared to the current federal PTC structure (including factors such as age) to prevent households from losing coverage due to incremental changes in household income and attract more consumers overall.
- **Cap the Growth Rate of Subsidy:** Under current law, federal PTC subsidies increase with premiums to match rising costs of the second lowest cost silver plan each year. There is essentially no cap on the subsidy. States could consider an alternative approach to reduce perverse incentives by capping the growth rate of the state subsidy as a component of a waiver in which state-specific premium assistance was designed.

### ***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 a SSPA 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 SSPA 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 (CCIO) to discuss goals and to receive technical assistance. Interested parties may send an email to [StateInnovationWaivers@cms.hhs.gov](mailto: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	<b>Sections 1301-1304:</b> 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	<b>Sections 1311-1313:</b> Exchange requirements
Subpart A of Part I of Subtitle E of Title I	<b>Section 1402:</b> Cost sharing reductions
Internal Revenue Code of 1986	<b>Sections 36B, 4980H and 5000A:</b> 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<sup>3</sup>, with additional guidance issued December 16, 2015 (2015 Guidance).<sup>4</sup> On October 24, 2018, the Departments issued updated guidance (2018 Guidance) related to section 1332 of the PPACA to expand state flexibility, empower states to address their unique insurance markets, and increase coverage

<sup>3</sup> *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>.

<sup>4</sup> "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>.

options for their residents.<sup>5</sup> 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).

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<sup>5</sup> "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: SSPA Waiver Concept Description

The SSPA waiver concept gives states the flexibility to design their own state subsidy structures to, for example, attract new consumers, which may help improve the health of their risk pool, strengthen their insurance market and reduce their rate of uninsured. Under the SSPA waiver concept, a state may waive federal PTC provisions and establish its own state subsidy structure, or redefine populations eligible for financial assistance, or both. In addition, states are permitted to use federal pass-through funding associated with an approved waiver to pay for administrative costs associated with implementation of a 1332 waiver.

For example, a state might:

1. **Close Coverage Gaps and Address Subsidy Cliffs:** Replace the federal PTC structure with a state framework designed to prevent subsidy cliffs that lead to sudden loss of affordable coverage. Currently, federal financial assistance helps to pay individual market premiums for individuals with incomes between 100 and 400 percent of the Federal Poverty Level (FPL), with no assistance available to consumers with incomes above or below these limits. Exchange enrollment rates for unsubsidized consumers are significantly lower than those able to access financial assistance. States may wish to broaden eligibility criteria for the state subsidy compared to the federal premium tax credits (including factors such as age) to expand the state subsidy program across a broader population to prevent households from losing coverage due to incremental changes in household income and attract more consumers overall.
2. **Cap the Growth Rate of Subsidy:** Waive federal PTC provisions and design a state subsidy structure that establishes a cap on the annual rate of growth of the state subsidy amount. Currently, a consumer's federal PTC is calculated as the lesser of (1) the premiums paid by the consumer, or (2) the difference between the second lowest cost silver plan and the consumer's contribution amount (as defined by the IRS). For example, a consumer whose household income is equal to 150% of the FPL (\$18,210 for an individual) is expected to contribute 4.15% of his or her income to the cost of the benchmark premium. As a result, federal subsidies increase to match rising costs of the second lowest silver plan each year. This formula offers few incentives for providers and issuers to curb healthcare service rate increases or to create other cost efficiencies. Under a 1332 waiver, a state could cap the growth of the state administered subsidy to some type of cost growth (e.g., medical inflation). Capping the growth of the state subsidy could create savings in addition to the amount that state residents would receive by waiving the federal PTC, which could be directed to fund the new state subsidy structure or other elements of the state plan. In addition, putting a limit on the growth of the state subsidy could put downward pressure on the growth of premiums, since insurers would know that future premium increases would not be funded by an automatic increase to federal PTC and consumers would be more cost conscious when shopping for healthcare coverage. Downward pressure on premium growth would help promote affordability both for the subsidized and the unsubsidized portions of the individual health insurance market. However, it is unlikely that this factor, alone, would permit a growth rate cap to meet the affordability guardrail; other plan elements addressing affordability would be required.

### *Design and Implementation Approaches*

To implement the SSPA waiver concept, states could request a waiver of the PTC for plans offered through the Exchange in the state (section 36B of the Internal Revenue Code, in addition to provisions around QHPs (section 1301(a)) and the Exchange's operations (section 1311(d)(2)(B)(i)), providing flexibility for states to develop a state premium subsidy program. This would likely be easier for existing SBEs to operationalize using existing SBE infrastructure as outlined in the options below since there are already connections to federal data sources.



States can also consider how to implement the new state subsidy structure. An advanceable subsidy structure based on consumers' projecting their income requires much more complexity than an age-adjusted tax credit. Income-based subsidies could also provide perverse incentives that discourage upward mobility and work, and states may wish to avoid these problems. States considering a subsidy structure based on income should also consider how consumers can report changes in income or if the state will perform an income reconciliation. States are encouraged to also consider additional innovations within the subsidy program to maximize positive impact on consumers.

Under the SSPA waiver concept, there would be no FFE operating in the state. Instead, applications for state financial assistance would be made available to consumers as part of the section 1332 waiver concept and administered by the state, and the state would assume all responsibilities associated with providing financial assistance. These responsibilities specifically include development of the new state subsidy structure, creation and processing of applications, eligibility determinations, payment of subsidies, providing consumer support and education to applicants and consumers, and adjudicating appeals of eligibility determinations.

Though consumers would no longer apply through the FFE, the state may still coordinate with CMS to utilize some back-end FFE functionality, such as authorities and technologies currently in place through the FFE connections to federal data sources. States would be required to reimburse CMS for waivers that require CMS to make technical changes to the federal eligibility and enrollment platform. States can also use direct enrollment with one or multiple vendors to customize the application, as a vehicle for eligibility and enrollment, or customize the window shopping experience, as a few examples to develop a unique tailored experience.

States should be aware that HHS is strongly committed to leveraging information technology components that have already been built to accomplish these tasks, as modeled in the examples below:

**Implementation Approach 1:** One implementation option for states would be to perform the eligibility determination using existing Medicaid or CHIP system connections to federal data sources (e.g., Department of Homeland Security and the Social Security Administration). The advantage of this approach is that states could leverage its current Medicaid system so it might be less burdensome than starting from scratch. This approach also takes advantage of existing agreements. States would be required to cost allocate expenses with Medicaid<sup>6</sup> in these circumstances, and perform data matching issue (DMI) processing for individuals who are not able to be electronically verified. This may require new data use agreements or updates to existing data use agreements with federal agencies but would have the benefit of streamlining health coverage assistance programs and consumer support channels within the state. States would be required to have the authority to access these federal data sources.

**Implementation Approach 2:** A second implementation option for states would be to perform the eligibility determination using authorities and technologies currently in place through the FFE connections to federal data sources (e.g., Department of Homeland Security and the Social Security Administration). Under this approach, the state would request that the FFE perform verification of certain eligibility factors, such as citizenship and immigration status, on behalf of the state. The advantage of this approach is that CMS could do these services potentially at a lower cost than the state because CMS has economies of scale. Related to the verification requests, the FFE would perform downstream DMI processing, and support the state in related appeals adjudication. States would use this federally-verified data (for example citizenship/immigration status) in combination with application responses and other state-verified data (for example state income) to make an eligibility determination.

For either implementation approach, states would communicate the eligibility result to the individual and provide the individual with information on how to use the state subsidy when enrolling in health coverage. Where necessary, the state would provide follow up information to the individual regarding the successful resolution of DMIs, or regarding the failure to resolve a DMI and the associated loss of subsidy eligibility. In addition either of these approaches could take advantage of direct enrollment mechanisms.

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<sup>6</sup> Per 2 CFR 200 (previously OMB-A-87), cost allocation principles would apply unless otherwise waived.



Once an eligibility determination is made, consumers could take advantage of the market's existing sales channels to purchase coverage. States are encouraged to consider waiving additional Exchange requirements (section 1311 of the PPACA) in order to maximize flexibility in implementing its tailored financial assistance program. More information related to SSPA waiver concept implementation can be found in the 2018 Discussion Paper.

### ***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 SSPA waiver concept based on the extent the state can manage the additional tasks related to direct state administration of subsidies. Under the SSPA waiver concept, states currently operating as a FFE that want to change the current federal tax credit structure to develop their own state administered subsidy, 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 its own amended Medicaid system (or a third-party contractor's system) for subsidy administration services at a state level.

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 SSPA 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 a SSPA waiver. Policy decisions may include, but are not limited to:

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

## Maximizing State Flexibility to Design Innovative Waivers

States are encouraged to look at options under the SSPA waiver concept in conjunction with other innovative approaches introduced by CMS in the 2018 Discussion Paper. These include the ability to permit consumers to choose from a wider variety of plan options to optimize value; 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. The SSPA 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.<sup>7</sup>

### Administrative Expenses

States may use federal pass-through funding associated with waived PTC to implement the section 1332 waiver and help fund the alternative state subsidy program. Any additional costs to fund the state subsidy program would be the state's responsibility. For example, if additional state premium subsidy costs are incurred through additional enrollment under these policy changes, the state would be responsible for covering that additional cost (either with 1332 federal pass-through funds or funds provided by the state). Please refer to the *Overview of 1332 Waiver Concepts* for information on when states can receive federal pass-through funding, and administrative costs to the federal government associated with the waiver.

- Implementation Approach 1: States would perform the eligibility determination using existing Medicaid or CHIP system connections to federal data sources.
  - *Administrative Expenses:* In this option, very few costs would be incurred by CMS, and the state would be treated by CMS in a similar way as a state operating its own Exchange with a redirect to the independent state website.
- Implementation Approach 2: States would perform the eligibility determination using authorities and technologies currently in place through the FFE's connections to federal data sources.
  - *Administrative Expenses:* In this option, costs would be incurred by the state to support up-front technical changes and ongoing processing of citizenship or immigration-related DMIs. The state will be responsible for reimbursing CMS for both types of costs incurred as part of the section 1332 waiver.

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<sup>7</sup> "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>