



Update on the Section 1332 Innovation Waivers

Updated October 2017

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BACKGROUND

Section 1332 of the Patient Protection and Affordable Care Act (ACA) allows states to seek State Innovation Waivers of certain ACA provisions beginning in 2017.

ACA Sections that may be Waived under Section 1332

Subtitle D, Part I	Sections 1301-1304: Qualified Health Plan (QHP) and Essential Health Benefits requirements; Requirements for QHP carriers; Special rules related to abortion services; Insurance-related definitions
Subtitle D, Part II	Sections 1311-1313: Exchange requirements
Subtitle E, Part 1	Section 1402: Cost-sharing reductions
Internal Revenue Code of 1986	Sections 36B, 4980H and 5000A: Premium tax credits; Individual coverage requirement; Large employer coverage requirement

In order to receive a Section 1332 Waiver, states must apply in accordance with the process set forth in 45 CFR 155.1300 through 155.1328 and 31 CFR 33.100 through 33.128, which may be done jointly with Section 1115 Medicaid Waivers. In the waiver application, the state must demonstrate that the waiver meets comparability requirements:

- It will provide coverage to at least a comparable number of the state's residents as would be provided without the waiver;
- It will provide coverage and cost-sharing protections that are at least as affordable as would be provided without the waiver;
- It will provide for coverage that is at least as comprehensive as would be provided without the waiver; and
- It will not increase the federal deficit.

States are increasingly looking to Section 1332 Waivers as a way to expand upon or customize the ACA to best address the unique circumstances within the state. As outlined below, a number of states have either submitted Section 1332 Waiver requests or have taken formal steps to begin the process of designing a Section 1332 Waiver. The new administration reminded states of the opportunities under Section 1332 in a letter sent to Governors in March¹ and a Section 1332 Waiver checklist that the Centers for Medicare and Medicaid Services subsequently released in May.² These communications highlighted the ability to use Section 1332 Waivers to further address access, affordability, choice and stabilizing the health insurance pools, and specifically noted the reinsurance focus of the waiver submitted by Alaska, as outlined below. The checklist highlighted the requirements to obtain a 1332 waiver - and data that must be submitted - both generally and specific to a waiver to support a reinsurance program.

As you will see below, the waivers that are being considered in states and may be of value to other states are very much state-specific and directly tied to: the existing context in the state; the needs of the state; and what flexibility may benefit the state. Therefore, understanding challenges currently affecting the health care system in the state and what sections can be waived is a crucial first step in considering whether and how to leverage Section 1332 Waiver authority. However, below is an overview of waivers being pursued or considered in states

¹ https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/March-13-2017-letter_508.pdf

² <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Checklist-for-Section-1332-State-Innovation-Waiver-Applications-5517-cpdf.pdf>

and examples of other ways in which Section 1332 Waiver authority could be leveraged in an effort to demonstrate what sort of flexibility may be possible.

OVERVIEW OF STATE SECTION 1332 WAIVERS³

Oregon

Approved Waiver: Receiving support for a state reinsurance program

Oregon's Section 1332 Waiver application⁴ - submitted on August 31, 2017 – was approved by CMS in October. The state will receive pass-through funding in support of a state-based traditional reinsurance program known as the Oregon Reinsurance Program (ORP).

The state noted in its application that its uninsured rate has decreased significantly (from 17 percent to under 5 percent) since the implementation of the ACA and that coverage is now affordable for more individuals in the state. In addition, uncompensated hospital care has decreased by approximately \$500 million per year. However, Oregon has seen “unprecedented” change to its market, with seven carriers (including two CO-OPs) having left the individual market. Though all Oregonians have the choice of multiple carriers and all counties have at least one on-Exchange carrier, remaining carriers have diminished their presence in the state and increased premiums. Oregon is taking action to stabilize the market and prevent continued rate increases and other changes that could lead to “bare” counties in the future.

The ORP is a traditional reinsurance program. The attachment point, cap, and coinsurance rate will be set by administrative rule based on the funding available, but the state expects a coinsurance rate of 50 percent and a reinsurance cap of \$1 million. The attachment point, cap, and coinsurance rate will be altered if funding becomes insufficient. As required for waiver approval,⁵ the state's authorizing legislation makes state funding for the ORP contingent on the Section 1332 Waiver being granted.

To implement the ORP, the state's request to waive Section 1312(c)(1) of the ACA was granted in order to allow carriers to include ORP payments as they develop premium rates. The state will also receive pass-through funding from savings to federal premium tax credits as a result of the reduced premiums. Oregon estimates a net premium decrease of 7.5 percent in 2018, 7 percent in 2019, and 6.4 percent in future years as a result of the reinsurance program. It projects the federal government to save in excess of \$30 million per year in premium tax credits as a result, since the tax credits are calculated based on premium rates. The state also projects more insurers to maintain and possibly expand coverage areas as a result of the waiver. The state will fund the balance of the \$90 million total cost for the ORP from insurer assessments and excess funds from existing state programs.

Oregon's application also detailed how the waiver meets all comparability requirements. It states that the waiver will not impact comprehensives of coverage and will reduce premiums, increasing affordability. The state also projects that coverage will increase by 1.7 percent in 2018 and 1.4 percent in future years as a result of the waiver. The federal deficit will not increase because funding would be provided from savings to premium tax credits.

³ See Table 1 at the end of the paper for a detailed list of each state's specific waiver requests.

⁴ <http://healthcare.oregon.gov/Documents/1332-application.pdf>

⁵ <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Checklist-for-Section-1332-State-Innovation-Waiver-Applications-5517-cpdf.pdf>

Minnesota

Approved Waiver: Receiving support for a state reinsurance program

On September 22, 2017, Minnesota's Section 1332 Waiver application⁶ was approved "in part." The five-year waiver enables the state to implement and receive federal support for its state-based reinsurance program known as the Minnesota Premium Security Plan (MPSP), from January 1, 2018 through December 31, 2022.

The state established the MPSP in April 2017⁷ to stabilize the state's individual market, which saw significant rate increases in 2017 following the withdrawal of its largest insurer. The risk profile of the market has also declined. The goals of the MPSP are to: stabilize premiums; encourage greater insurer participation and individual enrollment; eliminate unintended consequences of the state's Basic Health Plan and the federal premium tax credits; and create a fiscally sustainable program. The MPSP is modeled after the federal reinsurance program that was in effect from 2014 through 2016, and reimburses for 80 percent of individual market claims between \$50,000 and \$250,000. Participation in the program is invisible to individuals and required of insurers participating in the non-grandfathered individual market.

The Department of Health and Human Services and Department of the Treasury (the Departments) approved the state's request to waive the single risk pool requirement (Section 1312(c)(1)) to allow carriers to include reinsurance payments when establishing premium rates as well as the request for pass-through funding related to savings to premium tax credits as a result of the reinsurance program.⁸ The Departments did not approve the state's request to receive pass-through funding related to savings in federal contributions to the Basic Health Plan as a result of the reinsurance program. The Departments noted that Section 1332(a)(3) only provides for pass-through funding related to premium tax credits, cost sharing reductions, and small business tax credits. As a result, the approval limited the pass-through funding available to that related to savings to premium tax credits.

The state estimated that the MPSP will result in a reduction of premiums in the individual market by an average of over 20 percent (between \$125 and \$175 per member per month) and will maintain and increase enrollment of healthy residents (bringing into the market 20,000 more healthy individuals than are currently enrolled and 50,000 more than would ultimately be enrolled without the program). As a result of the premium savings, the state projected that the federal government will save money that it would have otherwise spent on the premium tax credits (estimated to be \$138 to \$167 million lower in 2018 than without the MPSP). The Specific Terms and Conditions estimate that pass-through funding for 2018 will be \$139.2 million and for the entire five-year waiver period will be \$1.002 billion. The actual payments will be determined on an annual basis based on data provided by the state related to premium tax credit savings. These payments will be provided in advance of MPSP payments to insurers. State contributions will fund the balance of the program.⁹

The state has stated that its waiver meets all comparability requirements because benefits and cost-sharing will not change under the waiver and coverage levels are expected to increase as outlined above. In addition, the federal funding will come from savings to federal spending for premium tax credits as a result of the waiver so the federal deficit will not increase.

⁶ <http://mn.gov/commerce-stat/pdfs/mn-1332-narrative.pdf>

⁷ As required for waiver approval, the state's authorizing legislation made implementation of the MPSP contingent on the waiver being granted.

⁸ The federal contribution for premium tax credits is based on the premium of the second lowest cost Silver plan, which the state projects to be lower as a result of the MPSP.

⁹ The total estimated cost of the MPSP for 2018 is \$271 million.

Alaska

Approved Waiver: Receiving support for the state reinsurance program

Alaska received approval of its Section 1332 Waiver application¹⁰ on July 7, 2017, which enables the state to receive federal funding to support the state-based Alaska Reinsurance Program (ARP) starting in 2018. A five-year waiver was granted.

In response to projections that premiums in the state's individual health insurance market were projected to increase 42 percent for 2017, the state created the ARP, which pays claims for individuals with high-cost conditions, removing those claims from the insurance risk pool. State funds were appropriated to fund the program only for 2017. As a result of the program, rates increased an average of only 7.3 percent.

The federal approval grants the state's request to waive the single risk pool requirement under Section 1312(c)(1) to the extent necessary to enable insurers to include state reinsurance payments when establishing premium rates. Related to that waiver, the state will receive federal pass-through funding from the savings the federal government accrues in premium tax credits because the reinsurance program has prevented what was projected to be a significant rise in premiums.¹¹ In addition, enrollment in individual market health insurance in the state is projected to increase generally, with more healthy individuals entering the market – this is also projected to result in premium savings. The state projects premiums to actually decrease up to four percent for 2018, saving the federal government \$51.6 million in premium tax credits.¹² The actual pass-through funding amounts will be determined on an annual basis and will be reduced to account for losses in shared responsibility payments and reductions in Exchange fees. The state will receive payments quarterly in advance of reinsurance payments to issuers. Funding can be used to pay claims and for administrative expenses.

Alaska had also requested to waive the opportunity to establish CO-OP health plans in the state, but that waiver was not granted.

The state met all comparability requirements because coverage rates are projected to increase while premiums decrease with cost sharing and benefits staying the same. The federal funding will come from savings to the federal government, with the state funding any delta between that funding and the cost of the program.

Hawaii

Approved Waiver: Maintaining its state-based employer coverage requirements

Hawaii is the first state with an approved Section 1332 Waiver,¹³ having received approval in December of 2016. The state sought the waiver to allow its long-standing small group health coverage law – the Prepaid Health Care Act - to remain intact. The law was enacted in 1974 as a result of an ERISA exemption and requires most small employers to offer coverage that meets state standards to their employees that work 20 hours or more a week and provides premium assistance for doing so. Under Hawaii law, employers are required to offer coverage that is more affordable and comprehensive than most plans that would be available through the Small Business Health Options Program (SHOP).

¹⁰ <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Alaska-Application-with-Attachments-51117.pdf>

¹¹ Those individuals that are eligible for tax credits have their required premium contribution limited to a set percentage of their annual income, with the tax credits paying what remains of the premium for the second lowest-cost Silver plan. Therefore, tax credits are calculated based on – and directly impacted by – the cost of premiums.

¹² While the application did not request expected savings from cost-sharing reductions, to the extent the reinsurance pays for a portion of claims, cost-sharing reductions would not be needed for those services, also reducing that federal expenditure.

¹³ https://governor.hawaii.gov/wp-content/uploads/2014/12/REVISED-Hawaii-1332-Waiver-Proposal_-August-10-2016.pdf

Via the waiver, Hawaii is released from the requirement to operate the SHOP and related provisions so that employers can continue to purchase more generous coverage outside of the Marketplace with state assistance without requiring the state to build a platform that would go largely unused in the state or allow employers to access a FF-SHOP which may lead to lack of awareness of state-based obligations. The waiver also allows for the pass-through of tax credit amounts that would have otherwise been paid to small employers that purchased coverage via the SHOP and met eligibility requirements. That funding is used, in turn, to support a state fund for small businesses that offer health insurance.

The waiver also includes flexibility as to which state agencies can carry out responsibilities for the Marketplace.

Under the waiver, there is not projected to be any decrease in coverage or change in affordability or benefits. Nor will it increase any federal expenditures.

Iowa

Withdrawn Waiver: Sought to implement an individual market “stopgap measure”

Iowa followed up on its abbreviated waiver request last June¹⁴ with a more robust waiver application that it submitted on August 21, 2017,¹⁵ and which sought support of the state’s Proposed Stopgap Measure (PSM) Plan. The state’s waiver application was determined complete on September 19, 2017. The state subsequently submitted and then updated a supplement¹⁶ to its application to address affordability and coverage concerns. However, following the Center for Consumer Information and Insurance Oversight letter to Iowa explaining that pass-through funding must be limited to gross federal savings under the program, the state withdrew its waiver request to support the PSM.

Iowa’s request was aimed at “preventing collapse” of its individual health insurance market. Insurers in the state’s individual market initially underestimated necessary premiums to support the market. Resulting losses led to a significant spike in premiums (70 to 100 percent since 2014), which, in turn, resulted in declining enrollment, a higher risk profile for the market, and issuer withdrawals. The state expressed concern that, without a waiver, there will be only one carrier on the state’s individual Marketplace in the state for 2018 with significantly increased rates (particularly for those who must switch carriers), resulting in significant losses in coverage.

Specifically, the state sought one-year authority¹⁷ to implement the PSM Plan, effective immediately, which would include:

- **A reinsurance program** – The state sought to implement a traditional (attachment point) reinsurance program in the individual market. In combination with the federal Risk Adjustment High-Cost Risk Pooling, individual market claims between \$100,000 and \$3,000,000 would be reimbursed at an 85 percent coinsurance rate (25 percent by the PSM and 60 percent by Federal Risk Pooling) and those over \$3,000,000 would be reimbursed at a 100 percent coinsurance rate (40 percent by the PSM and 60 percent by Federal Risk Pooling), with the state making up any shortfall from the federal program. To participate, carriers would be required to implement care management protocols. The state estimated the program would reduce claims by 15 to 17 percent.
- **A state-based premium subsidy mechanism** – In place of federal premium subsidies, the state proposed to provide state-based premium subsidies for all individuals who purchase the standardized plan outlined below. The subsidies would be flat dollar amounts based solely on age and income and paid directly to the carrier.

¹⁴ https://iid.iowa.gov/sites/default/files/state_of_iowa_proposed_stopgap_measure_6.12.2017.pdf

¹⁵ <https://iid.iowa.gov/documents/state-of-iowa-1332-waiver-submission>

¹⁶ https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Iowas-1332-Waiver-Stopgap-Measure-Supplement-1-Updated_10-05-2017.pdf

¹⁷ The state also seeks the option for a 1-year renewal.

- **State-based cost-sharing reductions** - In response to concerns that the PSM plan would not comply with the Section 1332 requirements for affordability and coverage, the state submitted a supplement to its waiver to provide cost-sharing credits to individuals with incomes between 133 percent and 200 percent of the Federal Poverty Level (FPL). The state intended to offer cost-sharing reductions in the same manner as the federal cost-sharing reductions (based on a 94 percent actuarial value plan for those 133-150 percent FPL and 83 percent actuarial value for those 150-200 percent FPL). Cost-sharing would be reduced for services, and, once individuals reached their out-of-pocket maximum (\$600 / \$1,200 for those 133-150 percent FPL and \$2,450 / \$4,900 for those 150-200 percent FPL), no further cost sharing would be required. Cost-sharing reduction payments would be made to carriers and would be reconciled.
- **A state-based standard health benefits plan** – As a condition of receiving reinsurance funding, the state would require each carrier to offer the standard Iowa PSM plan. The PSM plan would have Silver level actuarial value (68 to 72 percent) and would include the Essential Health Benefits and state mandated benefits. The cost sharing design would be standardized, with deductibles and out-of-pocket maximums set at \$7,350 for individuals and \$14,700 for families. The plans would also include primarily copayments, with coinsurance for “very few” services. These plans would be available for direct enrollment and on a guaranteed-issue basis via Open Enrollment and would not have annual or lifetime limits. These would be the only plans available in the individual market in 2018 other than grandfathered and transitional plans. Individuals who do not purchase the plan during Open Enrollment would be required to show proof of 12 months of continuous coverage to qualify for a Special Enrollment Period in circumstances other than birth or adoption, loss of coverage, becoming newly eligible, or gaining membership in a tribe.

In order to implement the PSM, the state sought the waiver of:

- Section 36B of the Internal Revenue Code (premium tax credits);
- Section 1402 of the Affordable Care Act (cost-sharing reductions); and
- Section 1302 of the Affordable Care Act (metallic coverage level requirements).

The state also requested pass-through funding from the waived premium tax credits and cost-sharing reductions (if appropriated) to fund the reinsurance program and the state-based premium subsidies in full. The state projected that PSM would cost approximately \$422 million inclusive of administrative costs, which would be fully funded by the pass-through funding, and requested that funding be provided “in an amount commensurate with the number of individuals that enroll” to ensure full funding.

The state reported that one additional carrier committed to participate in the PSM and it expected others would as well. It projected that the waiver would result in an 11 percent premium decrease and at least 22,000 additional individuals being insured. It acknowledges that while premiums would decrease for all enrollees, cost sharing would increase for some due to the waiver of cost-sharing reductions without a state replacement or a replacement to the same financial amount for part of the currently-eligible population, impacting affordability. In its supplement submission, the state reported that individuals between 133 percent and 150 percent FPL would have increased affordability as their premiums decrease and cost sharing remains constant. For those between 150 percent and 200 percent FPL, cost sharing would be greater than under the ACA but, coupled with premium subsidies, the state projected that the majority of that population would see face lower costs. Overall, the state projected that coverage would increase. The state projected that even with the addition of cost-sharing reduction payments, the total cost of the PSM would equal available pass-through funding (projected at \$422 million). The state reported that coverage would increase and comprehensiveness of coverage would remain unchanged. Iowa also reported that the waiver would not increase the federal deficit as it reallocated federal funds currently being paid.

Oklahoma

Withdrawn Waiver: Sought support for a state reinsurance program

While Oklahoma ultimately withdrew its request,¹⁸ the state had filed a Section 1332 Waiver application¹⁹ on August 16, 2017, in follow-up to its Section 1332 concept paper²⁰ that it released last March. The state's request sought federal pass-through funding for a state-based reinsurance program. The state shared that it saw this as a first step that will be followed by a broader subsequent reforms and likely future waiver requests.

The application was an attempt to stabilize the individual via the Oklahoma Individual Health Insurance Market Stabilization Program (OMSP). Modeled as a traditional reinsurance program, the OMSP was designed with an attachment point of \$15,000, a cap of \$400,000, and a coinsurance rate of 80 percent for Marketplace plans.

Oklahoma had requested a five-year waiver of Section 1312(c)(1) of the ACA to allow carriers to include reinsurance payments when establishing premium rates as well as pass-through funding related to the fact that premium tax credits would be reduced due to reduced premiums (based on which, premium tax credits are calculated). In total, the state expected the program to cost \$325 million (with \$309 million coming as pass-through funding) in 2018. The state projected that, as a result of the OMSP, premiums would be 34 percent lower in 2018 and enrollment would increase by 28,000 by the third year of the program.

In the waiver application, the state outlined that it met all comparability requirements. It projected that coverage would increase and that affordability would improve as premiums decrease and out of pocket costs would be unaffected. It also reported that coverage of Essential Health Benefits would remain and there would be no increase in the federal deficit since only funding related to premium tax credit savings are being requested.

The state had specifically requested expedited review and approval.

In its earlier concept paper, the state had noted that it was exploring the following waiver options:

- Eliminating the metallic coverage levels under the ACA in lieu of one minimum actuarial value for plans other than high deductible health plans;
- Introducing state-specific requirements focused on payment and delivery system reform for Qualified Health Plans (QHPs) and reducing the Essential Health Benefits (EHBs);
- Increasing administrative simplification for QHP carriers;
- Ending use of the Federally-Facilitated Marketplace (FFM) and instead utilizing an existing state-based coverage portal;
- Revisiting the dates of the Open Enrollment Period (OEP) and tighten rules for Special Enrollment Periods (SEPs);
- Adjusting eligibility for federal financial assistance to those under 100 percent FPL that are currently in the gap between Medicaid coverage and tax credits, tightening grace period rules, and enabling auto-enrollment;
- Establishing and utilizing Health Savings Accounts (HSAs) as a vehicle for financial assistance; and
- Eliminating certain exemptions from the individual coverage requirement.

¹⁸ <https://www.ok.gov/health2/documents/Oklahoma%201332%20Waiver%20Withdrawal%209.29.17.pdf>

¹⁹ <https://www.ok.gov/health2/documents/1332%20State%20Innovation%20Waiver%20Final.pdf>

²⁰ <https://www.ok.gov/health/documents/1332%20Waiver%20Concept%20Paper.pdf>

Massachusetts

Withdrawn Waiver: Sought support of a Premium Stabilization Fund

Massachusetts had submitted Section 1332 Waiver to support a Premium Stabilization Fund in lieu of cost-sharing reduction payments. The application was determined incomplete because there was not sufficient time to complete federal review ahead of the 2018 Open Enrollment Period.

The Commonwealth has announced that it will consider pursuing the waiver for 2019.

Vermont

Sought to maintain small group direct enrollment

In March of 2016, Vermont submitted a Section 1332 Waiver²¹ seeking to waive the requirement to establish a SHOP, and allow for continued direct enrollment through insurers. The Centers for Medicare and Medicaid Services informed the state that its submission was incomplete (missing required data and actuarial analysis) in June and there has been no public correspondence since.

Vermont has a merged individual and small group market and requires all coverage to be sold on the Marketplace, but allows for small groups to enroll directly through insurers. Insurers must make all of their plans available to employees, and employers can choose to offer employee choice across plans from all carriers by administering plan selection internally. With that structure, Vermont reports having the largest small group enrollment of all State-Based Marketplaces in 2014. Vermont sought to maintain this successful structure without having to invest in an internet portal.

California

Withdrawn Waiver: Sought to expand coverage options for immigrants

While California ultimately withdrew its waiver application,²² it had applied in December of 2016 with the aim of offering a new health insurance option to individuals excluded from enrollment in QHPs through the Marketplace due to their immigration status (undocumented immigrants and individuals granted Deferred Action for Childhood Arrivals). California sought to create “California Qualified Health Plans” (CQHPs), which would mirror and meet all the requirements of existing QHPs, and allow such individuals to enroll in those plans via the state Marketplace. This would allow mixed status families to access coverage through the streamlined Marketplace process. Such individuals would remain ineligible for financial assistance.

California reported that its proposal met comparability requirements by increasing coverage without impacting affordability or benefits and that there would be no federal cost.

²¹ <http://dvha.vermont.gov/global-commitment-to-health/vermont-1332-waiver-for-state-innovation-application.pdf>

²² <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Covered-California-Section-1332-Waiver-Application-12-16-16.pdf>

TABLE 1: SPECIFIC WAIVER REQUESTS (AS OF OCTOBER 2017)

	Waivable ACA Sections
	Subtitle D Subtitle D Part I Sections 1301-1304
Key Provisions	<p>Defines QHPs, including the requirement that they be certified by the Marketplace</p> <p>Defines Essential Health Benefits (EHBs) and requires QHPs to include them</p> <p>Outlines requirements for QHP carriers (must sell at least one Silver and one Gold plan; must charge the same premiums on- and off-Marketplace)</p> <p>Outlines coverage levels and actuarial value (AV) requirements and catastrophic plans</p> <p>Establishes CO-OPs</p> <p>Includes definition related to insurance market rules, including defining small and large employer</p>
Alaska (Reinsurance) Waiver	None ²³
Iowa (Individual Market Stopgap) Waiver Proposal	Eliminate metallic coverage level requirements
Minnesota (Reinsurance) Waiver	None
Oklahoma (Reinsurance) Waiver Proposal	None
Oregon (Reinsurance) Waiver Proposal	None
Hawaii (SHOP) Waiver	<p>Eliminates the reference to SHOP in the definitions of QHPs, CO-OPs, and multi-state plans</p> <p>Eliminates the requirement that carriers offer Silver SHOP plans</p> <p>Eliminates the provision regarding continued participation in the SHOP for growing small employers</p>
Vermont (SHOP) Waiver Proposal	None
California (Immigrant Coverage) Waiver Proposal	None
Examples of other ideas that are being or could be considered <i>(not intended to be an exclusive list)</i>	<p>Add another EHB service or substitute an EHB category across the Marketplace or in certain coverage levels (straight eliminations would not meet comparability requirements)</p> <p>Decrease cost-sharing limitations (increases would not meet comparability requirements)</p> <p>Eliminate requirement that carriers offer Gold and Silver plans to encourage carrier participation</p> <p>Add a new coverage level or eliminate one or more coverage levels</p> <p>Allow catastrophic plans to be purchased by a broader population</p> <p>Allow unique plans to be offered to specific populations</p> <p>Define small employers as including sole proprietors</p>

²³ Request to eliminate the opportunity to establish CO-OPs in Alaska was not granted.

Waivable ACA Sections	
Subtitle D Part II Sections 1311-1313	
Key Provisions	<p>Sets forth provisions relative to the creation and duties of Marketplaces</p> <p>Outlines QHP certification criteria and requirements</p> <p>Sets forth Marketplace consumer support tools</p> <p>Establishes the open enrollment period (OEP) and special enrollment periods (SEPs)</p> <p>Sets forth requirements related to consumer choice in the Marketplaces and SHOPs including the right to continue to purchase insurance off-Marketplace</p> <p>Sets forth the requirement for a single risk pool and allows states to merge their individual and small group markets</p> <p>Sets forth eligibility requirements for purchasing through the Marketplace</p> <p>Sets forth requirements related to Marketplace financial integrity (record-keeping, reporting, audits)</p>
Alaska (Reinsurance) Waiver	Eliminates the single risk pool requirement to allow insurers to factor in reinsurance payments received in calculating rates.
Iowa (Reinsurance) Waiver Proposal	None
Minnesota (Reinsurance) Waiver	Eliminates the single risk pool requirement to allow insurers to factor in reinsurance payments received in calculating rates.
Oklahoma (Reinsurance) Waiver Proposal	Eliminate the single risk pool requirement to allow insurers to factor in reinsurance payments received in calculating rates.
Oregon (Reinsurance) Waiver Proposal	Eliminate the single risk pool requirement to allow insurers to factor in reinsurance payments received in calculating rates.
Hawaii (SHOP) Waiver	<p>Eliminates the state requirement to establish a SHOP (and the federal establishment of a FF-SHOP); passes through amounts that would otherwise be available for small business tax credits through the SHOP to support state subsidies</p> <p>Waives employee choice</p> <p>Waives the definition of “qualified employer”</p> <p>Allows flexibility as to which state agencies can carry out responsibilities for the Marketplace</p>
Vermont (SHOP) Waiver Proposal	Eliminate the requirement that the state establish a SHOP. Also eliminate requirements that the following be available through a SHOP: rates, enrollee satisfaction system, enrollment portal, plan certification, consumer assistance, quality ratings, employee choice (this is all done through the individual market Marketplace which offers the same plans)
California (Immigrant Coverage) Waiver Proposals	Waive the requirement that the Marketplace only offer QHPs for the limited purpose of allowing it to offer CQHPs
Examples of other ideas that are being or could be considered <i>(not intended to be an exclusive list)</i>	<p>Waive individual Marketplace (replaced with direct enrollment or private exchanges)</p> <p>Allow rate setting by the Marketplace</p> <p>Adapt QHP criteria for all plans or a subset of plans offered to a limited population to promote better integration with Medicaid (including to allow premium assistance programs to be more seamlessly integrated on the Marketplace)</p> <p>Allow the state to maintain a merged market while allowing unique rules for enrollment and rate changes (MA)</p> <p>Expand the role of agents and broker to allow them to assist with financial assistance applications</p> <p>Expand the SHOP to only a subset of large businesses</p>

Waivable ACA Sections	
Subtitle E Part 1 Section 1402	
Key Provisions	Establishes and sets forth eligibility and requirements related to cost-sharing reductions (CSRs)
Alaska (Reinsurance) Waiver	None
Iowa (Individual Market Stopgap) Waiver Proposal	Eliminate CSRs and request pass-through funding
Minnesota (Reinsurance) Waiver	None
Oklahoma (Reinsurance) Waiver Proposal	None
Oregon (Reinsurance) Waiver Proposal	None
Hawaii (SHOP) Waiver	None
Vermont (SHOP) Waiver Proposal	None
California (Immigrant Coverage) Waiver Proposals	None
Examples of other ideas that are being or could be considered <i>(not intended to be an exclusive list)</i>	Change CSR amounts Allow CSRs to be used outside of the Silver level via a benchmark plan approach Allow CSRs to be funded through HSAs and applied to plans outside of the Marketplace Provide CSRs for certain employer-sponsored plans Provide CSRs for standalone dental (MN)

Waivable ACA Sections

	Internal Revenue Code of 1986 Section 36B Section 4980H Section 5000A
Key Provisions	Establishes and sets forth eligibility and requirements related to premium tax credits Outlines the large employer coverage requirement Outlines the individual coverage requirement
Alaska (Reinsurance) Waiver	Receiving pass-through funding from savings related to lower premium tax credits as a result of the state reinsurance program to fund the program
Iowa (Individual Market Stopgap) Waiver Proposal	Eliminate premium tax credits and request pass through funding
Minnesota (Reinsurance) Waiver	Receiving pass-through funding from savings related to lower premium tax credits as a result of the state reinsurance program to fund the program
Oklahoma (Reinsurance) Waiver Proposal	Request pass-through funding from savings to premium tax credits
Oregon (Reinsurance) Waiver Proposal	Request pass-through funding from savings to premium tax credits
Hawaii (SHOP) Waiver	None
Vermont (SHOP) Waiver Proposal	None
California (Immigrant Coverage) Waiver Proposal	None
Examples of other ideas that are being or could be considered <i>(not intended to be an exclusive list)</i>	Change premium tax credit calculation Eliminate the “family glitch” (MN) Allow premium tax credits to be administered at the family level Allow those who are income-eligible for premium tax credits to use them toward employer-sponsored plans that exceed affordability standards Include standalone dental premiums in the calculation for premium tax credits (MN) Smooth the subsidy continuum (CA) Further adjust the employer penalty for those employers that offer “skinny” plans Redefine seasonal employees Replace the individual mandate with another continuous coverage incentive (premium assessment, auto-enrollment) Adjust the individual penalty for those who purchase inadequate plans



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