

Section 1332 State Relief and Empowerment Waiver Concepts

Account-Based Subsidies (ABS) Waiver Concept

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Section 1: Executive Summary of Account-Based Subsidies (ABS) 1332 Waiver Concept

Overview: Expanding State Flexibility

The Department of the Treasury and the Centers for Medicare & Medicaid Services (CMS) in the Department of Health and Human Services (collectively, the Departments) released the Account-Based Subsidies (ABS) waiver concept to encourage state innovation. The ABS waiver concept provides states the opportunity to design and implement new alternatives to the Patient Protection and Affordable Care Act's (PPACA's) premium tax credit (PTC) subsidy structure to stabilize health insurance markets and address market distortions created by the PPACA in many states. The ABS waiver concept is one of four waiver concepts detailed in the November 29, 2018, "[Section 1332 State Relief and Empowerment Waiver Concepts: Discussion Paper](#)" hereafter referred to as the 2018

Discussion Paper.¹ The waiver concepts are part of the Departments' effort to provide states with the ability to tailor health insurance programs to best serve the needs of state residents while still meeting the requirements of federal law, including protections for individuals with pre-existing conditions. The ultimate goal is to empower states and consumers with flexible tools to drive better coverage and increased choice and competition, resulting in more informed and cost-effective healthcare decisions. The four section 1332 waiver concepts may be used alone or in combination with other waiver concepts, state proposals, or policy changes.

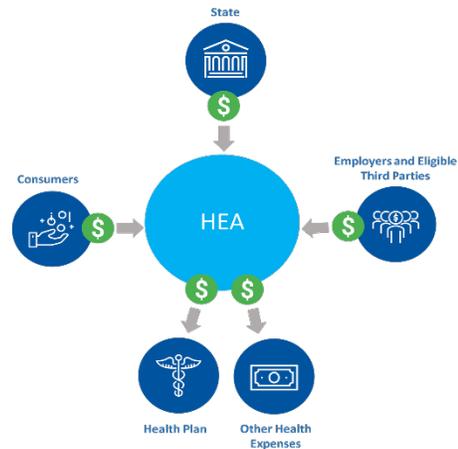


Figure 1: ABS Waiver Concept

The ABS waiver concept provides states with the flexibility to direct state-administered subsidies into a defined-contribution, consumer-directed account that an individual may use to pay health insurance premiums or other healthcare expenses. This consumer-directed Health Expense Account (HEA) is the backbone of the ABS waiver concept. This approach gives consumers greater choice to use the account to select a plan based on an individual's or their family's needs, including a higher deductible plan with lower premiums, as well as other health expenses. The ABS waiver concept would require the state to design and implement a new state-administered subsidy structure to fund the HEA, which can be done through a State Specific Premium Assistance (SSPA) waiver concept.

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Flexible Approaches

The ABS waiver concept, if approved for a state, would enable a state to take advantage of the flexibility provided under section 1332 of the PPACA to waive the current federal PTC structure, and receive federal pass-through funding which can be used to reinvest funds into a state subsidy program that includes a HEA account. The HEA funds may be aggregated from multiple sources, such as eligible third-parties, individual, or employer contributions. Funds in the HEA could then be used by enrollees to pay health insurance premiums and other healthcare expenses, such as out-of-pocket costs.

By providing states with the flexibility to create HEAs for consumers, the Departments seek to give states tools to empower consumers to make more cost-conscious health care spending decisions by allowing them to manage their own health care budget, this provides for greater consumer choice in healthcare decisions, and provides additional ways consumers to pay for coverage. States are free to explore a wide range of plan designs, and the Departments encourage innovation. Innovative examples of how states might apply the ABS waiver concept are outlined below. For more information, please see Section 3. The discussion here assumes all section 1332 waiver guardrails, discussed in Section 2 below, are met. Actual waivers are subject to approval by the Departments and must meet all statutory requirements.

¹ Centers for Medicare & Medicaid Services. "Section 1332 State Relief and Empowerment Waiver Concepts: Discussion Paper." *CMS.gov*, 29 Nov. 2018, <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Guidance.PDF>

- **Contribution Amount:** The state establishes a framework for setting a contribution amount. For instance, the contribution amount could be a flat amount based on age, family size, income, a percentage of the premium for a benchmark plan, or other criteria.
- **Allowable Uses of Funds:** The state defines allowable reimbursable expenses. For instance, a state may want to limit the HEA to paying for certain services or plans; for example, only allow funds to be used for plans with certain actuarial value levels or health expenses such as copayments and deductibles; states may choose to limit the HEA to premium payments, a new standard, or another existing standard like section 213(d) of the Internal Revenue Code.
- **Family Account Structure:** The state creates an account structure which allows a single account to contain multiple family members to make it easier for both the state and family to administer changes.
- **Account Administrator:** The state creates and administers HEA accounts. A state could establish each HEA as a trust administered by a private financial institution on behalf of the consumer or the state itself could hold and administer the HEA.
- **Excess HEA Funds:** The state determines use of excess funds at year end. States decide what are allowable uses of excess funds at the end of the plan year, such as rolling over funds to future years, return funds to the state, etc.
- **Tax Implications:** States should consider what (if any) federal tax consequences there will be for the individual and/or reporting requirements for the state as a result of establishing an HEA.

Section 1332 Waiver Funding Options

For all section 1332 waivers, a state may receive funding equal to the amount of federal financial assistance that would have been provided to its residents absent the waiver. This funding, known as federal pass-through funding, must be used by the state for implementation and administration of the approved section 1332 waiver. States may use federal pass-through funding in addition to state contributions to fund an ABS waiver concept to enhance affordability or comprehensiveness of benefits.

Take the Initial Step – Start Discussion with the Departments

The Departments are committed to empowering states to take full advantage of new opportunities to innovate in ways that will strengthen their health insurance markets and meet their unique needs. The goal is to make it significantly easier for states to apply and gain approval for all section 1332 waiver concepts, including the ABS waiver concept. State engagement with CMS on section 1332 waiver concepts and applications is encouraged and welcomed.

Where to Find Out More Information

CMS encourages states that are interested in section 1332 waivers to contact the Center for Consumer Information and Insurance Oversight (CCIO) to discuss goals and to receive technical assistance. Interested parties may send an email to StateInnovationWaivers@cms.hhs.gov for more information.

Section 2: Section 1332 Background and State Planning

Section 1332 of the PPACA permits states to request waivers of certain rules governing Exchanges under federal law to pursue innovative strategies for providing their residents with access to high quality, affordable health insurance. These waivers can be used to modify certain PPACA provisions including those related to EHBs, QHPs, the duties of a state Exchange, federal financial assistance, and the individual and employer mandates. The following table outlines the specific provisions that may be waived beginning on or after January 1, 2017.

Specific Provisions That May Be Waived	
Part I of Subtitle D of Title I	Sections 1301-1304: QHP and EHB requirements; Requirements for QHP issuers; Special rules related to abortion services; Insurance related definitions
Part II of Subtitle D of Title I	Sections 1311-1313: Exchange requirements
Subpart A of Part I of Subtitle E of Title I	Section 1402: Cost-sharing reductions
Internal Revenue Code of 1986	Sections 36B, 4980H and 5000A: PTC; Large employer coverage requirement; Individual coverage requirement

Section 1332 of the PPACA permits states to apply for waivers. The Departments may grant a waiver if a state's section 1332 waiver meets four statutory requirements (or "guardrails"). The section 1332 waiver must:

1. Provide coverage that is at least as comprehensive as the coverage defined in section 1302(b) as would be provided absent the waiver;
2. Provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as coverage absent the waiver;
3. Provide coverage to at least a comparable number of residents as would be provided absent the waiver; and
4. Not increase the federal deficit.

The Departments finalized regulations for the section 1332 statutory waivers on February 27, 2012², with additional guidance issued December 16, 2015 (2015 Guidance).³ On October 24, 2018, the Departments issued updated guidance (2018 Guidance) related to section 1332 of the PPACA to expand state flexibility, empower states to address their unique insurance markets, and increase coverage

² *Application, Review, and Reporting Process for Waivers for State Innovation*. Department of Health and Human Services and Department of the Treasury, 27 Feb. 2012, <https://www.govinfo.gov/content/pkg/FR-2012-02-27/pdf/2012-4395.pdf>.

³ "Waivers for State Innovation Guidance." *Federal Register*, Departments of Health and Human Services and the Department of the Treasury, 16 Dec. 2015, <https://www.federalregister.gov/documents/2015/12/16/2015-31563/waivers-for-state-innovation>.

options for their residents.⁴ The 2018 Guidance, which supersedes the 2015 Guidance, provides additional flexibility on how states may meet the four guardrails. Specifically, the 2018 Guidance permits a state to meet the comprehensiveness, affordability and coverage guardrails for its residents in aggregate and by assessing the availability of affordable, comprehensive, coverage, rather than only looking at the coverage people purchase. A state's waiver application will not be denied, for example, simply because people may choose a plan that is more affordable for them rather than opting to buy more expensive (but perhaps more comprehensive) coverage under current law.

State Planning for a Section 1332 Waiver

As with all new insurance program changes, states must carefully plan and design their section 1332 waiver application to meet the needs of their residents. As states design and apply for a section 1332 waiver, a thorough planning process will be critical to the waiver's approval and successful implementation. The Departments, specifically the Center for Consumer Information and Insurance Oversight (CCIIO) within CMS, will work closely with states during the comprehensive planning process. Initial planning activities, which may occur in any order, include:

- **Complete Insurance Market Study** – The Departments encourage states to leverage data-based profiles of their current health insurance market to develop effective waiver solutions. A market study may be completed by an independent vendor, or internally, and states may reach out to issuers to collect claims data. States may also look at a variety of federal and non-federal resources to gather information on their market.
- **Conduct Preliminary Stakeholder Engagement** – The Departments encourage states to begin informal conversations with issuers, consumers, providers, legislators, and other key stakeholders before finalizing a waiver approach to build consensus around goals and objectives.
- **Begin Routine Contact with CMS/CCIIO** – The designated state 1332 waiver team should establish points of contact at CMS/CCIIO, schedule periodic meetings to assess section 1332 waiver application progress and begin collaborative problem solving on key issues.
- **Draft a Section 1332 Waiver Application** – The Departments encourage states to draft a section 1332 waiver application that identifies the state's customized approach. This should include a description of challenges the waiver will address and how the waiver will alleviate those challenges. The state should also consider the implementation and section 1332 waiver application review timelines.
- **Determine Section 1332 Waiver Application Governance** – The state should determine the entity with responsibility for drafting the section 1332 waiver and administering the application phases. States may wish for this responsibility to reside in the Department of Insurance, with the State Exchange entity, the Governor's Office, or another state agency.
- **Obtain Necessary State Authority to Implement Waiver** – A key driver of waiver success is the ability to obtain timely authority to implement the waiver. States are required under the statute to enact or amend state laws to apply for and implement state actions under a section 1332 waiver. In addition, per the 2018 Guidance, the Departments clarify that in certain circumstances, existing state legislation that provides statutory authority to enforce PPACA provisions and the section 1332 waiver, combined with a duly-enacted state regulation or executive order, may satisfy the requirement that the state enact a law under section 1332(b)(2).

⁴ "Waivers for State Innovation." Federal Register, Departments of Health and Human Services and the Department of the Treasury, 24 Oct. 2018, <https://www.federalregister.gov/documents/2018/10/24/2018-23182/state-relief-and-empowerment-waivers>

Section 3: ABS Waiver Concept Description

The ABS waiver concept provides states with the flexibility to direct state subsidies into a defined-contribution and consumer-directed HEA. A HEA is a new type of account that consumers could use to pay health insurance premiums or other healthcare expenses. The account could be primarily funded with federal pass-through funding made available by waiving PTC (section 36B of the Code) or the small business tax credit (section 45R of the Code), along with any additional state funds to implement the section 1332 waiver. The account could also allow consumers to aggregate funding from additional sources, including the consumer, state, and employer. Figure 2 represents a sample ABS waiver concept process flow.

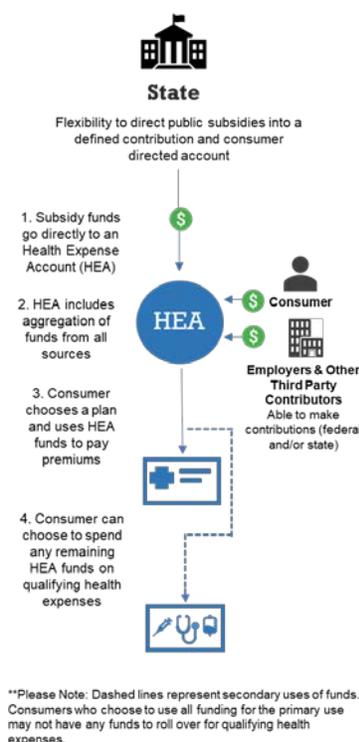


Figure 2: ABS Waiver Concept Process Flow

The ABS waiver concept is intended to potentially provide consumers with more choices, improve incentives to make cost-conscious healthcare spending decisions through managing a healthcare budget, and better enable them to maintain health coverage regardless of changes in income or other life circumstances. This approach could also allow a consumer greater ability to select a plan based on the individual's or their family's needs, such as a higher deductible plan with lower premiums. The ABS waiver concept promotes program features which support the following policy goals:

- **Consumer Choice and Engagement** – Emphasizes consumer management of a healthcare budget and can be used to expand health plan shopping options for participants.
- **Defined Contribution** – Permits states to make a fixed contribution to the consumer account. The total account balance, which could consist of deposits from the state, consumers, and other eligible third-parties (e.g., employer) may exert downward pressure on the plan premium as issuers price products to align with the contribution amount.
- **Fund Aggregation** – Allows funds to be aggregated from multiple sources, such as eligible third-parties, individual, state, or employer contributions.

Design and Implementation Approaches

Design flexibility is a key component of section 1332 waiver concepts. States have the flexibility to design and implement an innovative program that meets its consumer needs. Two main design components are the HEA and revised state subsidy program, but the structure and operation of each is at the state's discretion. As states design their ABS waiver concept, the following design elements should be considered:

HEA Design Options	
Determine Account Funding	<p>States have flexibility in determining how much money to contribute to the HEA. For example, states could structure the account state subsidies as follows:</p> <ul style="list-style-type: none">• A flat amount by age or family size;• Scaled to income or the percentage of the premium for a benchmark plan;• Wellness programs, where consumers could earn contributions into their account by participating in programs or meeting certain requirements outlined in the wellness program. <p>In addition, states have the option to determine who, in addition to the state, may contribute money to the account by allowing contributions from:</p> <ul style="list-style-type: none">• The consumer• A consumer's employer, and/or• Other eligible third-parties
Determine Use of Rollover Funds	<p>States need to consider what to do with remaining funds at the end of the year (i.e., if and how a consumer can rollover excess funds from year to year). Options include:</p> <ul style="list-style-type: none">• Return excess funds to the state for use towards the state waiver plan (this option may have less of an impact on consumer behavior);• Keep remaining funds in the consumer's account for availability to pay other healthcare expenses incurred during the plan year or saved to pay for future plan year healthcare expenses for or future plan years; or• Direct excess funds to wellness programs (e.g., smoking cessation programs).
Determine Allowable Use of Funds	<p>States may define the types of services that the HEA can reimburse as well as what sorts of plans it can be coupled with. For instance, a state may want to limit the HEA to paying for certain services or plans; for example, only allow funds to be used for plans with certain actuarial value levels or health expenses such as copayments and deductibles; states could also specify which plans HEA's can be</p>

	coupled with to include QHPs, direct primary care (DPCs), non-QHPs, etc.; or a state may choose to limit the HEA to premium payments and another standard for allowable health expenses that already exists like section 213(d) of the Code or a new state established criteria.
Determine Family Account Structure	States can structure the accounts so that families are under a single account or provide individual accounts for each family member. Having multiple family members under a single account generally makes it easier to administer for both the state and the family. However, a single account approach requires procedures for removing family members from the account under certain circumstances, such as a divorce or a child aging out of the plan.
Establish Account Administration	States could establish each HEA as a trust administered by a private financial institution on behalf of the consumer or the state itself could hold and administer the HEA.

The implementation of an ABS waiver concept requires a state to implement a new state subsidy structure, which may be accomplished through the SSPA waiver concept. An SSPA provides states with the flexibility to design a new state subsidy structure to target public assistance to better help the vulnerable and to expand the risk pool. In addition, to maximize the benefits of the ABS and SSPA waiver concepts, a state may wish to customize plan options available to consumers, which can be accomplished through an Alternative Plan Options (APO) waiver concept. Through an APO waiver concept, states could change the types of plans that are eligible for state premium subsidies to make coverage more affordable for individuals and to increase consumer choice. Refer to the 2018 Discussion Paper for additional information on section 1332 waiver concepts.

States could:

- Create a new platform, or
- Waive the PPACA's Exchange and QHP provisions and rely entirely on the private market.

If a state chooses to waive the PPACA's provisions related to Exchanges (section 1311) and QHPs (section 1301), the implementation could be similar to the implementation approach for the APO waiver concept, which allows state-subsidies to be applied to non-QHPs. This provides the opportunity for consumers to use the account to purchase a wider variety of plans.

Another approach is for a state to leverage the existing Federally Facilitated Exchange (FFE) backend infrastructure in the state. States would need to work with the FFE and effectively "turn off" the financial assistance component of the FFE for the state to do their own subsidy program. In this option, states would cover costs incurred for the technical build to adjust the HealthCare.gov website and backend system and to make changes to consumer support channels (including the call center, messaging, etc.). This option can be done in conjunction with the SSPA waiver concept implementation approach.

Section 1332 Waiver Administration Options

In deciding how to implement and administer their section 1332 waiver, states have a range of options. In some cases, the federal government may be able to offer support in implementing the waiver. In other cases, states may wish to leverage private sector technology and resources to create a more flexible platform for carrying out the waiver. States should work with CMS to determine the level of the FFE operations that can be utilized for the state plan based on the specifics of the state's section 1332 waiver proposal. Subject to the requirements of the Intergovernmental Cooperation Act (ICA) and OMB Circular A-97, if a waiver requires CMS to make technical changes to the federal eligibility and enrollment platform, the state will be responsible for reimbursing CMS for any costs incurred for certain technical and

specialized services covered under the ICA (either with 1332 federal pass through funds and/or funds provided by the state to fully reimburse CMS). A state may administer its own information technology system, contract with a vendor(s) to outsource functions for eligibility and enrollment that the Exchange currently performs, or, where feasible, continue to utilize FFE functions that are not modified by the section 1332 waiver. States have the flexibility to structure the ABS waiver concept based on the extent the state can manage the additional tasks related to direct state administration of subsidies. Under the ABS waiver concept, states currently operating as an FFE would need to effectively “turn off” the financial assistance component of the FFE for the state. In this option states would cover costs incurred for the technical build to adjust the HealthCare.gov website and backend system, and make changes to the consumer support channels (including the call center, messaging, etc.). This option would build off of the SSPA waiver concept.

The Departments understand that states will have questions about the potential cost and complexity of administering a state Exchange that vary from HealthCare.gov. CMS is prepared to work with states to discuss this model and lay out the range of potential options available in carrying out the waiver. While states may decide to establish their own State-based Exchanges (SBEs) in order to implement the waiver, it is important to remember that the Exchanges themselves may be waived under section 1332, and that the Exchange concept may be altered to be more tailored to the state’s waiver plan. States may also access FFE services in administering their waiver; any fees for accessing FFE services to carry out the 1332 waiver would be determined with each state and would depend on the requested support or changes needed.

Policy Choices for States

As states begin to think through how to design and implement the ABS waiver concept, it will be important to fully understand the desired objectives, available resources, and potential overlap with existing state programs; these factors will drive the policy choices that will be necessary to effectively design an ABS waiver. Policy decisions may include, but are not limited to:

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

Maximizing State Flexibility to Design Innovative Waivers

States are encouraged to look at options under the ABS waiver concept in conjunction with other innovative approaches introduced by CMS in the 2018 Discussion Paper. These include the flexibility to design a state’s own subsidy structure; the ability to permit consumers to choose from a wider variety of plan options to optimize value; and offering solutions for high-cost claims, such as reinsurance programs or other programs to provide better care for people with complex needs. An ABS waiver concept could be paired with any of the other concepts, as well as other innovative policies initiated by the state. States are also encouraged to look at additional flexibilities for section 1332 waivers as outlined in the 2018 Guidance.⁵

Administrative Expenses

States may use federal pass-through funding associated with waiving section 36B of the Code for the ABS waiver concept to implement the section 1332 waiver and help partially fund the state account-based

⁵ “Waivers for State Innovation.” Federal Register, Departments of Health and Human Services and the Department of the Treasury, 24 Oct. 2018, <https://www.federalregister.gov/documents/2018/10/24/2018-23182/state-relief-and-empowerment-waivers>

subsidy program. In place of the PTC, states could receive federal pass-through funding in the amount individuals would have otherwise received in PTC. States would use this federal funding to contribute to the HEAs based on rules established by the state and consistent with federal law.

As a reminder, a state must ensure that the waiver meets the four statutory guardrails of affordability, comprehensiveness, coverage, and federal deficit neutrality. Any additional costs to fund the account-based subsidy program would be the state's responsibility.