



Improving and Expanding Health Insurance Coverage through State Flexibility

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REPORT

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Table of Contents

3	Introduction
5	Opportunities for State Flexibility Using State Innovation Waivers
6	Overview of State Innovation Waivers (Section 1332)
7	Provisions Subject to State Innovation Waiver
10	Provisions That May Not Be Waived
11	Opportunities for State Flexibility using Waiver Authority under the Social Security Act
14	Recommendations
17	Conclusion
19	Endnotes

Introduction



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Recommendations

1. Advance new and innovative approaches to health insurance coverage by convening governors and the secretaries of Health and Human Services and Treasury to seek agreement on a reasonable interpretation of “guardrails” for Section 1332 State Innovation Waivers. The secretaries should issue guidance based on those convenings.
2. Define the guardrail requiring federal deficit neutrality to permit the requirement to be applied across programs waived (i.e., tax-credits and Medicaid), to demonstrate neutrality over the entire term of the waiver, and require strong standards to assure federal deficit neutrality.
3. Improve consumer choice and competition in insurance markets by implementing federal law permitting states to form interstate compacts to sell insurance across state lines (Section 1333 of the Affordable Care Act).
4. Assure access to affordable coverage for spouses and children by fixing the so-called “family glitch” and fully offsetting the cost at the federal level.

The Affordable Care Act (ACA) has been the subject of controversy since its enactment in March 2010. Over the past six years, the ACA has faced legal challenges, problems with its first open-enrollment period, votes to repeal or defund the law in whole or in part, and opposition by many state legislatures and governors. Further, polls continue to show deep divisions in public opinion on the law.ⁱ

Despite the controversy, an additional 13.2 million individuals have enrolled in Medicaid and the Children's Health Insurance Program (CHIP).¹ Some of the new enrollment is the result of states expanding coverage to "newly eligible" individuals; however, many were previously eligible but not enrolled.² Further, an estimated 8.3 million individuals purchasing health insurance coverage through state and federal health insurance exchanges received federal financial assistance in the form of tax credits or cost-sharing assistance.³

Although dozens of bipartisan changes to the ACA have been enacted since the ACA was signed into law,⁴ most have been clarifying amendments, or changes designed to provide offsets for other legislation, such as extensions of expiring Medicare provisions.⁵ Some changes have been more substantive. For example, in 2011, Congress passed legislation and the president signed into law, a repeal of business reporting requirements to the Internal Revenue Service (IRS).⁶ In October 2015, a law was enacted to block implementation of a provision combining small- and mid-sized employers into a single insurance market.⁷ Business and insurance industry experts estimated the combining of these two employers would have resulted in insurance premium increases for both groups of employers.⁸ The prospects for repeal or major modifications to the law are slim before a new president and Congress take office in January 2017. There remain in addition, however, important opportunities to influence policymaking at the agencies and to focus on the states as a frontier for innovation and reforms in health care.

ⁱ RWJF Tracking of the ACA, September 2015: 45 percent unfavorable, 41 percent favorable. Question: "As you may know, a health reform bill was signed into law in 2010. Given what you know about the health reform law, do you have a generally favorable or generally unfavorable opinion of it?"

Opportunities for State Flexibility using State Innovation Waivers



The Bipartisan Policy Center's (BPC) health leaders agree on several principles, including the importance of: (1) expanding coverage to the uninsured; (2) reducing health care costs; and (3) improving the quality of health care delivery. Achieving these goals will require changes in the law. Given the ongoing discord, BPC's leaders encourage dialogue among federal and state policymakers to identify opportunities to maintain and expand coverage, simplify administration, and provide increased choice to families and individuals through increased state flexibility.

Significant opportunities (and limitations) to advance this dialogue lie with the ACA itself. Section 1332 of the ACA, based on a provision in bipartisan legislation offered by Senators Ron Wyden (D-OR) and Bob Bennett (R-UT),⁹ permits states to test alternative means of providing coverage while upholding the principles of

expanding coverage, reducing costs, and improving quality of care.

This paper outlines Section 1332 of the ACA, including its opportunities and limitations. This paper also discusses the potential of 1332 and its interactions with Section 1115 of the Social Security Act (SSA), a waiver authority that allows states to expand Medicaid coverage with certain restrictions, and Section 1115A, which offers opportunities for delivery system reform. This paper describes BPC leaders' recommendations on the implementation of Section 1332 and other provisions of the ACA that are designed to make health insurance more affordable and to improve consumer choice in health plans, such as the implementation of laws permitting interstate compacts to improve choice in health insurance plans and fixing the "family glitch." These proposals are outlined in the following pages.

Overview of State Innovation Waivers (Section 1332)



Beginning in 2017, states will have the opportunity to test alternative health insurance coverage models through State Innovation Waivers, authorized under Section 1332 of the ACA. Section 1332 gives states the opportunity to redesign health care delivery by permitting states to request waivers of certain provisions of law related to the structure of health insurance markets. These waivers must adhere to four constraints, or “guardrails,” required by the law. Section 1332 was included in the Senate Finance Committee chairman’s mark, which was considered and reported by the Finance Committee. Citing his home state of Oregon, Senator Wyden indicated that innovation in health care typically comes from the states, and the provision was designed to encourage and support that innovation.¹⁰

Although the waiver offers states broad discretion in reforming

their health care delivery systems, the statute also requires that a state’s suggested reforms meet certain requirements or guardrails, which include:

- Providing coverage that is at least as comprehensive as the Essential Health Benefits package;
- Providing coverage and cost-sharing protections that are at least as affordable as under current law;
- Providing coverage to at least a comparable number of residents; and
- Not increasing the federal deficit.¹¹

The secretaries of Health and Human Services (HHS) and Treasury released a final rule governing the application process under

Section 1332 on February 27, 2012; however, the rule did not address how the guardrails would be interpreted.¹²

States may submit applications for waiver authority provided under Section 1332 along with waivers available under Medicare, Medicaid, and CHIP, and any other federal law providing health care items or services.¹³ Although waivers may be combined, Section 1332 does not change existing waiver authorities. For example, should a state choose to submit a single application combining a Section 1332 waiver with a Medicaid waiver using authority under Section 1115 of the Social Security Act, existing requirements under Section 1115 would apply.

Under the law, states would have access to the same amount of revenue that would otherwise have been available to residents of the state in the form of small-business tax credits, premium tax credits, and cost-sharing assistance. Each year, the HHS secretary would determine the aggregate amount of those subsidies, and those amounts would be available to the state.¹⁴

According to some policy analysts, Section 1332 has the potential to be a significant and unpredictable game-changer of federal and state health care policy, a “super waiver” for states to explore new frontiers.¹⁵ Section 1332 offers an enormous amount of technical and political opportunity to bridge the divide over major provisions of the ACA.¹⁶ However, other analysts argue that Section 1332 is not broad enough, that the states will need to enact more substantial changes than the waiver permits, and that it does not allow states to waive some of the ACA’s more costly requirements.¹⁷

In recent months, a number of states have begun considering options under the law. Among the ideas are ways to increase enrollment to promote sustainability in the individual insurance market, streamlining the operations of state-based insurance marketplaces, and considering how to mitigate the impact of premium and cost-sharing requirements for lower-income populations.¹⁸

When combined with other waiver authorities, states could have significant flexibility to test new ways to provide access to quality health care to their residents. Whether Section 1332 provides sufficient flexibility or is too restrictive remains to be seen and will depend on how the guardrails are interpreted by federal agencies. Implementation of Section 1332 will require an open dialogue between states and the federal government, a willingness to consider new ideas, and leadership at both the state and federal levels.

Provisions Subject to State Innovation Waiver

Section 1332 permits waiver of the following provisions:

1. Qualified Health Plan (QHP) Requirements¹⁹

QHPs must meet certain requirements to be offered through the state or federal health insurance exchange (now marketplace). Under current law, QHPs must:

- Be certified or recognized by each exchange through which the plan is offered;
- Provide essential health benefits;
- Be offered by an insurer licensed in each state in which the plan is offered;
- Must be offered at the silver level and the gold level in each exchange the QHP issuer offers coverage;
- Charge the same premium rate whether offered through the exchange or outside the exchange.²⁰

2. Essential Health Benefits (EHB)

Non-grandfathered plans in the individual and small-group markets both inside and outside of the marketplaces must include the ten statutorily defined EHB, which include:

- Ambulatory patient services;

- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance-use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.²¹

In defining the benefits, the HHS secretary must meet a series of requirements relating to the scope of benefits, balance among categories of benefits, non-discrimination provisions, and other requirements.²² In addition, the law sets requirements relating to annual limits on cost-sharing and on deductibles for employer-sponsored plans, establishes levels of benefits (i.e., bronze, silver, gold, and platinum), and permits the purchase of catastrophic health insurance plans for certain populations.²³

Under federal regulation, states may define EHB by choosing one of the following four types of health plans (at least through plan year 2017):

- The largest plan by enrollment in any of the three largest small-group insurance products in the state's small-group market;
- Any of the largest three state employee health benefit plans by enrollment;
- Any of the largest three national Federal Employees Health Benefits Program plan options by enrollment; or
- The largest insured commercial non-Medicaid Health Maintenance Organization operating in the state.²⁴

3. Rules Governing Health Insurance Exchanges

The ACA sets forth criteria for the establishment of health insurance exchanges and related exchange functions. The HHS secretary established criteria for certification of health plans as QHPs such as:

- Meet marketing requirements;
- Ensure a sufficient choice of providers;
- Include within plan networks essential community providers that serve predominately low-income medically underserved individuals;
- Meet quality and data requirements, including those regarding pediatric quality;
- Be accredited by the secretary;
- Use standard enrollment forms;
- Use standard format for health plan options; and
- Provide information to enrollees and prospective enrollees and the exchange on certain quality measures.²⁵

4. Reduced Cost-Sharing for Individuals Enrolling in QHPs²⁶

QHPs must reduce cost-sharing for lower-income individuals enrolled in a silver-level qualified health plan by reducing out-of-pocket spending limits and by decreasing the cost-sharing amounts.

For eligible individuals with incomes between 100 and 250 percent of poverty, the out-of-pocket cost-sharing limit for in-network coverage of EHB is reduced as follows:

- 100–200 percent of FPL: 2/3 reduction
- 201–250 percent of FPL: 1/5 reduction
- 251 percent of FPL and above: No reduction²⁷

Plans must also increase the actuarial value of plans for certain populations adjusted by family size:

- 94 percent for individuals with incomes from 100–150 percent of FPL;
- 87 percent for individuals with incomes from 151–200 percent of FPL; and
- 73 percent for individuals with incomes from 201–250 percent of FPL.

5. Premium Tax Credits²⁸

Premium tax credits are available to taxpayers (1) with household incomes between 100 percent and 400 percent of the FPL (\$11,670–\$46,680 for an individual in 2015); (2) who may not be claimed as a dependent by another taxpayer; (3) who purchase coverage through the marketplace; and (4) who are unable to get affordable coverage through employment or through government programs.²⁹

The premium tax credit is calculated using the amount the individual should be able to pay for the premium of the second-lowest priced silver plan available to each member of the household (the “benchmark plan”). The expected contribution, adjusted annually after 2014, is calculated as a percentage of the individual’s household income as follows for taxable years starting in 2015:

- Less than 133 percent of FPL: 2.01 percent
- At least 133 but less than 150 percent of FPL: 3.02–4.02 percent
- At least 150 but less than 200 percent of FPL: 4.02–6.34 percent
- At least 200 but less than 250 percent of FPL: 6.34–8.10 percent

- At least 250 but less than 300 percent of FPL: 8.10–9.56 percent
- 300 to 400 percent of FPL: 9.56 percent³⁰

Eligible individuals may choose to have the tax credit paid directly to their insurer in advance so that monthly premiums are lowered, or the eligible individual can claim the credit when the eligible taxpayers files their tax return for the year. If the individual chooses to have the tax credit paid in advance, the amount of the tax credit will be reconciled when they file their tax return.³¹

6. Employer Requirement³²

The ACA requires large employers to offer affordable, minimum-value health coverage to their full-time employees (and dependents) or pay a penalty. Large employers are those with at least 50 full-time employees (including full-time equivalents) during the preceding year. For 2015, large employers are defined as those with at least 100 full-time employees. Employers with 50–99 full-time employees (including full-time equivalents) have until 2016 to comply.³³ Employers must pay a penalty if at least one full-time employee receives a premium tax credit or cost-sharing reduction.

7. Individual Requirement³⁴

Beginning in 2014, the ACA requires that most individuals obtain minimum essential coverage for themselves and their dependents or pay a penalty.³⁵ Minimum essential coverage is generally defined as government-sponsored or private health insurance. The penalty is the greater of a percentage of the individual’s household income that exceeds the tax-filing threshold for that tax year or a flat-dollar amount.³⁶ The percentage of household income is 2 percent for 2015 but increases to 2.5 percent for 2016 and beyond, and the flat-dollar amount increases each year from \$325 in 2015 to \$695 in 2016. So, for example, in 2015, the penalty would be the greater of 2 percent of yearly household income (only above \$10,150 for an individual) or \$325 per person (\$162.50 per child under 18).

The maximum penalty per family, however, cannot be more than the cost of the national average bronze-level plan (for the relevant family size) offered through the marketplaces.

There are certain individuals who are exempt from the mandate:

- Members of a recognized religious sect who are conscientiously opposed to medical care;
- Members of a health care sharing ministry;
- Individuals who are incarcerated; and
- Individuals who are not lawfully present.

Other individuals who are subject to the mandate but exempt from the penalty:

- Individuals who cannot afford coverage (self-only coverage contribution exceeds 8.05 percent of household income);
- Individuals who have household income less than the filing threshold for federal income taxes;
- Members of Indian tribes;
- Individuals who lose coverage for less than three months;
- Individuals who the HHS secretary determines have suffered a hardship (these individuals are eligible for catastrophic coverage).³⁸ HHS has identified some hardships, including individuals that are not eligible for Medicaid because their state did not opt to expand the Medicaid program.³⁹

Individuals will report whether they have maintained minimal essential coverage annually on their federal income tax returns. In addition, every entity that provides minimum essential coverage must present a return to the IRS as well as a statement to the individual covered.⁴⁰

Provisions That May Not Be Waived

Other than provisions expressly listed under Section 1332 as subject to waiver, no other provisions of the ACA may be waived as part of the Waivers for State Innovation. For example, states would not be able to waive the following private insurance market reforms:

- Prohibiting plans from imposing preexisting-condition exclusions;
- Prohibiting plans from varying premiums within a rating area except for family size, age, and tobacco use. Age variation is limited to 3:1 and tobacco use by 5:1;
- Requiring plans to guarantee issue and guarantee renewal of policies;
- Prohibiting discrimination based on health status;
- Requiring coverage of EHB in the individual and small-group marketⁱⁱ; and
- Limiting waiting periods to no longer than 90 days.

The inability of states to waive insurance market reforms, have led some analysts to conclude that states will have difficulty maintaining stable insurance markets, while at the same time waiving some of the more controversial aspects of the law. For example, if a state would like to develop an approach that eliminated the individual requirement to purchase insurance coverage and, instead, implement a late-enrollment penalty similar to the structure applied in Medicare parts B and D, the inability to waive premium-rating requirements would likely prevent states from implementing the penalty.

ⁱⁱ ACA Section 1201 amended the Public Health Service Act by adding section 2707, which applies the EHB requirement in ACA section 1302(a) (which is subject to a 1332 waiver) to all insurers in the individual or small-group market, both inside and outside the marketplace.

Opportunities for State Flexibility using Waiver Authority under the Social Security Act

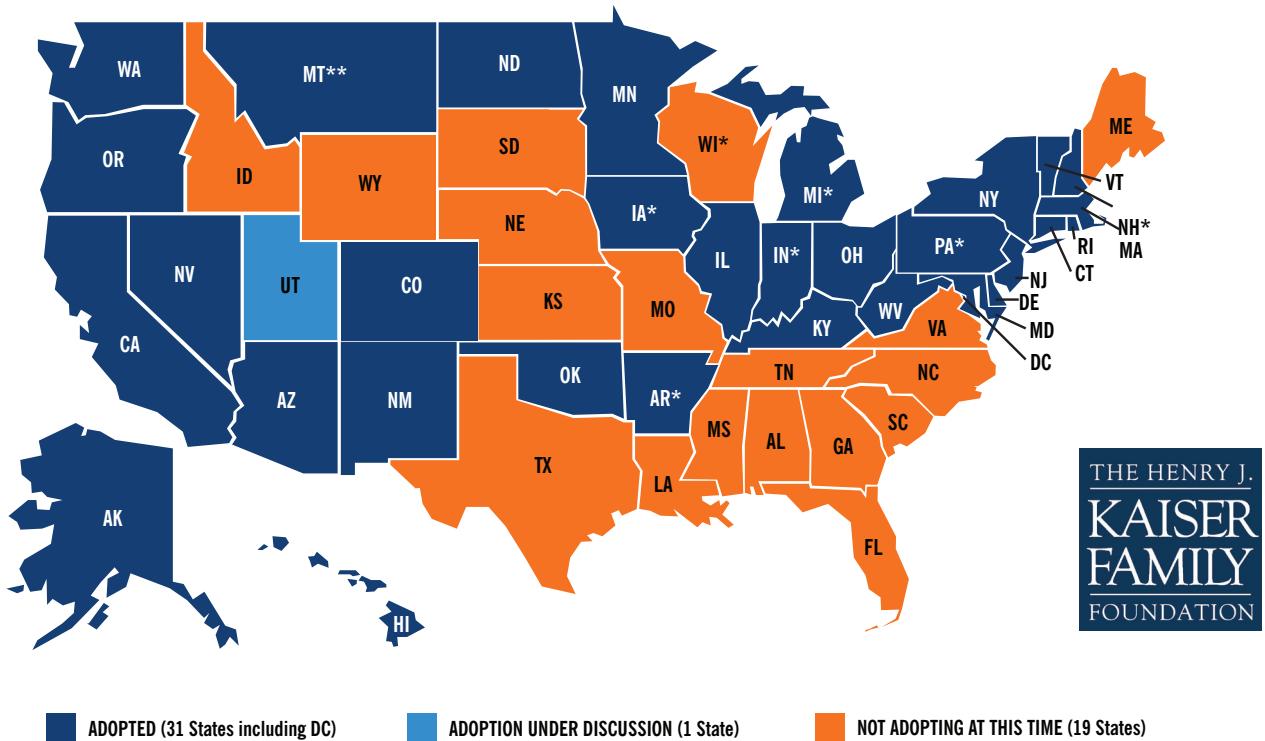


States may combine the application process for State Innovation Waivers (Section 1332) with the processes of any existing health program waiver authority such as Medicaid waivers using Section 1115 of Social Security Act (SSA) or models tested through the Center for Medicare and Medicaid Innovation (CMMI) (Section 1115A of SSA). Medicaid waivers under Section 1115 are one of the most likely candidates to be included in a combined application with Section 1332. States have commonly utilized research and demonstration authority under Section 1115 of the SSA to expand Medicaid eligibility and to make other changes to state Medicaid programs. Section 1115 permits waivers of health and welfare programs authorized under the SSA, including Medicaid and CHIP.⁴¹ A research and demonstration waiver under Section 1115 must further the goals of the program in order to be approved by the

secretary. Upon approval, states may use funds for purposes not otherwise permissible under the law, such as covering individuals not traditionally eligible for Medicaid.⁴² Section 1115 permits states to seek waivers of Section 1902 of the Medicaid program, which establishes federal requirements for a state plan for medical assistance, such as eligibility, benefits, payments to providers, enrollment requirements, fair hearings, program administration requirements, and other provisions.⁴³

Historically, the secretary of HHS has required 1115 waivers to be budget neutral; however, this is not required by statute or by regulation. Some states have used Section 1115 of the SSA to improve the scope of benefits or to expand eligibility to individuals who would not otherwise qualify, while others have used Section 1115 to limit eligibility or benefits, such as providing a limited set

Figure 1. Current Status of State Medicaid Expansion Decisions



*Notes: Current status for each state is based on KCMU tracking and analysis of state executive activity. **MT has passed legislation adopting the expansion; it requires federal waiver approval. *AR, IA, IN, MI, PA and NH have approved Section 1115 waivers. Coverage under the PA waiver went into effect 1/1/15, but is transitioning coverage to a state plan amendment. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.*

of benefits, setting limits on enrollment, or seeking changes in beneficiary cost-sharing.⁴⁴

Since the Supreme Court ruling in NFIB v. Sebelius,⁴⁵ which essentially made the ACA provision expanding Medicaid coverage to individuals with incomes up to 138 percent of the FPL optional for states, Section 1115 has become a means of permitting states that chose not to expand Medicaid under the ACA to provide coverage to certain low-income populations. Likewise, some states have used Section 1115 waivers to make changes to impose premiums and cost-sharing. Currently 30 states and the District of Columbia have expanded Medicaid coverage, either by a state plan amendment or through Section 1115.⁴⁶

Source: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated September 1, 2015. <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>

The ACA added a new section 1115A under the SSA, creating the CMMI to test new models of health care delivery and reimbursement. A number of states have included delivery system reforms in new demonstrations.⁴⁷ CMMI has the authority to “test innovative payment and service delivery models to reduce program expenditures under Medicare and Medicaid while preserving or enhancing the quality of care furnished to individuals under such titles.”⁴⁸

Although 1115A provides broad authority to CMMI to test innovative delivery models, the law directs the HHS secretary to “give preference to models that also improve the coordination, quality, and efficiency” of care for Medicare beneficiaries, Medicaid beneficiaries, and dual eligibles.⁴⁹ The law cites a number of

delivery models, including accountable care organizations and patient-centered medical homes, among others.⁵⁰

A number of states have expressed interest in testing new models of care. And a number of states have actively begun testing new models of health care delivery under Section 1115A.⁵¹ Arkansas, for example has begun implementation of a patient-centered medical home model through the Center for Medicare and Medicaid Services (CMS) State Innovation Models Initiative. Among the states awarded funding to test models in the initial round are Arkansas, Maine, Massachusetts, Minnesota, Oregon, and Vermont.⁵² These and similar waivers will likely be used in combination with Section 1332 waivers to test new reimbursement models.

Recommendations



Recommendation 1:

Advance new and innovative approaches to health insurance coverage by convening governors and the secretaries of Health and Human Services and Treasury to seek agreement on a reasonable interpretation of “guardrails” for Section 1332 State Innovation Waivers. The secretaries should issue guidance based on those convenings.

States’ ability to use Section 1332 depends largely on how the four guardrails are interpreted by the secretaries of HHS and Treasury, as well as the director of the Office of Management and Budget. States need clear guidelines. Governors play an integral part in

the implementation of a state’s health care delivery system and health care budget. Their expertise should be used to negotiate how the guardrails are defined to accomplish the goals of the ACA while still allowing states the flexibility to reform their health care systems to fit the needs of their citizens while maintaining fiscal viability. Guardrails should be interpreted to foster state innovation, permitting new approaches to health insurance coverage that can be adopted by other states or applied at the federal level. Toward that end, the secretaries of HHS and Treasury should convene discussions with governors to negotiate and define guardrails, and the secretaries should issue regulations based on that convening.

Recommendation 2:

Define the guardrail requiring federal deficit neutrality to permit the requirement to be applied across programs waived (i.e., tax-credits and Medicaid), to demonstrate neutrality over the entire term of the waiver, and require strong standards to assure federal deficit neutrality.

As part of the negotiations between federal and state officials, the guardrails should be designed in a way that permits flexibility for states in designing alternative health insurance and delivery models, while also assuring that those models do not add to the federal deficit. Strong safeguards should assure federal deficit neutrality. At the same time, deficit neutrality should be applied across the provisions of law that have been waived. For example, if the state seeks to combine 1115 waivers and Section 1332 waivers in a single waiver request, the impact on the federal deficit should be calculated across these programs instead of individually within each program.

Calculating budget neutrality across programs gives states the flexibility to be creative in designing proposals to provide high-quality health care coverage to their residents while still maintaining fiscal responsibility. In doing so, the secretary and the state should ensure that such coordinated calculations and proposals assure full and appropriate health coverage to the state's lower-income citizens before moving to assist those with higher incomes. Similar to existing 1115 waivers, for the purposes of determining impact on the deficit, the secretary should assume that the state expanded Medicaid pursuant to the ACA, provided the state covers these individuals in the waiver. Deficit neutrality should be calculated over the full five-year term of the waiver rather than on a yearly basis to permit states to make necessary investments in infrastructure and to address unmet needs of currently eligible individuals, including those with mental illness.

Recommendation 3:

Improve consumer choice and competition in insurance markets by implementing federal law permitting states to form interstate compacts to sell insurance across state lines (Section 1333 of the ACA).

At least 22 state legislatures have considered permitting the sale of insurance across state boundaries to increase competition and coverage options, but only six have enacted legislation.⁵³ Those states include Rhode Island, Washington, Wyoming (prior to passage of the ACA), Georgia, Kentucky, and Maine.⁵⁴

Section 1333(a) permits two or more states to form health care choice interstate compacts in which the states enter into an agreement under which qualified health plans could be offered in all participating states' individual markets, subject to regulation by the state in which the plan was written or issued. Insurers will be subject to the market conduct, unfair trade practices, network adequacy, consumer protection, and dispute-resolution standards of any state in which the insurance was sold; must be licensed in each state; and must notify consumers that the insurer is not otherwise subject to the laws of the selling state.⁵⁵

States should have the option of permitting the sale of insurance across state lines. This is especially important in states with rural or frontier areas in which residents have limited choices. Recent consolidation in the insurance industry has the potential to further limit those choices. This policy, however should assure that state insurance commissioners have the ability to enforce regulations and contracts between carriers, employers, and plan enrollees in their states.

Section 1333 required the secretary of HHS, in consultation with the National Association of Insurance Commissioners (NAIC), to issue regulations regarding health care choice compacts by

July 1, 2013. No such regulations have been issued and these compacts are scheduled to take effect beginning January 1, 2016. The secretary should work with NAIC to create regulations that establish standards and best practices as well as oversight of these interstate compacts.

138 percent of FPL will not have access to Medicaid if they fall in the glitch.⁵⁸ The cost of addressing the family glitch should be offset at the federal level.

Recommendation 4:

Assure access to affordable coverage for spouses and children by fixing the so-called “family glitch” and fully offsetting the cost at the federal level.

Under the ACA, individuals with access to employer-sponsored health insurance are not eligible for premium and cost-sharing subsidies to purchase health insurance coverage through the state or federal marketplaces. An exception applies if the employer's coverage is not “affordable.” A premium is affordable under the ACA if the premium cost to the employee is less than a specific percentage of the employee's household income, currently 9.56 percent. The affordability test is based on the cost of the premium for only *individual* coverage not for that of *family* coverage. Under this interpretation, no family member qualifies for federal subsidies through an exchange, even if the cost of family coverage exceeds 9.56 percent of the family's income, resulting in what is known as the “family glitch.” Congress should address this issue to assure that spouses and children of workers have access to affordable coverage.

Estimates of the number of family members affected by the family glitch vary between two to four million.⁵⁶ Those adults most affected would be workers in the lowest 25 percent wage category, as they typically pay a higher portion of their income to obtain employer-sponsored coverage than those workers in the highest 25 percent wage category.⁵⁷ The number of people affected would be higher in those states that have not expanded Medicaid through the ACA's expansion option because families with incomes between 100 and

Conclusion



Controversy around the enactment, implementation, and repeal of the ACA will continue in the near-term and could continue well into the next decade. The use of Section 1332, which is designed to permit states the flexibility to implement alternatives, has the potential to allow states to expand coverage, make health insurance more affordable, and improve consumer choice in health plans. The ability of states to effectively utilize this option will depend on the interpretation of this Section by federal policymakers.

Changes should be made to improve the availability and affordability of health insurance. Allowing states to form interstate compacts has the potential to increase choice of plans, while at the same time assuring state insurance

commissioners have the ability to enforce state insurance laws. Likewise, fixing the family glitch will permit greater access to affordable coverage through state and federal marketplaces, if coverage offered to the employed spouse or parent is unaffordable. Policymakers should acknowledge the tremendous variation in health care delivery that can work from state to state, and Section 1332 can serve as a critical tool in allowing states to test alternatives. Lessons learned may ultimately lead to additional bipartisan modifications to the law. The ACA should permit variation consistent with the principle that individuals should have access to meaningful, quality, and affordable health insurance coverage.

End Notes

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