

ISSUE BRIEF

No. 4739 | JULY 21, 2017

Waiving Federal Insurance Rules: How the Senate Bill Would Allow States to Improve Their Health Insurance Markets

Robert E. Moffit, PhD

The Senate health reform bill allows states to take advantage of a broad waiver authority that would enable them to regulate their own health insurance markets. By applying for a waiver under an *amended* provision of current law (Section 1332 of Obamacare), states would be able to set their own standards for the kinds of health plans and benefits available to their citizens, as well as the financing arrangements of these health plans. In effect, states would be able to secure broad consumer choice of health plans and stimulate robust competition among plans and providers within their borders.

This is sound policy. Washington's imposition of standardized regulation on diverse state health insurance markets has proven to be a costly and painful experiment. This unhappy experience should help to dispel the lingering faith among Washington policymakers that centralized federal power produces better health policy results.

The Urgency

Competition in the individual health insurance markets has declined precipitously: In 70 percent of U.S. counties, enrollees have a choice of only one or two health insurers.¹ Meanwhile health insurance costs, especially for middle-class families in the indi-

vidual and small-group markets, have grown substantially. In 39 states where the federal government has been administering the health insurance exchanges, according to the U.S. Department of Health and Human Services (HHS), health insurance premiums increased 105 percent from 2013 to 2017.²

Obamacare's excessive regulatory regime has directly contributed to higher costs and fewer choices. For example, the insurance age-rating rules artificially increase premiums for younger persons, thus discouraging younger persons from enrolling in coverage and leaving the insurance pools with older and sicker enrollees.³ Likewise, the law's "actuarial value" mandate, specifying the level of coverage that plans must provide, increases costs. All individual and small-group plans must also offer 10 categories of health benefits, regardless of consumers' needs or preferences.

Expanding Waivers Under Section 1332

The Senate bill would repeal the (3-to-1) age-rating rule and substitute a 5-to-1 age rating rule as a default setting.⁴ It also would allow states to choose a different ratio and determine for themselves the most appropriate rating options for their citizens. It would further allow the states to determine health insurance medical loss-ratio rules (the percentage of medical claims paid out of premium revenues).

Like the House bill,⁵ the Senate bill would also allow the states to waive Obamacare health insurance rules.⁶ Specifically, the Senate bill makes certain key changes to Section 1332 of the Affordable Care Act. Under Section 1332 of existing law, a state waiver can last for five years; the Senate bill would extend the life of the state waiver to eight years. It

This paper, in its entirety, can be found at <http://report.heritage.org/ib4739>

The Heritage Foundation
214 Massachusetts Avenue, NE
Washington, DC 20002
(202) 546-4400 | heritage.org

Nothing written here is to be construed as necessarily reflecting the views of The Heritage Foundation or as an attempt to aid or hinder the passage of any bill before Congress.

specifically provides that state officials must provide alternatives for “increasing access to comprehensive coverage, reducing average premiums, providing consumers the freedom to purchase the health insurance of their choice, and increasing enrollment in private health insurance.”⁷

The bill requires certification of a state governor or insurance commissioner to implement the terms of the waiver. It also authorizes the Secretary to establish an expedited process for granting the waiver to a state if there is an “urgent or emergency situation with respect to health insurance coverage within a state.”⁸

A Broader Scope

The Senate bill would give states broader authority to restructure their health insurance markets through an amended version of existing law. Under Section 1332, states could apply to the Secretary of HHS and get a waiver of “all or any requirements... with respect to health insurance coverage within that state for plan years beginning on or after January 1, 2017.”⁹ The scope of the waivers would include:

- **Health insurance provisions.** This encompasses the definition of a “qualified health plan” and health insurance coverage; “essential health benefits” requirements; rules governing cost sharing and deductibles; the actuarial value mandates and levels of coverage required; rules governing catastrophic coverage; definitions of the group and individual markets and the large and small-group markets; rules for determining employer size, as well as rules relating to abortion coverage in health plans.¹⁰ Though the abortion rules¹¹ are technically waiverable, elsewhere the Senate bill stipulates that even if a state receives a waiver the HHS Secretary will retain the authority to impose penalties for noncompliance established by an amendment to the Public Health Service Act (PHSA).¹²
- **Insurance market provisions.** This includes provisions governing the health insurance exchanges and the requirements for establishing these exchanges; the rules governing the merger of individual market and shop exchanges; enroll-

-
1. Edmund F. Haislmaier and Alyene Senger, “The 2017 Health Insurance Exchanges: Major Decrease in Competition and Choice,” Heritage Foundation *Issue Brief* No. 4651, January 30, 2017, <http://www.heritage.org/sites/default/files/2017-01/IB4651.pdf>.
 2. U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Planning and Evaluation, “Individual Market Premium Changes: 2013–2017,” May 23, 2017, <https://aspe.hhs.gov/system/files/pdf/256751/IndividualMarketPremiumChanges.pdf> (accessed July 21, 2017).
 3. Edmund F. Haislmaier and Drew Gonshorowski, “Freeing States from the Obamacare Insurance Mandates,” Heritage Foundation *Issue Brief* No. 4689, April 26, 2017, http://www.heritage.org/sites/default/files/2017-04/IB4689_0.pdf.
 4. The Better Care Reconciliation Act of 2017, Section 204. This is the same as the House-passed bill.
 5. The American Health Care Act, Section 136. States would be able to secure a 10-year waiver (the MacArthur Amendment) from Obamacare’s insurance rating and health benefit requirements. As a condition for getting a waiver, states must establish high-risk pools, adopt a program to stabilize the premiums of such persons with pre-existing medical conditions, or participate in a new federal insurance risk-sharing program designed to secure continuing coverage and market stability.
 6. Patient Protection and Affordable Care Act of 2010, Section 1332, Waiver for State Innovation.
 7. Better Care Reconciliation Act of 2017, Section 207.
 8. *Ibid.*
 9. Patient Protection and Affordable Care Act of 2010, Section 1332, (a) (1).
 10. These items are governed under the Patient Protection and Affordable Care Act of 2010, Title I, Subtitle D, Part I.
 11. Obamacare established a set of accounting rules requiring insurers that offer abortion coverage on Obamacare exchanges to separate money used to pay for elective abortion procedures from taxpayer subsidized premium payments used to pay for all the other covered services. While hardly a satisfactory solution to preventing taxpayer funding for abortion coverage in the first place, a 2014 Government Accountability Office report showed that some insurers were not even abiding by those accounting rules.
 12. Better Care Reconciliation Act, Section 209. According to the Budget Committee’s section-by-section analysis, a “plan issuer that fails to comply with these requirements would be liable for a penalty of up to \$100 for each day for each individual with respect to whom such a failure occurs. In determining the actual amount of a penalty, the HHS Secretary would consider a plan issuer’s previous record of compliance and the gravity of the violation.” U.S. Senate, Committee on the Budget, “Section by Section Summary Better Care Reconciliation Act [ERN17490] Titles I & II,” undated, <https://www.budget.senate.gov/imo/media/doc/BCRA%20Section%20by%20Section%20Summary%207.13.17.pdf> (accessed July 21, 2017).
-

ment in the exchanges; state-mandated benefits in the exchanges; the functions of the exchanges; the administration of the exchanges; rules governing regional or interstate exchanges; requirements governing risk pools; requirements for congressional enrollment in the exchanges; provisions relating to state flexibility; rewards for quality and quality improvement, and patient safety; the role of navigators; the qualifications for persons to be enrolled in the exchanges; rules governing employer participation in the exchanges; and the financial and accounting requirements for officers of the exchanges.¹³

- **Cost-sharing rules.** This includes determinations of eligibility for cost-sharing reductions; rules for low-income persons; methods of cost sharing; and definitions and special rules governing cost-sharing categories of enrollees, including those enrolled through the Indian Health Service (IHS).¹⁴
- **Premium tax credits.** The waiver would also apply to statutory provisions governing refundable tax credits for coverage under qualified health plans. This would include the determination of the amount and payment of the credits; the percentage available by income category; the indexing of the credits—currently adjusted by the consumer price index—for eligible persons (those with annual incomes between 100 percent and 400 percent of the federal poverty level); the applicable benchmark for setting the credit amount (currently the second lowest cost silver plan); rules relating to taxpayers and employers; and terms and definitions related to family size, household income, poverty, the reconciliation of credits and advanced credits, excess advance payments, and information requirements.¹⁵

The Section 1332 waiver provisions would also apply to the individual and employer mandates,¹⁶ but the Senate bill would directly repeal those mandate penalties. With regard to state-level funding, the states would retain the ability to secure all of the Obamacare subsidies that would otherwise finance enrollees in the Obamacare exchanges.¹⁷

Easing the Process

To facilitate the waiver process, the Senate bill would repeal certain key Obamacare conditions imposed on the states that are seeking these regulatory exemptions. As Joel Ario, a managing director of Manatt Health and a former HHS official, has observed, “These [existing law] limitations have largely discouraged states from proposing sweeping reforms.”¹⁸

Specifically, states would no longer be required to demonstrate to the Secretary of HHS that their state insurance alternatives would be:

- As “comprehensive” as Obamacare’s coverage requirements, or
- Meet Obamacare’s cost-sharing standards, or
- Enroll as many persons in health insurance coverage as Obamacare.

Moreover, the Secretary of HHS would now be required to follow a process that is expeditious in transferring regulatory authority to the states. The Senate bill would:

- Permit states to apply for a waiver without enacting authorizing legislation (as per current law). States would have additional options to legislation, such as allowing the state’s governor and insurance commission to initiate a waiver.

13. These items are governed under the Patient Protection and Affordable Care Act, Title I, Subtitle D, Part II.

14. The Patient Protection and Affordable Care Act, Section 1402.

15. 26 U.S. Code, Section 36B.

16. The individual mandate is authorized by 26 U.S. Code, Section 5000A; the employer mandate by 26 U.S. Code, Section 4980H.

17. Heather Howard and Galen Benshoof, “Section 1332 Waivers and the Future of State Health Reform,” Health Affairs Blog, December 5, 2014, <http://healthaffairs.org/blog/2014/12/05/section-1332-waivers-and-the-future-of-state-health-reform/> (accessed July 21, 2017).

18. Joel Ario, JD, “The ACA’s Section 1332 Waivers: Will We See More State Innovation in Health Care Reform?” The NICHM Foundation, August 2016, <https://www.nihcm.org/categories/the-aca-s-section-1332-waivers-will-we-see-more-state-innovation-in-health-care-reform> (accessed July 21, 2017).

- Allow states to obtain a waiver, as long as the state’s proposed alternative refrains from contributing to an increase in the federal deficit.¹⁹ (Under Obamacare, the law says the HHS Secretary “may” approve waivers that meet certain parameters; the Senate bill changes this to say the Secretary “shall” improve the waiver.)
- Permit states to receive a waiver for eight years, as opposed to the current law’s five-year waivers.

By easing the process and eliminating existing obstacles, the Senate bill would give states ample opportunity to pursue more aggressive reforms of the insurance markets, allowing innovation to emerge in the “bottom-up” policy experimentation central to American federalism.²⁰ Some critics assert that the Senate’s liberalized waiver authority would not only result in a “misuse” of federal dollars, but also “substantial losses” in insurance coverage and affordability.²¹ To the contrary, if states can indeed reduce health care costs through a liberalized waiver process, they can also expand affordability and thus increase coverage.

Centralizing control of health insurance markets in the federal government was a bad idea from the start. It has contributed directly to higher insurance costs. For almost a century, states were responsible for general insurance regulation, and they regulated individual health insurance markets until the enactment of Obamacare in 2010.²² States can and should be engines of innovation in public policy, and their wider range of experimentation with new and different methods of health care financing and delivery is a far more prudent path than the unilateral imposition of failed federal regulatory controls.

Conclusion

The Senate’s amended Section 1332 waiver process would exempt states from the most significant Obamacare rules, such as those mandating health plan coverage levels, the definitions of individual and small-group coverage, and the federal “essential health benefit” requirements. In effect, states receiving such a broad waiver would be able to establish the kind of individual and small-group health insurance markets, as well as the financing and subsidy arrangements, that they think best for their citizens.²³

Americans, especially those in small businesses, want relief from the high health care costs that currently bedevil them in the individual and small-group markets. While the House bill genuinely attempts to reduce health care costs, its capacity for generating state-based innovation is more constrained than the Senate’s product. The Senate bill is thus an improvement over both current law and the House bill and holds open the possibility of securing an even broader range of coverage options and more robust cost control. Congress can thus repair the severe damage that current law has inflicted on the individual and small-group markets: deteriorating market conditions aggravated by federal regulatory inflexibility.

—*Robert E. Moffit, PhD, is a Senior Fellow in Domestic Policy Studies, of the Institute for Family, Community, and Opportunity, at The Heritage Foundation.*

19. 42 U.S. Code, Section 18052.

20. For a discussion of the possibilities, see James C. Capretta, “Health Reform from the Bottom Up,” American Enterprise Institute, September 3, 2015, <https://www.aei.org/publication/health-care-reform-from-the-bottom-up/> (accessed July 21, 2017).

21. See, for example, Jason Levitis, “Changes to State Innovation Waivers in the Senate Health Bill Undermine Coverage and Open the Door to Misuse of Federal Funds,” The Brookings Institution, June 23, 2017, <https://www.brookings.edu/blog/up-front/2017/06/23/changes-to-state-innovation-waivers-in-the-senate-health-bill-undermine-coverage-and-open-the-door-to-misuse-of-federal-funds/> (accessed July 21, 2017).

22. In 1912, most of the states enacted standard insurance provisions modelled on the recommendations of the National Convention of Insurance Commissioners. The Health Insurance Association of America, *Source Book of Health Insurance Data* (Washington, DC: The Health Insurance Association of America, 2002), p. 177.

23. See, for example, Stuart M. Butler, “Repeal and Replace: What Could It Mean?” *Journal of the American Medical Association, JAMA Forum*, November 30, 2016, <https://newsatjama.jama.com/2016/11/30/jama-forum-repeal-and-replace-obamacare-what-could-it-mean/> (accessed July 21, 2017). See also Joel M. Zinberg, “State ACA Waivers: A Bipartisan Solution,” The American Enterprise Institute, July 6, 2015, <http://www.aei.org/publication/state-aca-waivers-a-bipartisan-solution/> (accessed July 21, 2017).