DECENTRALIZED HEALTH INSURANCE REFORM THROUGH 1332 WAIVERS

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Table of Contents

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Introduction

The escalating cost of health insurance in the U.S. is an ongoing issue that has become more concerning over the past decade. A number of the main insurance regulations established by the Patient Protection and Affordable Care Act (ACA) took effect in 2014, including the expansion of Medicaid eligibility to non-disabled adults and the introduction of premium tax credit subsidies to low- and middle-income Americans purchasing an individual market plan through a health insurance exchange. These provisions of the law were meant to increase access to affordable coverage (CMS, 2021a, p.1). However, other regulations, such as the closure of state high-risk pools, premium rating requirements, mandated essential health benefits, health insurance taxes, the exchange user fees, and the structure of the premium tax credit have contributed to an increase in the cost of health insurance. In spite of generous subsidies in the form of the ACA's premium tax credits, many Americans, especially those without access to employer-sponsored coverage and earning too much money to qualify for the subsidies, still find ACA options either too expensive or unattractive. At the same time, the individual market has become less competitive and more unstable because of interference by the federal government.

Key Points

- A number of the ACA's centralized regulations have stifled innovation, de-stabilized the individual health insurance market, and contributed to an increase in health insurance costs.
- Linked to the rise in costs is a decline in enrollment in individual market plans among those people without a premium subsidy as well as a corresponding increase in the number of uninsured.
- Although a number of states have been approved for Section 1332 waivers, with few exceptions these have been limited to the implementation of re-insurance programs.
- Early experience shows that Section 1332 waivers have the ability to lower premium costs and to stabilize the individual health insurance market.

The centralized regulatory policies of the ACA stifle innovation and do not work for many Americans. However, Section 1332 waivers offer states an opportunity to address some of the failings of the ACA and craft innovative solutions for their distinctive populations and markets without increasing federal spending. Through policies such as risk mitigation programs to stabilize the individual health insurance market or more innovative ideas such as empowering consumers by giving them more control over their healthcare resources, states like Texas should take advantage of the latitude afforded them under the law in order to use available resources to meet the healthcare needs of their residents without adding to the already considerable financial burden on taxpayers. The U.S. Centers for Medicare & Medicaid Services (CMS) should reduce the barriers to innovation and provide the flexibility that states need to develop policies that increase access to quality, affordable healthcare coverage.

The ACA and the Individual Health Insurance Market

In 2013, prior to implementation of major ACA insurance regulations, the average monthly premium on the individual health insurance market was $242. In 2014, the monthly premium increased by 45% to $352, and by 2018, it increased to $588, or 143% higher than the 2013 premium (CMS, 2021a, p. 2). Linked to the rise in premiums was a steady decline in enrollment in individual market plans among those people who purchase coverage without a premium subsidy and a corresponding increase in the number of uninsured (CMS, 2021a, pp. 4–6). Between 2016 and

2019, the number of unsubsidized enrollees in the individual market declined by 2.8 million and the proportion of unsubsidized enrollees in the market declined from 43% to 29%. Between 2018 and 2019, 80% of the decrease in enrollment occurred among people who did not qualify for subsidies (CMS, 2020). In 2013, 395 insurers sold coverage in the individual market across all states and the District of Columbia. By 2018, that number fell to 181 and by that measure, the 2018 exchanges were 54% less competitive than the individual market was before the ACA changes were implemented. Although increased insurer participation at both the state and county levels occurred following actions taken during the Trump administration (plan years 2019 through 2022), the 2022 exchanges were still 25% less competitive than the individual market was before the implementation of the ACA regulations (Haislmaier, 2022).

The COVID-19 pandemic further highlighted the failings of the individual health insurance market. Using data from the U.S. Bureau of Labor Statistics, Families USA (Dorn, 2020) estimated that 21.9 million Americans lost or left their jobs between February and May 2020 and at least 5.4 million U.S. adults under 65 lost health insurance coverage during the same period. In Texas, 659,000 adults lost health insurance coverage in that period, a 15% increase from pre-pandemic levels. Many of these unemployed workers had limited and prohibitively expensive health coverage options.

The $1.9 trillion American Rescue Plan Act of 2021 (ARPA; Pub. Law 117-2) that was passed by Congress and signed into law by President Biden in March 2021, significantly increased subsidies for people who were already eligible for financial assistance and removed the income cap on subsidy eligibility. The Kaiser Family Foundation (Rae et al., 2021) estimated that, with passage of the ARPA, the number of people eligible for a subsidy to purchase marketplace coverage increased 20% from 18.1 million to 21.8 million. Although expansion of premium subsidies can temporarily reduce the personal cost of premiums and increase individual market enrollment, it does so by increasing federal spending, reducing the number of price-sensitive consumers and unsubsidized beneficiaries in the individual market, and further inflating the cost of health insurance (Nelson, 2021).

Overview of 1332 Waivers

The practice of allowing states to waive requirements of federal health coverage programs is not new. Congress enacted Section 1115 via amendments to the Social Security Act in 1962 (Pub. L. No. 87-543) to allow flexibility to address problems in the nation's welfare programs and help make them more responsive to local needs (Albanese, 2019). When Title XIX was enacted in 1965, the waivers were increasingly applied to the Medicaid program, notably in the use of managed care and to secure funding for individuals and services not otherwise eligible for Medicaid. As of May 2022, there were 63 approved Section 1115 waivers across 47 states (Kaiser Family Foundation, 2022). Waivers have also been available in the Medicare program, often in response to public health emergencies, such as the COVID-19 pandemic, but also to allow innovative delivery system and payment reforms. However, they are generally limited in scope and are usually administered by the federal government rather than the states (CMS, n.d.-b).

Section 1332 of the ACA

Section 1332 of the Patient Protection and Affordable Care Act (ACA) permits a state to apply for a State Innovation Waiver, also referred to as a Section 1332 waiver (42 U.S. Code § 18052). If approved, a state can waive any or all of certain 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 then implement its own plan to provide residents with access to high-quality, affordable health insurance with options that better address the healthcare needs of the state's population.

Waiver Application Process

A state needs to complete preliminary steps before submitting its Section 1332 waiver application, including enacting a law or revising existing law authorizing implementation of the waiver and providing for public notice, public hearings, and a period for public comment (CMS, n.d.-a). The state may then submit its application to the secretary of the U.S. Department of Health and Human Services (HHS) for review. Any application seeking to waive requirements in the Internal Revenue Code must also be reviewed by the secretary of the Treasury. To be deemed complete, the application must contain information about the enacted state authorizing legislation, a description of the plan 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. A completed application is then made available for public review and comment, and a final decision is issued no later than 180 days after a completed application is received. The waivers can be approved for up to five years and can then be considered for extension (Rosso, 2021).

In order for a Section 1332 waiver to be approved by the HHS and the Department of the Treasury, states also need to show that the waiver will meet certain "guardrails" throughout the period that the waiver is to be in effect. The waiver must

> (1) provide coverage that is at least as comprehensive as the coverage provided without the waiver; (2) provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as without the waiver; (3) provide coverage to at least a comparable number of residents as without the waiver; and (4) not increase the federal deficit. (CMS, n.d.-a, p. 3)

State Innovation Waivers were made available in January 2017.

Pass-Through Funding

When a Section 1332 waiver is approved, the state is eligible to receive federal funding equal to the amount the federal government would have spent on premium tax credits, small employer tax credits, and cost-sharing reductions without the waiver. This "pass-through funding" can only be used to support the state waiver program.

States are required to submit the data on what health insurance rates would have been in the absence of the waiver, including total premiums, and advanced premium tax credits, among other information. CMS and the Treasury Department use these data to calculate the amount of pass-through funding for each state on an annual basis (CMS, n.d.-a). For all states, total federal pass-through funding for 2022 is more than $1.87 billion, with five states[1] receiving almost 70% of the total pass-through funding. The methodology for calculating pass-through funding includes recent macroeconomic assumptions, such as the impact of the COVID-19 pandemic. Federal pass-through funding is much higher for 2021 and 2022, given enhanced subsidies under the American Rescue Plan Act (Keith, 2022).

What Can Be Waived Pursuant to a State Innovation Waiver?

The secretaries of both the U.S. Health and Human Services and the Treasury are authorized to waive the following provisions of the Affordable Care Act of 2010 (Pub. L. 111-148) and the Internal Revenue Code (Pub. L. 99-514) under their respective jurisdictions:

- **Part I of Subtitle D of Title I of the ACA**
  This part defines a qualified health plan (QHP) as a health insurance plan that meets certain requirements established by the ACA, including the essential health benefit (EHB) requirements. It also places limits on the cost-sharing charges that enrollees must pay, sets standards for the plans that insurers offer, including catastrophic plans, and defines which employers are subject to ACA requirements for small-group plans.

- **Part II of Subtitle D of Title I of the ACA**
  This part includes minimum standards for exchange plans, as well as the functions that marketplaces must perform. For example, plans need to include a sufficient choice of healthcare providers in their networks, meet certain quality standards, provide a telephone hotline and website, and provide various enrollment and claims data.

- **Section 1402 of the ACA**
  This section establishes the cost-sharing subsidies available to reduce the deductibles, copayments, and overall annual out-of-pocket costs that low- and moderate-income people pay under marketplace plans.

- **Section 36B of the Internal Revenue Code**
  This section establishes the premium tax credit to assist people buying health insurance through the marketplace and determines who is eligible and how the credit is calculated, including the premium contributions for people at different income levels.

- **Section 4980H of the Internal Revenue Code**
  This section establishes the standards that employer-sponsored coverage must meet to be considered affordable and adequate, and the penalties for employers of 50 or more full-time-equivalent workers that do not provide coverage.

- **Section 5000A of the Internal Revenue Code**
  This section includes the individual mandate, which specifies that most individuals have health coverage or pay a penalty. It defines the minimum essential coverage (MEC) needed to avoid the penalty, the amount of the penalty, and the categories of people who are exempt from the requirement.

Section 1332 does not change existing waiver authority for provisions in other federal health programs such as

1 The five states are Colorado ($196.7 million), Georgia ($255.2 million), Maryland ($344.1 million), New Jersey ($323 million), and Wisconsin ($181.9 million).

Medicaid or Medicare and the Center for Medicare and Medicaid Innovation or section 1115 waivers related to Medicaid and CHIP. It also does not apply to other ACA provisions such as guaranteed issue and renewability or modified community rating (Lueck & Schubel, 2017).

Regulations and Guidance

According to the CMS website, the goal of the Section 1332 State Innovation waivers is to give states the flexibility to design and implement "innovative strategies for providing residents with access to high quality, affordable health insurance" (CMS, n.d., para. 1). CMS issued the final regulations implementing 1332 waiver requirements in February 2012 (Application, Review, and Reporting Process , 2012) and supplemented these regulations with sub-regulatory guidance in December 2015 (Waivers for State Innovation, 2015). On October 24, 2018, CMS released updated Section 1332 guidance and related implementation regulations, which included increased flexibility on how a state plan may meet Section 1332 eligibility standards (State Relief and Empowerment Waivers, 2018). However, this updated guidance was met with considerable opposition (Letter from U.S. Sens Ron Wyden et al., 2018) and the guidelines were rescinded on November 26, 2021, and replaced by new guidance largely mirroring the 2012 regulations and 2015 sub-regulatory guidance (Patient Protection and Affordable Care Act; Updating Payment, 2021).

State Relief and Empowerment Waiver Concepts

On November 29, 2018, CMS released a discussion paper titled *Section 1332 State Relief and Empowerment Waiver Concepts* (CMS, 2018), intended to foster discussion and encourage innovation by illustrating how states might take advantage of the flexibilities provided in the updated guidance. The four waiver concepts included (1) State-Specific Premium Assistance; (2) Adjusted Plan Options; (3) Account-Based Subsidies; and (4) Risk Stabilization Strategies. The paper pointed out that these waiver concepts are not inclusive of the full range of waiver options available to the states, that incorporation of any of these waiver concepts does not guarantee approval of a waiver application, and that any proposal must still meet the statutory guardrails.

State-Specific Premium Assistance Waiver Concept

Current federal Premium Tax Credits (PTCs) are subject to the same allocation formula in all states and the District of Columbia, even though income, Medicaid eligibility, plan availability, and underlying healthcare costs vary greatly across the country. In the *State-Specific Premium Assistance* waiver concept, states can opt out of this "one-size-fits-all" approach by designing a new state-implemented subsidy structure to replace the federal PTC structure, such as redefining the amount of financial assistance provided as a state subsidy (e.g., state tax credit) or the populations who are eligible for the subsidy. For example, a state could design a new per-member, per-month subsidy structure or modify an existing state subsidy structure. The new structure would still be required to meet the 1332 coverage, affordability and other guardrails and not increase an individual's out-of-pocket healthcare spending (CMS, 2018, pp. 8–12).

Adjusted Plan Options Waiver Concept

With the goal of increasing consumer choice and making coverage more affordable, the *Adjusted Plan Options* waiver concept would allow states to provide financial assistance for non-QHPs, as well as expand the availability of catastrophic plans beyond the current eligibility limitations. States would need to determine the standards and establish the requirements that a non-QHP would need to meet to be eligible for state subsidies, as well as demonstrate that it meets the statutory guardrails (CMS, 2018, pp. 13–19).

Account-Based Subsidies Waiver Concept

The *Account-Based Subsidies* waiver concept would allow states to direct public subsidies into a defined-contribution, consumer-directed account to provide more choices and more stable health coverage for beneficiaries, as well as incentives to make cost-conscious healthcare spending decisions through ownership and control of their healthcare resources. Funding for the account could come from waiving the federal PTC or the small business tax credit (SBTC) and may be supplemented by any already available state funds. Funding from other sources, such as individual and employer contributions, would also be allowed to aggregate in the account and the funds could then be used to pay for health insurance premiums and other healthcare expenses. This waiver concept could be combined with other waiver concepts, such as the *State-Specific Premium Assistance* waiver option and the *Adjusted Plan Options* to create innovative coverage choices. However, any waiver plan will need to meet the statutory guardrails, including affordability, especially for low-income populations and those with high healthcare costs (CMS, 2018, pp. 20–24).

Risk Stabilization Strategies Waiver Concept

States can use the *Risk Stabilization Strategies* waiver concept to address the high costs incurred by individuals with expensive medical conditions and ease the financial burden of those expenses on people who purchase coverage

in the individual market. For example, states can waive the single risk pool under 1312(c)(1) of the ACA and implement a state-operated reinsurance program or high-risk pool. States can structure the reinsurance programs in several ways, including a claims cost-based model,[2] a condition-based model,[3] or a hybrid model.[4] These programs can then be used with other waivers or reforms to lower premiums, improve market stability, and increase consumer choice. The states may be eligible to receive pass-through funding to apply to the reinsurance or high-risk pool if the program can reduce federal spending on the PTC that would otherwise apply (CMS, 2018, pp. 25–36).

State Waiver Activity

Of the 18 waiver applications that have been approved since 2017, 16 are for a waiver of Section 1312(c)(1)[5] of the Affordable Care Act, allowing the implementation of a state-operated reinsurance program to protect insurers from high costs incurred by beneficiaries with complex medical needs and reduce health insurance premiums, especially in the individual market (CMS, n.d.-a). In 2016, Hawaii was approved for a waiver of ACA Section 1311(b)(1)(B)[6] allowing the state to opt out of establishing a Small Business Health Options Program (SHOP), since this requirement would conflict with the state's Prepaid Health Care Act, which has been in place since 1974 and meets or exceeds the objectives of the ACA for employer-sponsored health coverage (Letter from CMS Acting Administrator Andrew Slavitt, 2016b). The state receives federal pass-through funding equal to the subsidies that the federal government would have provided to the state for operating the SHOP.

On June 23, 2022, the U.S. Department of Health & Human Services and the U.S. Department of the Treasury approved Colorado's waiver amendment application, allowing the state to waive ACA Section 1312(c)(1) and (c)(2) and implement a state-based standard health benefit plan to be offered on the state's Health Insurance Marketplace. Colorado will also continue to operate its state-based reinsurance program as per the original waiver agreement (Letter from CMS Administrator Chiquita Brooks-Lasure, 2022a).

Besides Colorado, several states submitted waiver applications that involved substantial changes to their state insurance markets, all of which were either withdrawn or deemed incomplete. For example, in 2017, California withdrew its waiver application that would have allowed undocumented immigrants to purchase coverage through Covered California, the state's health insurance marketplace (Letter from Covered California Executive Director Peter Lee 2017). Waiver applications from Massachusetts (Letter from CMS Deputy Administrator Randy Pate, 2017) to establish a premium stabilization fund, Ohio (Letter from CMS Deputy Administrator Randy Pate, 2018) to waive the individual mandate, and Vermont(Letter from Secretary of Health and Human Services Sylvia Burwell, 2016) to waive the requirement to establish a Small Business Health Options Program were deemed incomplete.

According to the CMS website, the goal of the Section 1332 State Innovation waivers is to give states the flexibility to design and implement "innovative strategies for providing residents with access to high quality, affordable health insurance."

In 2020, Georgia was approved for a two-part waiver. The first phase is for a state-operated reinsurance program starting in 2022. The second phase allows the state to withdraw from the federally facilitated exchange HealthCare.gov and establish a private sector platform called the Georgia Access Model beginning in Plan Year 2023. However, in April 2022, the state was notified that due to "changes in Federal Law, Policy and other circumstances" since the original approval, the state needs to submit additional documentation showing that the Georgia Access Model phase of the waiver still meets all of the required guardrails (Letter from CMS Administrator Chiquita Brooks-Lasure, 2022b).

2 In a claims cost-based model, issuers are reimbursed for a portion of the costs of enrollees whose claims exceed a certain amount (attachment point).
3 In a conditions-based model, insurers are reimbursed for costs of individuals with one or more pre-determined, high-cost conditions.
4 A hybrid model incorporates elements of the claims cost-based model and the conditions-based model.
5 Section 1312(c)(1) of the ACA is the requirement to consider all enrollees in a market to be part of a single risk pool.
6 Section 1311(b)(1)(B) of the ACA is the requirement for states to establish a Small Business Health Options Program (referred to as a "SHOP Exchange") that is designed to assist qualified small employers in the state in facilitating the enrollment of their employees in qualified health plans in the small group market.

In 2021, Hawaii and Colorado were approved for five-year waiver extensions. As of July 2022, Oregon, Alaska, and Wisconsin have applications pending to extend their current waiver, and Colorado and Maine have applications pending to amend previously approved waivers (CMS, n.d.-a). At least four states submitted waiver applications that were deemed incomplete, and three states withdrew previously submitted waiver applications (Howard, 2021). As of June 2021, at least seven states, including Texas, had enacted authorizing legislation but had yet to submit a 1332 waiver application to CMS (Pistor & Scotti, 2021).

Early Waiver Experience

In August 2021, CMS (2021b) published an overview of state-based reinsurance programs implemented as of Plan Year 2021. At the time of that report, 14 states had designed and implemented different reinsurance models, including claims cost-based models (CO, DE, MD, MN, MT, ND, NH, NJ, OR, PA, RI, WI); a conditions-based model (AK); and a hybrid conditions and claims cost-based model (ME). According to the report, states that have implemented Section 1332 state-based reinsurance waivers for the individual market have reduced statewide average second-lowest-cost silver plan premiums by an average of 14.1%, with a range of 3.75% to 41.17% relative to premiums absent the waiver over the Plan Years 2018 to 2021 (CMS, 2021b, Table 3).

Reinsurance programs have had additional benefits. For example, Colorado's reinsurance program reduced premiums by 20.9% in its first year (2020) for state residents who purchased insurance on the individual market and maintained a 20% premium reduction on average statewide in its second year (2021). Notably, rural areas of the state that historically have had the highest premiums saw the greatest reductions. The program was also credited with bringing stability to Colorado's individual health insurance market, with all insurers remaining in the market from 2019 to 2020 and one new insurer offering plans in 2020 (Letter from Colorado Commissioner of Insurance Michael Conway, 2021).

Alaska's reinsurance program reduced premiums by 38.5% on average in its first five years (2018 to 2022) for residents who purchased insurance on the individual market and also brought stability to the state's individual health insurance market, with an additional insurer re-joining the market in 2020. This was particularly important during the COVID-19 pandemic public health emergency as many residents lost employer-based insurance (Alaska Division of Insurance, 2022).

The Georgia reinsurance program has also successfully reduced premiums and stabilized the individual market. A total of 11 carriers (increased from 4 in 2019) now offer plans in the individual market with 5 new carriers entering the market in 2022. Almost 90% of counties have 3 or more carriers and 28% have 5 or more. Premiums were reduced 11.8% on average with the highest cost counties seeing the greatest reductions, and enrollment increased 26% in 2022 (Georgia Office of the Commissioner of Insurance and Safety Fire, n.d., 2022).

Hawaii's waiver of the ACA requirement to establish a SHOP and to continue operating the state's Prepaid Health Care Act has been successful and, as noted above, in 2021, the state received approval to extend the waiver (Novak et al., 2021; Letter from Hawaii Department of Labor and Industrial Relations, 2021).

1332 Waivers: An Opportunity for Texas

Like most states, Texas saw a dramatic increase in the cost of health insurance on the individual market following the implementation of the ACA insurance regulations. Average monthly premiums rose from $221 in 2013 to $521 in 2019, an increase of 136% (Haislmaier & Slagle, 2021). In addition, fewer health insurers offered individual health plans, especially in rural areas of the state (Haislmaier, 2018). It has been noted that Texans, including the uninsured, are "demographically and geographically diverse, making a one-size-fits-all approach to insurance reform unrealistic and therefore a variety of strategies should be considered" (Grubbs & Wright, 2020). Texas should consider using 1332 waivers as one component of a plan to stabilize and reform health insurance in the state.

Texas 1332 Waiver History

In 2017, Texas enacted two pieces of legislation authorizing 1332 waiver applications. SB 1406 (2017) authorized the Texas Department of Insurance (TDI) to apply for a 1332 waiver of the actuarial value requirements and related levels of health plan coverage requirements for small employer health benefit plans. SB 2087 (2017) allowed TDI to apply for a waiver under Section 1332 in order to use available federal funds to establish and administer a temporary health insurance risk pool. In 2019, SB 1940 (2019) was passed, extending the expiration date of the SB 2087 provisions until August 31, 2021.

In 2020, TDI retained NovaRest Actuarial Consulting to analyze the impact on the state of a Section 1332 waiver in order to "facilitate discussions with stakeholders regarding policy options to stabilize the Texas individual health

insurance market." The report modeled a number of scenarios for establishing a state-based reinsurance program, with varying impacts on coverage, affordability, availability of pass-through funding and cost responsibility to the state, depending on the model parameters.[7] A key takeaway in the report was the assessment that, according to the preliminary analysis, a state-based reinsurance program is "well aligned with Texas' goals of stabilizing the individual health insurance market and improving the affordability and accessibility of individual health insurance coverage in the state" (Novak et al., 2021).

Policy Options

The aim of Section 1332 is to allow states to consider a number of different policy options and innovative approaches, and Texas should consider using 1332 waivers as part of an overall plan to stabilize and reform the state's health insurance market. However, the regulatory constraints and procedural requirements involved in a waiver approval have been criticized as being overly restrictive and a barrier to real innovation (Badger & Haislmaier, 2018). Since 2017, relatively few truly innovative proposals have been submitted and, with few exceptions, successful waiver applications have been essentially limited to requests to use pass-through funding to establish state-based reinsurance programs.

In the *Section 1332 State Relief and Empowerment Waiver Concepts* discussion paper (CMS, 2018), CMS noted that, rather than dictating state options, the goal of releasing the waiver concepts was to encourage state innovation and illustrate some of the approaches that states might take if given adequate flexibility. The paper also clearly stated that any waiver proposal must meet the Section 1332 statutory requirements, including satisfaction of the four guardrails and would not be approved just because it is based on one of the concepts. Although the 2018 updated Section 1332 guidance (State Relief and Empowerment Waivers, 2018) was rescinded in 2021, CMS should support the goal of increasing flexibility and reducing barriers with respect to the manner in which a state plan may meet Section 1332 eligibility standards, in order to permit State Innovation Waivers to function as intended. CMS should work with states to design and implement truly innovative and sustainable programs that provide access to quality and affordable healthcare coverage.

As noted, reinsurance programs have shown the ability to lower health insurance premiums for health plans sold in the individual market, increase competition between private plans, and enable individuals previously priced out of the market to afford coverage. Texas should initially move toward stabilizing the individual health insurance marketplace by re-introducing legislation authorizing the TDI to apply for a 1332 waiver of the single risk pool under 1312(c)(1) of the ACA and implementing a state-operated reinsurance program or high-risk pool. An updated actuarial analysis that accounts for relevant current law will be needed to inform policymakers on how to best implement the program. Once the authorizing legislation is passed, Texas will need to complete the application process, including documentation that the proposed plan will meet the statutory guardrails. The state will also need to consider options for funding any costs of the program that may not be covered by pass-through federal funding.

In addition to stabilizing the individual market with the implementation of a state-based reinsurance program, Texas should pursue broader approaches to better meet the specific health insurance needs of Texans. CMS and the secretaries should work with the state and favorably consider waiver applications that advance some or all of the following objectives: improve coverage and affordability for all residents, including individuals with high healthcare costs and those with limited financial resources; reduce spending growth through increased choice and competition; incentivize value-based healthcare decisions by giving residents greater control of their healthcare resources; foster truly innovative and sustainable state-level reform. Texas should appoint a task force to examine the feasibility of using the Section 1332 waiver concepts discussed above, as well as other innovative options to pursue these overarching policy goals.

7 The NovaRest report did not model the impact of new federal subsidies made available under the American Rescue Act on a potential Texas 1332 reinsurance program.

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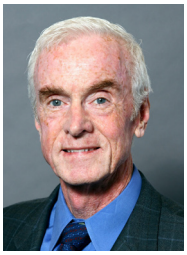

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