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State Innovation Waivers: Frequently Asked Questions

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SUMMARY

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State Innovation Waivers: Frequently Asked Questions

Section 1332 of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) provides states with the option to waive specified requirements of the ACA. In the absence of these requirements, a state is to implement its own plan to provide health insurance coverage to state residents that meets the ACA's terms.

Under a state innovation waiver, a state can apply to waive ACA requirements related to qualified health plans, health insurance exchanges, premium tax credits, cost-sharing subsidies, the individual mandate, and the employer mandate. The state can apply to waive any or all of these requirements, in part or in their entirety.

To obtain approval for a waiver application, a state must show that the plan it will implement in the absence of the waived provision(s) meets certain requirements. Under current guidance, the state's plan must provide coverage to as many state residents as would be covered absent the waiver and must make available to a comparable number of residents coverage that is both as affordable and as comprehensive as would be absent the waiver. However, applications do not need to demonstrate that the affordable and comprehensive coverage will be purchased by a comparable number of state residents. Additionally, the state's plan cannot increase the federal deficit.

The Secretary of the Department of Health and Human Services (HHS) and the Secretary of the Treasury share responsibility for reviewing state innovation waiver applications and deciding whether to approve applications. The earliest a state innovation waiver could have gone into effect was January 1, 2017.

In October 2018, the Centers for Medicare & Medicaid Services (CMS) released updated guidance regarding the state innovation waiver process that superseded previously issued CMS guidance from December 2015. In general, the updated guidance attempts to make it easier for a state plan to be approved. The updated guidance applies to all waiver applications that had not been approved prior to the date of the guidance's release. Waivers approved under the previously issued guidance did not require reconsideration.

As of the date of this report, eight states—Alaska, Hawaii, Maine, Maryland, Minnesota, New Jersey, Oregon, and Wisconsin—have approved state innovation waivers. All of these waivers were considered and approved under the initial state innovation waiver guidance, and all but one of the approved waivers implement a variant of a statewide individual market reinsurance program.

Massachusetts, Ohio, and Vermont have submitted applications and received notification that their applications were incomplete. It does not appear that any of these states has modified its application in response to the notification (as of the date of this report). If these states take action, any further review of their waiver application would be under the updated state innovation waiver guidance. Three states—California, Iowa, and Oklahoma—submitted waiver applications and have since withdrawn their applications.

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Section 1332 of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) allows states to apply for waivers of specified provisions of the ACA. Under a state innovation waiver, a state is expected to implement a plan (in place of the waived provisions) that meets certain minimum requirements. The Centers for Medicare & Medicaid Services' (CMS's) initial interpretation of these requirements was published in guidance released in 2015 but has since been superseded, as with other aspects of the waiver process, in updated guidance released by the agency on October 24, 2018.[1]

Under current guidance, the state's plan must provide health insurance coverage to as many state residents as would be covered absent the waiver and must make available to a comparable number of residents coverage that is both as affordable and as comprehensive as it would be absent the waiver. However, applications do not need to demonstrate that the affordable and comprehensive health insurance coverage will be purchased by a comparable number of state residents. Additionally, the state's plan cannot increase the federal deficit.

This report answers frequently asked questions about how states can use and apply for state innovation waivers. It also addresses recent changes to the Section 1332 waiver process, as made by the 2018 CMS guidance.

Which ACA Provisions May a State Waive Under a State Innovation Waiver?

A state may apply to waive *any or all* of the ACA provisions listed below for plan years beginning on or after January 1, 2017.[2]

- **Part I of Subtitle D of the ACA:** Part I of Subtitle D comprises Sections 1301-1304. In general, the provisions in Part I relate to the establishment of qualified health plans (QHPs).[3]
- **Part II of Subtitle D of the ACA:** Part II of Subtitle D comprises Sections 1311-1313, which largely include provisions related to the establishment of health insurance exchanges and related activities.
- **Section 1402 of the ACA:** This section includes the provision of cost-sharing reductions to eligible individuals who purchase individual market coverage through a health insurance exchange.[4]
- **Section 36B of the Internal Revenue Code (IRC):** This section includes the provision of premium tax credits to eligible individuals who purchase individual market coverage through a health insurance exchange.

[1] The requirements are not specified in regulations. Department of the Treasury, Department of Health and Human Services (HHS), "Waivers for State Innovation," 80 *Federal Register* 78131, December 16, 2015. Department of the Treasury, HHS, "State Relief and Empowerment Waivers," 83 *Federal Register* 53575, October 24, 2018 (Hereinafter "State Relief and Empowerment Waivers guidance").

[2] 42 U.S.C. §18052(a)(2).

[3] A qualified health plan (QHP) is a plan that meets certain requirements and is certified to be sold through a health insurance exchange (in the non-group or small-group market). Although QHPs are certified to be sold through exchanges, they also can be sold in the non-group or small-group market outside of exchanges. For more information, see CRS Report R44065, *Overview of Health Insurance Exchanges*.

[4] For more information about the current status of the cost-sharing subsidies, see CRS Insight IN10786, *Payments for Affordable Care Act (ACA) Cost-Sharing Reductions*.

- **Section 4980H of the IRC:** This section includes the shared responsibility requirement for large employers (often called the *employer mandate*).[5]
- **Section 5000A of the IRC:** This section includes the requirement for individuals to maintain health insurance coverage (often called the *individual mandate*).[6]

Each part noted above is comprised of many provisions, which makes the scope of the provisions that can be waived under a state innovation waiver quite broad. For example, Part I of Subtitle D of the ACA includes provisions that outline requirements for health plans to be certified as QHPs. It defines the essential health benefits (EHB) package that each QHP must offer, places limitations on the enrollee cost sharing that QHPs may impose, and requires that QHPs provide coverage meeting a minimum level of actuarial value.[7] Additionally, Part I of Subtitle D establishes requirements for catastrophic health plans and determines eligibility for such plans.

Which Federal Agencies Have the Authority to Grant a Waiver?

The Secretary of the Department of Health and Human Services (HHS) is to review and grant waiver requests for provisions not included in the IRC; the Secretary of the Treasury is to review and grant requests to waive provisions in the IRC (the availability of premium tax credits and the application of the employer and individual mandates).[8]

What Are the Minimum Requirements for a Successful Application?

The Secretary of HHS or the Treasury is to assess a waiver application to determine whether the state's plan meets the requirements related to coverage, affordability, comprehensiveness, and federal-deficit neutrality outlined in statute and further described in guidance.[9] These requirements are described in **Table 1**. The Secretary or Secretaries (as appropriate) may grant a request for a state innovation waiver if a state's application meets the requirements. In making this determination, the Secretaries will "consider favorably" any waiver that incorporates some or all of the following principles: provide increased access to affordable private market coverage, encourage sustainable spending growth, foster state innovation, support and empower those in need, and promote consumer-driven health care.[10]

In guidance, HHS and the Treasury note that their assessment of a state's waiver application considers changes to the state's health care system that are contingent only upon approval of the

[5] For more information about the employer mandate, see CRS Report R43981, *The Affordable Care Act's (ACA) Employer Shared Responsibility Determination and the Potential Employer Penalty*.

[6] For more information about the individual mandate, see CRS Report R44438, *The Individual Mandate for Health Insurance Coverage: In Brief*. The 2017 tax revision, P.L. 115-97, effectively eliminates the individual mandate penalty beginning in 2019.

[7] For more information about the essential health benefits package, see CRS Report R44163, *The Patient Protection and Affordable Care Act's Essential Health Benefits (EHB)*.

[8] 42 U.S.C. §18052(a)(6).

[9] 42 U.S.C. §18052(b)(1) and State Relief and Empowerment Waivers guidance.

[10] State Relief and Empowerment Waivers guidance.

waiver.[11] Their assessment does not consider policy changes that are dependent on further state action or other federal determinations. For example, the Secretary's or Secretaries' (as appropriate) assessment of a state innovation waiver application would not consider changes to Medicaid or the state Children's Health Insurance Program (CHIP) that require approval outside of the state innovation waiver process, and savings accrued as a result of changes to Medicaid or CHIP would not be considered when determining whether the state innovation waiver meets the deficit-neutrality requirement. HHS and the Treasury indicate that this is the case regardless of whether a state's application for a state innovation waiver is submitted alone or in coordination with another waiver application. (For more information about the coordinated waiver process, see "May States Submit State Innovation Waiver Applications in Coordination with Other Federal Waiver Applications?")

Table 1. Requirements for a Successful State Innovation Waiver Application

(as described in statute and guidance)

Statute	Current Guidance	Previous Guidance
Coverage: The state's plan must provide coverage to at least a comparable number of individuals as the provisions of Title I of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) would provide.	At least as many individuals who had health care coverage absent a waiver must have health care coverage under the waiver.[a] This requirement generally must be forecast to be met for each year the waiver is in effect, but a waiver may be approved if a temporary reduction in coverage would produce longer-term increases in coverage. In considering whether this requirement is met, the plan's impact on all state residents, regardless of coverage type, will be considered. Whether the plan sufficiently prevents gaps in or discontinuations of coverage also will be considered.	At least as many individuals who had minimum essential coverage (MEC) absent a waiver must have MEC under the waiver.[b] This requirement generally must be forecast to be met for each year the waiver is in effect. In considering whether this requirement is met, the plan's impact on all state residents, regardless of coverage type, will be considered and the plan's effects on different groups of individuals in the state, particularly those considered vulnerable, will be assessed.[c] A state plan that satisfied this requirement in the aggregate but reduced coverage for vulnerable populations would not be approved. Whether the plan sufficiently prevents gaps in or discontinuations of coverage also will be considered.

[11] State Relief and Empowerment Waivers guidance.

Statute	Current Guidance	Previous Guidance
Affordability: The state's plan must provide coverage and cost-sharing protections that are at least as affordable as the provisions of Title I of the ACA.	At least as many individuals who had access to affordable and comprehensive health care coverage absent a waiver must have access to affordable and comprehensive health care coverage under the waiver.[d] Applications do not need to demonstrate that affordable and comprehensive coverage will actually be purchased by a comparable number of state residents. Affordability is generally measured by comparing the sum of an individual's premium contributions and cost-sharing responsibilities for a health plan or direct payments for health care to the individual's income. In considering whether this requirement is met, the plan's impact on all state residents, regardless of coverage type, and the plan's effects on all groups of individuals in the state, including low-income residents and those with high expected health care costs, will be considered. In assessing the plan, access to affordable coverage will be considered according to the number of individuals for whom available coverage has become more affordable and the magnitude of such changes.	An individual's health care coverage under the waiver must be as affordable as coverage absent the waiver. Affordability is generally measured by comparing the sum of an individual's premium contributions and cost-sharing responsibilities for a health plan to the individual's income. Spending on health care services that are not covered by a health plan may be considered if the services are affected by the state's plan. This requirement generally must be forecast to be met for each year the waiver is in effect. In considering whether this requirement is met, the plan's impact on all state residents, regardless of coverage type, will be considered, and the plan's effects on different groups of individuals in the state, particularly those considered vulnerable, will be assessed.[c] A state plan that satisfied this requirement in the aggregate but reduced affordability for vulnerable populations would not be approved. In assessing the plan, the affordability of coverage on average will be considered, and how the plan affects the number of individuals who have large heath care spending burdens relative to their incomes will be examined.
Comprehensiveness: The state's plan must provide coverage that is at least as comprehensive as the essential health benefits (EHB),[e] as certified by the Office of the Actuary of the Centers for Medicare & Medicaid Services (CMS).	At least as many individuals who had access to affordable and comprehensive health care coverage absent a waiver must have access to affordable and comprehensive health care coverage under the waiver.[d] Applications do not need to demonstrate that affordable and comprehensive coverage will actually be purchased by a comparable number of state residents. Comprehensiveness is measured by comparing coverage under the plan to coverage under the state's EHB benchmark plan, any other state's benchmark plan chosen by the state, or any benchmark plan chosen by the state that could potentially become its EHB benchmark plan. In considering whether this requirement is met, the proposal's impact on all state residents, regardless of coverage type, will be considered.	Health care coverage under the state plan must be at least as comprehensive overall for individuals as coverage absent the waiver. Comprehensiveness is measured by comparing coverage under the plan to coverage under the state's EHB benchmark plan or coverage under the state's Medicaid program and/or the State Children's Health Insurance Programs (CHIP), as appropriate.[e] This requirement generally must be forecast to be met for each year the waiver is in effect. In considering whether this requirement is met, the proposal's impact on all state residents, regardless of coverage type, will be considered, and the effects of the proposal on different groups of individuals in the state, particularly those considered vulnerable, will be assessed.[c] A state plan that satisfied this requirement in the aggregate but reduced comprehensiveness for vulnerable populations would not be approved.

Statute	Current Guidance	Previous Guidance
Deficit Neutral: The state's plan must not increase the federal deficit.	Projected federal spending net of federal revenues must be equal to or lower than it would be absent the waiver. The state's plan must not increase the federal deficit over the period of the waiver or in total over the 10-year budget plan submitted by the state as part of its application.[f]	Projected federal spending net of federal revenues must be equal to or lower than it would be absent the waiver. The state's plan must not increase the federal deficit over the period of the waiver or in total over the 10-year budget plan submitted by the state as part of its application.[f]

Source: Congressional Research Service's compilation and summary of statute (42 U.S.C. §18052(b)(1)) and guidance (80 *Federal Register* 78131, December 16, 2015, and 83 *Federal Register* 53575, October 24, 2018). The requirements are not covered in regulations.

Notes: Previous guidance applies to all waivers approved prior to October 24, 2018. The Secretary of the Department of Health and Human Services (HHS) is to review requests to waive provisions not included in the Internal Revenue Code (IRC); the Secretary of the Treasury is to review requests to waive provisions in the IRC (the availability of premium tax credits and the application of the employer and individual mandates).

a. Health care coverage includes all types of coverage that would qualify as MEC in the tax code (26 U.S.C. §5000A(f)) or would be included in the definition of the term in regulations (45 C.F.R. §144.103). MEC is defined in the tax code (26 U.S.C. §5000A(f)) and includes most types of comprehensive coverage, including public coverage, such as coverage under programs sponsored by the federal government (e.g., Medicaid, Medicare), as well as private insurance (e.g., employer-sponsored insurance, non-group coverage). Health insurance coverage is defined in regulations (45 C.F.R. §144.103) to include group health insurance coverage (e.g., employer-sponsored insurance, association health plans), individual health insurance coverage, and short-term, limited-duration insurance.

b. MEC is defined in the tax code (26 U.S.C. §5000A(f)) and includes most types of comprehensive coverage, including public coverage, such as coverage under programs sponsored by the federal government (e.g., Medicaid, Medicare), as well as private insurance (e.g., employer-sponsored insurance, non-group coverage).

c. Vulnerable individuals include "low-income individuals, elderly individuals, and those with serious health issues or who have a greater risk of developing serious health issues" (80 *Federal Register* 78131, December 16, 2015, p. 78132).

d. The affordability and comprehensiveness guardrails are considered in conjunction and not in isolation (i.e., a state plan must make coverage that is both comprehensive *and* affordable available to a comparable number of individuals).

e. Under the ACA, certain health plans must cover the EHB. The ACA does not explicitly define the EHB; rather, it lists 10 broad categories from which benefits and services must be included and requires the Secretary of HHS to further define the EHB. For information about the 10 categories as well as how the EHB are currently defined, see CRS In Focus IF10287, *The Essential Health Benefits (EHB)*.

f. The state innovation waivers cannot extend longer than five years unless a state requests continuation and such request is not denied by the appropriate Secretary. Statute requires that an application for a waiver include a 10-year budget plan that is budget neutral for the federal government (42 U.S.C. §18052(a)(1)(B)(ii)). This determination takes into account costs associated with changes to federal administrative processes.

g. This determination takes into account costs associated with changes to federal administrative processes.

May a State Modify Its Federally Facilitated Health Insurance Exchanges Under a State Innovation Waiver?

Although not possible initially, HHS and the Treasury indicated in the updated guidance released in October 2018 that technical enhancements have made it feasible for CMS to support some

federally facilitated health insurance exchange (FFE) variation.[12] For example, waivers that would require a state to create its own website to replace the consumer-facing aspects of HealthCare.gov also can incorporate CMS's enrollment functionalities (e.g., account creation, application, enrollment and coverage maintenance experience for consumers). States are asked to work with HHS early in the waiver application process to determine whether specific modifications can be accommodated.

States are responsible for funding all FFE modifications and associated operational support. Therefore, these costs are not considered when determining whether a waiver application satisfies the deficit neutrality requirement; however, any other changes to CMS administrative processes are taken into account.

Are There Any Limitations on the Scope of State Innovation Waivers?

In guidance issued in October 2018, HHS and the Treasury describe some federal operational considerations that may limit the scope of the waivers.[13] Specifically, the Internal Revenue Service (IRS) generally is not able to accommodate any state-specific changes to tax rules. The IRS may be able to accommodate small changes to the administration of federal tax provisions, in particular when such changes overlap with the IRS's current capabilities. For example, waivers that would require the IRS to expand premium tax credit eligibility to individuals with household income under 100% of the federal poverty level may be feasible, because it incorporates a similar special rule that the IRS currently administers.[14]

States are responsible for funding all changes to IRS administrative processes associated with wavier implementation. These costs are incorporated into the assessment of whether a waiver application satisfies the deficit neutrality requirement.

What Is the Application Process for a State Innovation Waiver?

A state seeking a state innovation waiver must enact a law that allows the state to carry out the actions under the waiver prior to submitting an application for a waiver.[15] In certain circumstances, a state can be considered to have enacted such a law by coupling a state law that enforces ACA provisions and/or the state plan with administrative or executive actions.[16] Prior to submitting an application, a state must provide a public notice and comment period and conduct public hearings regarding the state's application.[17] Upon conclusion of these activities, a state

[12] HHS administers all FFEs, and it operates the same infrastructure technology platform in each state that has an FFE. State Relief and Empowerment Waivers guidance.

[13] State Relief and Empowerment Waivers guidance.

[14] For more information about how household income is calculated to determine premium tax credit eligibility, see CRS Report R43861, *The Use of Modified Adjusted Gross Income (MAGI) in Federal Health Programs*.

[15] 42 U.S.C. §18052(b)(2).

[16] State Relief and Empowerment Waivers guidance.

[17] The public notice and comment period is to be "sufficient to ensure a meaningful level of public input for the application for a section 1332 waiver." 45 C.F.R. §155.1312.

may submit its application to the Secretary of HHS. The Secretary of HHS is to transmit any application seeking to waive requirements in the IRC to the Secretary of the Treasury for review.

The Secretary or Secretaries (as appropriate) are to review a state's application to determine whether it is complete. A state's application is not considered complete unless it includes the materials identified in regulations.[18] The materials include, but are not limited to, information about the enacted state legislation allowing the state to carry out the actions under the waiver, a description of the plan or program the state expects to implement in place of the waived provisions, and analyses showing that the state's plan or program meets the requirements for granting a waiver. If a state's application is not complete, the state is to be notified about the missing elements and given an opportunity to submit them. Once the Secretary or Secretaries (as appropriate) make a preliminary determination that a state's application is complete, the entire application is to be made available to the public for review and comment.[19]

The final decision of the Secretary or Secretaries on a state's application must be issued no later than 180 days after the determination that the Secretary of HHS received a complete application from a state.[20]

Is Any Federal Funding Available Under a State Innovation Waiver?

It is possible for a state to receive federal funding under an approved waiver. A state's receipt of a state innovation waiver could result in the residents of the state not receiving the "premium tax credits, cost-sharing reductions, or small business credits under sections 36B of the Internal Revenue Code of 1986 or under part I of subtitle E for which they would otherwise be eligible."[21] If this occurs, the state is to receive the aggregate amount of subsidies that would have been available to the state's residents had the state not received a state innovation waiver—this is referred to as *pass-through funding*. The amount of pass-through funding is to be determined annually by the appropriate Secretary and may be updated at any time to account for changes in state or federal law. The state is to use the pass-through funding for purposes of implementing the plan or program established under the waiver.[22]

How Long Can a State Innovation Waiver Be in Effect?

State innovation waivers cannot extend longer than five years unless a state requests continuation and such request is not denied by the appropriate Secretary.[23] Requests for continuation are to be deemed granted if they are not denied by the appropriate Secretary within 90 days of submission.

[18] 45 C.F.R. §155.1308(f).

[19] The public notice and comment period is to be "sufficient to ensure a meaningful level of public input and does not impose requirements that are in addition to, or duplicative of, requirements imposed under the Administrative Procedures Act, or requirements that are unreasonable to unnecessarily burdensome with respect to state compliance." 45 C.F.R. §155.1316(b).

[20] 42 U.S.C. §18052(d)(1) and 45 C.F.R. §155.1316(c).

[21] 42 U.S.C. §18052(a)(3).

[22] 42 U.S.C. §18052(a)(3).

[23] 42 U.S.C. §18052(e).

May States Submit State Innovation Waiver Applications in Coordination with Other Federal Waiver Applications?

The Secretaries are required to develop a process for coordinating applications for state innovation waivers and applications for other existing waivers under federal law relating to the provision of health care, including waivers available under Medicare, Medicaid, and CHIP.

Under the coordinated process, a state must be able to submit a single application for a state innovation waiver and any other applicable waivers available under federal law.[24] The single application must comply with the procedures described for state innovation waiver applications and the procedures in any other applicable federal law under which the state seeks a waiver.[25]

As discussed in the answer to the question "What Are the Minimum Requirements for a Successful Application?," HHS and the Treasury have indicated that an application for a state innovation waiver will be assessed on its own terms and that assessment of the state innovation waiver will not consider the impact of changes that require separate federal approval. This is the case even if the state submits a single application for multiple waivers.

How Many States Have Applied for State Innovation Waivers?

As of the date of this report, 14 states have submitted applications for state innovation waivers—Alaska, California, Hawaii, Iowa, Maine, Maryland, Massachusetts, Minnesota, New Jersey, Ohio, Oklahoma, Oregon, Vermont, and Wisconsin.[26] HHS and the Treasury have approved eight applications, from Alaska, Hawaii, Maine, Maryland, Minnesota, New Jersey, Oregon, and Wisconsin. All of these waivers were considered and approved under the initial state innovation waiver guidance, and all but one of the approved waivers implement a variant of a statewide individual market reinsurance program.[27]

Massachusetts, Ohio, and Vermont received notification from HHS and the Treasury that their applications were incomplete, and it does not appear that any of these states has modified its application in response to the notification. If one of these three states does take action, any further review of its waiver application would be under the updated state innovation waiver guidance. California, Iowa, and Oklahoma have withdrawn their applications.[28]

See **Table 2** for more details.

[24] 42 U.S.C. §18052(a)(5).

[25] 45 C.F.R. §155.1302(a).

[26] For information about each state's application, see CMS, Center for Consumer Information and Insurance Oversight (CCIIO), "Section 1332: State Innovation Waivers," at https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.html.

[27] For more information on reinsurance, see CRS In Focus IF10707, *Reinsurance in Health Insurance*.

[28] To read the withdrawal letters, see CMS, CCIIO, "Section 1332: State Innovation Waivers," at https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.html.

Table 2. States That Have Applied for State Innovation Waivers

(as of January 4, 2019)

	Application Information		Waiver Information		
State	**Submitted**	**Status**	**Overview**	**Estimated Pass-Through Funding**	**Effective Period**
			Approved Waivers		
Alaska	December 29, 2016	Approved—July 17, 2017	Alaska established a state-based reinsurance program, the Alaska Reinsurance Program (ARP), to help health insurance issuers offering plans in the individual market offset the cost of covering enrollees with 1 or more of 33 specified high-cost conditions. Under the approved waiver, the Patient Protection and Affordable Care Act (ACA; P.L. 111-148) provision requiring issuers to consider all enrollees in individual plans offered by the issuer to be members of a single risk pool is waived,[a] to the extent the provision prohibits issuers from including expected reinsurance payments from the ARP when establishing market-wide index rates. The expected effect of allowing issuers to consider the ARP payments when setting market-wide rates is to reduce premiums in the individual market, and the expected effect of the reduced premiums is reduced federal spending on premium tax credits for residents of Alaska. The state is to receive the resulting reductions in federal spending as pass-through funding. Under the waiver, Alaska is to use the pass-through funding to support ARP and corresponding payments to issuers beginning in calendar year (CY) 2018. The approved waiver does not modify the eligibility criteria for premium tax credits for residents of Alaska.	The Centers for Medicare & Medicaid Services (CMS) estimated Alaska would receive $58.5 million for CY2018 and $68.7 million for CY2019.[b]	CY2018-CY2022
Hawaii	June 16, 2016	Approved—December 30, 2016	Under the approved waiver, multiple ACA provisions relating to the establishment and operation of a Small Business Health Options Program (SHOP) exchange, as they pertain to small employers and SHOP exchanges, are waived.[c] As a result, Hawaii is no longer required to operate SHOP exchanges for small employers. The amount that small employers in Hawaii would have received in small business tax credits for coverage purchased through a SHOP exchange is provided to the state in pass-through funding to support a program that assists small employers with the cost of health insurance coverage.	CMS estimated Hawaii would receive $459,169 for CY2017, $999,069 for CY2018, and $306,406 for CY2019.[b]	CY2017-CY2021

	Application Information		Waiver Information		
State	**Submitted**	**Status**	**Overview**	**Estimated Pass-Through Funding**	**Effective Period**
Maine	May 9, 2018	Approved—July 30, 2018	Maine established a hybrid state-based reinsurance/invisible high-risk pool program administered by the Maine Guaranteed Access Reinsurance Association (MGARA). Starting in CY2019, MGARA will help health insurance issuers offering plans in the individual market offset the cost of covering enrollees with one or more of eight specified high-cost conditions. Under the waiver, health insurance issuers offering plans in the individual market also will have the discretion to include additional enrollees in the program if such determinations are made during the first 60 days of an enrollee's plan year. Maine's approved waiver is similar to other reinsurance-type waivers in that the ACA provision requiring issuers to consider all enrollees in individual plans offered by the issuer to be members of a single risk pool is waived,[a] which allows issuers to consider MGARA payments when setting market-wide index rates. The expected effect is that individual market premiums will decrease and federal spending on premium tax credits for residents of Maine will decrease. The state will receive the resulting reductions in federal spending as pass-through funding. Under the approved waiver, Maine will use the pass-through funding to support MGARA and corresponding payments to issuers beginning in CY2019. The approved waiver does not modify the eligibility criteria for premium tax credits for residents of Maine.	CMS estimated Maine would receive $65.2 million for CY2019.[b]	CY2019-CY2023
Maryland	May 31, 2018	Approved—August 22, 2018	Maryland established a state-based reinsurance program administered by the Maryland Health Benefit Exchange. Starting in CY2019, the reinsurance program will reimburse issuers selling coverage in the state's individual market for a percentage of enrollees' claims between an attachment point and a cap. Maryland's approved wavier is similar to other reinsurance-type waivers in that the ACA provision requiring issuers to consider all enrollees in individual plans offered by the issuer to be members of a single risk pool is waived,[a] which allows issuers to consider the state's reinsurance program payments when setting market-wide index rates. The expected effect is that individual market premiums will decrease and federal spending on premium tax credits for residents of Maryland will decrease. The state requested to receive a portion of the resulting reductions in federal spending as pass-through funding. Under the waiver, Maryland will use the pass-through funding to support the reinsurance program and corresponding payments to issuers beginning in CY2019 and continuing through CY2021, unless additional funds become available.[d] The approved waiver does not modify the eligibility criteria for premium tax credits for residents of Maryland.	CMS estimated Maryland would receive $373.4 million for CY2019.[b]	CY2019-CY2023[d]

	Application Information		Waiver Information		
State	**Submitted**	**Status**	**Overview**	**Estimated Pass-Through Funding**	**Effective Period**
Minnesota	May 5, 2017	Approved[e]—September 22, 2017	Minnesota established a state-based reinsurance program, the Minnesota Premium Security Plan (MSPS), which reimburses issuers selling coverage in the state's individual market for a percentage of enrollees' claims between an attachment point and a cap. Minnesota's approved waiver is similar to other reinsurance-type waivers in that the ACA provision requiring issuers to consider all enrollees in individual plans offered by the issuer to be members of a single risk pool is waived,[a] which allows issuers to consider MSPS payments when setting market-wide index rates. The expected effect is that individual market premiums will decrease and federal spending on premium tax credits for residents of Minnesota will decrease. The state will receive the resulting reductions in federal spending as pass-through funding. Under the waiver, Minnesota is to use the pass-through funding to support MSPS and corresponding payments to issuers beginning in CY2018. The approved waiver does not modify the eligibility criteria for premium tax credits for residents of Minnesota.	CMS estimated Minnesota would receive $130.7 million for CY2018 and $84.8 million for CY2019.[b]	CY2018-CY2022
New Jersey	July 2, 2018	Approved—August 16, 2018	New Jersey established a state-based reinsurance program, the Health Insurance Premium Security Plan. Starting in CY2019, the reinsurance program will reimburse issuers selling coverage in the state's individual market for a percentage of enrollees' claims between an attachment point and a cap. New Jersey's approved wavier is similar to other reinsurance-type waivers in that the ACA provision requiring issuers to consider all enrollees in individual plans offered by the issuer to be members of a single risk pool is waived,[a] which allows issuers to consider the state's reinsurance program payments when setting market-wide index rates. The expected effect is that individual market premiums will decrease and federal spending on premium tax credits for residents of New Jersey will decrease. The state will receive the resulting reductions in federal spending as pass-through funding. Under the waiver, New Jersey will use the pass-through funding to support the reinsurance program and corresponding payments to issuers beginning in CY2019. The approved waiver does not modify the eligibility criteria for premium tax credits for residents of New Jersey.	CMS estimated New Jersey would receive $180.2 million for CY2019.[b]	CY2019-CY2023

	Application Information		Waiver Information		
State	**Submitted**	**Status**	**Overview**	**Estimated Pass-Through Funding**	**Effective Period**
Oregon	August 31, 2017	Approved—October 18, 2017	Oregon established a state-based reinsurance program, the Oregon Reinsurance Program (ORP), which reimburses issuers selling coverage in the state's individual market for a percentage of enrollees' claims between an attachment point and a cap. Oregon's approved wavier is similar to other reinsurance-type waivers in that the ACA provision requiring issuers to consider all enrollees in individual plans offered by the issuer to be members of a single risk pool is waived,[a] which allows issuers to consider ORP payments when setting market-wide index rates. The expected effect is that individual market premiums will decrease and federal spending on premium tax credits for residents of Oregon will decrease. The state will receive the resulting reductions in federal spending as pass-through funding. Under the waiver, Oregon is to use the pass-through funding to support ORP and corresponding payments to issuers beginning in CY2018. The approved waiver does not modify the eligibility criteria for premium tax credits for residents of Oregon.	CMS estimated that Oregon would receive $54.5 million for CY2018 and $41.8 million for CY2019.[b]	CY2018-CY2022
Wisconsin	April 18, 2018	Approved—July 29, 2018	Wisconsin established a state-based reinsurance program, the Wisconsin Healthcare Stability Plan (WIHSP). Starting in CY2019, the WIHSP will reimburse issuers selling coverage in the state's individual market for a percentage of enrollees' claims between an attachment point and a cap. Wisconsin's approved wavier is similar to other reinsurance-type waivers in that the ACA provision requiring issuers to consider all enrollees in individual plans offered by the issuer to be members of a single risk pool is waived,[a] which allows issuers to consider WIHSP payments when setting market-wide index rates. The expected effect is that individual market premiums will decrease and federal spending on premium tax credits for residents of Wisconsin will decrease. The state will receive the resulting reductions in federal spending as pass-through funding. Wisconsin will use the pass-through funding to support WIHSP and corresponding payments to issuers beginning in CY2019. The approved waiver does not modify the eligibility criteria for premium tax credits for residents of Wisconsin.	CMS estimated Wisconsin would receive $127.7 million for CY2019.[b]	CY2019-CY2023

State	Application Information		Waiver Information		
	Submitted	Status	Overview	Estimated Pass-Through Funding	Effective Period
			Pending Applications		
Massachusetts	September 8, 2017	Received notification of incomplete application—October 23, 2017	Massachusetts is seeking to create a Premium Stabilization Fund (PSF), which would be used to reimburse issuers amounts equal to what would have been provided by cost-sharing reduction payments. At the time the application was submitted, cost-sharing reduction payments were still being made to insurers; however, there was uncertainty as to whether the current administration would continue to make payments moving forward. Massachusetts sought to use the waiver process to avoid the need for a rate revision in the event that cost-sharing reduction payments stopped. Under the proposed waiver, the ACA provision that provides for cost-sharing subsidy payments to issuers from HHS would be waived,[f] which Massachusetts indicates would allow the state to substitute these payments with allocations from the PSF. The expected effect is that individual market premiums would decrease and federal spending on premium tax credits for residents of Massachusetts also would decrease. The state would receive the resulting reductions in federal spending as pass-through funding. Under the proposed waiver, Massachusetts would use the pass-through funding for PSF payments to issuers for an initial period of one year, beginning in CY2018, and the state would request the opportunity to renew the waiver through CY2022.	Massachusetts estimated it would receive between $143 and $146 million for CY2018	N.A.
Ohio	March 30, 2018	Received notification of incomplete application—May 17, 2018	Ohio is seeking to waive the requirement that individuals must maintain minimum essential coverage, as established under the ACA's individual mandate provision.[g] Under the proposed waiver, the requirement would be waived beginning in CY2019.[h]	Ohio is not requesting pass-through funding	N.A.
Vermont	March 15, 2016	Received notification of incomplete application—June 9, 2016	Vermont is seeking an exemption from the requirement that a state must establish a SHOP exchange for small employers. Under the proposed waiver, Vermont seeks to waive multiple ACA provisions relating to the establishment and operation of a SHOP exchange.[i] As a result, Vermont indicates that employers in the small-group market would purchase qualified health plans directly from an issuer.	Vermont is not requesting pass-through funding	N.A.

State	Application Information		Waiver Information		
	Submitted	Status	Overview	Estimated Pass-Through Funding	Effective Period
			Withdrawn Applications		
California	December 6, 2016	Withdrawn—January 18, 2017	California sought to provide undocumented immigrants with the ability to purchase unsubsidized insurance through its exchange. Under this waiver, the ACA provision that prohibits the marketing of nonqualified health plans (QHPs) on the exchanges would have been waived,[j] which California indicates would have allowed "California Qualified Health Plans (CQHP)" to be offered through its exchange. CQHPs would have differed from QHPs only in that undocumented individuals could purchase CQHPs and enrollment in CQHPs would disqualify individuals from receiving premium tax credits and cost-sharing subsidies.	California did not request pass-through funding	N.A.
Iowa	August 21, 2017	Withdrawn—October 23, 2017	Iowa sought to allow issuers in its individual market to offer one standard health plan, to provide age- and income-based premium tax credits to individuals purchasing the standard plans, and to support a state-based reinsurance program. Under this waiver, Iowa sought to waive the following ACA provisions.[k] • Iowa applied to waive the provisions establishing premium tax credits and cost-sharing reductions. Iowa indicates that it would have received the resulting reductions in federal spending as pass-through funding and would have allocated this funding to its age- and income-based premium tax credit and its reinsurance program. • Iowa applied to waive the provision that defines the coverage levels based on actuarial value. Iowa indicates waiving the provision would authorize issuers to offer one standard plan to consumers. The standard plan would be similar in actuarial value to a silver-tier plan and would be purchased directly from an issuer. • Finally, Iowa applied to waive the provision that provides the Secretary with 180 days to review all state innovation waiver requests. Iowa indicates that waiving the provision would have allowed for expedited review of its waiver application. The Iowa waiver would have begun in CY2018 and would have allowed Iowa to request renewal of the program for CY2019 if necessary.	Iowa estimated it would have received $422 million for CY2018	N.A.

	Application Information		Waiver Information		
State	**Submitted**	**Status**	**Overview**	**Estimated Pass-Through Funding**	**Effective Period**
Oklahoma	August 16, 2017	Withdrawn—September 29, 2017	Oklahoma established a state-based reinsurance program, the Oklahoma Individual Health Insurance Market Stabilization Program (OMSP). Had the waiver been approved, the OMSP would have reimbursed issuers selling coverage in the state's individual market for a percentage of enrollees' claims between an attachment point and a cap. Oklahoma's withdrawn waiver was similar to Minnesota's, Alaska's, and Oregon's approved waivers in that the ACA provision requiring issuers to consider all enrollees in individual plans offered by the issuer to be members of a single risk pool would have been waived,[a] which would have allowed issuers to consider OMSP payments when setting market-wide index rates. The expected effect was that individual market premiums would have decreased and federal spending on premium tax credits for residents of Oklahoma also would have decreased. The state would have received the resulting reductions in federal spending as pass-through funding. Under the waiver, Oklahoma would have used the pass-through funding for OMSP payments to issuers beginning in CY2018.	Oklahoma estimated it would have received $309 million for CY2018 and $1,395 million over the period CY2018-CY2022	N.A.

Source: Various documents available on the CMS website, "Section 1332: State Innovation Waivers," at https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.html, viewed June 5, 2018.

Notes: Estimated pass-through funding describes either the amount of pass-through funding that a state estimates it will receive in its waiver application or, when available, the amount of pass-through funding CMS estimates it will provide to the state as determined annually by the Secretary of the Department of Health and Human Services and/or the Secretary of the Department of the Treasury (as appropriate). For more information on reinsurance, see CRS In Focus IF10707, *Reinsurance in Health Insurance*, by Bernadette Fernandez.

a. Specifically, ACA §1312(c)(1).

b. The actual amount received by the state is subject to a final determination by the Department of the Treasury and, subsequently, budget sequestration.

c. Specifically, the following ACA §§: 1301(a)(1)(C)(ii); 1301(a)(2); 1304(b)(4)(D)(i) and (ii); 1311(b)(1)(B); 1312(a)(2); 1312(f)(2)(A); and 1321(c)(1).

d. Although Maryland's waiver application anticipated having enough funds to operate the Maryland State Reinsurance Program from CY2019 through CY2021, the application requested, and was approved for, an effective period from CY2019 through CY2023.

e. In addition to what is described in the table about Minnesota's approved waiver, Minnesota's waiver application also requested that the state receive, in pass-through funding, the amount that the federal government would save in payments to Minnesota's Basic Health Program because of premium reductions due to MSPS. This request was not granted under the approved waiver. For details, see Letter from Mark Dayton, Governor of Minnesota, et al. to Thomas Price, Secretary of the U.S. Department of Health and Human Services, September 19, 2017, http://mn.gov/gov-stat/pdf/2017_09_19_Governor_Dayton_Letter_to_Secretary_Price_1332_Waiver.pdf, and Letter from Mark Dayton, Governor of Minnesota, to Seema Verma, Administrator of the Centers for Medicare & Medicaid Services, October 16, 2017, https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Approval-Letter-MN.pdf.

f. Massachusetts applied to waive ACA §1402(c)(3)(A).

g. Ohio applied to waive 26 U.S.C. §5000A(a), which was added to the Internal Revenue Code by ACA §1501.

h. Ohio's House Bill 49 requires Ohio's department of insurance to submit a 1332 waiver application that includes a request to waive the ACA's individual and employer mandates. In its waiver application, Ohio acknowledges that the 2017 tax revision (P.L. 115-97) effectively eliminates the penalty associated with the individual mandate beginning in CY2019 but points out that the law does not eliminate the individual mandate. As such, Ohio's 1332 waiver application requests to waive the individual mandate (however, the application does not include a request to waive the employer mandate).

i. Vermont applied to waive the following ACA §§: 1311(b)(1)(B); 1311(c)(3); 1311(c)(4); 1311(c)(5); 1311(d)(1); 1311(d)(2); 1311(d)(4)(A); 1311(d)(4)(B); 1311(d)(4)(C); 1311(d)(4)(D); 1311(d)(4)(E); 1311(d)(4)(G); 1311(k); 1312(a)(2); 1312(f)(2)(A).

j. California applied to waive ACA §1311(d)(2)(B)(i).

k. Iowa applied to waive ACA §§1402; 1401(a); 1302(d); and 1332(d).

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