The Patient Protection and Affordable Care Act Ten Years Later: States Take the Lead

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INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) was signed into law by President Barack Obama on March 23, 2010, beginning the process of putting into place a landmark reform of the healthcare system aimed at increasing access, lowering costs, and improving quality. The ACA was designed to build on and improve the country's existing, complex healthcare system. It reformed the commercial insurance market and introduced subsidies, expanded public programs, enacted delivery system reforms, advanced transparency and innovation, and provided support to public health, long term care and the workforce.

The implementation of major, long-term provisions of the ACA began just over 10 years ago, on September 23, 2010, and in the decade since, the ACA has become solidly intertwined into the healthcare system nationwide. However, just like the road to passage of the ACA that was filled with unexpected twists and turns, implementation of the law has not been a straight line. While implementation of laws rarely proceed as expected, implementation of the complex and politically polarizing provisions of the ACA has been uniquely bumpy. On one hand, this has raised challenges for states, as they have had to deal with unexpected challenges and shifting sands at the federal level as they attempt to implement ACA provisions. On the other hand, the unique history of the ACA has left space for states who have risen to the occasion, leveraged opportunities, and addressed gaps that resulted from changes during implementation to make the law work best for their local needs.

As we pass the 10-year mark of the beginning of the ACA implementation process, this paper examines the successes and expansion areas of states, focusing on how states have implemented, adapted and leveraged sections of the ACA in order to provide the best healthcare for their populations.

I. THE ROAD TO IMPLEMENTATION OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

Despite the fact that the ACA has gained popularity since its passage, its implementation has faced challenges both related to the complexity of some provisions and ongoing opposition of what is still a politically polarizing law. While much attention has been paid to the broad-based challenges to the ACA and its implementation, some of the surprises, particularly those related to implementation at the state level, have been much more technical in nature. For example, initial post-passage projections anticipated that many states would move to establish their own state-based health insurance exchange (SBEs), which meant that they would be responsible for performing all functions of the individual and small group markets and would establish and maintain websites through which consumers would apply and enroll in health insurance coverage. However, prior to the 2015 roll out of the new exchange model - the state-based exchange-federal platform (SBE-FP) - only 12 states had established SBEs. Four states quickly adopted the SBE-FP model, aimed at providing support to address the ongoing IT system issues that plagued some of the early adopter SBEs. Looking to 2021, it is projected that there will be 30 federally facilitated exchanges (FFEs), 15 SBEs,[1] and 6 SBE-FPs.[2]

Similarly, there has been less activity related to Section 1332 State Innovation Waivers for certain ACA provisions than expected. As explored in more detail in the second section of this paper, of the 15 waivers that have been approved and have been or are being implemented, all but one are to establish state-based reinsurance programs.

[1] SBEs are in California, Colorado, Connecticut, District of Columbia, Idaho, Maryland, Massachusetts, Minnesota, Nevada, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, Washington.
[2] SBE-FPs are in Arkansas, Kentucky, Maine, New Mexico, Oregon, and Virginia.

At the federal level, implementation has been marked with ongoing legislative changes as well as litigation challenges, some of which have stripped away or altered some of the ACA's components. Despite the fact that broad-based "repeal and replace" legislation failed to pass in 2017, more targeted federal policy changes and legislation have chipped away at the ACA. On the financing side, the "Cadillac" tax and medical device taxes used to finance provisions of the law were repealed effective 2020 and the health insurance tax will be repealed effective 2021. Notably, repeal of the health insurance tax means that several states have state authority to increase assessments to fund their state-based reinsurance programs under Section 1332 Waivers.

While those changes largely did not directly impact states, by setting the individual mandate penalty to $0, the Tax Cuts and Jobs Act[3] has required states to consider how to take action to protect the viability of their markets in light of the connection of the mandate to the prohibition on pre-existing condition exclusions and guaranteed issue. States have also had to grapple with the elimination of payments for cost-sharing reductions and the more tangential expansion of Association Health Plans and Short-Term Limited Duration Insurance plans, all of which have impacted premiums nationwide and required states to consider whether and how to take action.

Finally, there have been numerous legal challenges to the ACA and its implementation in the judicial system. Most of these challenges relate to specific provisions of the law, such as the requirement to cover birth control and the provision of premium tax credits via FFEs as well as the implementation of the cost-sharing reductions, the employer mandate, the provider fee, and the federal Risk Adjustment program.

The two most prominent cases challenging the ACA not only challenge particular provisions of the law but also argue that, as a result of the purported unconstitutionality of certain provisions, the entire ACA should be overturned. *National Federation of Independent Businesses (NIFB) v Sebelius* challenged both the ACA's individual mandate, which required most individuals to purchase insurance or pay a penalty, and the expansion of Medicaid for low-income adults that do not qualify under any of the preexisting categories of eligibility.[4] The lawsuit made it up to the Supreme Court, which held in 2012 that the individual mandate was constitutional under Congress' taxing power but that the Medicaid expansion was an unconstitutional coercive use of Congress' spending power. As a result, the individual mandate remained in effect following the lawsuit (though challenges to it have continued), while the Medicaid expansion was changed from being mandatory to optional for states. Because the individual mandate was found to be constitutional, the question of whether the entire law should be invalidated based on that challenge was not decided.

California v. Texas (originally referred to as *Texas v U.S.*), which is pending in the Supreme Court, once again challenges the constitutionality of the individual mandate following the elimination of the penalty via the Tax Cuts and Jobs Act of 2017.[5] Beyond claiming the individual mandate is unconstitutional, the plaintiffs again claim that the provision is critical to the law and, as such, cannot be separated from the remainder of the law, so the entire law should be struck down. The District Court and a panel of the Appeals Court that heard the case found that, following the changes under the Tax Cuts and Jobs Act, the individual mandate is no longer a constitutional use of Congress' taxing power. The District Court also held that the provision was not severable from the remainder of the law, finding the entire ACA unconstitutional. The case is now at the Supreme Court, where it will be heard just after the election.

This context of implementation surprises and ongoing evolution of the law has both raised challenges for states while also providing them an opportunity to take leadership roles as they innovate and build on the ACA in regards to the enforcement of the individual mandate, expansion of Medicaid programs, and

[3] https://www.congress.gov/115/bills/hr1/BILLS-115hr1enr.pdf
[4] https://casetext.com/case/natl-fedn-of-indep-bus-v-sebelius-2
[5] https://www.supremecourt.gov/docket/docketfiles/html/public/19-840.html

implementation of ongoing reinsurance programs. In the next section, we explore how states have stepped up and played a leading role in implementation of those key areas of the ACA.

II. STATE LEADERSHIP IN ACA IMPLEMENTATION

THE INDIVIDUAL MANDATE

The Evolution of the Individual Mandate

Though the individual mandate survived the initial challenge to its constitutionality under *NFIB v Sebelius*, the reduction of the penalty to $0 under the Tax Cuts and Jobs Act vastly undercut its impact. Originally proposed by the Heritage Foundation in the late 1980s and first implemented under Massachusetts' landmark health reform law,[6] the individual mandate was included in the ACA to ensure the stability of health insurance markets and premiums in markets in which pre-existing condition exclusions are prohibited and guaranteed issue is required. More broadly, the mandate is a means to expand coverage and reduce uncompensated care.

When the mandate penalty was zeroed out via the 2017 Tax Cuts and Jobs Act, it seemed that the effects on insurance enrollment would be drastic. Interestingly, recent census data has shown that health coverage remained relatively steady in 2019.[7] Coverage via the exchanges decreased from 12.2 million people to 11.4 million people, which fell far short of the 2017 projections from the Congressional Budget Office (CBO) that estimated a decrease of four million people with health coverage with a repeal of the mandate.[8] However, the reduction of the mandate penalty has been cited as a cause for increased premiums.[9]

Advent of State-Based Individual Mandates

With the federal individual mandate largely neutralized, many states continue to have concerns about the impact on coverage rates, market stability, and premiums. Some have acted in pursuit of state-based solutions. In particular, several states have considered, and many of those states have adopted, state-based individual mandates. Currently, five states and Washington D.C. have passed their own individual mandates. California, Massachusetts, Rhode Island, Vermont, New Jersey, and Washington D.C. all require or will soon require their residents to purchase some form of health insurance to avoid a financial penalty. In addition to supporting coverage and market and premium stability, states have used state-based mandates as a mechanism to prevent plans with substandard coverage from proliferating through the market and to collect revenue that can be put back into the state healthcare system. The below chart shows a comparison of the individual mandates in each state and their parameters.

[6] https://malegislature.gov/Laws/SessionLaws/Acts/2006/Chapter58
[7] https://www.census.gov/library/publications/2020/demo/p60-271.html
[8] https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf
[9] http://files.kff.org/attachment/Issue-Brief-How-Repeal-of-the-Individual-Mandate-and-Expansion-of-Loosely-Regulated-Plans-are-Affecting-2019-Premiums

State-Based Individual Mandates				
State	Effective Date	Required Coverage	Penalty Amount	Other Provisions
California State statute	January 1, 2020	Minimum essential coverage (MEC) under the federal definition	The greater of either 2.5 percent of household annual income or a flat total of $750 per adult and $375 per child	Three-year program to provide additional subsidies to help people purchase insurance through Covered California
Massachusetts State statute	January 1, 2007	Minimum Creditable Coverage as defined by MA state standards	Penalties range from $264 to $1,428 for a full year of payment based on household income as a percentage of the Federal Poverty Level.	Established as part of the pre-existing state health reform law.
Rhode Island State statute	January 1, 2020	MEC under the federal definition	The greater of 2.5 percent of household income or $695 per adult and $347.50 for each child under 18.	Creation of a reinsurance program - the “Health Insurance Market Integrity Fund” – with the penalty dollars.
Vermont State statute	January 1, 2020	MEC under the federal definition	There is no penalty	Data collected during the 2020 tax year will be used to “provide targeted outreach to assist those residents [without minimum essential coverage] in enrolling in appropriate and affordable health insurance or other health coverage.”
New Jersey State statute	January 1, 2019	MEC under the federal definition	The greater of 2.5 percent of household income or $695 per adult and $347.50 for each child under 18.	Revenue from the individual mandate will fund a state-based reinsurance program.
Washington, D.C. DC law	June 30, 2020	MEC under the federal definition	The greater of 2.5 percent of household income or a per person charge upwards of $695 per adult and $250 per child	There is a requirement for employers and plan sponsors with at least 50 full time employees to maintain coverage of their employees, with reporting beginning in 2020.

Additionally, five other states are considering passing their own versions of individual mandates: Connecticut,[10] Maryland,[11] Minnesota,[12] Hawaii,[13] and Washington.[14] These bills have been proposed in state legislatures and will be debated and voted on over the coming months and years. Further, if *California v. Texas* permanently eliminates the individual mandate, it is possible that more states will implement some type of state mandate to preserve the benefits derived from the mandate.

MEDICAID EXPANSION

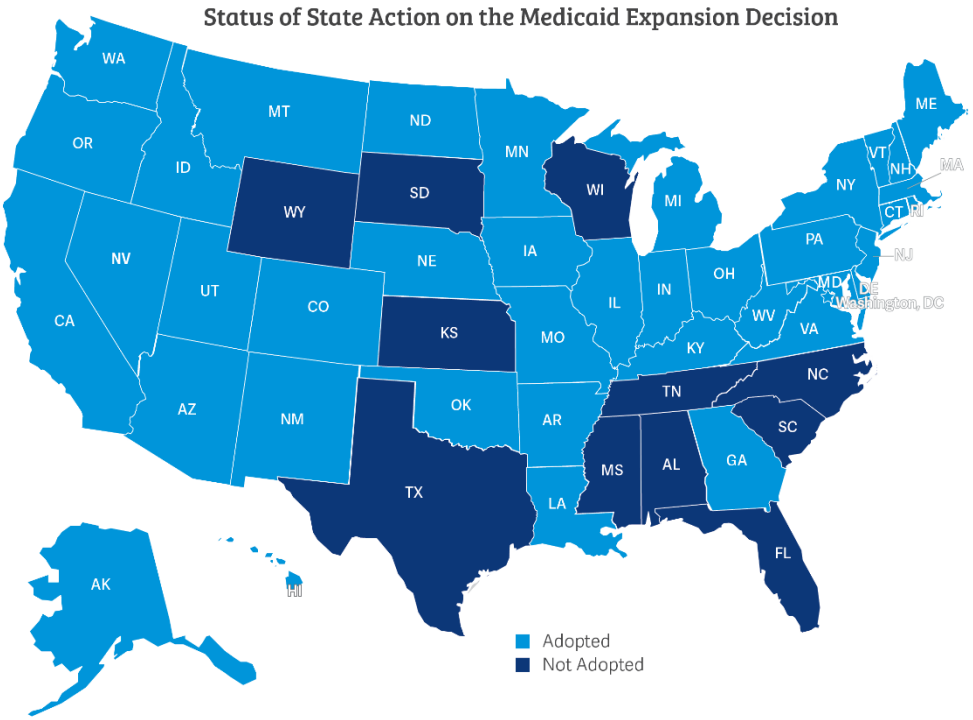
State Action on Optional Medicaid Expansion

The expansion of Medicaid eligibility to all adults under age 65 with incomes below 133% of the Federal Poverty Level (FPL) is one of the most impactful but controversial provisions of the ACA. Prior to the ACA, Medicaid was traditionally limited to children at various income eligibility thresholds and low-income pregnant women, adults with disabilities, seniors, and parents, and did not include healthy, childless adults. With the *NFIB v Sebelius* decision making the ACA's Medicaid expansion optional, states got a significant degree of flexibility relative to the choice of whether to expand. Despite being optional as of August 2020, 39 states and the District of Columbia have chosen to expand Medicaid to the adult expansion population outlined in the ACA, leveraging the available enhanced federal funds for coverage. 32 states and D.C. expanded coverage on the original statutory effective date of January 1, 2014. The following seven states expanded coverage more recently, many via an approved ballot measure:

- Maine: Effective January 1, 2019 with coverage retroactive to July 2, 2018
- Idaho: Effective January 1, 2020
- Utah: Effective January 1, 2020
- Nebraska: Enrollment began on August 1, 2020, with coverage effective October 1, 2020
- Georgia: Implementation starting July 2021 (waiver approved on October 15, 2020)
- Oklahoma: Estimated to be effective as of July 1, 2021 (approved via a ballot measure in June 2020, requiring waiver/SPA submission within 90 days of ballot measure approval)
- Missouri: Estimated to be effective as of July 1, 2021 (approved via a ballot measure in August 2020, requiring waiver/SPA submission to CMS no later than March 2021)

On other hand, 11 states still have not expanded Medicaid. The following map provides a graphical view of which states have expanded coverage and those which have yet to do so.

[10] https://cga.ct.gov/asp/cgabillstatus/cgabillstatus.asp?selBillType=Bill&which_year=2018&bill_num=5379
[11] https://www.documentcloud.org/documents/4345443-Maryland-Insurance-Downpayment-Bill-Factsheet-004.html?embed=true&responsive=false&sidebar=false
[12] https://www.wsj.com/articles/states-look-at-establishing-their-own-health-insurance-mandates-1517659200?mod=e2tw
[13] https://www.capitol.hawaii.gov/session2018/bills/SB2924_.HTM
[14] https://app.leg.wa.gov/billsummary?BillNumber=6084&Year=2018



Kansas, one of the remaining 11 states that has not expanded Medicaid, will be an interesting state to watch in 2021, especially if there is a change in the federal administration. In 2019, a bipartisan Medicaid expansion proposal made its way through the state's legislature. The compromise proposal, which included a January 1, 2021 deadline for expansion and premiums, work referral elements, and a plan to transition 100-138% of the FPL from Medicaid to Exchange coverage, was to be funded through a hospital surcharge. Although the bill failed to pass the state legislature last May, it is likely this debate will continue in some form in 2021.

More broadly, the ongoing struggle to provide healthcare during the COVID-19 pandemic and the pandemic-driven job losses and economic crisis, has renewed the expansion discussion in states that have traditionally been anti-expansion. In South Dakota, two Medicaid ballot initiatives are attempting to gather the requisite signatures to put Medicaid expansion to a vote in 2022.[15] Additionally, at a meeting in Wyoming to address the COVID-19 crisis, lawmakers voted to include Medicaid expansion as a policy discussion for the state's Joint Revenue Committee in the coming months. Time will tell if more states join South Dakota and Wyoming in pursuing expanded Medicaid in the wake of the COVID-19 pandemic.

Medicaid Expansion and Section 1115 Waivers

Whether to expand or restrict Medicaid access, Section 1115 Waivers have been an effective tool to shape state Medicaid priorities and react to the changing political and administrative priorities. This waiver opportunity has been leveraged for a variety of proposals since the passage of the ACA, particularly related to Medicaid expansion. The most controversial and unprecedented proposals – work requirements and block grants – have been implemented most recently. Additionally, the revival of the concept of a buy-in program continues to be an avenue for exploration for those states seeking to advance the central goals of the ACA: access to affordable healthcare, reducing the uninsured rate, and promoting continuity of care.

[15] The signatures must be collected by November 2021.

Work Requirements

One of the most controversial Section 1115 Waiver concepts was advanced in 2017 by the Centers for Medicare and Medicare Services (CMS) alerting state governors of the option to "fast-track" Section 1115 Waiver applications that include additional "flexibility" to craft their Medicaid programs, including relative to eligibility requirements that would predicate coverage on a number of non-income related eligibility standards such as work requirements. This paved the way for approval of work requirements, or "community engagement" eligibility requirements, for the first time in the 55-year history of the Medicaid program. Work requirements or "community engagement" was defined by CMS as employment, community service, caregiving, education and/or substance use disorder treatment, with states defining the required number of hours[16] needed in the above activities in order to remain eligible for Medicaid.

In 2017, both Kentucky and Arkansas filed and were granted Medicaid Section 1115 Waivers that included work requirement/community engagement elements. Kentucky's application to CMS predated the agency's 2017 letter to governors but contained requests similar to the state flexibility options the administration later announced. The Section 1115 Waiver demonstration program, entitled Engage and Achieve Long Term Health (also known as KY HEALTH), outlined Kentucky's vision for a complete transformation of its Medicaid program, including the addition of community engagement/work requirements for the expansion population[17] and reporting requirements for some of its traditional population members as well as limited retroactive eligibility, limited non-emergency medical transport, long lock out periods, increased premiums, and more stringent reporting requirements for eligible individuals.

In 2017, Governor Asa Hutchinson proposed amendments to the delivery of Medicaid in Arkansas, including implementation of work requirements as well as the elimination of retroactive eligibility. Arkansas received approval in March 2018 for the "Arkansas Works" program, subjecting certain populations to work requirement eligibility standards starting in January 2019. With that approval, Arkansas became the first state to implement such eligibility requirements.

Both waiver approvals resulted in lawsuits and ultimately ended up before Judge James Boasberg of the United States District Court for the District of Columbia. Judge Boasberg issued rulings on March 27, 2019 on these back-to-back cases addressing work requirement eligibility criteria. Judge Boasberg ruled against the implementation of a Medicaid work requirement in Kentucky, while also ruling that Arkansas must halt the operation of its work requirement program.[18] The decisions vacated the CMS approval of the waiver provisions in both states.

The decisions addressed the fundamental questions of whether work requirements/community engagement requirements serve to promote health coverage and if the states adequately considered the potential impact of the requirements on access to healthcare. In both states, large losses in coverage were projected as a result of the barriers to access created by the requirements. An estimated 100,000 people were estimated to lose coverage in Kentucky and over 18,000 people lost coverage in Arkansas in just the brief time the work requirements were in place. The federal administration filed appeal notices[19] on behalf of both states in April 2019, vowing to continue to fight this challenge to state flexibility to deliver Medicaid, and Kentucky filed a notice of appeal as well in April 2019.

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[16] The range so far has been between 20-100 hours a month.
[17] The waiver requires 80 hours per month of qualifying activities.
[18] https://healthlaw.org/wp-content/uploads/2019/03/Opinion-Stewart-v-Azar.pdf; https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv1900-58
[19] https://s3.amazonaws.com/assets.fiercemarkets.net/public/004-Healthcare/work_requirements_appeal.pdf https://s3.amazonaws.com/assets.fiercemarkets.net/public/004-Healthcare/work_requirements_appeal1.pdf

Despite the pending appeals, and federal court precedent, Oklahoma recently submitted a Healthy Adult Opportunity waiver[20] in April 2020 that included premiums and work requirements for the expansion population, but in August 2020 withdrew the request. At recent count, there are nine other states with work requirement waiver provisions like Kentucky and Arkansas pending.[21]

This ongoing controversial element of Medicaid care delivery will continue to play out in the coming months and years and may even gain more traction as states try to address rising enrollment and healthcare spending related to the COVID-19 crisis.

Block Grants

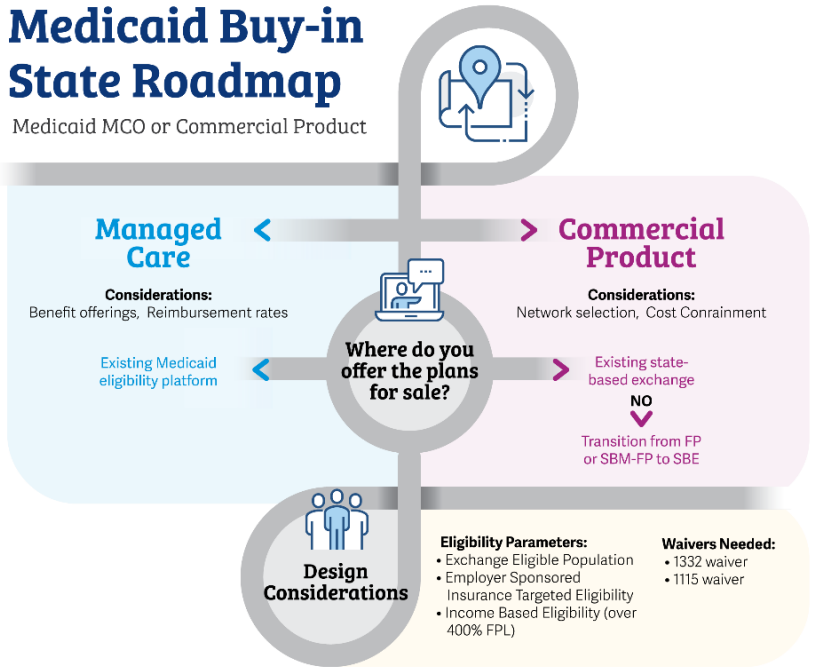
In January of 2019, CMS released the long-anticipated Medicaid block grant guidance, entitled the Healthy Adult Opportunity (HAO).[22] HAO waivers allow states extensive flexibility to administer and design their programs - including relative to eligibility, benefits, cost sharing, and program administration - within a defined budget. State Medicaid Managed Care programs could also be subject to less federal oversight[23] and states with HAO waivers may have the opportunity to share in federal savings. Waivers would be provided under Section 1115(a) of the Social Security Act and would specifically apply to the covered adult population under age 65 who are not eligible for coverage based on a disability or the need for long-term care services and supports or otherwise under the state plan.[24] To date, only two states have submitted waivers under this new approach to Medicaid delivery, with Oklahoma withdrawing its HAO application this past August.

As we previously reported on Health Policy News,[25] Tennessee was the first state to submit a Section 1115 Waiver amendment application seeking a $7.9 billion "modified" block grant.[26] Tennessee is one of the 11 states that has not expanded Medicaid and sought waiver approval in order to do so via a block grant. The draft waiver application was filed in September 2019 and is a non-traditional block grant waiver request in that it both calls for the federal government to increase its Medicaid funding to the state if enrollment grows beyond initial state projections and only includes core medical services. To date, this application has still not been approved and so all eyes will remain on Tennessee to see if it will move forward in implementing a block grant in 2021.

[20] https://www.okhca.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=24704&libID=23687
[21] The nine states include: Alabama, Georgia, Idaho, Mississippi, Montana, Nebraska, Oklahoma, South Dakota, and Tennessee.
[22] https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20001.pdf
[23] The guidance provides that, under these waivers, states may make ongoing "program adjustments" without the need for further prior approval.
[24] For a more detailed fact sheet of the HAO opportunity and fiscal impact, please visit the fact sheet released previously in February 2019 by Health Policy News.
[25] https://pcghealthpolicy.com/2019/09/26/tennessee-releases-its-block-grant-plan/
[26] https://www.tn.gov/content/dam/tn/tenncare/documents2/Amendment42FinalVersion.pdf

Medicaid-Buy-In / Public Option

While not specific to Medicaid expansion, states have considered Medicaid buy-ins both to expand coverage to currently ineligible and uncovered populations more generally and to move forward the public option concept that was included in early versions of the ACA. Many states considering a Medicaid buy-in public option have expressed hope that it will provide an affordable coverage option for individuals, noting that insurance remains highly costly even for those individuals receiving federal premium subsidies or employer contributions. The concept of a public option in the form of a public program buy-in emerged briefly as an alternative to the standalone public option plan proposal during the debate over the ACA, with proposals to allow those under the age of 65 to buy into the Medicare program. State proposals and discussions[27] have included policy proposals that would offer the buy-in with benefits based on existing plans - either mirroring public program benefits, or a Silver-level commercial product, as proposed in federal legislation.[28] Buy-in plans have been proposed to be offered on the existing Medicaid or Exchange eligibility portals. Generally, enrollees would be charged premiums for the full cost of the plan, though states are exploring utilizing state and/or federal funds to provide subsidies to low-income enrollees. Some of the main decision points of a buy-in approach were outlined in Health Policy News at the end of last year.[29] It could be that post-pandemic states have more bandwidth to devote to long term Medicaid delivery planning and that this option regains the momentum that the buy-in option had before the COVID-19 pandemic.



SECTION 1332 STATE INNOVATION WAIVERS

Evolution of the Section 1332 State Innovation Waiver Opportunity

Similar to Section 1115 Waivers and other Medicaid waivers, Section 1332 of the ACA allows states to seek waivers of certain ACA provisions.[30] This waiver opportunity – known as State Innovation Waivers and more recently dubbed State Relief and Empowerment Waivers – was one of the later implemented provisions of the ACA with an effective date on January 1, 2017**.** Since passage, however, it has been the

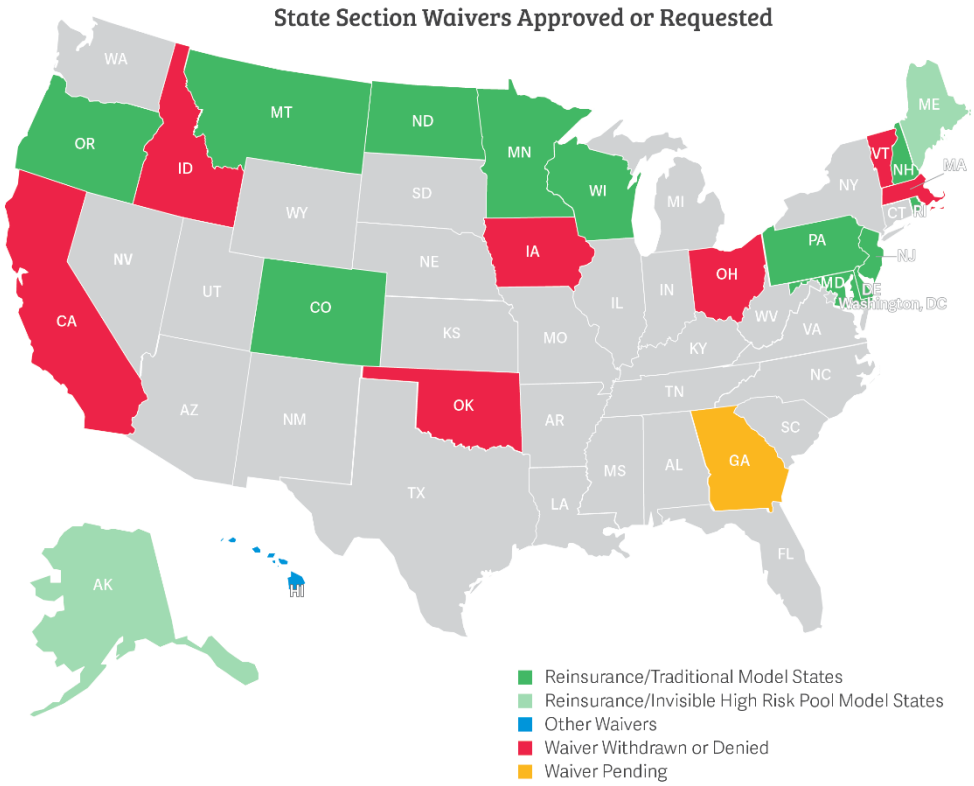
[27] Several states have had legislation in recent years that called for exploration of this option, or studies ordered of the feasibility, including New Mexico, Connecticut, Maryland, Massachusetts, Minnesota, Nevada and Wisconsin.
[28] https://pcghealthpolicy.com/wp-content/uploads/2018/07/revisiting-the-public-option-medicaid-buy-ins_final-2.pdf
[29] https://pcghealthpolicy.com/2019/12/20/2020-prediction-continued-focus-on-ensuring-access-to-healthcare-prescription-drugs-and-healthy-food-to-combat-diet-related-illness/#buyin
[30] Section 1332 allows for waiver of enumerated provisions including relative to: Qualified Health Plans; Essential Health Benefits; Exchanges; Premium tax credits and cost-sharing reductions; the individual mandate; and the employers mandate.

subject of significant guidance, including formal regulations and guidance as well as subregulatory letters and application checklists.[31]

Notably, with the goal of increasing state flexibility, CMS released guidance in 2018 that superseded prior guidance and made it easier to meet the statutory guardrails that are intended to ensure waiver programs do not undermine key goals of the waivable provisions of the ACA.[32] For example, the new guidance specified that a waiver could be considered to meet the guardrails even if certain individuals are worse off under the waiver. It is sufficient for the waiver to meet the guardrails for most of the impacted population.

State Responses to the Waiver Opportunity

Despite the increased flexibility provided by the new guidance, there has been a high degree of uniformity in the Section 1332 Waivers that have been granted. Since 2016, 23 states have submitted Section 1332 Waivers. The below map shows the states that have approved Section 1332 Waivers.



[31] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-

[32] "Waiver guardrails" require that states demonstrate that the waiver:

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

The first waiver approved was for the state of Hawaii on December 30, 2016, effective January 1, 2017 – the earliest effective date for Section 1332 Waivers. Hawaii's waiver allows the state to maintain its existing and long-term state-based employer coverage requirement and premium assistance for small employers under the state's Prepaid Health Care Act. Specifically, the requirement to operate a Small Business Health Options Program (SHOP) and related provisions as well as the small business tax credits were waived. The amount the federal government saves because of the waiver of small business tax credits is paid to the state annually as "pass-through funding" to support the state's premium assistance for small employers.

All of the remaining 14 waivers that have been approved were for the development of state-based reinsurance programs. Two primary models have emerged in the design of state-based reinsurance programs federally-authorized and funded via Section 1332 Waivers. Most states that have established state-based reinsurance programs have adopted traditional reinsurance programs (also known as attachment point models) that largely mirror the federal transitional reinsurance program and fund a portion of claims (based on a set co-insurance amount) between an attachment point and a cap. Alaska and Maine have adopted Invisible High-Risk Pool models, whereby "eligible individuals" are identified prospectively based on health conditions and ceded behind the scenes to the reinsurance program for payment of claims, though they remain in their selected commercial insurance plan.

Interestingly, the reinsurance waivers are much more about the pass-through funding that can accompany Section 1332 Waivers than receiving authority for a policy development that would otherwise be prohibited under federal law. States can establish reinsurance programs without federal approval. However, as a result of the reductions in premiums that result from individual market reinsurance programs, premium tax credits (PTCs) - which are calculated based on premiums - are reduced. Via an approved waiver, the states can receive the money saved in reduced PTCs as pass-through funding to help to fund their reinsurance programs.

As noted above, there have been fewer innovative ideas for state-specific tailoring of the ACA than many expected with the inclusion of the Section 1332 Waiver opportunity and despite the increased flexibility provided from the federal level. On the other hand, the waiver opportunity allowed states to learn from each other's innovation and adopt similar approaches to those advanced successfully in other states, adapted to the needs of their states. For the 14 states that have received federal approval for state-based reinsurance programs via Section 1332 Waivers, it has also allowed them to continue to benefit from the positive impact of reinsurance on premiums and coverage after the end of the federal transitional reinsurance program that was only authorized for three years under the ACA.

As we look toward 2021, it will be interesting to see if state interest in reinsurance programs continues, particularly in light of concerns regarding premium increases due to the pandemic, and if any states propose or adapt reinsurance programs to specifically address COVID-19 costs.

The fact that most approved waivers are similar also does not tell the full story. States have proposed other concepts for Section 1332 Waivers; however, all of those different waivers have either been withdrawn or found to not meet the requirements for approval. Georgia's reinsurance waiver proposal, which includes broader reforms, is pending.

Unapproved Section 1332 Waiver Requests		
State	Overview of Waiver Proposal	Status
California Waiver application	Sought to offer "California Qualified Health Plans" to individuals ineligible to purchase QHPs based on their immigration status	Withdrawn
Georgia Waiver application	Phase 1: Seeks a waiver and pass-through funding (based on savings in premium tax credits due to reduced premiums) to support a state-based reinsurance program Phase 2: Seeks to waive the requirement for an Exchange and restrictions on the availability of non-QHPs for the individual market to allow the state to implement a "Georgia Access Model," which would allow individuals to purchase QHPs or eligible non-QHPs offering fewer benefits through web-based brokers or carriers and still receive premium tax credits to be administered by the state and funded through pass-through funding (based savings from the waiver of federal premium tax credits and cost-sharing reductions)	Pending
Idaho Waiver application	Sought to modify eligibility for premium tax credits and cost-sharing reductions to allow individuals with incomes between 100 percent and 138 percent of the federal poverty level to qualify for the subsidies as long as they are not *enrolled in* Medicaid (filed jointly with a Medicaid 1115 Waiver)	Determined incomplete
Iowa Waiver application	Sought to implement a standard plan design; restructure premium credits and cost-sharing reductions into a state-based, flat premium credits based on age and income and state-based cost-sharing limitations; and create a state-based reinsurance program (the final two provisions were to be funded with pass-through funding based on the waiver of premium tax credits and cost-sharing reductions)	Withdrawn
Massachusetts Waiver application	Sought to waive cost-sharing reduction payments and to establish a Premium Stabilization Fund (funded with pass-through funding based on resulting reduced premiums and, as a result, premium tax credits) to, alternatively, reimburse issuers	Determined incomplete
Ohio Waiver application	Sought to waive the individual mandate	Determined incomplete
Oklahoma Waiver application	Sought to develop a state-based reinsurance program as a first step in a planned broader reform	Withdrawn
Vermont Waiver application	Sought to waive the requirement to establish a SHOP	Determined incomplete

It will be interesting to watch Georgia's waiver to see if it becomes the first unique waiver concept approved in recent years. If it is approved, other states may get renewed interest in pursuing unique waiver designs.

III. CONCLUSION

States continue to make decisions about the future of health policy via decisions related to the implementation of the ACA. As outlined above, more action relative to state-based individual mandates, Medicaid expansion, work requirements and block grants, and Section 1332 Waivers is likely.

More broadly, while the ACA is entrenched in our nation's health care system, questions about the future of the law and health policy in the United States remains. Will the law in full or significant parts be overturned by a Supreme Court with newer appointees? Will a possible new administration shore up and build on the law? With key turning points in both of those arenas, coming next month, all eyes will remain on the law as we enter 2021 and determine the path forward for comprehensive health reform and the top priorities going forward.

When the dust settles following the election, we will turn to the predictions about the future of the ACA and continued efforts at the state level to best serve constituents in these unpredictable and unprecedented times.