

# Texas Waiver Options and Implementation Analysis

## Executive Summary

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The Patient Protection and Affordable Care Act (ACA), contains a provision for a waiver for state innovation in health care. This 1332 State Innovation Waiver (Waiver) provides the ability, subject to certain constraints, for states to request waivers from certain provisions of the ACA, subject to certain requirements colloquially known as “guardrails.”

Pass-through funding, authorized by section 1332 of the ACA, can be a source of funds for states implementing waivers. If a state waiver results in a reduction in federal advance premium tax credit (APTC) and cost sharing reduction (CSR) subsidies, those funds can be transferred to the states. Pass-through funding has been a significant component of several state waiver applications, particularly with respect to high-risk reinsurance programs.

The waivers are limited to specific provisions of the ACA related to qualified health plan standards, establishment of exchanges, subsidies, and the individual and employer mandates. Other requirements, such as guaranteed issue, modified community rating, and coverage for dependents to age 26 may not be waived under section 1332. The maximum term of a waiver is five years, which may be renewed for subsequent terms.

The guardrails require that coverage under any waiver cover at least as many individuals, be at least as comprehensive, and at least as affordable as coverage required without the waiver. A waiver must also not increase the federal deficit. In addition to the statutory guardrails, current CMS and IRS guidance do not allow for waivers that require changes to the federal exchange or federal administration of tax subsidies. These guardrail requirements limit the actual flexibility available to states under the waiver program and may require substantial actuarial support and microsimulation studies to demonstrate compliance. Under current CMS and IRS guidance, Texas may have to assume functions currently performed at the federal level, such as plan management, exchange operations, and subsidy calculation and disbursement, to implement many waiver options.

## Background

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### What are 1332 waivers?

Section 1332 waivers are named for the original section of the Patient Protection and Affordable Care Act (ACA) that provides for waivers for state innovation (subsequently codified as 42 U.S. Code §18052). The section provides the ability, subject to certain constraints, for states to request waivers from certain provisions of the ACA. The implementing regulations are in 45 CFR Part 33. The maximum term of a waiver is five years, which may be renewed for subsequent terms.

## What can be waived?



## What can't be waived?

Provisions and sections of the ACA that are not specifically included in section 1332, such as:

- guaranteed issue;
- rating based on pre-existing conditions;
- annual and lifetime coverage limits; and
- coverage for dependents up to age 26.

## Pass-through funding

A major feature of section 1332 is pass-through funding. If, as a result of a waiver, the amount of APTCs and CSRs that individuals and small businesses would otherwise collectively qualify for is less than the amount that would be paid if the state did not receive the waiver, the aggregate amount of the savings may be transferred to the state for purposes of implementing the waiver. The total APTC amount for Texas individuals in 2017 is approximately \$3,315,000,000. In October 2017, cost-sharing reduction payments to issuers were ended but could be resumed depending on the final outcome of litigation. Tax credit amounts for small businesses are not available, but they are expected to be minimal in comparison to APTCs.

## Guardrails

Section 1332 has requirements, or “guardrails,” that a waiver application must meet to be approved. Depending on HHS processes these may present significant hurdles to state innovation and add complexity to the waiver application process.

A state innovation program under section 1332 must:

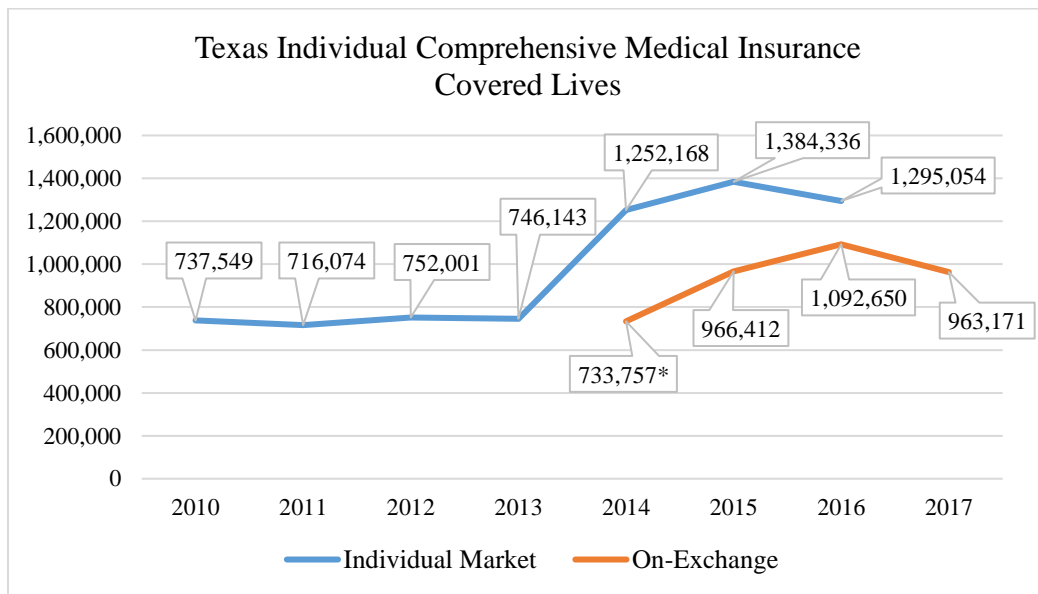
- provide coverage to at least a comparable number of the state’s residents as would be provided without the waiver;

- provide coverage and cost-sharing protections that are at least as affordable as would be provided without the waiver;
- provide for coverage that is at least as comprehensive as would be provided without the waiver; and
- not increase the federal deficit.

In addition to the statutory guardrails, CMS has provided guidance stating that a waiver may not require changes to the FFM exchange platform and operations as these cannot be reasonably modified on a state-by-state basis. The IRS has also stated that tax subsidies cannot be administered differently on a state-by-state basis.

## Texas Individual Comprehensive Health Insurance Market Snapshot

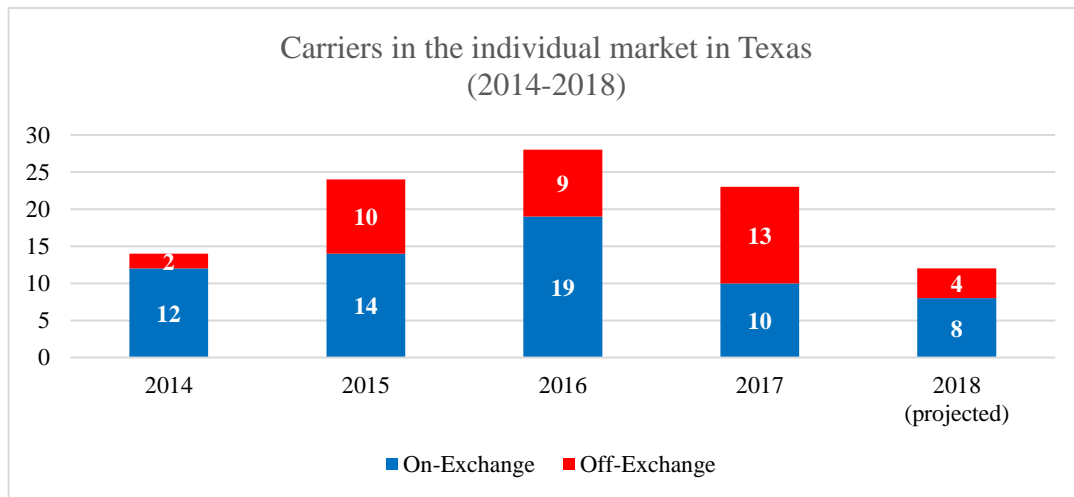
**Enrollment** - Texas ACA FFM effectuated enrollment (2017) has declined for the first time since implementation of the ACA.



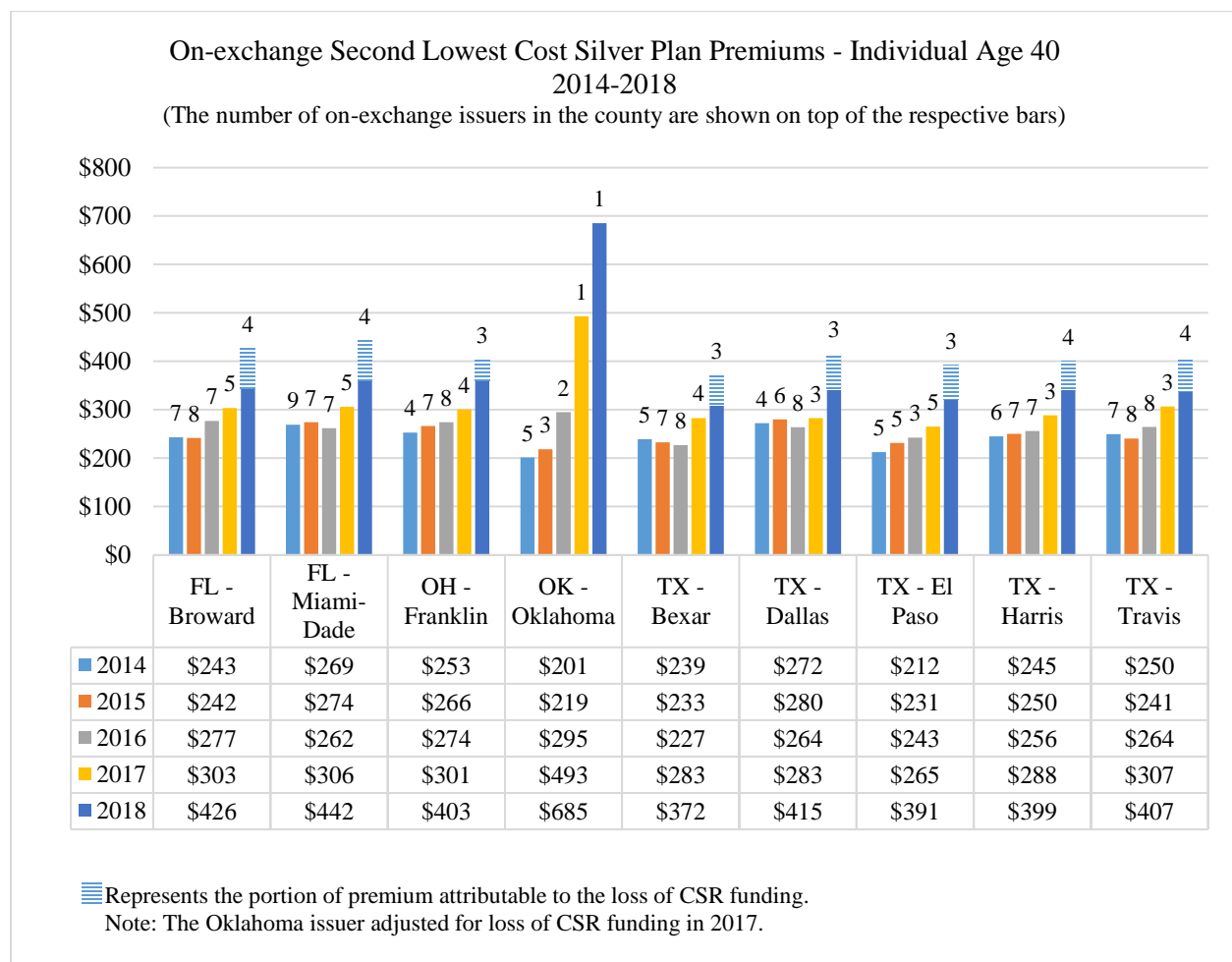
\* On-exchange enrollment for 2014 is based on initial enrollment and may include individuals who did not pay their first premium. Figures for 2015-2016 are based on effectuated enrollment (individuals who paid their first month's premium).

Note: Individual market enrollment (in blue) is taken from the Supplemental Healthcare Exhibits. Individual market enrollment also includes off-exchange enrollment and non-ACA (transitional and grandfathered) enrollment.

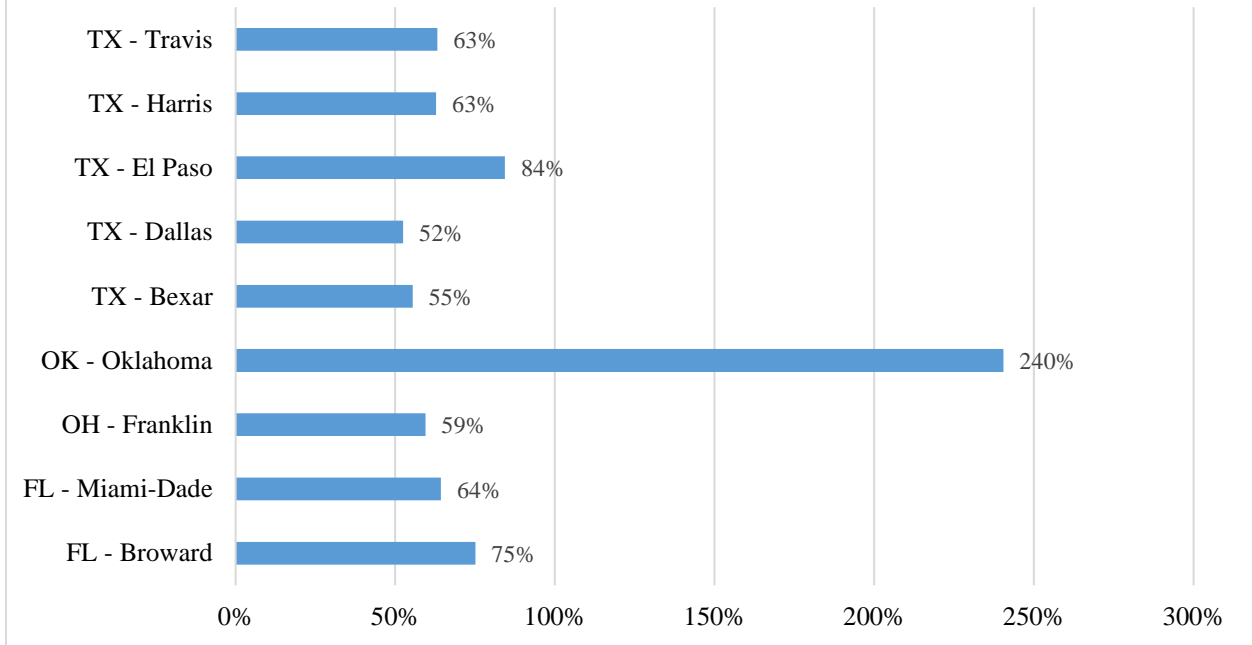
**Competition** - The number of carriers offering plans on the exchange has dropped from a high of 19 in 2016 to 8 in 2018 (projected).



**Premiums** - The chart below illustrates the rising costs of silver plans in Texas and other states. Second-lowest cost silver plans are the basis for determining APTCs.



### Second Lowest Cost Silver Plan On-exchange Rate Change 2014-2018

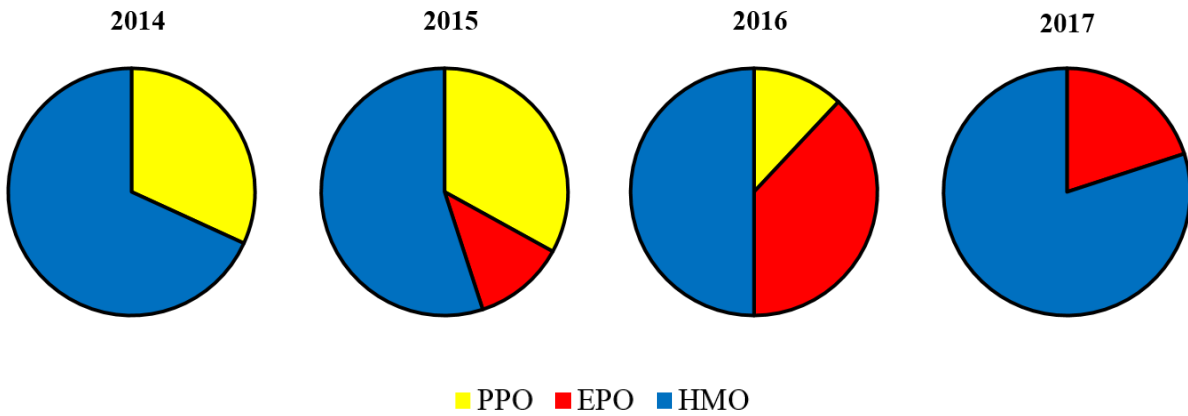


#### Subsidies:

- The APTC has increased from \$233 per month in 2014 to \$333 per month in 2017.
- 86 percent of Texas enrollees on the exchange received APTC subsidies in 2017.
- 63 percent of enrollees received CSR assistance.

#### Changes in Product Types:

Distribution of Carriers by Product Type on the Exchange



## Impact of the ACA:

- Narrower networks and less choice of providers
  - There has been a significant shift from PPOs to HMOs and EPOs in the individual market.
  - There were no carriers offering PPOs on-exchange in 2017.
- Increasing premiums for unsubsidized individuals.
- Increased cost-sharing for individuals ineligible for CSR subsidies.
- Lower uninsured rate - The non-elderly uninsured rate declined from 23 percent in 2013 to 18 percent in 2015 (a 22 percent decrease).
- Stable premiums for individuals receiving APTC subsidies.
- Coverage is more comprehensive than pre-ACA:
  - Essential Health Benefits (EHBs) must be covered.
  - Preventive care with no cost-sharing.
  - No annual or lifetime limits.
- Coverage is more accessible:
  - No pre-existing condition exclusions.
  - No premiums based on health status.

## Potential Waiver Opportunities

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Several potential waiver options are presented below. Common goals are of waiver options are:

- affordability – lowering the premiums and total out of pocket costs to enrollees;
- stability – stabilizing the market by encouraging healthy individuals to enroll and reducing adverse selection;
- competition and choice – increase carrier participation in the market; and
- accessibility – reducing the uninsured rate.

## Creation of a High-risk Reinsurance Pool

### Background:

A high-risk reinsurance pool may address three issues facing the individual insurance market: defensive pricing and market competition, premium increases for unsubsidized individuals, and coverage for individuals with high-cost preexisting conditions. A brief explanation of these issues follows.

### Defensive pricing and market competition:

Very high-cost, low-frequency, claims are difficult to predict. Without reinsurance, issuers may adopt defensive pricing strategies to protect against worst-case scenarios and thereby contribute to market instability. Reinsurance makes claims costs more predictable and may also encourage smaller carriers to enter or remain in the individual market.

Premium increases for unsubsidized individuals:

The current structure of federal ACA subsidies puts a disproportionate burden on unsubsidized individuals (those earning over 400 percent of the federal poverty level). The premiums for persons eligible for APTCs are capped at a percentage of income. Once this cap is reached, further increases in premiums have no impact on the net cost of the second-lowest cost silver plan and less expensive plans for APTC eligible individuals.

Unsubsidized enrollees bear the entire cost of premium increases and are more likely to exit the market as premiums increase. Healthier individuals, who receive less economic benefit from insurance, may be the most likely to drop coverage and this can increase the average morbidity of the remaining risk pool. A state reinsurance program may provide a method of using federal subsidies to reduce the cost of insurance for unsubsidized individuals. This is accomplished by using reinsurance funds to cover a portion of claims costs, lowering the overall premiums, and funding a portion of the reinsurance via federal pass-through funding available due to the lower subsidy amounts needed for people receiving APTCs.

Because the number of subsidized individuals is less than the number of total enrollees, in the absence of dramatic morbidity improvement, the pass-through funding will always be less than the total cost of the reinsurance program. Outside funding sources are needed to make up the difference.

Individuals with high-cost preexisting conditions:

For a risk to be “insurable” it must be random in nature, having an element of chance. Preexisting high cost conditions are not “insurable risks” in the traditional sense but the community rating and guaranteed issue provisions of the ACA require individual market issuers to cover these costs. Placing the burden of these costs on the small segment of society that purchases plans in the individual market, even with subsidies, may lead to adverse selection with healthier individuals leaving the market due to disproportionately high premiums, resulting in a sicker remaining risk pool and a further exodus of healthy enrollees. Reinsuring the claims of high-cost individuals may insulate the individual market from the effects of uninsurable risks resulting in lower premiums, reduced adverse selection, and market stability.

**Potential goals:**

- Lower premiums
- Increase competition
- Stabilize the market by:
  - subsidizing a portion of premiums for high-risk individuals (invisible risk pool);  
or
  - reinsuring a portion of the claims cost for high-cost individuals.

**Waiver required:** Waiver of single risk pool requirements under section 1312(c)(1) of the ACA (Subtitle D, Part I).

**Considerations:**

- A reinsurance plan is compatible with the FFM, so Texas would not have to manage exchange functions.
- May result in lower premiums for currently unsubsidized individuals.
- May encourage healthier individuals to enroll, stabilizing the market.
- May result in more carriers entering the market, as risks are mitigated, increasing choice and competition.
- Pass-through funding levels are based on complex estimates of enrollment behavior, so actual pass-through funding may be more or less than anticipated.
- May remove incentives for issuers to control the cost of reinsured claims.
- Changes in federal laws may impact the availability of continued federal funds.

**Barriers to Implementation:**

- Deficit neutrality guardrail may be difficult to justify and achieve.
- Time constraints.
- Costs may exceed appropriated amounts.

**Funding and Impact:**

The impact of a high-risk reinsurance program on premiums and enrollment depends on several variables in addition to overall funding levels. Major factors include the sensitivity of enrollment numbers to changes in premium, the health of new enrollees and their need for financial assistance, and the degree to which reinsurance payments to issuers are passed on as premium reductions to enrollees. A detailed actuarial analysis will be necessary for a more accurate estimate; however, preliminary internal estimates, assuming the current market requirements, indicate the state's share of the costs would be hundreds of millions of dollars.

The premium impact and funding estimates expected in other states using a waiver to establish a reinsurance program are summarized below.

Comparison of State Reinsurance Plan Premium Impact and Funding							
		2018		2019		2020	
State	Premium Reduction	Total Funding	State Funding	Total Funding	State Funding	Total Funding	State Funding
AK	4%*	\$60M	\$11M	\$64M	\$12M	\$69M	\$13M
MN	20%	\$271M	\$133M	\$298M	\$147M	\$328M	\$163M
OR	7.50%	\$90M	\$57M	\$95M	\$63M	\$100M	\$69M
OK	30%	\$325M	\$16M	\$325M	\$63M	\$325M	\$51M

\*Alaska implemented a state reinsurance program in 2017 which resulted in a premium increase of 7.3 percent compared with pre-reinsurance estimates of 42 percent.



## Waiver of QHP Standards

### Background:

A Qualified Health Plan (QHP) is a plan certified to meet certain benefit (including EHB), cost-sharing, actuarial value, issuer, and other standards. QHPs are certified by CMS for the federally facilitated marketplace, and by the states (using federal standards) for the state-based exchanges. QHPs are the only plans that may be offered on an exchange and are the only plans eligible for APTCs and CSRs. A QHP also qualifies as minimum essential coverage under the ACA individual shared responsibility provision.

QHP standards are set at the federal level but a state may request a section 1332 waiver to establish its own standards for QHP certification. Current CMS guidance does not allow state-specific modifications to the federal exchange platform therefore most waivers of QHP standards would require a state to assume plan management and exchange operation functions. As with all 1332 waivers, any proposed waiver of QHP standards must comply with the federal guardrails.

Waivers of QHP standards could be used to expand choice and competition in the marketplace, but increased plan variation may lead to adverse selection. Conversely, plan variation could be limited to reduce adverse selection. EHBs could be redefined under a waiver program, but the coverage would have to be at least as comprehensive as the ACA benefits under the current guardrails.

### Potential Goals:

- Stabilize the market by reducing adverse selection.
- Increase flexibility in plan design and choices.
- Improve market competition.
- Better align benefits with Texas specific needs.

### Waiver examples:

- Waive the requirement for carriers to offer at least one gold and one silver plan on-exchange.
- Redefine essential health benefits (EHBs) that must be provided by QHPs.
- Change or eliminate metal level and/or actuarial value requirements.
- Expand eligibility for catastrophic plans.

**Waiver required:** Waiver of qualified health plan requirements under Subtitle D, Part I of the Affordable Care Act.

### Considerations:

- Greater flexibility in plan design and choices may lead to more participation and choices on the exchange.
- Reduced administrative costs related to maintaining actuarial values within a narrow range may improve affordability.

- Limitation of plan choice may reduce adverse selection and stabilize the market.
- Essential health benefits may be better aligned with Texas's needs.
- Eliminating metal levels makes comparison between plans more difficult.
- More choices could lead to further adverse selection.

**Barriers to Implementation:**

- Texas would have to assume plan management functions and establish its own exchange.
- Reduction of EHBs may not conform to the guardrail requiring plans be at least as comprehensive as the ACA EHBs.
- Expansion of EHBs may not be compatible with the deficit neutrality guardrail.
- Costs may exceed appropriated funds.

**Waiver of Exchange Standards**

**Background:**

In addition to the QHP standards outlined in the previous section, the ACA also establishes exchange standards for both the federally facilitated marketplace and state-based exchanges. Exchange standards that may be waived include, but are not limited to, provisions relating to the type of plans that may be offered, the individuals eligible to purchase plans on an exchange, open and special enrollment periods, Navigator provisions, and issuer administrative requirements. Current CMS guidance does not allow state-specific modifications to the federal exchange platform therefore waivers of exchange standards would require a state to establish a state-based exchange.

**Potential Goals:**

- Reduce the uninsured rate.
- Minimize adverse selection.
- Stabilize the market.

**Waiver examples:**

- Change open enrollment and special enrollment periods.
- Expand exchange eligibility standards; allow individuals currently ineligible to purchase exchange plans.
- Allow sales of non-QHP plans on the exchange.
- Expand eligibility for Navigator grants to agents and brokers.

**Waiver required:** Waiver of exchange standards under Subtitle D, Part II of the Affordable Care Act.

**Considerations:**

- May reduce adverse selection and improve stability.

- May increase enrollment and lower the uninsured rate in Texas.
- Potential incompatibility of expansion of enrollment eligibility with deficit neutrality may require additional state funds.

**Barriers to Implementation:**

- Texas would have to assume plan management functions and establish its own exchange.
- Costs may exceed appropriated funds.

**Waiver of Cost-sharing Reductions and Premium Tax Credits**

**Background:**

The ACA includes two programs to assist in affordability of premiums and the affordability of care, APTCs and CSRs. Under the APTC program enrollees earning between 100 percent and 400 percent of the FPL (inclusive) are required to pay only a percentage of income to purchase the second-lowest cost silver plan with a subsidy to make up the difference. The CSR provisions require issuers to reduce deductible and/or copayments for enrollees earning up to 250 percent of the FPL. Subsidy payments for CSRs were stopped in October 2017, pending resolution of the House v. Price lawsuit but the requirement for issuers to provide reductions in cost sharing remains. The current subsidy structure provides no APTCs for enrollees below 100 percent of the FPL (the “coverage gap”) and none for those above 400 percent of the FPL (the “cliff”).

Through section 1332 waivers states, via the pass-through funding provision, could use the subsidy funds to restructure the subsidy program. For example, through waivers, subsidies could be extended to enrollees below 100 percent and above 400 percent of the FPL, changed from income to age-based eligibility, or converted to a flat payment system. Total APTC funding to Texas residents for 2017 is estimated at \$3,315,000,000. Current IRS guidance does not permit the IRS to operate different subsidy programs for different states and would require Texas to manage and disburse pass-through funds under a state-run program.

**Potential Goals:**

- Decrease the uninsured rate.
- Improve affordability.
- Stabilize the individual market.

**Waiver examples:**

- Replace the current CSR program with state-funded HSA-type accounts.
- Allow subsidies for off-exchange plans and other metal levels in addition to silver.
- Eliminate the “coverage gap” by providing subsidies to enrollees earning below 100 percent of the FPL.
- Change the premium subsidy structure from the current income and plan cost basis.

**Waiver required:** Waiver of section 1402 of the ACA and section 36B of the IRS Code.

**Considerations:**

- May provide incentives for younger and healthier individuals to enroll in coverage, reducing the uninsured rate and stabilizing the risk pool.
- May make plans more affordable for older enrollees and those earning below 100 percent of the FPL.
- May reduce the rate of increase of health care costs by returning control of funds to enrollees via HSA-type accounts.
- State administrative costs may be substantial.
- Expansion of enrollment eligibility may not be compatible with the deficit neutrality guardrail.
- Expansion of subsidies to additional plans and individuals may impact deficit neutrality.
- Pass-through funding may not continue at expected levels if federal rules and laws change.

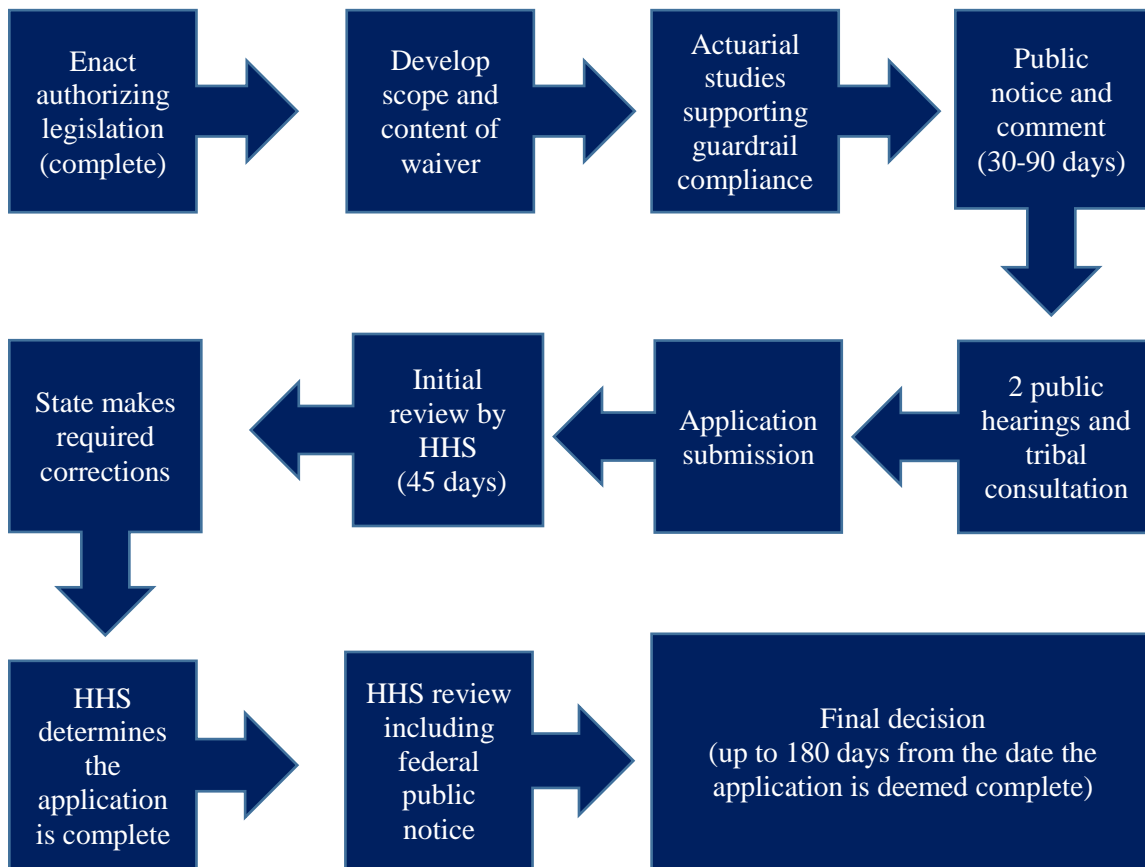
**Barriers to Implementation:**

- Texas would have to assume plan management functions and establish its own exchange.
- Texas would have to waive the entire IRS-based system of subsidies and administer subsidies at the state level, funded by pass-through funding and other sources.

## Waiver of Individual and Employer Mandate and Penalties

To meet the coverage guardrail, a comparable number of state residents must be forecast to have coverage under the waiver as would have coverage absent the waiver. Under current guidance any waiver of the mandates would probably violate the coverage and deficit neutrality guardrails. Waiver of the mandates may also lead to adverse selection and a deteriorating risk pool.

### Waiver application process and timeline



## Other State Actions

State	Description	Status
<a href="#">Alaska</a>	Allow federal pass through funding to partially finance the state's reinsurance program.	Approved 7/7/17
<a href="#">California</a>	Allow undocumented immigrants to purchase coverage through the state's marketplace, Covered California, without premium subsidies.	Withdrawn
<a href="#">Hawaii</a>	Retain the employer coverage provisions currently in place through the state's Prepaid Health Care Act, which was enacted in 1974.	Approved 12/30/16
<a href="#">Idaho</a>	Extend APTC and CSR eligibility to those below 100 percent of FPL, and expand Medicaid eligibility through a Section 1115 waiver for those below 400 percent of FPL with specified medical conditions.	Not yet submitted
<a href="#">Iowa</a>	Create a Proposed Stopgap Measure plan that would be the only plan offered in the marketplace; replace advanced premium tax credits with flat premium subsidies based on age and income and eliminate cost-sharing subsidies; and establish a reinsurance program. Federal pass through funds would finance the new premium subsidies and the reinsurance program.	Withdrawn 10/23/17
<a href="#">Massachusetts</a>	State proposes to pay CSRs, which would generate pass-through funding from the savings in APTCs that result from lowering the second lowest cost silver plan.	Submitted 9/8/17; however, HHS deemed the application incomplete.
<a href="#">Minnesota</a>	Create a new state reinsurance program to be funded with a combination of federal pass through funds and state appropriations.	Approved 9/22/17
<a href="#">Oklahoma</a>	Create a new state reinsurance program to be funded with a combination of federal pass through funds and state appropriations.	Withdrawn
<a href="#">Oregon</a>	Create a new state reinsurance program to be funded with a combination of federal pass through funds and state appropriations.	Approved 10/18/17
<a href="#">Vermont</a>	Continue to allow small employers to enroll directly with health insurance carriers rather than through an online SHOP web portal.	On hold